

VERSION 2.0 WORK IN PROGRESS: Emergency Preparedness Expert Panel Summary December 17, 2019



The Public Health Accreditation Board is a 501(c)3 nonprofit organization dedicated to improving and protecting the health of the public by advancing and transforming the quality and performance of governmental public health agencies in the U.S. and abroad.



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The Public Health Accreditation Board (PHAB) held an Emergency Preparedness Expert Panel Meeting on December 17, 2019 at the Task Force for Global Health in Decatur, GA. The purpose of the expert panel was to review the current health department accreditation standards and measures related to emergency preparedness; to discuss any pertinent changes to emergency preparedness practice and/or support for health department work in this area; and to recommend potential revisions in the accreditation standards and measures as PHAB prepares Version 2.0.

Among the items discussed at the expert panel meeting were CDC's Public Health Emergency Preparedness and Response (PHEP) requirements; the PHEP/Accreditation Standards alignment Matrix; Project Public Health Ready (PPHR) and Potential for Reciprocity; and discussion of both current and emerging issues in emergency preparedness and response.

Overarching Recommendations for Proposed Changes to the PHAB Standards and Measures

- PHAB and NACCHO should work together to explore the establishment of a formal agreement about reciprocity for PPHR recognition for those local health departments that have recently obtained that status or are in active status (over 500 to date). The time frame for PPHR is five years.
- Administration and management of a health department should include consistency in maintaining capacity and competency in emergency preparedness and response. This concept should be referred to the Administration/Management Think Tank for consideration in Domain 11. NACCHO has done work on the concept of administrative preparedness.
- PHAB should be cautious in developing requirements related to community resilience because, while it is related to prevention, it is still ill-defined. However, community resilience is an important concept that goes beyond emergency preparedness, and PHAB can help to further define it as part of the overall Version 2.0 work.
- The operationalization of "community resilience," while a vital community capacity, requires the additional development of definition, models, and tools.
- Inclusion or integration of health impact assessment efforts and capacity should be considered.
- Incident management is an important concept that should be added. Defining public health recovery is challenging

because health department mission and authorities can vary from jurisdiction to jurisdiction and also may change depending upon the type of public health threat or emergency. PHAB should be flexible in the requirements for this area of responsibility.

- A potential measure that requires health departments to strengthen linkages between the health department and other governmental units would apply to emergency preparedness. Greater collaboration between emergency preparedness and other units of the health department was also recommended.
- For reaccreditation, a new requirement for a jurisdictional risk assessment (JRA) is recommended. Public health departments should participate with others during the JRA process. This would include legal, emergency management, healthcare system, local NGOs and stakeholder groups, mental/behavioral health, environmental health, etc.
- Refer updated requirements related to social media use in emergency preparedness to the Communication Science Expert Panel.
- Add the PHEP/Accreditation Alignment Matrix to PHAB's resources and market it in PHAB's newsletter when it is released. It is a valuable tool for health departments working on accreditation or reaccreditation.
- Review states' roles in emergency preparedness and consider adding state specific measures, including state support or the state role vis-à-vis local health departments and tribes, if relevant.
- Public health emergency law is an emerging body of work that should be mentioned in Domain 6. Similarly, emergency preparedness ethics could be referenced in the ethics measure in Domain 11.

Recommendations for Proposed Changes to the PHAB Standards and Measures

- Measure 2.2.2 should be moved to Domain 5 with the Emergency Operations Plan (EOP) for clarity and flow. Part of the EOP development process should include the process for determining when the EOP is implemented.
- Measure 5.4.1 and 5.4.2 requirements for an All-Hazards Emergency Operations Plan (EOP) is realistic, but some clarifications are in order, given the nature of changes in the functioning of health departments since Version 1.5 was developed. Those changes include:
 - The EOP should be the health departments' emergency operations plan and not the emergency management agency's plan. In order to clarify this aspect, PHAB could ask the health department to describe their statutory mandates/authorities; the process of the development of the plan; their partnerships to carry out those mandates; and their overall jurisdictional role. Following those descriptions, the health department's EOP should be required to address those elements. PHAB should add to the guidance where ESF 8 (FEMA) aligns with the measure requirements. Typical categories would be prevention, recovery, and mitigation, as examples. There are also six key areas in an EOP according to FEMA (Communication; Resources and Assets; Safety and Security; Staff Responsibilities; Utilities Management; Patient and Clinical Support Activities; and Regular Testing and Evaluation). The health department's role in incident command should also be included in the EOP. The EOP might not cover everything; sometimes, the EOP is a higher-level strategic document, with operational details occurring in other documents or annexes.
 - A separate measure could then ask where the health department fits into the overall jurisdictional emergency management plan and how it works with the jurisdiction's lead

organizations on emergency management. To be consistent with the PPHR guidelines, PHAB should consider asking the following:

- If the health department is not the lead agency for a particular task, a description of the following should be provided:
 - Identification of the lead agency and their roles and responsibilities
 - Description of the support roles and responsibilities of the health department
 - Description of how the health department partners with the lead agency to plan for, and prepare to deliver the emergency services
 - Description of the health department's coordination and communication process for supporting the work of the lead agency
 - Description of how the health department will work with the lead agency during or following an emergency response
 - An example of how this collaboration has worked in the past, how it was exercised, or how it is addressed in the health department workforce development plan; and if applicable, description of the authority or documentation formalizing the relationship with the lead agency (e.g., mutual aid agreements, contracts, regulatory obligations).
- The requirement for an After Action Report (AAR) is only good if they are required to follow the exercise cycle and a question is asked about what was done with the learning from that debriefing. The requirement should relate to debriefing an actual event and/or a planning, exercise, and improvement drill. This could also be related to Domain 9 and could be an example of a QI project. The improvements may not result in a change in the EOP itself, so RD 3 under Measure 5.4.1 should be broadened.
- The language regarding continuity of operations in Measure 5.4.2 is weak and should be strengthened.
- Measure 5.4.3 for State Health Departments should address their role in developing and implementing/regulating crisis standards of care. Part of this role includes review of laws and authorities about the provision of care in response to an emergency and is typically a State Health Department function.

Recommendations Regarding Terminology and Definitions

Current Terms in PHAB Glossary	Existing Definition	Proposed Definition/ Recommendation/Notes
All-hazards EOP	An emergency operations plan is a document that assigns responsibility to organizations and individuals for carrying out specific actions at projected times and places in an emergency that exceeds the capability or routine responsibility of any one agency; sets forth lines of authority and	Keep as is. FEMA has not updated this definition.

	<p>organizational relationships, and shows how all actions will be coordinated; describes how people and property will be protected in emergencies and disasters; identifies personnel, equipment, facilities, supplies, and other resources available--within the jurisdiction or by agreement with other jurisdictions--for use during response and recovery operations; and identifies steps to address mitigation concerns during response and recovery activities. As a public document, an EOP also cites its legal basis, states its objectives, and acknowledges assumptions.</p> <p>(http://www.fema.gov/pdf/plan/slg101.pdf)</p>	
After Action Report	<p>An After Action Report is a narrative report which captures observations of an exercise (for example: table top, functional exercise, or full scale exercise) and makes recommendations for post-exercise improvements; this is supplemented by an Improvement Plan (IP), which identifies specific corrective actions, assigns them to responsible parties, and establishes targets for their completion. (Adapted from: US Department of Homeland Security. Exercise and Evaluation Program (HSEEP) Volume 1: HSEEP Overview and Exercise Program Management. Washington, DC: The Department; 2007)</p>	<p>Keep the definition but add a reference to the HSEEP format.</p> <p>https://emergency.cdc.gov/training/ERHMScourse/pdf/127961885-Hseep-AAR-IP-Template-2007.pdf</p>
Community Resilience	<p>Community resilience is a measure of the sustained ability of a community to utilize available resources to respond to, withstand, and recover from adverse situations.</p> <p>(http://www.rand.org/topics/communityresilience.html)</p>	Keep as is.
Emergency	<p>An emergency is any natural or manmade situation that results in injury, harm, or loss to humans or property. (Turnock, BJ. Public Health: What It Is and How It Works. Jones and Bartlett. 2009)</p>	Keep as is.

Public Health Emergency	<p>A public health emergency is an occurrence or imminent threat of an illness or health condition, caused by bioterrorism, epidemic or pandemic disease, or novel and highly infectious agent or biological toxin, that poses a substantial risk of a significant number of human fatalities or incidents of permanent or long term disability. Such or health condition includes, but is not limited to, an illness or health condition resulting from a natural disaster. (Gostin, L.O., et al. The Model State Emergency Health Powers Act: Planning for and Response to Bioterrorism and Naturally Occurring Infectious Diseases, JAMA 2002: 288: 622.)</p>	<p>Keep the definition but add the following: The Secretary of the Department of Health and Human Services (HHS) may, under section 319 of the Public Health Service (PHS) Act, determine that: a) a disease or disorder presents a public health emergency (PHE); or b) that a public health emergency, including significant outbreaks of infectious disease or bioterrorist attacks, otherwise exists.</p> <p>https://www.phe.gov/emergency/news/healthactions/ph/Pages/default.aspx</p>
Public Health Preparedness	<p>Public health preparedness is the ability of the public health system, community, and individuals to prevent, protect against, quickly respond to, and recover from health emergencies, particularly those in which scale, timing, or unpredictability threatens to overwhelm routine capabilities. Activities focus on protecting and improving the overall health of communities and include:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Monitoring and investigating health threats (surveillance and disease detection) <input type="checkbox"/> Communicating critical information with public health officials at local, state, and federal levels <input type="checkbox"/> Building and operating laboratories with capabilities to identify disease agents, toxins, and other health threats <input type="checkbox"/> Operating and maintaining the Strategic National Stockpile of critical medical assets for rapid deployment to states <input type="checkbox"/> Developing, practicing, and improving emergency response plans at state and local public health departments to ensure rapid and effective responses to real health security threats (http://www.cdc.gov/phpr/whatcdcdoing.htm) 	<p>Public health emergency preparedness (PHEP) is the capability of the public health and health care systems, communities, and individuals, to prevent, protect against, quickly respond to, and recover from health emergencies, particularly those whose scale, timing, or unpredictability threatens to overwhelm routine capabilities. Preparedness involves a coordinated and continuous process of planning and implementation that relies on measuring performance and taking corrective action.</p> <p>https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1854988/#__sec5title</p>

Risk Assessment	<p>Risk assessment is a process used to formally assess the potential harm due to a hazard taking into account factors such as likelihood, timing, and duration of exposure. (Riegelman, R. Public Health 101. Jones and Bartlett. MA. 2010)</p>	<p>RISK ASSESSMENT: Definition: product or process which collects information and assigns values to risks for the purpose of informing priorities, developing or comparing courses of action, and informing decision making Sample Usage: The analysts produced a risk assessment outlining risks to the aviation industry. Extended Definition: appraisal of the risks facing an entity, asset, system, network, geographic area or other grouping Annotation: A risk assessment can be the resulting product created through analysis of the component parts of risk.</p> <p>RISK ASSESSMENT METHODOLOGY: Definition: set of methods, principles, or rules used to identify and assess risks and to form priorities, develop courses of action, and inform decision making Sample Usage: The Maritime Security Risk Analysis Model (MSRAM) is a risk assessment methodology used to assess risk at our Nation's ports.</p> <p>RISK ASSESSMENT TOOL: Definition: activity, item, or program that contributes to</p>

		<p>determining and evaluating risks</p> <p>Sample Usage: A checklist is a common risk assessment tool that allows users to easily execute risk assessments in a consistent way.</p> <p>Annotation: Tools can include computer software and hardware, standard forms, or checklists for recording and displaying risk assessment data.</p> <p>https://www.dhs.gov/xlibrary/assets/dhs-risk-lexicon-2010.pdf</p>
Surge Capacity	<p>Surge capacity refers to the ability to expand care or service capabilities in response to unanticipated or prolonged demand. (The Joint Commission. Health Care at the Crossroads: Strategies for Creating and Sustaining Community-Wide Emergency Preparedness Strategies. Washington, DC. 2003)</p>	<p>Surge capacity is a measurable representation of ability to manage a sudden influx of patients or a sudden and unexpected change in services. It is dependent on a well-functioning incident management system and the variables of space, supplies, staff and any special considerations (contaminated or contagious patients, for example).</p> <p>https://www.ncbi.nlm.nih.gov/pubmed/28264731</p>
Proposed New Terms		
Administrative preparedness	None	<p>Administrative preparedness is the process of ensuring that fiscal, legal, and administrative authorities and practices governing funding, procurement, contracting, and hiring can be modified,</p>

		<p>accelerated, and streamlined during an emergency to support public health preparedness response and recovery efforts.</p> <p>https://www.naccho.org/programs/public-health-preparedness/systems-preparedness/administrative-preparedness-legal-guidebook</p>
Crisis standards of care	None	<p>Standards of care that should apply in disaster situations-both naturally occurring and man-made-under conditions of scarce resources.</p> <p>https://www.ncbi.nlm.nih.gov/pubmed/24830057</p>
ESF 8 Emergency Support Function #8	None	<p>Emergency Support Function (ESF) #8 – Public Health and Medical Services provides the mechanism for coordinated Federal assistance to supplement State, tribal, and local resources in response to a public health and medical disaster, potential or actual incidents requiring a coordinated Federal response, and/or during a developing potential health and medical emergency.</p> <p>https://www.fema.gov/media-library-data/20130726-1825-25045-8027/emergency_support_function_8_public_health_medical_services_annex_2008.pdf</p>

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VERSION 2.0 WORK IN PROGRESS: Emergency Preparedness – What Have We Learned from Accredited Health Departments? December 2019



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This document summarizes what PHAB has learned about how health departments (HDs) participating in accreditation are addressing emergency preparedness-related activities. In particular, it focuses on the reasons that HDs struggled with measures that relate to preparedness. It also includes findings from Section II of accredited HDs' Annual Reports.

Below is a summary of the distribution of assessments for related measures. These data are for 179 HDs assessed under Version 1.0 and 146 HDs assessed under Version 1.5.

Measure	%Fully Demonstrated	%Largely Demonstrated	%Slightly Demonstrated	%Not Demonstrated	N
2.1.1	69.5%	22.2%	7.1%	1.2%	325
2.1.2 (ver 1.0)	60.9%	29.1%	8.9%	1.1%	179
2.1.2 (ver 1.5)	47.9%	27.4%	21.9%	2.7%	146
2.1.3	89.5%	4.6%	3.1%	2.8%	325
2.1.4	63.4%	28.6%	8.0%	0.0%	325
2.2.1	68.6%	22.2%	7.7%	1.5%	325
2.2.2	58.2%	25.5%	14.2%	2.2%	325
2.2.3	54.5%	37.8%	7.7%	0.0%	325
2.3.1	68.9%	28.0%	3.1%	0.0%	325
2.3.2	80.0%	17.2%	2.8%	0.0%	325
2.3.3	51.4%	37.2%	10.2%	1.2%	325
2.3.4	72.6%	23.7%	3.1%	0.6%	325
2.4.1	71.1%	25.8%	3.1%	0.0%	325
2.4.2	66.8%	28.3%	4.9%	0.0%	325
2.4.3	54.5%	39.1%	6.2%	0.3%	325
2.4.4	57.9%	39.5%	2.6%	0.0%	38
3.2.3 (ver 1.0)	91.1%	6.7%	2.2%	0.0%	179
3.2.4 (ver 1.5)	64.4%	28.1%	7.5%	0.0%	146
5.4.1	49.2%	40.9%	9.8%	0.0%	325
5.4.2 (ver 1.0)	51.4%	40.8%	7.8%	0.0%	179
5.4.2 (ver 1.5)	40.4%	50.0%	9.6%	0.0%	146
5.4.3	86.8%	10.5%	2.6%	0.0%	38

Data are presented separately for health departments assessed under Version 1.0 and Version 1.5 of the Standards & Measures if there was a substantive change in the requirements. If the two versions are substantively the same, the aggregate data are presented. The numbering of one of the measures changed between Version 1.0 and Version 1.5. (For example, Measure 3.2.3 in Version 1.0 changed to Measure 3.2.4 in Version 1.5.)

To better understand HDs' performance on these Measures, PHAB conducted an analysis of the conformity comments of HDs that were assessed as Slightly or Not Demonstrated (SD/ND) in at least 5% of the Site Visit Reports. The results of those analyses are shown below. For each Measure, the most common reasons for the assessment are listed, including the number of HDs for which that reason was indicated. One HD could have multiple reasons listed. The reasons are linked to specific required documentation (RD) listed in the PHAB Standards and Measures. For reference, please see:

https://www.phaboard.org/wp-content/uploads/2019/01/PHABSM_WEB_LR1.pdf.

Measure 2.1.1: Protocols for investigation process

Of the 25 HDs assessed as SD/ND, the most common challenges were deficiencies in documentation of the following:

- RD1b: Inclusion of a timeline (11 HDs)
- RD1a: Assignment of responsibilities (10 HDs)
- Within the timeframe of 24 months (9 HDs)
- RD1b: Case investigation steps (8 HDs)
- RD1b: Reporting requirements (8 HDs)

Measure 2.1.2: Capacity to conduct an investigation of infectious disease

Of the 53 HDs assessed as SD/ND, the most common challenges were:

- Documentation did not align investigation reports with procedures (32 HDs)
- Lack of demonstration of HD's capacity to respond to outbreak (26 HDs)
- Documentation did not represent an audit or peer review of investigation reports (15 HDs)

For state HDs, the measure requires documentation of the capacity to conduct and/or support investigations of multiple diseases simultaneously. (Of the 5 state HDs that were assessed as SD/ND, 2 were cited for concerns related to simultaneous investigations.)

Measure 2.1.3: Capacity to conduct investigations of non-infectious health problems, environmental, and/or occupational public health hazards

Of the 18 HDs assessed as SD/ND, the most common challenge was deficient documentation of the following:

- Completed investigation of a non-infectious health problem or hazard (9 HDs)

Measure 2.1.4: Collaborative work through established governmental and community partnerships on investigations of reportable diseases, disease outbreaks, and environmental public health issues

Of the 17 HDs assessed as SD/ND, the most common challenges were deficiencies in documentation of the following:

- RD1: Documentation of contracts/MOAs/MOUs/etc. that established partnerships for the investigation of outbreaks of disease, health care associated infections, or environmental public health concerns (7 HDs)
- Within appropriate timeframes (6 HDs)
- RD1: Appropriate partners within the HD's jurisdiction (5 HDs)
- RD1: Related to disease outbreak or environmental health investigations (5 HDs)
- RD2: Description of partner roles and responsibilities (5 HDs)

Measure 2.2.1: Protocols for containment/mitigation of public health problems and environmental public health hazards

Of the 25 HDs assessed as SD/ND, the most common challenges were deficiencies in documentation of the following:

- Protocols that address prophylaxis/biologics (14 HDs)
- Protocols that address clinical management (12 HDs)

- Protocols that address disease-specific mitigation and containment (11 HDs)
- Protocols that address the process for exercising legal authority for disease control (11 HDs)
- Protocols that address contact management (11 HDs)

Measure 2.2.2: A process for determining when the All Hazards EOP will be implemented

Of the 50 HDs assessed as SD/ND, the most common challenges were deficiencies in documentation of the following:

- Providing protocols that addressed All Hazards Emergency Operations Plan activation in the following circumstances:
 - RD1: Infectious disease outbreaks (25 HDs)
 - RD2: Environmental public health issues (25 HDs)
 - RD3: Cluster evaluations (22 HDs)
- Providing any protocols that addressed the following circumstances
 - RD2: Environmental public health issues (21 HDs)
 - RD3: Cluster evaluations (20 HDs)
 - RD1: Infectious disease outbreaks (15 HDs)

Measure 2.2.3: Complete After Action Reports (AARs)

Of the 20 HDs assessed as SD/ND, the most common challenges were deficiencies in documentation of the following:

- RD1: Documentation of a protocol describing the processes used to determine when events rise to the significance of requiring an AAR (11 HDs)
- RD2: List of events comprehensive of outbreaks and environmental public health risks (8 HDs)
- RD2: List of events including indication of which required an AAR (8 HDs)

Measure 2.3.3: Access to laboratory and other support personnel and infrastructure capable of providing surge capacity

Of the 36 HDs assessed as SD/ND, the most common challenges were deficiencies in documentation of the following:

- RD2: Staffing lists indicating specific staffing needed for a surge response and how the HD will fill those needs (24 HDs)
- RD2: How staff will access that staffing list (22 HDs)
- RD1: Pre-identified support personnel to provide surge capacity (20 HDs)

Measure 2.4.3: Timely communication provided to the general public during public health emergencies

Of the 20 HDs assessed as SD/ND, the most common challenges were deficiencies in documentation of the following:

- RD1: Communication methods to communicate with members of the public requiring particular communication considerations (10 HDs)
- RD2: Communications through the media (7 HDs)
- RD2: Consideration of members of the public requiring particular communication considerations (7 HDs)

Measure 3.2.4: Risk Communication Plan (includes Measure 3.2.3 version 1.0)

Of the 18 HDs assessed as SD/ND, the most common challenges were deficiencies in documentation that demonstrated the following:

- How information will be provided 24/7 (11 HDs)
- How message clearance will be expedited (11 HDs)
- Risk communication plan for a given situation (9 HDs)

- How information is disseminated in case technology is disrupted (9 HDs)
- How the HD will prevent public alarm by dealing with misconceptions/misinformation (8 HDs)

Measure 5.4.1: Process for the development and maintenance of an All Hazards Emergency Operations Plan (EOP)

Of the 27 HDs assessed as SD/ND, the most common challenges were:

- RD3: Documentation provided represented a public health-specific EOP, not an All Hazards EOP (14 HDs)
- RD2: Documentation represented a department/public health-specific EOP, not an All Hazards EOP (8 HDs)
- RD2: Documentation did not clearly describe the HD's coordination of partners (6 HDs)
- RD3a: Documentation did not clearly describe a collaborative review of the All Hazards EOP (6 HDs)
- RD3: HD did not upload a revised EOP (6 HDs)

Measure 5.4.2: Public health emergency operations plan (EOP)

Of the 28 HDs assessed as SD/ND, the most common challenges were deficiencies in documentation of the following:

- RD2a: Process for testing the EOP (20 HDs)
- RD3b: Updates/revisions to the EOP (11 HDs)
- RD3b: Revisions to the EOP based on an AAR (11 HDs)

Annual Reports

More than 90% of Annual Reports in 2018 indicated work related to preparedness. Examples of activities include:

- Revamped procedures for emergency/disaster shelters
- Conducted tabletop exercises/training drills
- Developed toolkits for Medical Countermeasures Point of Dispensing
- Provided trainings ("Stop the bleed," psychological first aid)
- Refined understanding of special needs during response
- Participated in collaboration to address barriers to response/recovery
- Developed highly infectious disease plan
- Pursued Project Public Health Ready recognition

VERSION 2.0 WORK IN PROGRESS: Evidence Related to Public Health Emergency Preparedness April 2020



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This document represents findings from a scan of the literature related to public health emergency preparedness (PHEP) activities by health departments. It is not meant to be an exhaustive search. It concludes with articles about the link between accreditation and preparedness. This topic is evolving rapidly. If there are other resources on this topic of which you think PHAB should be aware, please contact Jessica Kronstadt at jkronstadt@phaboard.org. Please note, PHAB has previously conducted evidence scans on related topics—including Public Health Laboratories and Surveillance. Please see: <https://phaboard.org/version-2-0/>.

Progress and Current State

Jurisdictions have made substantial progress in their preparedness capabilities since 9/11.¹ In particular, those areas that receive funding through CDC's Public Health Emergency Preparedness program, have demonstrated dramatic improvements in some of those capacities, such as having an incident command system with pre-assigned roles in place.² A 2020 report from Trust for America's Health notes that "a majority of states have made preparations to expand capabilities in an emergency, often through collaboration."³ Similarly, the 2019 release of the National Health Security Preparedness Index reported continued improvements in preparedness. However, citing gaps in the healthcare delivery domain, the report noted that "current levels of health security remain far from optimal."⁴

Domains in Preparedness

Several efforts have articulated core domains in preparedness.^{4,5,6,7,8,9} Common elements include:

- Governance & leadership
- Communications
- Planning
- Risk assessment
- Resource management
- Collaborative networks
- Community engagement
- Workforce capacity
- Surveillance & monitoring
- Incident management system
- Healthcare delivery
- Countermeasure management
- Environmental & occupational health
- Laboratory testing
- Resilience
- Prevention & mitigation
- Training, exercising, evaluation, and corrective action & continuous quality improvement

Several of these domains are described in greater detail below.

Communications

While communications has always been a central component of preparedness, it has taken on added significance in the context of online information and social media. One commentary posed this question: "As reliance on information from online resources increases, how can public health safeguard the dissemination of accurate information needed for action when lives are at stake?"¹⁰ (p5258)

Consistent with that theme, a checklist for response to infectious disease events includes the following:⁵

- "Communication plans should include multiple communication approaches—including town hall meetings, social media, guest spokespersons, and telephone information lines—to disseminate information quickly and provide the opportunity for 2-way communication with the public;" and
- "Establish procedures and personnel to monitor social media and links with the public to identify and rapidly respond to rumors and misinformation."

In addition, a literature review on preparedness-related communications, noted the following:¹¹

- Timely release of information and trust in the communicator are associated with increased likelihood that individuals will implement recommended changes in behavior.
- Because access to information and information-seeking behavior may differ based on sociodemographic characteristics, public health officials should ensure that communications efforts are targeted to different audiences and take into account the needs of low-literacy populations.

Partnerships and Community Engagement

A 2018 survey about preparedness found that most local health departments have strong partners, particularly with emergency management, state and local governments, and environmental health, but opportunities remain to strengthen partnerships with pharmacies, behavioral health/mental health, and local businesses.¹² Health departments are encouraged to look broadly in terms of potential partners, for example, faith-based organizations can provide key assistance in times of emergencies.¹³ One study found that a larger number of partners is associated with higher levels of administrative preparedness.¹⁴

In addition to coordinating with partner organizations, health departments must conduct outreach directly with community members, moving from a response focused on government to a "whole-of-community" model.¹⁵ As Schoch-Spana framed it, "Community engagement is an integral feature of PHEP, rather than a luxury or standalone activity competing for resources."¹⁶ (P 362) Those authors suggest the following as starting points for local health departments that are just beginning to consider community engagement in their preparedness work: conduct strategic planning that draws a connection between PHEP and partnership work; develop an agency-wide inventory of existing relationships; and update community profiles focusing on where the agency can better understand health priorities and strengthen relationships with influential leaders in vulnerable populations.¹⁶ One analysis suggests the importance of having an explicit policy about community engagement in PHEP.¹⁷

Vulnerable Populations and Equity

Public health experts have highlighted the need to consider groups that will be disproportionately affected by emergencies,¹⁸ including, for example, individuals with access and functional needs.¹⁹ A 2018 survey of local health departments found that nearly all address elderly and people with disabilities in their preparedness planning.¹² Trust for America's Health 2019 report on

preparedness includes a recommendation that state and local governments build health equity leadership and adopt strategies to incorporate equity into preparedness.³

Noting the vulnerability of some populations (e.g., minorities and individuals with low socioeconomic position), a review of the literature points out that “Social networks, small-group discussions led by a health promoter, and culturally tailored messages can be effective in improving disaster preparedness among vulnerable groups.”¹¹

Resilience

The Department of Health and Human Services defines community health resilience as “the ability of a community to use its assets to strengthen public health and healthcare systems and to improve the community’s physical, behavioral, and social health to withstand, adapt to, and recover from adversity.”²⁰ Amobi and colleagues have suggested that “community-led work that involves community members organizing toward shared goals builds resiliency, or the ability to ‘bounce forward’ from adversity, by fostering social capital, community pride and local communication channels.”²¹ (p. 292) When issuing the 2019 Association of State and Territorial Health Officials (ASTHO) President’s Challenge, Amobi asked public health professionals to consider this idea of “bouncing forward” along with notions of community leadership and social cohesion.²²

The emphasis on resilience has also manifested itself in the development of a Resilience Intelligence Network to harness learnings from clinical trials,²³ and the development of the Composite of Post-Event Well Being (COPEWELL) assessment tool.²⁴

Assessment

Health departments use a variety of assessment tools. The CDC developed the Community Assessment for Public Health Emergency Response (CASPER) methodology to quickly gather household-level data about health status, which “can be used by emergency managers to make informed decisions, allocate scarce resources, provide valid information to the news media to dispel rumors, support funding needs for recovery efforts and plan for future disasters.”²⁵ (p. S186)

As an example of a different type of assessment, Drexel University’s Dornsife School of Public Health developed a tool to calculate the expected impact of a hazard on such domains as human health, health care services, in-patient health care infrastructure, community health, and public health services.²⁶

Public Health Emergency Management

Public health emergency management “is an emergent field of practice that draws on specific sets of knowledge, techniques, and organizing principles found in the fields of emergency management and public health that are necessary for the effective management of complex health events and emergencies with serious health impacts.”⁹ It draws on existing frameworks, including the emergency management cycle (mitigation, preparedness, response, and recovery) and the incidence management system.⁹

Drills and exercises are common practice in preparedness and several studies reinforce the importance of trainings that provide opportunities for coordination between public health, public safety, environmental, and health care organizations to establish relationships prior to an incident. **Error! Bookmark not defined.** Others have noted how using PHEP tools, including the incidence management system, can also be applied more broadly to agency efforts addressing communicable diseases.²⁷

Administrative preparedness

The National Association of County and City Health Officials (NACCHO) describes administrative preparedness as “the process of ensuring that the fiscal, legal, and administrative authorities and practices that govern funding, procurement, contracting, and hiring are appropriately integrated into all stages of emergency preparedness and response.”²⁸ Their 2018 survey indicates that most local health departments have at least one expedited procedure in place (e.g., receiving and using emergency funding, reducing time for contracting/procurement; reducing time to hire/reassign staff).¹² As one aspect of administrative preparedness, laws play a critical role in creating “the infrastructure through which emergencies are detected, prevented, declared, and addressed.”²⁹ Another focus is on the funding mechanisms for public health emergencies and how they can be accessed.³⁰

Preparedness and Accreditation

The PHAB accreditation standards have been cross-walked with CDC's Public Health Preparedness Capabilities and there is significant overlap.³¹ Recognizing the importance of having a strong public health infrastructure to prepare and respond to emergencies, the National Health Security Preparedness Index includes as an indicator whether the state health department is PHAB accredited.³² State health department accreditation is also featured as one of the 10 indicators included in the Trust For America's Health annual report “Ready or Not.”³

Several health departments have shared their stories about how PHAB accreditation has played a role in readying them to respond to emergencies. In a case study, the Florida Department of Health describes how preparation for accreditation helped identify opportunities to strengthen an integrated surveillance system and how partnerships with health care and other community organizations enabled them to provide health information and testing in hard-to-reach and underserved populations.³³ To read about other examples of how accreditation has influenced health department preparedness activities, see <https://phaboard.org/wp-content/uploads/Public-Health-Emergency-Preparedness-April-2020.pdf>.

Studies on other Accreditation Programs

Studies on North Carolina's state-based accreditation program have also identified a link between accreditation and preparedness. A 2009 study found that among local health departments in North Carolina, those that were accredited performed a greater scope of activities in response to the H1N1 outbreak and implemented them more rapidly than non-accredited health departments in the state.³⁴ Another study compared local health departments accredited in North Carolina with similar health departments in other states. While preparedness capabilities declined for all health departments as funding dried up, there appeared to be a protective effect among the state-accredited health departments and they saw fewer significant decreases in their capacity.³⁵

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³ Trust for America's Health. *Ready or not: protecting the public's health from diseases, disasters, and bioterrorism 2020*. Washington, DC: Trust for America's Health; 2020.

⁴ National Health Security Preparedness Index 2019: Release summary of key findings. Lexington, KY: University of Kentucky; May 2019.

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