

2012 County Health Department (CHD) Preparedness Expectations
As of 06/22/2012
V1.3

The Florida Department of Health (FDOH) is an integrated public health system, with the CHDs being statutory entities under the direction of FDOH headquarters. This creates a structure that provides services and programs in a more standardized manner, with seamless alignment of electronic data management and reporting systems. Florida's structure also enhances integration and coordination between other local and state entities, such as emergency management and domestic security. This integrated public health system is a key strength allowing Florida to respond more efficiently and effectively during a disaster.

Preparedness is operationalized in three overlapping entities: public health and health care, emergency management, and domestic security. Public Health and Medical Preparedness is essential to achieving the Florida Department of Health's mission to promote, protect and improve the health of people in Florida. Facilitating collaboration among the state's health care partners, including pre-hospital, hospital, and medical practitioners, is critical, in order to respond as a holistic system of care. The goals, objectives and strategies in Florida's *2012-2014 Public Health and Healthcare Preparedness (PHHP) Strategic Plan* unify the principles of the three entities and provide the direction for preparing the state's health and medical system.

The intent of this document is to help define and clarify expectations for local preparedness and response activities as outlined by current federal / state guidance and policy, state statute, and/or federal funding guidelines. Additionally, these expectations align with Florida's Domestic Security Strategy and the 2012-2014 *PHHP Strategic Plan*. Ensuring preparedness for our citizens and visitors requires a continuous cycle of organizing, equipping, developing plans, training to these plans, testing the plans through exercises or real events, evaluating outcomes through after action reports, and implementing improvements. History has shown that the public will look to the healthcare system to provide information, guidance, and care during any situation that threatens to impact their health.

References:

Public Health Preparedness Capabilities: National Standards for State and Local Planning, Centers for Disease Control and Prevention, March 2011.

2012-14 Public Health and Healthcare Preparedness Strategic Plan, Florida Department of Health, January 2012.

Appendix VIII: ESF 8 – Health and Medical Services, Florida Comprehensive Emergency Management Plan, February 2010.

**2012 County Health Department (CHD) Preparedness Expectations
As of 06/22/2012
V1.3**

Background:

The 2012-14 CHD Preparedness Expectations were developed utilizing the national standards outlined in the CDC's Public Health Preparedness Capabilities guidance document. Select capabilities were highlighted within the guidance as priority capabilities for development within the state. Leaning forward, the state selected CHD Expectations to align with both federal and state initiatives. Additionally, it is anticipated that performance relative to these expectations will provide critical information regarding local level capabilities. These expectations were developed with input from the Regional Domestic Security Task Force Health & Medical Co-Chairs, the CHD Directors/Administrators, the Public Health Preparedness planners and the PHHP Program Managers, to ensure the state's ability to capture relevant information related to local level preparedness capabilities with minimal burden to the CHD staff charged with collecting and reporting on such information.

Category	2012 Expectation Definition	Scoring Methodology
Planning		
<p>CHD Emergency Operations Plan</p> <p>Should address the following elements:</p> <ul style="list-style-type: none"> • Hazard/Vulnerability Analysis • Continuity of Operations • Alert/Notification Process • Data/Voice Communications • Crisis & Emergency Risk Communications • Isolation/Quarantine • Mass Prophylaxis • Special Needs Sheltering 	<p>All county, regional, and state all hazard response plans will align with requirements of the National Response Framework and NIMS requirements. Additionally, these plans will be developed in collaboration with community stakeholders and clearly identify linkages to larger community planning activities/processes. Exercises testing any of the annexes that are a part of the EOP, by definition, require testing of the EOP base plan and would meet the AAR/IP expectation.</p> <p>Included within the plans should be:</p> <ul style="list-style-type: none"> • Identification and prioritization, based on lethality and large population exposure, of hazards that potentially impact human health. • Continuity of public health operations • A process for alerting and notifying internal incident response information using an established system. This system shall collect, manage, and coordinate information about the event and response activities and be available 24/7/365 to reach at least 90% of key stakeholders. • An interoperable communications process for the county health department that ensures redundancy through multiple systems. • Systems and process for communicating public information that are able to handle large call volumes (at least 1% of the county's households), contain formats appropriate for vulnerable populations including those with disabilities and those that are non-English speaking, and effectively disseminate health and safety information to the public • Isolation and quarantine processes that include coordination of law enforcement, provision of services and monitoring of those under isolation and quarantine, and management of public information releases. • Plans for supporting/accommodating vulnerable needs populations, including Special Needs Sheltering plans, developed in collaboration with 	<p>Pass / Fail 1 = Fail 5 = Pass</p> <p>County should be able to produce a written plan that has been updated at least once within the last 36 months and that addresses, at a minimum, the elements listed.</p>

**2012 County Health Department (CHD) Preparedness Expectations
As of 06/22/2012
V1.3**

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	local emergency management and other appropriate agencies that define the community's approach to sheltering persons with special needs.	
County Comprehensive Emergency Management Plan	The roles and responsibilities of the CHD should be documented in the County Comprehensive Emergency Management Plan (CEMP). Some county CEMPs do not designate the roles/responsibilities of the CHD but, instead, designate the roles and responsibilities of ESF8 (for which the CHD has the lead).	Pass / Fail 1 = Fail 5 = Pass
Response Workforce Development	TBD based on national revisions in Project Public Health Ready – Not scored.	Not scored for 2012
After Action Report and Improvement Plan	<p>Each CHD either conducted an exercise or engaged in a real-life incident/event activation within the past 24 months, and documented the activity in an HSEEP-compliant AAR/IP within 30 days of the end of the activation/event/incident.</p> <p>While this standard is found for other capabilities throughout the CHD Expectations document, the intent of this expectation is to ensure the county has a documented process for completing an AAR/IP.</p>	<p>Within the past 24 months:</p> <p>1 = CHD conducted an exercise or real event activation 3 = CHD completed an AAR/IP of the exercise or activation 5 = CHD completed AAR/IP within 30 days of exercise or activation</p>
Emergency Operations Coordination		
CHD decision-maker for EOC operations	<p>Each CHD should have written plans that include, but are not limited to, activation procedures and levels, including who is authorized to activate the plan and under what circumstances. (<i>CDC PHEP Capabilities guidance</i>). The key decision maker(s) have been identified by the CHD, based on current planning assumptions and standard operating procedures outlining local EOC operations.</p> <p>The identified decision-maker(s) must be able to respond/report for duty within 60 minutes of request. Responding/reporting for duty via phone or virtually (video conference) may be acceptable to local emergency management based on the needs of the incident/event.</p> <p>The CHD must demonstrate and document this capability via an exercise or test within the last 12 months.</p>	<p>This expectation will be scored as follows:</p> <p>1 = CHD decision-maker identified to support EOC operations 3 = CHD decision-maker identified to support EOC operations and can report for duty within 60 minutes 5 = CHD decision-maker identified, can report to duty within 60 minutes and has been tested within last 12 months</p>
Continuity of Operations	Each CHD has an approved Continuity of Operations Plan that has been exercised or activated within the last 24 months, with the exercise or activation documented in an HSEEP-compliant AAR/IP. Consistent with HSEEP standards, the AAR/IP should include the type of exercise conducted (i.e. drill, tabletop, full scale, etc.) and exercise outcomes. (HSEEP provides several different exercise types, and a full-scale exercise is not required to meet the expectation unless specified)	<p>This expectation will be scored as follows:</p> <p>1 = Plan is approved within last 24 months, but not tested 3 = Plan is approved and exercised/activated within past 24</p>

**2012 County Health Department (CHD) Preparedness Expectations
As of 06/22/2012
V1.3**

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		months 5 = Plan is approved, exercised/activated and documented in AAR/IP within past 24 months
Notification Contacts	<p>Key contacts for notification of public health issues would be determined by local operations. Each CHD shall maintain a list of these key contacts and this list will be updated at least annually. However, the CHD may establish more frequent updates based on their environment and preparedness needs.</p> <p>Key contacts should include entities, groups, agencies, businesses, professional associations, or other service providers, as well as individual service providers that the CHD deems critical in terms of one or more of the following criteria. The entity:</p> <p>1) provides health and human services (e.g., food, shelter/housing, social services, mental/behavioral) to vulnerable or at-risk populations in the context of a significant disaster or public health emergency.</p> <p>2) is an essential vehicle for community outreach, information dissemination, or other similar communications with vulnerable and hard-to-reach populations, as well as the general public, during response or recovery following an incident.</p> <p>3) is or would be an essential primary partner in a jurisdiction-wide disaster or public health emergency response in terms of resource sharing, provision of goods or services, surge capacity, representation in the Incident Management Structure (e.g., the Emergency Operations Center) or other type of formal integration into a CHD's response to a public health emergency.</p>	Pass / Fail 1 = Fail 5 = Pass
Florida Department of Health Emergency Notification System (FDENS) Alerts	<p>CHD key contacts are internal individuals who are designated to receive and confirm notification alerts from the state. CHD will ensure key contacts are identified to receive state level FDENS alerts and are registered FDENS users. The contacts may include, but are not limited to, the CHD Director/Administrator, Business Manager, Nursing Director, Environmental Health Director, Medical Director, FDENS Administrator and PIO.</p> <p>The CHD key contacts that are identified must respond to state level alert drills and real events as required to demonstrate this capability.</p>	<p>Actual time is reported from FDENS alert report. Expectation will be scored as follows:</p> <p>% of identified individuals responding within 30 minutes or less:</p> <p>1 = 0% - 20% 2 = 21% - 40% 3 = 41% - 60% 4 = 61% - 80% 5 = 81% - 100%</p>

**2012 County Health Department (CHD) Preparedness Expectations
As of 06/22/2012
V1.3**

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Community Preparedness		
Risk Assessment	TBD – under development and will be revisited in 2013	Not scored for 2012
Vulnerable Populations	<p>At risk or vulnerable populations are often defined as groups whose unique needs may not be fully integrated into planning for disaster response. These populations include, but are not limited to, those who are physically or mentally disabled, blind, deaf, hard-of-hearing, cognitively impaired, or mobility challenged. Also included in this group are those who are non-English (or not fluent) speakers, geographically or culturally isolated, medically or chemically dependent, homeless, frail elderly and children.</p> <p>The CHD is responsible to identify and assess the vulnerable populations within its county. Local planners are encouraged to utilize the Vulnerable Populations toolkit, which includes county-specific, vulnerable populations profiles, to facilitate the identification and needs of local vulnerable populations. (http://www.doh.state.fl.us/demo/bpr/VulnerablePopulations.html)</p> <p>An assessment tool is also available and can be found at http://www.doh.state.fl.us/demo/bpr/PDFs/VPAssessmentTool.doc which provides assessment criteria for 10 priority target populations.</p> <p>Utilizing the Local Vulnerable Population Assessment Tool, the CHD is responsible to assign values for the following numerator and denominator:</p> <p style="padding-left: 40px;">Numerator: Number of priority vulnerable populations categories fully identified and assessed. Denominator: 10 priority target populations categories derived from Local Vulnerable Population Assessment Tool.</p>	<p>Expectation will be scored as follows:</p> <p>CHD reports actual numerator and denominator. Percentage calculated and scored as follows:</p> <p>1 = 0% - 20% 2 = 21% - 40% 3 = 41% - 60% 4 = 61% - 80% 5 = 81% - 100%</p>
Community Engagement	<p>The CHD will work with key organizations and community agencies to engage their participation in public health, medical, and/or mental/behavioral health-related emergency preparedness efforts.</p> <p>Key organizations are often characterized as: 1) having a significant 'footprint' or service area in a community; 2) high-volume or throughput in terms of goods or services provided; 3) serving hard-to-reach, vulnerable, or at-risk populations; 4) historically significant institutions, or key figures/icons, with a community, often with significant influence within one or more cultural or affinity groups (e.g., community leaders); and/or 5) providers of narrow or unique but critical services to the community (e.g., media outlets, hospitals). Representatives of the key organizations should be in a position to commit their organization and/or its resources to local community preparedness and recovery efforts."</p>	<p>Expectation will be scored as follows:</p> <p>CHD reports actual numerator and denominator. Percentage calculated and scored as follows:</p> <p>1 = 0% - 20% 2 = 21% - 40% 3 = 41% - 60% 4 = 61% - 80% 5 = 81% - 100%</p>

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As of 06/22/2012
V1.3**

Category	2012 Expectation Definition	Scoring Methodology
	<p>The following numerator and denominator should be used:</p> <p>Numerator: Number of community sectors in which CHD identified key organizations to participate in public health, medical, and/or mental/behavioral health-related emergency preparedness efforts.</p> <p>Denominator: 11 community sectors (businesses, community leadership, cultural and faith-based groups/organizations, education and childcare settings, emergency management, health care, housing and sheltering, media, mental/behavioral health, social services, senior services)</p>	
Mass Care		
Special needs sheltering (SpNS) operations	Each CHD has a SpNS Operations plan that must be revised, updated and approved within the past 36 months. Additionally, the CHD is responsible to test, through exercise or activation, the plan's validity. The exercise or activation should be documented in an HSEEP compliant AAR/IP within 30 days of the exercise or activation. Consistent with HSEEP standards, the AAR/IP should include the type of exercise conducted (i.e. drill, tabletop, full scale, etc.) and exercise outcomes. (HSEEP provides several different exercise types, and a full-scale exercise is not required to meet the expectation unless specified.)	<p>Expectation will be scored as follows:</p> <p>1 = Plan is approved w/in last 36 months, but not tested</p> <p>3 = Plan is approved and exercised/activated w/in past 36 months</p> <p>5 = Plan is approved, exercised/activated and documented in AAR/IP w/in past 36 months</p>
Functional Needs Support Services (FNSS)	Each CHD is responsible to participate in local FNSS planning activities. For more information regarding FNSS, see http://www.fema.gov/pdf/about/oddc/fnss_guidance.pdf	<p>Pass / Fail</p> <p>1 = Fail</p> <p>5 = Pass</p>
Shelter Surveillance	<p>Selected CHDs will participate in the development of shelter surveillance standards, tools and processes for mass shelters. Written plans will include a process to conduct ongoing shelter population surveillance, including the following elements:</p> <ul style="list-style-type: none"> • identification or development of mass care surveillance forms and processes • determination of thresholds for when to start surveillance • coordination of health surveillance plan with partner agencies' (eg, Red Cross) activities <p>NOTE: This expectation will not be scored for 2012</p>	Not scored for 2012
Crisis & Emergency Risk Communications		
Risk communication messaging development and dissemination	The CHD is responsible to ensure there is an integrated system to disseminate appropriate and timely public information and address media needs in collaboration with response partners during urgent/emergent situations. Within the past 24 months, the CHD has conducted and	<p>Expectation will be scored as follows:</p> <p>1 = Processes are documented, but not</p>

**2012 County Health Department (CHD) Preparedness Expectations
As of 06/22/2012
V1.3**

Category	2012 Expectation Definition	Scoring Methodology
	<p>documented the following activities:</p> <ul style="list-style-type: none"> • Risk communication message development and dissemination procedures are documented • Procedures are tested to ensure message can be disseminated to public within 3 hours of incident • Exercise outcomes are documented in an HSEEP compliant AAR/IP 	<p>tested w/in last 24 months 3 = Processes are documented and exercised/activated w/in past 24 months 5 = Processes are documented, exercised/activated and documented in AAR/IP w/in past 24 months</p>
Public Information Officer and spokespersons	<p>CHD has a designated PIO trained to DOH CERC standards, as well as, epidemiology and environmental health spokesperson(s) trained to DOH CERC standards.</p> <p>Documented plans/agreements to use Regional PIOs and/or spokespersons are acceptable, so long as those individuals meet DOH CERC standards.</p>	<p>Expectation will be scored as follows:</p> <p>1 = PIO designated but not trained 3 = PIO designated and trained 4 = PIO designated /trained and Epi/EH spokesperson(s) designated but not trained 5 = PIO designated and trained and Epi/EH spokesperson designated and trained</p>
Joint Information Center/Joint Information System Participation	<p>The CHD should have a ready list of health and medical contacts that is reviewed and updated at least annually, to provide to the local ESF8 and Joint Information Center/Joint Information System Operations lead, as necessary. The CHD may establish a more frequent review/update schedule based on their community's needs.</p> <p>The list may include, but is not limited to, points of contact for potential surge operation partners, including emergency medical services, fire service, law enforcement, and healthcare organizations.</p>	<p>Pass / Fail 1 = Fail 5 = Pass</p>
Responder Safety & Health		
N-95 Fit Testing	<p>The CHD has procedures for conducting medical clearance that are reviewed and updated annually. Additionally, the CHD maintains a roster of qualified and trained staff to conduct fit testing that is reviewed and updated annually.</p>	<p>Pass / Fail 1 = Fail 5 = Pass</p>
Responder Risk and Mitigation	<p>This expectation will not be scored until 2014. The 2012 expectation identifies the participation of select counties in a workgroup to identify and prioritize potential risks to responders</p>	<p>Not scored for 2012</p>

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V1.3**

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Medical Countermeasures Dispensing (Mass Prophylaxis)		
Medical Countermeasure Dispensing	<p>The CHD should have a Medical Countermeasures Dispensing plan that outlines activities need to minimize the time needed to dispense mass therapeutics and/or vaccines, and align with the requirements of the Strategic National Stockpile guidance. Additionally, plans must include processes that ensure mass dispensing/vaccination requirements for highly infectious diseases can be accomplished in the appropriate timeframes. Within the past 36 months, the CHD will:</p> <ul style="list-style-type: none"> • Have a Medical Countermeasure Dispensing Plan, outlining how the county will 1) request, 2) receive, 3) dispense, 4) report dispensing of medical countermeasures, and 5) report adverse events. This plan should be approved and tested through exercise or activation, and the results should be documented in an HSEEP compliant AAR/IP. 	<p>Expectation will be scored as follows:</p> <p>1 = Plan is approved w/in last 36 months, but not tested</p> <p>3 = Plan is approved and exercised/activated w/in past 36 months</p> <p>5 = Plan is approved, exercised/activated and documented in AAR/IP w/in past 36 months</p>
Public Health Surveillance & Epidemiological Investigation		
Competencies and skills in applied Epidemiology	<p>The data for these expectations are reported by the Bureau of Epidemiology in the Core Epidemiology Measures Performance and Education/Training Report.</p> <ul style="list-style-type: none"> • Counties with population greater than 100,000: Epidemiologist calls in to at least 20 Bi-weekly Epidemiology Conference Calls per year and attends 3 Grand Rounds presentations per year • Counties with population less than 100,000: Epidemiologist calls into at least 12 bi-weekly epidemiology conference calls during year and attends 3 Grand Rounds presentations per year 	<p>Pass / Fail</p> <p>1 = Fail</p> <p>5 = Pass</p>
24/7 health department access to collect, review and respond to reports of selected diseases.	<p>Processes must be in place and maintained for 24/7/365 reporting to the public health agency of suspicious symptoms, illnesses, or circumstances. Additionally, processes must be in place to minimize delays in disease reporting in order to expedite the initiation of appropriate mitigation and control interventions.</p> <p>The data for these expectations are reported by the Bureau of Epidemiology in the Core Epidemiology Measures Accessibility & Timeliness Reports.</p> <ul style="list-style-type: none"> • Process exists to ensure 24/7/365 reporting of cases and suspected cases • Data provided via 75% or higher rate of disease reporting within 14 days • 30% or less annual error rate or unknown values for selected diseases. 	<p>Pass / Fail</p> <p>1 = Fail</p> <p>5 = Pass</p>
Florida Poison Information Center Network (FPICN)	<p>FPICN data is one of several sources of data available in ESSENCE. The CHD is expected to have at least one individual identified to support local epidemiology functions, who is trained to use FPICN data in ESSENCE.</p> <ul style="list-style-type: none"> • Counties with population greater than 100,000 have at 	<p>Pass / Fail</p> <p>1 = Fail</p> <p>5 = Pass</p>

**2012 County Health Department (CHD) Preparedness Expectations
As of 06/22/2012
V1.3**

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	least one epidemiologist trained and routinely using FPICN data in ESSENCE <ul style="list-style-type: none">• Counties with population less than 100,000 have at least one epidemiologist trained to use the FPICN data in ESSENCE	