Whole Community Inclusion Planning Workshop
(date)

Situation Manual

Preface

There are many issues that can put individuals within communities at risk of not being able to receive information or be able to take vital lifesaving actions during an emergency. Age, economic disadvantage, language and literacy, medical issues and disabilities, cultural/geographic/social isolation are factors that are present in every community and must be properly planned for to ensure messages are received, understood, and emergency response resource are accessible to everyone.

The attendees for this workshop should include of a cross-section of individuals who represent the many characteristics, cultures, needs, and interests that define the community. The wide scope of participants includes: trusted persons within at-risk populations, community and neighborhood leaders, reporters, editors, announcers, and news directors in media outlets, religious leaders, and other trusted contacts such as barbers and hair stylists, or matriarchs of families. Including the right mix of representatives at this workshop will help ensure the people know how best to communicate and collaborate with the community have a voice in strengthening emergency response plans.

This Situation Manual (SitMan) provides participants with all the necessary tools for their roles in this workshop. All participants should use appropriate guidelines to ensure the proper control of information within their areas of expertise and to protect this material in accordance with current jurisdictional directives.

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Handling Instructions

1. The title of this document is the *Whole Community Inclusion Planning Workshop.*

2. The information gathered in this SitMan is *For Official Use Only (FOUO)* and should be handled as sensitive information not to be disclosed. This document should be safeguarded, handled, transmitted, and stored in accordance with appropriate security directives. Reproduction of this document, in whole or in part, without prior approval from the (LHD Name) is prohibited.

3. At a minimum, the attached materials will be disseminated only on a need-to-know basis and when unattended, should be stored in a locked container or area offering sufficient protection against theft, compromise, and inadvertent access.

4. This publication was supported by the Cooperative Agreement Number 5U90TP000528 – 04 from the Centers for Disease Control and Prevention (CDC) and the Office of Assistant Secretary for Preparedness and Response.

5. For more information, please consult the following points of contact (POCs):

Name

Title

Agency

Email

# Workshop Overview

|  |  |
| --- | --- |
| **Exercise Name** | Whole Community Inclusion Planning Workshop |
| **Exercise Date** | [Date][Time] |
| **Location** | [Location and Address] |
| **Scope** | This four-hour workshop is intended for local health department staff and community leaders representing the diverse interests and needs of local at-risk populations |
| **Threat or Hazard** | All Hazards |
| **Sponsors** | [LHD Name] |

## AGENDA

|  |  |
| --- | --- |
| **Time** | **Activity** |
| 8:30 AM | Welcome and Introductions  |
| 8:45 AM | Background and purpose |
| 8:55 AM | Introduction to public health emergency planning and response |
| 9:15 AM | Breakout Session  |
| 10:35 AM | Break |
| 10:45 AM | Report Out of Key Findings  |
| 11:30 AM | Comparing Findings to Current Plans |
| 11:45 AM | Lessons Learned, Best Practices, and Next Steps |
| 12:15 PM | Adjourn |

# Workshop Purpose and Objectives

The workshop is intended to introduce participants to the LHD Emergency Operations Plan (EOP) and focus on refinement of the plan. The objectives in the table below describe the expected outcomes for the workshop.

|  |
| --- |
| Workshop Objectives |
|  |
| 1. | Introduce and discuss the LHD emergency preparedness and response plans to create a working understanding of public health responsibilities. |
| 2. | Educate participants on the department’s role in responding to a variety of specific hazards, and how the LHD ECC can support response activities and resource needs in conjunction with the local EOC and State, when applicable. |
| 3. | Develop an understanding of the scope of communities served by the LHD and the barriers and challenges to outreach in an emergency. |
| 4. | Identify areas for improvement within the LHD emergency response plans and generate recommendations to strengthen planning. |

# Breakout Session

The purpose of the breakout session is to identify gaps in the LHD planning and generate ideas to strengthen emergency response plans and procedures. The breakout session provides participants with a specific section of the plan to review and offer critical feedback. Participants will discuss the following aspects of public health emergency planning:

*Include broad categories of planning the LHD would like to further explore with an outside audience. The breakout session should be structured around the unique audiences attending. Creating engaging questions to allow participants to comfortably share their perspectives is key. Ask about broader issues regarding what motivates the populations they work with, who/what their cultural influencers are, do they have needs are consistently overlooked, etc. The breakout structure can be as simple as questions posed to the group or can be more complicated with multiple tables dedicated to different components of public health emergency response that individual groups rotate discussion around. Rather than just going through a dry overview of plans, consider starting discussions that will provide you with feedback that will be targeted enough to compare your audience’s answers with what your plans outline. If possible, take these notes in real time and close out the session with a discussion on the similarities and gaps you observed when comparing your plan components with their answers.*

* **Communication During an Emergency**
	+ Getting messages to diverse audiences
		- Understanding trusted sources of information
		- Sending messages through effective channels
	+ Making sure messages are understandable
		- Language barriers
		- Cultural differences
		- Plain language and image-driven materials
		- Avoiding stigma
	+ 2-way communication
* **Providing Timely Emergency Medical Countermeasures**
	+ Location of PODs near affected populations
	+ Mass transit availability and costs
	+ Accessible site needs
		- Wheelchair access/availability
		- Provisions for service animals
	+ Security/safety concerns
	+ Familiarity of POD locations
	+ Wheelchairs Available
	+ Climate Controlled/Sheltered Waiting Areas

*Additional breakout options:*

Breakout Session Procedure:

Participants will be divided into four teams and assigned to a table. Each table consists of:

* Suggested questions to consider for discussion
* LHD emergency plan components overview
* Planning excerpts
* Laptop with digital template to scribe key findings and project on screen *(optional – can use paper for notes as well)*

Participants will have four rounds to give teams a chance to review each section of the plan and note observations. Each round will last for the following duration of time:

* Round One, 30 minutes
* Round Two, 20 minutes
* Round Three, 15 minutes
* Round Four, 15 minutes

Based on the specific section of the plan at the workstation, participants are to:

* Utilize existing knowledge to respond to the scenario and questions
* Identify strengths and potential gaps in local health emergency planning considerations
* Build upon the previous teams comments and recommendations

When the allotted time has elapsed, participants will rotate to the next workstation.

Participants will rotate stations counterclockwise.

Discussion of the responses will follow the conclusion of the Breakout Session.

Report Out of Key Findings and Best Practices:

Participants will present their key findings of the last round that they completed.

Participants will address emergency response procedures, differences in standard procedures that may occur during an emergency, and areas of interest that may have been neglected. Participants will also have the opportunity to discuss discrepancies that may have arisen during the breakout session.

# Background

The potential for emergencies is always on horizon. There is constant news of natural disasters and emerging infectious diseases. People rely more and more on technology and smartphones which have unique sets of pros and cons during disasters. Every emergency tends to have public health implications and therefore, local health departments must be prepared to communicate and respond effectively to reach and serve everyone in their communities.

Local health departments across have experienced a range of emergency responses which have tested and challenged their abilities to communicate effectively with audiences that are sometimes very difficult to reach. During the 2009 H1N1 pandemic, complicated messages regarding vaccine availability and priority groups approved to receive it needed to be catered and disseminated to those specific audiences all at once. Multiple flooding incidents over the last decade have pushed LHDs to communicate the health threats of contaminated water from rural, isolated populations to those hard-to-reach audiences in urban areas. The Flint water response challenged local, state, and federal health officials to directly contact every resident within a city. The 2017 MI hepatitis A outbreak adversely affected portions of the community that may not have had access to traditional media outlets.

Understanding the unique factors that can put individuals at risk during emergencies and having conversations with the people that belong to and represent the varied populations that make up a community helps to strengthen emergency plans and improve outcomes during emergency responses.

Risk factors for not being able to receive or act on emergency guidance can be broad and apply to large portions of communities. Thinking broadly on what specific influences can make people more vulnerable, helps to frame how emergency plans should be structured to ensure the individual needs of the community can be met. Below are list of factors to consider when planning or responding to emergencies:[[1]](#footnote-1)

* Economic Disadvantage
	+ Very broad category with diverse needs living below the poverty level. Poverty affects the ability of individuals follow emergency directives if resources are not available to do what is being asked.
* Language and Literacy
	+ Planning must take place for how materials will be developed for people who have a limited ability to read, speak, write or understand English, have low literacy skills, or who cannot read at all.
* Medical Issues and Disability (physical, mental, cognitive, or sensory)
	+ According to the [2010 US Census](https://www.census.gov/newsroom/releases/archives/miscellaneous/cb12-134.html), nearly 1 in 5 people have a disability. Reported disabilities range from difficulty with walking and climbing stairs, to hearing and seeing, to even depression and anxiety. Disabilities can affect people’s ability to do daily activities around the house without assistance and can have a negative impact on employment and monthly income. Older adults were found to be more likely to have a disability and by 2030, the number of U.S. adults aged 65 or older is expected to more than double[[2]](#footnote-2).
* Isolation (cultural, geographic, or social)
	+ **Rural populations** include ranchers, farmers, and people who live in sparsely populated communities. Rural areas can have special communication challenges, such as dependence on satellite television, which does not always provide local channels or news. Additionally, radio stations have moved to a canned commercial feed in many communities and might not be useful for dispensing local information in an emergency.
	+ **In urban areas**, people can be isolated because of language, lack of education, cultural practices, chronic health problems, fear, lack of transportation or access to public transit systems, unemployment, and other factors. Even if they have access to mass media, they might not have the means to respond to emergency directives.
	+ **Temporary residents** can be a major population for many communities, but there are big differences in the types of temporary residents: people living on a military base, students, tourists, or seasonal farm workers, for example.
	+ **Undocumented immigrants** are foreign-born persons who reside in the United States and have not yet achieved legal residency. Therefore these individuals might consciously avoid interaction with social and public agencies.
	+ **Single parents and caregivers** face challenges because they have no one to share their responsibilities to care for those who are dependent on them. This increased responsibility can impair their ability to plan for emergencies or carry out public health directives, and it can be emotionally overwhelming.
	+ **Religious and cultural practices** may reduce the likelihood of certain groups receiving emergency communications. For example, mass media communications would be ineffective for reaching Amish and Mennonite communities which usually do not have televisions or radios.
* Age
	+ Although many elderly people are competent and able to access health care or provide for themselves in an emergency, chronic health problems, limited mobility, blindness, deafness, social isolation, fear, and reduced income put older adults at an increased risk during an emergency.
	+ Infants and children under the age of 18 can also be at-risk, particularly if they are separated from their parents or guardians. They could be at school, in daycare, or at a hospital or other institution—places where parents expect them to be cared for during the crisis. There are also increasing numbers of children who are home alone after school. Separation of family members can cause its own havoc in a crisis, as demonstrated during evacuations for the 2005 hurricane season when members of some families were separated and sent to separate shelters, even to different states.

It is the goal that the cross section of attendees present at this workshop are varied and diverse enough to properly represent the needs of the entire community. The factors listed above complicate a community’s ability to receive and follow emergency response directives. By attendees providing a perspective of the vulnerable populations within the jurisdiction, the health department can take a proactive approach to ensure planning efforts account for everyone’s needs.

# Post-Exercise Evaluation

Please rate, on a scale of 1 to 5, your overall assessment of the exercise relative to the statements provided below, with **1** indicating **strong disagreement** with the statement and **5** indicating **strong agreement.**

*Workshop Assessment*

| **Assessment Factor** | **Strongly** **Disagree** | **Strongly Agree** |
| --- | --- | --- |
| a. | The workshop increased my knowledge of the LHD emergency response plans and its applicability to the communities I serve in Michigan | 1 | 2 | 3 | 4 | 5 |
| b. | The workshop increased my knowledge of the Crisis and Emergency Risk Communications (CERC) Plan. | 1 | 2 | 3 | 4 | 5 |
| c. | The workshop increased my knowledge of the Strategic National Stockpile (SNS). | 1 | 2 | 3 | 4 | 5 |
| d. | The workshop increased my knowledge of the LHD’s Point of Dispensing (POD) planning efforts. | 1 | 2 | 3 | 4 | 5 |

*Exercise Design Assessment*

| **Assessment Factor** | **Strongly** **Disagree** | **Strongly Agree** |
| --- | --- | --- |
| a. | The exercise was well-structured and organized | 1 | 2 | 3 | 4 | 5 |
| b. | The materials provided helped me understand and become engaged in the workshop | 1 | 2 | 3 | 4 | 5 |
| c. | Participation in the exercise was appropriate for someone in my position | 1 | 2 | 3 | 4 | 5 |
| d. | The participants included were the right people in terms of level and mix of disciplines | 1 | 2 | 3 | 4 | 5 |

*Short Answers*

1. Based on your area of expertise and experience, what is unique about the communities you serve?

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1. Which topics would you like discussed further in future training and exercises?

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1. Please provide any additional comments and/or recommendations.

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# APPENDIX A: Acronyms

| **Acronym** | **Term** |
| --- | --- |
| CERC | Crisis and Emergency Risk Communication |
| CDC | Centers for Disease Control and Prevention |
| ECC | Emergency Coordination Center |
| FOUO | For Official Use Only |
| LHD  | Local Health Department |
| MDHHS | Michigan Department of Health and Human Services |
| SitMan | Situation Manual |
| SNS | Strategic National Stockpile |

# APPENDIX B: Venue Information

*Insert directions, address, phone, and map for workshop*

1. Centers for Disease Control and Prevention (n.d.). Public Health Workbook to define, locate, and reach special, vulnerable, and at-risk populations in an emergency. Retrieved from <https://emergency.cdc.gov/workbook/pdf/ph_workbookfinal.pdf> [↑](#footnote-ref-1)
2. Centers for Disease Control and Prevention (2011) Healthy aging at a glance, 2011: helping people to live long and productive lives and enjoy a good quality of life. Retrieved from <https://stacks.cdc.gov/view/cdc/22022> [↑](#footnote-ref-2)