Table Discussions

Core Capabilitiy Inclusion for a Long-Term Response

Capability 1: Community Preparedness: The ability of communities to prepare for, withstand, and recover – in both the short and long terms – from public health incidents by engaging and coordinating with emergency management, healthcare organizations (private and community-based), mental/behavioral health providers, community and faith-based partners, state, local, and territorial partners.

1. If applicable to a public health jurisdiction, what is our role with tribal partners and how will we work together for an extended response? If I am representing a tribe, what is my role with local public health as it relates to a long-term campaign?
2. Do we meet with our response stakeholders to evaluate current mass dispensing plans and discuss planning considerations for transitioning from a non-medical POD to a medical POD?
3. How have response stakeholders contributed to plan development when addressing vulnerable population needs?
4. Have we addressed how a local health department and/or tribal community will work with hospitals during this event? What are important considerations to plan for?
5. Has the jurisdiction identified and mapped vulnerable and at-risk populations? Is this information available through the health department or emergency manager? Can mapping be done in partnership with LEPC (Local Emergency Planning Committee) partners?
6. Have we addressed circumstances that ensures vulnerable populations have access to all information distributed in a POD in accessible formats?
7. What considerations should be made in terms of access and functional needs if choosing an alternate POD site is necessary during a long-term dispensing campaign?

Capability 3: Emergency Operations Coordination: **The ability to direct and support an event or incident with public health or medical implications by establishing a standardized, scalable system of oversight, organization, and supervision consistent with jurisdictional standards and practices and with the National Incident Management System.**

1. Have we exercised our COOP with health department staff? Other county administration staff? Should this be considered and is it achievable?
2. What are the steps outlined in our existing plan to maintain essential functions/services for the department during a long-term MCM Distribution and Dispensing campaign?
3. What if any programs can be suspended during operations for needed staff to contribute to a long-term response?
4. What types of mutual aid do we have in place to augment staff in a sustained response?
5. Can we work with the National Guard or other military personnel to determine their capacity to assist with operational needs? What are other local resources?
6. Based on the health department's local governance structure, are there collaborations in place with healthcare organizations, medical ethicists, community advocates, and other partners to exercise health officer authorities in establishing priorities for potentially scarce medical resources?
7. Taking into consideration that the focus of hospitals may be treatment not prophylaxis, has the department/tribal partner identified and held advanced meetings with private sector vendors

such as long-term care facilities, urgent care centers, and/or alternate treatment centers to discuss contracted resources with the response?

Capability 4: Emergency Public Information and Warning: **The ability to develop, coordinate, and disseminate information, alerts, warnings, and notifications to the public and incident management responders.**

1. Will multi-agency coordination of information result in consistency across various methods of public information? How will this be achieved?
2. Do we have crisis and emergency risk communication messaging pre-developed plans to address public messaging on adverse events? Do they include how to address identified cases and where to report this information? Do we incorporate adverse event reporting procedures and available data in public messaging and health alerts, to vulnerable populations as well?
3. Do the services we provide in long-term dispensing plans assure access and compliance with needs? Have we meet with community organizations to foster public health, medial, and mental or behavioral health social networks?
4. Has engagement of community partners taken place to pre-identify individuals or agencies that can assist with translation services or information formats for the visually impaired or those who are hearing impaired?
5. Have long-term dispensing media messaging that encompass populations that may include physical, mental, emotional, or cognitive status, culture, ethnicity, religion, citizenship, or socioeconomic status been developed in addition to language barriers? What types information should be considered most important in the development for functional and access needs populations?

Capability 6: Information Sharing: **The ability to conduct multijurisdictional, multidisciplinary exchange of health-related information and situational awareness data among federal, state, local, territorial, and tribal levels of government, and the private sector. This capability includes the routine sharing of information as well as issuing of public health alerts to federal, state, local, territorial, and tribal levels of government and the private sector in preparation for, and in response to, events or incidents of public health significance.**

1. Is there effective coordination and information sharing systems to support situational awareness and resource management with stakeholders?
2. Do plans have mechanisms to engage with regional media providers to report specific needs for long-term messaging? Do plans address how to engage media outlets that are more focused on larger communities vs. smaller jurisdictions?
3. What partners need to remain involved in a Joint Information System (JIS) during a sustained response to ensure consistency in messaging?
4. What strategies or systems are in place to track doses administered over a 60-day period?
5. What communication methods are in place to communicate sensitive information to stakeholders?
6. Does it make sense to develop a regional policy for using social media during a long-term campaign? What partners might be included with this function? Who would take the lead to encourage the use of this medium to control or limit rumors?

Capability 8: Medical Countermeasure Dispensing: **The ability to provide medical countermeasures (including vaccines, antiviral drugs, antibiotics, antitoxin, etc.) in support of treatment or prophylaxis (oral or vaccination) to the identified population in accordance with public health guidelines and/or recommendations.**

1. Is there sufficient staffing capacity to maintain a long-term dispensing tempo throughout a possible 60-day operation?
2. Has our plans address the possibility of competition between POD sites for MCM supplies? What are the procedures regarding allocation of limited resources if not immediately addressed by the CDC through priority group distribution?

3. Are there developed relationships with local pharmacies and medical providers so that they are included in AVA administration?
4. Has the department revised dispensing plans to determine the number, type, and location of sites needed to not only dispense oral antibiotics but to administer vaccine? Is this needed?
5. Can the department and/or POD site support a dual dispensing (antibiotic screening/dispensing as a single POD function combined with first vaccine dose) model with separated staff functions?
6. Can existing POD sites support extended use? Has this discussion with POD partners taken place? Are Open POD sites flexible enough to be reactivate if needed to continue a long-term response? Have considerations been addressed as to how it may affect normal use on the site's end?

Capability 9: Medical Materiel Management and Distribution: **Medical materiel management and distribution is the ability to acquire, maintain (e.g., cold chain storage or other storage protocol), transport, distribute, and track medical materiel (e.g., pharmaceuticals, gloves, masks, and ventilators) during an incident and to recover and account for unused medical materiel, as necessary, after an incident.**

1. Are nursing staff trained on cold-chain management standards? Would it be beneficial if all staff were trained? Is it a possibility?
2. Does the department/POD site have adequate receiving space allocation to support the entire and/or next 50-day shipment, including cold-chain storage for the designated community's population? Does this include POD considerations?
3. What mechanisms are in place to work with regional LHD's to address security needs rather than acting in isolation? How will this need, or response be communicated within the region?
4. How are your security partners affected during an ongoing, long term criminal investigation?
5. If there is an assumption that the CDC will not have sufficient ancillary supplies to administer anthrax vaccine, can this be addressed as a department? Does the current plan address this and/or stock needed resources? Does the existing operating budget support this?

Capability 13: Public Health Surveillance and Epidemiological Investigation: **The ability to create, maintain, support, and strengthen routine surveillance and detection systems and epidemiological investigation processes, as well as to expand these systems and processes in response to incidents of public health significance.**

1. What epidemiology resources (systems, staff, etc.), do you have access to during a long-term dispensing campaign?
2. Will data collected be electronic or manual? If done electronically, would computers across a region be able to keep up with the demand on systems? If paper needs to be used, how does that affect data collection?
3. Some individuals may report adverse events directly to their healthcare provider or treatment center. It is possible that those providers or facilities may not report this information to the local health department or to VAERS. Do we have a mechanism in place to gather this information to be included in our surveillance procedures?
4. What existing capabilities and resources are available to address the department's follow-up response to planning for this event? What is the scope of the follow-up response? Will using partners with this strategy be an asset to follow-up activities?
5. Have we determined how to address mild adverse events vs. severe events? How will this be reported and addressed? Have we thought about our department's response to hours, days, weeks, months, or years reactions? What would a long-term tracking tool entail?

Capability 14: Responder Safety and Health: **The responder safety and health capability describes the ability to protect public health agency staff responding to an incident and the ability to support the health and safety needs of hospital and medical facility personnel, if requested.**

1. Do we have mandatory policy about employee prophylaxis response to an event?
2. Are employees or first responders prioritized for AVA considering limited quantities?
3. What is specific within my MCM plan that addresses psychological support or family support during a public health crisis for staff? Is this a formal position in your ICS structure?
4. Do staff working in out-of-office POD settings receive basic training in elements of infection prevention, including an overview of the possible or likely hazards to which they may be exposed to in a public health emergency setting? Will our current trainings be applicable to a long-term response? What revisions need to be made to satisfy this? Is a refresher training available?
5. What safety considerations need to be made when choosing an alternate POD site during a long-term dispensing campaign?

Capability 15: Volunteer Management: **Volunteer management is the ability to coordinate the identification, recruitment, registration, credential verification, training, and engagement of volunteers to support the jurisdictional public health agency's response to incidents of public health significance.**

1. Are there developed mutual aid agreements with regional partners, schools of nursing, medical facilities, or providers, pharmacy, etc. to request additional staff? Is that a jurisdictional option? What might other sources be used in mutual aid agreements?
2. The staffing demand will change as the MCM campaign transitions, can we meet those demands with appropriate professionals (i.e., doctors, nurses, or others approved to provide vaccinations in a declared emergency? How will we address this?
3. What resources do we have to develop MOU's for staffing considerations? For different disciplines in the response?
4. What might volunteer needs look like for a dual POD model if the numbers suggest deploying volunteers who may need to cross jurisdictional or state lines? What does this look like for our tribal partners and what considerations should be addressed pre-event?
5. How are call center staffing needs addressed? Do we plan/train for staff and/or other county/tribal employees to understand their role within a call center? If we do not have dedicated staff, will we use resources to hire some temporary employees to fill this role? What if a federal or state disaster declaration has not been enacted, what are funding considerations?