

DRAFT MINUTES
Leadership Group Meeting
ASPH Preparedness and Response Core Competency Development Project
Monday, August 31, 2009
8:30 a.m. – 4:30 p.m.
Atlanta Marriott Perimeter Center
246 Perimeter Center Parkway, NW Atlanta, GA 30346

Members Present:

Audrey Gotsch, Co-Chair (UMDNJ)
Bill Keck, Co-Chair (NEOUUCOM)
Jim James (AMA)
Molly Jo Lamb (NACCHO)
Kraig Humbaugh (Kentucky DOH)
Kathy Miner (Emory)
Bill Riley (Minnesota)
Steve Rottman (UCLA)
Ken Schor (USUHS)
Andrea Young (CDC)
Liaison Craig Thomas (CDC)

CDC:

Liane Hostler

Wanda King
Robyn Lebovitz

ASPH:

Katie Fischer
John McElligott
Elizabeth Weist

Leadership Group Members Not Able to Attend Meeting:

Rick Clover (Louisville)
Kristine Gebbie (CUNY)
Mike Handrigan (ASPR)
David Marcozzi (DHHS)

Welcome and Introductions

Dean Gotsch and Dr. Bill Keck welcomed everyone to the meeting. Then, they reviewed the group's charge and the agenda for the day. After reviewing the PAHPA legislation and briefing the leadership group on the August 26-27 Workgroup Meeting, the co-chairs also reviewed the Project Guiding Principles and Tenets from the June 2-3 meeting in Alexandria.

Andrea Young then shared her briefing from the Board of Scientific Counselors presentation.

Project Status Review Briefing

Dr. Kathy Miner reviewed the terminology that the group would use from this point forward, "domains," instead of "competency." Dr. Miner then explained the concept of the "array" of behaviors that the workgroup had decided upon. She stated that it is important to start with the people who would fall in the middle of this array because it would be easiest to ratchet down and up from there. The DeKalb County Health Department in Georgia, for example is comprised of people across a spectrum of experience and skills. Their competencies will fit into the picture of the health department, however, in some cases, the department of health will have collaborative relationships (e.g. with fire department or a community-based organization) to be fully prepared. The expectation that all people will display all behaviors is not relevant, as the

behaviors and skills someone must display will depend on the position and role within the organization. Members also discussed:

- Avoiding educational benchmarks in this process;
- Staying clear of competencies that come from one group's intellectual property; and;
- Focusing on core skills, stating that this is a training and preparedness-oriented educational model and is neither certification exam nor accreditation-focused.

Breakout Groups to Evaluate Workgroup Output (n =14 domains)

Breakout #1

Ken Schor reported a summary from his breakout group

Domains:

- Surveillance and Detection
- Investigation and Analysis
- Situational Awareness
- Collaboration, Connectivity, and Community Relations
- Decision Making and Prioritizing
- Preparedness and Response Strategies and Interventions

Can combine a few domains:

- Surveillance and Detection + Investigation and Analysis
- Situational Awareness + Collaboration, Connectivity, and Community Relations
- Decision making and Prioritization + Preparedness and Response Strategies and Improvement (call it Preparedness, Planning and Improvement)

Still missing some cross-cutting domains: team building, leadership, tactical communication (cannot assume the communication systems are intact and operational; can involve IT; and is different from crisis and risk communication), intra-organization communication

Breakout #2

Jim James reported a summary from his breakout group.

- Risk and Crisis Communication
- Preparedness Improvement
- Incident Management System
 - Decision Making and Prioritizing
- Surveillance and Detection
 - Investigation and Analysis
- Preparedness and Response Strategies and Interventions (Ability to deploy – cross-cutting?)
 - Situational Awareness
- Safety and Protection
 - Hazard, Vulnerability, and Risk Assessment

- Resilience (changed from “Mental Health”) Collaboration, Connectivity, and Community Relations
- Public Health Law
 - Ethics

Dr. James reported that the workgroup was focused on competencies, not domains, per the following list:

1. Risk and Crisis Communication
2. Prep Improvement
3. IMS – *Decision making and prioritizing falls here*
4. Surveillance and Detection—*Investigation and analysis falls here*
5. Preparedness/Response + Deployability—*Situational awareness falls here (event driven)*
6. Safety/Protection—*Hazard and Risk Assessment falls here*
7. Resilience (Mental Health)
8. Collaboration/Community
9. PH Law and Ethics (collapse two categories into one)

He then stated if the workgroup had been focused on overarching domains, the output may have looked different.

Breakout #3

Steve Rottman reported a summary from his breakout group, noting:

Leave as is:

- Risk and Crisis Communication (includes internal communications)
- Psychological Aspects
- Public Health Legal Authority
- Surveillance and Detection (includes laboratories)
- Incident Management System
- Decision Making and Prioritizing
- Hazard, Vulnerability, and Risk Assessment
- Responsible and Ethical Conduct
- Preparedness Improvement (includes evaluation)

Consider grouping differently:

- Investigation and Analysis + Preparedness and Response Strategies and Interventions + Surveillance and Detection
- Under IMS: Situational Awareness + Collaboration, Connectivity, and Community Relations

Think about adding:

- Financial, Recovery, Internal Communications

General Discussion:

Members posed the following questions:

- Do you train a health department with all of these elements in mind?
- How do we differentiate across all people in a department versus those in a response role within Incident Command Management.?
- Within IMS, does every public health worker need to function in the context of situational awareness and collaboration, connectivity, and community relations?
- Do we need to include finances (under ICM), recovery, and internal communications?
- Because IMS was not designed for public health applications, how do we find a public health corollary to the IMS?
- Do triage and/or surge fall under IMS? Yes, per Steve Rottman.
- What are the commonalities across what we have just heard? While it is not necessary to gain consensus about how the domains should be collapsed, some members had a sense that the 14 are too many.

SUMMARY

The Leadership Group decided to continue with the following domains:

1. Hazard, Vulnerability, and Risk Assessment
2. Tactical and Crisis Communication
3. Preparedness Planning and Improvement
4. Incident Management System
5. Leadership
6. Investigation and Surveillance
7. Safety and Protection
8. Psychological Aspects
9. Legal and Ethics

Discussion:

- The model is missing a domain for Strategies and Intervention (i.e. mitigation, containment). There is not currently a domain to capture the action of solving the problem. This may include many specialties, so it may be difficult to include in this model as these competencies are meant to be core public health preparedness competencies.
 - This domain may be derived from Hazard, Vulnerability, and Risk Assessment and Preparedness Planning and Improvement or could fit as a sub-domain under ICM
 - If it is pulled out and assumed that the plan in Preparedness Planning and Improvement sets the strategy and the ability goes in Incident Management System, what else is missing?
 - If the Council on Linkages set is foundational, then perhaps it is covered. However, this cross-cutting domain is not in the COL and we may need a

cross-cutting category that is specific to preparedness (e.g. deployability, finances).

Develop Initial Behavioral Content

Dr. Kathy Miner gave an overview of the correct way to write a competency. She indicated knowledge is content and that all competencies have a verb followed by something that is teachable – they are a higher order of a learning objective.

Staff posted Bloom's Taxonomy around the room to keep the group on track. Members then suggested initial behavioral content, as follows:

1. Hazard, Vulnerability, and Risk Assessment
 - a. Making decisions and balancing benefits and risks
 - b. Have data sharing agreements
 - c. Inventory of hazards by frequency and impact.
 - d. Vulnerability parameters for population sub-groups (geography, economic, demographics, resources for buffers)
 - e. Comparing risk across population data.
 - f. Gather data from populations.
 - g. Feed data to decision maker.
 - h. Compare hazards with population attributes.
 - i. Recommend courses of action.
 - j. Implement courses of action.
 - k. Develop data collection instruments.
 - l. Share data with partner agencies. (Data sharing agreements)

2. Tactical and Crisis Communication
 - a. Have broadband communication capability
 - b. Assure phones/IT/etc. work to run the dept accordingly
 - c. Giving multi-level input for the spokesperson to use
 - d. Knows the internal and external communication anatomy/needs
 - e. Demonstrate/operate the hardware (and software)
 - f. Interpret info gleaned from the hardware
 - g. Utilize multiple means of communication
 - h. Provide inputs for messaging/assist in message development
 - i. Know sources, synthesize it, and disseminate it
 - j. Synthesize information
 - k. Knows spokesperson for health department
 - l. Appoint spokesperson for health department
 - m. Provide input for message preparation
 - n. Prepares messages (advanced)
 - o. Identify important information for messages
 - p. Synthesize information
 - q. Operate communication equipment
 - r. Ensures communication equipment is operational
 - s. Practices cultural competence
 - t. Recognize internal and external communication needs
 - u. Communicate with the correct partners

- v. Interpret processes to assemble information
 - w. Disseminate information...to whom?
 - x. Read languages appropriate to the population
 - y. Write in languages appropriate to the population
 - z. Communicate risk
 - aa. Knows agreements with translation agencies
 - bb. Apply communication principles of Incident Command System
 - cc. Describe how information flows in the Joint Information Center/System
 - dd. Implement Joint Information Center Standard Operating Procedures
3. Preparedness Planning and Improvement
- a. Workforce development
 - b. Know the parts of a plan
 - c. Perform/Implement one's response role during an incident or exercise
 - d. Produce a draft of one's job action sheet related to Standard Operating Procedures for one's unit (all-hazards and hazard-specific)
 - e. Apply feedback from real responses or exercises to improve plan after action reports and corrective action programs
 - f. Participate in exercises
 - g. Recognize importance of exercises (more basic)
 - h. Evaluate the effectiveness of the plan
 - i. HSEEP compliance
 - j. Contribute to development of preparedness and response plans
 - k. Apply knowledge of planning to preparedness cycle
 - l. Conduct a training needs assessment
 - m. Prepare a budget
 - n. Survey a community for POD locations
 - o. Recognize purpose and importance of exercises. (basic level)
 - p. Knows the planning process is more important than the plan.
 - q. Homeland Security Exercise and Evaluation Program-compliant
4. Incident Management System - look to work done by FEMA
- a. Contribute to situational awareness
 - b. Strategies and Interventions
 - c. Manage scarce resources
 - d. Use organization's IMS tools and resources
 - e. Initiate Incident Command Structure
 - f. Apply principles of public health Incident Command Structure to specific function
 - g. Know Emergency Support Function-8
 - h. Know National Response Framework
 - i. Check work done by DHS and FEMA to ensure consistency, need to make sure this doesn't violate what has been done
 - ii. need to get public health incident command structure people in this effort, not just emergency management people who are not in public health
5. Leadership - look to other work done by SLU Heartland, Harvard, Five Dimensions of Meta-Leadership

- a. Collaboration, Connectivity, and Community Relations
 - b. Understand “followership”
 - c. Engage critical partners
 - d. Prioritize stakeholders
 - e. Establish relationships with preparedness partners
 - f. Continue relationships with partners
 - g. Make evidence-based decisions in times of uncertainty
 - h. Make timely decisions
 - i. Contribute to process of evidence-based decision-making
 - j. Interpret contributions from partners
 - k. Distinguish between contributions from partners
6. Investigation and Surveillance- look to CSTE Applied Epidemiology Competencies and forthcoming Laboratory Competencies and ensure the APHL is represented in pool of subject matter experts
- a. Know principles of epidemiology and data provided
 - b. Set parameters for information gathering
 - c. Demonstrate capacity to conduct data analysis
 - d. Interpret data/perform surveillance during certain window of time (pre, during, and post incidents)
 - e. Know where to send lab specimens (in-house or elsewhere)
 - f. Know special handling of items, shipping, logistics of PH lab network and testing protocols
 - g. Calculate necessary lab supplies (will vary by jurisdiction and hazard)
 - h. Know limitations of data
 - i. Demonstrate ability to use data and tools
 - j. Determine threshold for reporting
 - k. Syndromic surveillance
 - l. Know diff between containment and mitigation phases
 - m. Apply targeted surveillance techniques to specific sites/situations
 - n. Apply targeted surveillance for situation.
 - o. Forensic epidemiology
 - p. Recognize when to convey information to investigators or other agencies
 - q. Know principles of epidemiology and data provided.
 - r. Set parameters for information gathering
 - s. Interpret health information and data.
 - t. Collect health information and data.
 - u. Analyze health information and data.
 - v. Calculate needed laboratory supplies.
 - w. Know if organization has a laboratory.
 - x. Recognize changes in protocols and laboratory reporting.
 - y. Know limitations of data sets.
 - z. Use tools of epidemiology-related information technology.
 - aa. Enhance surveillance before, during, and after events.
 - bb. Determine threshold for reporting.
 - cc. Syndromic surveillance
 - dd. Containment vs. mitigation phases
 - ee. Interface between public and private laboratories

7. Safety and Protection
 - a. Ensure safety within the EOC, field epidemiologists
 - b. Review issues of vaccinations, prophylaxis, etc.
 - c. Collaborate with law enforcement on PODs, traffic officials, and other partners
 - d. Use personal protection equipment consistent with agency protocols
 - e. Ensuring awareness of subordinates
 - f. Apply protocols to at-risk pops (could be colleagues, community members, etc.)
 - g. Enforce at-risk populations to use countermeasures, protection equipment consistent, etc.
 - h. Ensure the safety of volunteers
 - i. Follow the evacuation plan
 - j. Follow protocol for suspicious substances
 - k. Occupational safety and protection
 - l. Safety and protection of colleagues and the public
 - m. Collaborate with law enforcement
 - n. Use personal protective equipment consistent with organization protocols.
 - o. Identify at-risk populations for personal protective equipment (enforce use of protection equipment consistent)
 - p. Follow through with environmental and community needs organizations.

8. Resilience/Mental Health/Psychological? (for workers and for populations served)
 - a. Implement protocols to identify stress in workforce
 - b. Assess mental health readiness of staff to respond to situations
 - c. Recognize existence of psychological first aid for populations affected by disasters.
 - d. Implement psychological first aid for populations affected by disasters.
 - e. Recognize degrees of psychological exposure.
 - f. Refer persons affected by disasters to appropriate psychological professionals.
 - g. Differentiate between persons affected by disasters and persons with mental illnesses.
 - h. Conduct psychological triage in affected populations, including the public health workforce.
 - i. Implement protocols in organization to identify stress in public health workforce.
 - j. Assess personal capacity to respond to emergencies.
 - k. Assess mental health readiness of subordinates.
 - l. Establish rhythm for public health workforce

9. Legal and Ethics - look to competencies from Disaster Medicine and Public Health Preparedness
 - a. Be equitable in regard to care for disparate pops
 - b. Make decisions regarding who receives care and who does not
 - c. Apply public health decision making frameworks [cannot separate these from the clinical ethic]
 - d. Share data with partner agencies. (Data sharing agreements)
 - e. Distinguish between what is ethically right and what is required by law.

- f. Know the difference between individual and population ethics.
- g. Know how to measure benefit in ethical situations
- h. Allocate resources
- i. Open alternate care centers
- j. Be equitable in regard to care for disparate populations
- k. Equity in health jurisdictions
- l. Develop public health decision-making frameworks
- m. Apply public health decision-making frameworks
- n. Act in accordance with professional ethics.
- o. Act in accordance with organization's ethical priorities, standards, and guidance during emergency situations. (Note: part of definition from workgroup)
- p. Ensure continuity of operations. (Note: part of definition from workgroup)
- q. Act in a transparent manner.
- r. Repeat rules, regulations, statutes, and ordinances.
- s. Know organizational policies during emergencies.
- t. Be aware of ethical obligations to self, family, organization
- u. Act in compliance with public health emergency laws, statutes, and regulations (i.e. local, tribal, state, and federal). (Note: definition of legal authority from workgroup).

ASPH Staff Report

John McElligott and Elizabeth Weist gave an update on the outreach efforts to stakeholders as well as the project website that members and the public can access for further updates. A presentation for use by Leadership Group members will be forthcoming from staff. Ms. Weist also asked for names of additional individuals recommended for participating in the Delphi and upcoming workgroups.

Closing

Dr. Keck and Dean Gotsch thanked participants for attending the meeting and for committing to the competency development effort. They then adjourned the meeting at 4:00 p.m.