

NCALHD ATTENDANCE ROSTER

Sept 29

~~August 20, 2009~~

Health Director Initial by County

Bold = Dues Paid

JB Alamance/Barry Bass (E)
JB Albemarle District/Jerry Parks (E)
 Alexander/Leanne Whisnant
 Anson/Dr. Francis Kateh (E)
JB Appalachian Dist/Danny Staley (E)
EH Beaufort/Roxanne Holloman
 Bladen/Wayne Stewart
 Brunswick/Don Yousey
JB Buncombe/ Gibbie Harris (E)
ELB Burke/David Rust
 Cabarrus/Phred Pilkington
DN Caldwell/Denise Michaud
 Carteret/J.T. Garrett
 Caswell/Fred Moore
De Catawba/Doug Urland
Wh Chatham/Holly Coleman (E)
 Cherokee/David Badger, Interim
YFP Clay/Janice Patterson
DN Cleveland/Denese Stallings
K/S Columbus/Kimberly Smith
TC Craven/Scott Harrelson
DW Cumberland/
at Dare/Anne Thomas
JB Davidson/Layton Long
JB Davie/Suzanne Wright
JB Duplin/Ila Davis
JB Durham/Gayle B. Harris
 Edgecombe/Karen Lachapelle
EM Forsyth/Tim Monroe
CS Franklin/Chris M. Szwagiel
CB Gaston/Colleen Bridger
JP Graham/Alicia Parham, Interim
HRD Granville-Vance/Dr. Roddy Drake
JD Greene/Linda Sewall (E)
MG Guilford/Merle Green
LP Halifax/Lynda Smith (E)
DN Harnett/John Rouse (E)
JB Haywood/Carmine Rocco (E)
JB Henderson/Tom Bridges

Hertford/Ramona Bowser & Diane
 McLawhorn, Interims
 Hoke/Cynthia Oxendine
 Hyde/Wesley Smith, Interim
 Iredell/Donna Campbell
JB Jackson/Paula Carden
 Johnston/Marilyn Pearson
 Jones/Kristen Richmond-Hoover
 Lee/Howard Surface
 Lenior/Joey Huff
WSD Lincoln/Maggie Dollar (E)
JB Macon/Jim Bruckner
CM Madison/Carolyn Moser (E)
XD MTW/Kathleen DeVore Jones
EW Mecklenburg/Earl Mabry
 Montgomery/Tammie Bell *Julie Clark*
 Moore/Robert Wittman
 Nash/William Hill, Jr.
JB New Hanover/David Rice
 Northhampton/Sue Gay
JB Onslow/George O'Daniel
JB Orange/Rosemary Summers (E)
 Pamlico/ Davin Madden
JB Pender/Jack Griffith
 Person/Janet Clayton
 Pitt/Dr. John Morrow
 Randolph/MiMi Cooper
 Richmond/Tommy Jarrell
YS Robeson/Bill Smith (E)
JB Rockingham/Glenn Martin
 Rowan/Leonard Wood
 RPM Dist./~~Back Wilson~~
 Sampson/Wanda Robinson
RD Scotland/Ron Sapp
 Stanly/Dennis Joyner
JS Stokes/Josh Swift
AC Surry/Samantha Ange *Call Creed, DON*
JWS Swain/Linda White
 Toe River Dist./Jesse Greene

U

~~SE~~ Transylvania/Steve Smith

Union/Phillip Tarte

~~Wake/Betsy Wilson, Interim~~

Warren/ Andy Smith, RS, MPA,

Interim

Wayne/Jim Roosen

Wilkes/Beth Lovette (E)

~~Wilson/Felix Meyer~~

~~Yadkin/Mike Reavis~~

Ramon Lopez
Stacy

Lynette Tolson, Executive Director

Jeff Engel, M.D., N.C. State Health Dir.

Terry Pierce, Environmental Hlth Dir.

DPH
Dennis Harrington, DPH Liaison

Joy Reed, DPH Liaison

GUESTS AND LIASONS FROM OTHER ORGANIZATIONS

Robert Blackburn ANCBH

Carolyn Coley Ed, DPH, Wayne County

Steve Cline DPH

Steven W. Garner DPH

Percentage of LHD who complete Profile Questionnaire

North Carolina	98%
National	83%

N(North Carolina)=83

N(National)=2794

Geographic areas served by North Carolina LHDs

County	92%
City/County	1%
Multi-county, district, region	7%

n=83

Percentage of North Carolina LHDs with Local Board of Health

North Carolina	100%
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n=82

Distribution of LHDs by Size of Population Served

Size of population served	Percentage of LHDs	
	North Carolina	National
<25,000	13%	43%
25,000-49,999	22%	21%
50,000-99,999	34%	15%
100,000- 199,999	25%	12%
200,000-499,999	4%	5%
500,000-1,000,000	2%	3%

n(North Carolina)=83

n(National)=2332

Total Number of LHDs in state 85

Total Number of LHDs in data 83

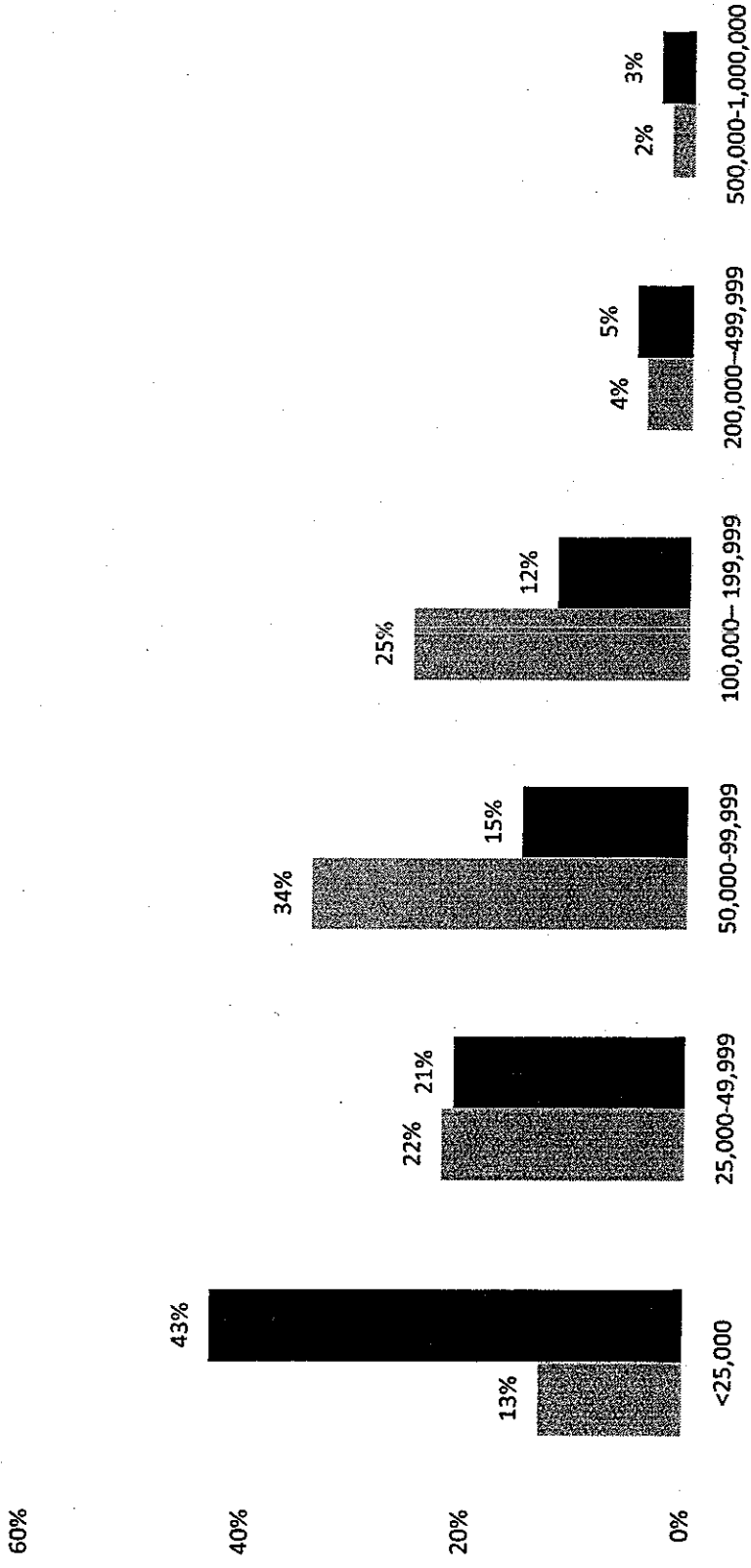
Total Annual LHD Expenditures

	North Carolina	National
<\$2,500,000	15%	68%
\$2,500,000-4,499,999	24%	11%
\$4,500,000-6,499,999	22%	5%
\$6,500,000-8,999,999	19%	5%
\$9,000,000+	19%	11%

n(North Carolina)=78

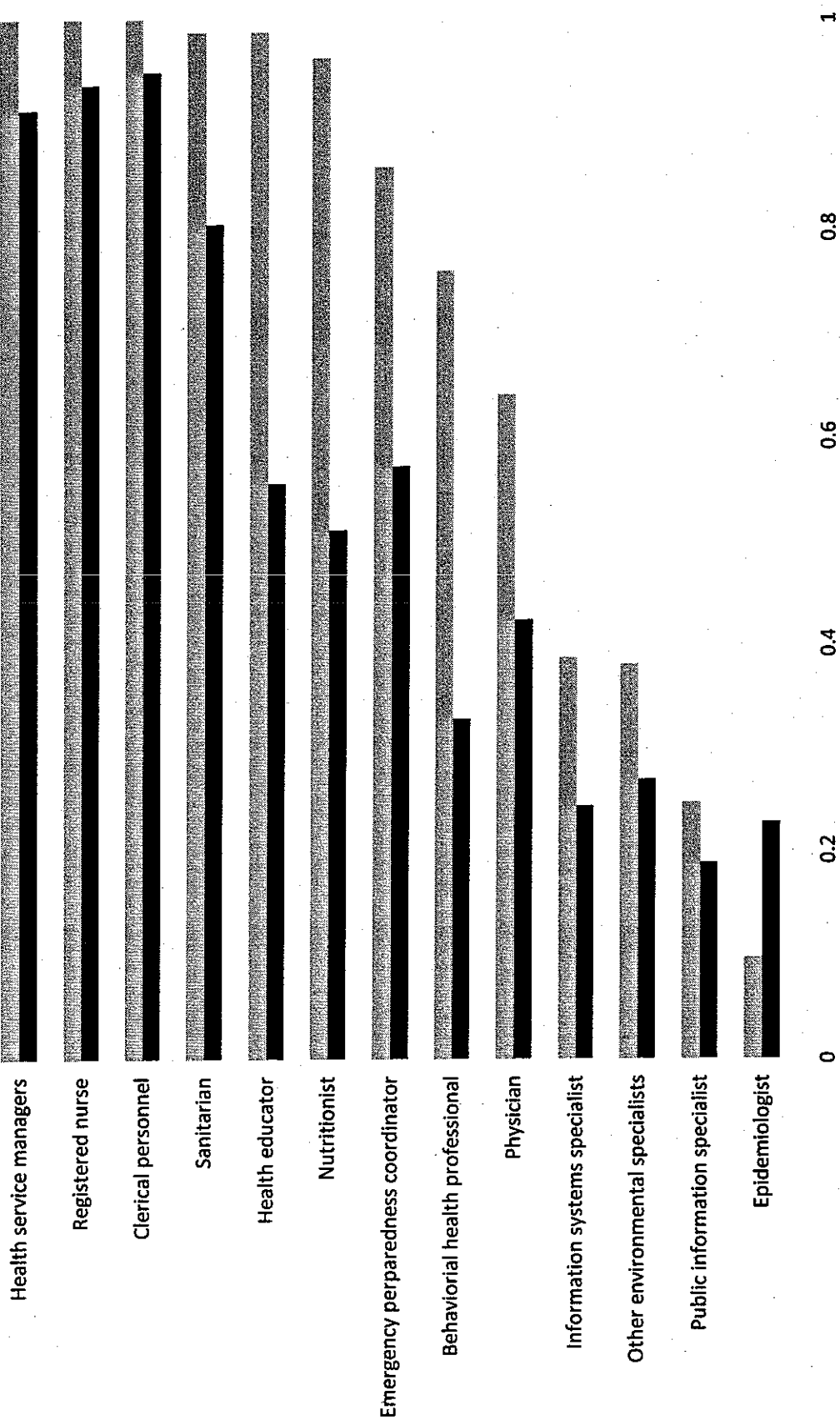
n(National)=2097

■ North Carolina ■ National



n(North Carolina)=83; n(National)=2332

■ North Carolina ■ United States



n(North Carolina)=69-83; n(National)=1983-2260

Percentage of LHDs

Activities and Services Provided by >100% LHDs in North Carolina

Adult Immunization	100%
Child Immunization	100%
HIV/AIDS Screening	100%
STD Screening	100%
TB Screening	100%
Blood lead screening	100%
Family planning	100%
Communicable/infectious disease surveillance	100%
Vital records services	100%

n ranged from 76 to 83

**Activities and Services: North Carolina vs National*
Provided More Frequently in North Carolina**

Activity or Service			Difference
	North Carolina	National	(North Carolina-National)
Laboratory services	90%	25%	65%
Prenatal care	88%	33%	55%
Vital records services	100%	50%	50%
Well child clinic	89%	41%	48%
Lead inspection regulation	98%	49%	48%
Cancer screening	89%	42%	47%
Health-related facilities regulation	78%	31%	47%
Body art regulation	96%	50%	46%
Family planning	100%	54%	46%
Hotels/motels regulation	94%	51%	42%
	n=76-83	n=2230-2313	

Community Health Assessment and Improvement Plan: North Carolina vs. National

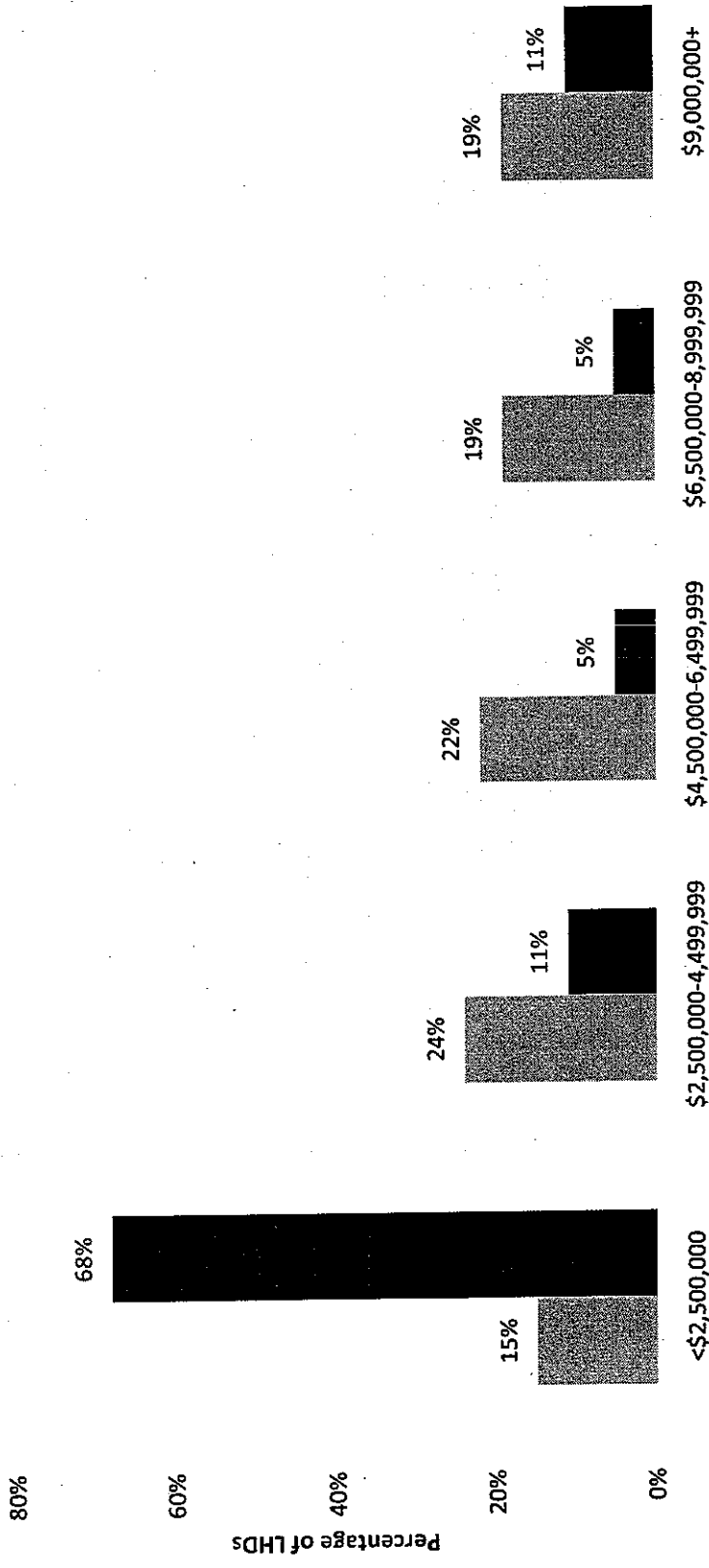
	North Carolina	National
Community Health Assessment	88%	63%
Community Health Improvement Plan	77%	49%

n(North Carolina)=82 and 81, respectively

n(National)=2300 and 2220, respectively

■ National

▨ North Carolina



Total Annual Expenditures

n(North Carolina)=78; n(National)=2097

Percentage Distribution of LHD Revenues from Various Sources		
	North Carolina	National
Local Government	29%	25%
State Direct	13%	20%
Federal Pass-Through	8%	17%
Federal Direct	0%	2%
Medicaid and Medicare	32%	15%
Other Sources	18%	21%
	n=63-64	n=1458-1629



Characteristics of LHD Top Executives		
	North Carolina	National
Full-time position	100%	86%
Less than two years in position	23%	21%
Ten or more years in position	29%	35%
% Race White	89%	94%
% Hispanic	0%	2%
% Female	46%	56%
Holds a graduate degree	96%	62%
	41%	
Holds a public health degree		21%
<i>n(North Carolina) ranged from 80 to 83</i>		
<i>n(National) ranged from 2156-2298</i>		

Report from LTAT Branch to NCALHD
September 29, 2009

- 1) **The NC Board of Nursing adopted a position statement at their September 25 meeting allowing nurses to delegate the administration of immunizations to unlicensed assistive personnel during times of “declared State or National Emergencies or Federal/State DHHS or CDC Initiated Mass Immunization Campaigns.” Copies of this are available and a copy has been given to the Secretary to attach to the minutes. The statement makes it clear that the RN must train and document competency of these individuals and retains the responsibility for assessment and must be on-site during the immunization clinics. This should not be taken as an opportunity to allow anyone to provide these immunizations, but could allow LHDs to capitalize on nursing students at all levels who are not yet licensed, retired nurses who have allowed their licenses to lapse, etc. to enhance the LHDs immunization capacity.**

- 2) **For the first time since beginning its biennial survey of all local health departments in the country, NACCHO allowed states to receive an individual state report of the information submitted. A part of this process was requiring us to review the data for errors. Joy Reed did the review for NC and found two major errors – 100% of NC LHDs were listed as providing EMS services and a very small percentage were listed as providing environmental health services; they identified the source of those errors and corrected that in our final NC report (the data is still inaccurately reflected in NACCHO’s published report based on all states.) NC, as usual, had a terrific response rate – only two of our 85 LHDs did not respond. Highlights of the report are provided and again, a copy has been given to the Secretary to attach to the minutes.**

- 3) **The division of Medical Assistance has changed its policy related to the billing of Health Check visits and as of July 1, no longer requires that the linked reportable services be included in the claim in order for the claim to be paid (e.g., a 99392 EP will pay whether or not the required hearing, vision and developmental testing is reported with that claim.) However, DMA has also indicated that they will be monitoring the claims for these services and that providers who routinely do not include those reportable services with the preventive medicine visit will be audited to verify that these required services are documented in clinical records. Therefore, DPH strongly recommends that local health departments continue to include the reportable services with all Health Check claims.**



Agenda #13
Delegation of Immunization Administration to UAP
in Defined Immunization Campaigns Position
Statement
Sept 2009
Meeting

Delegation of Immunization Administration to UAP in Defined Immunization Campaigns

Position Statement for RN and LPN Practice

Declared State or National Emergencies or Federal/State DHHS or CDC Initiated Mass Immunization Campaigns may require the immunization of large numbers of citizens in a short, designated period of time. It may, at such times, be necessary and appropriate for Licensed Nurses (RN and LPNs) to delegate the task of immunization administration, consistent with agency policies and procedures, by any appropriate route, to unlicensed assistive personnel (UAP) as part of timely, effective mass immunization programs. The UAP assisting in such programs may include any unlicensed personnel, regardless of title, who participate in mass immunization activities through the delegation process.

Consistent with G.S. 90-171.20 (7) & (8), nursing law permits the delegation of tasks to unlicensed assistive personnel by the RN and LPN.

In order for the RN or LPN to delegate activities to UAP the following criteria listed in Administrative Code Rule 21 NCAC 36.0221(b) must be met:

"Tasks may be delegated to an unlicensed person which:

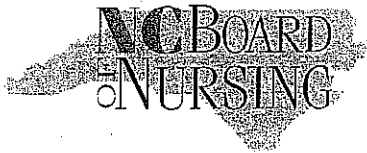
- (1) frequently recur in the daily care of a client or group of clients;
- (2) are performed according to an established sequence of steps;
- (3) involve little or no modification from one client-care situation to another;
- (4) may be performed with a predictable outcome; and
- (5) do not inherently involve ongoing assessment, interpretation, or decision-making which cannot be logically separated from the procedures(s) itself."

The RN or LPN may only delegate **technical** aspects of immunization administration to UAP in these State or National Emergencies or Campaigns.

The licensed nurse (RN or LPN) may not delegate the professional judgment or decision-making responsibility to UAP which includes:

- (1) recognizing side effects;
- (2) recognizing toxic effects;
- (3) recognizing allergic reactions;
- (4) recognizing immediate desired effects;
- (5) recognizing unusual and unexpected effects;
- (6) recognizing changes in client's condition that contraindicates administration of the immunization;
- (7) anticipating those effects which may rapidly endanger a client's life or well-being; and making judgments and decisions concerning actions to take in the event such untoward effects occur. [21 NCAC 36 .0221 (c)].

The RN or LPN delegating immunization administration must, therefore, remain available to the UAP **on site** to address any issues identified in pre-administration screening of the client and for the ongoing assessment and evaluation of the client as indicated by the situation and by RN or LPN Scope of Practice.



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The **RN** has the overall responsibility and accountability for educating the UAP in appropriate administration techniques and for then assessing the capabilities of the UAP to include validation of their competence (i.e., qualifications, knowledge, and skills) in carrying out the technical role of immunization administration.

The **RN retains responsibility and accountability for comprehensive assessment and evaluation of the client** as defined in Administrative Code Rule 21 NCAC 36 .0224 (b) and (e) "Components of Practice for the Registered Nurse." The **RN** has the overall responsibility and accountability for educating the UAP in appropriate administration techniques and for then assessing the capabilities of the UAP to include validation of their competence (i.e., qualifications, knowledge, and skills) in carrying out the technical role of immunization administration. In addition, the **RN** is responsible for delegating appropriately and providing the UAP with ongoing supervision, teaching, and evaluation as defined in Administrative Code Rule 21 NCAC 36 .0224 (i) and (j)

The **LPN participates in the assessment and evaluation of the client** as defined in Administrative Code Rule 21 NCAC 36 .0225 (b) and (e) "Components of Practice for the Licensed Practical Nurse." The **LPN** is accountable for her/his decision to delegate immunization administration to a qualified UAP previously educated and validated as competent by an **RN**. The **LPN** oversees the performance of the UAP, verifying that tasks have been performed as delegated to the UAP and in accordance with the established standards of practice and as defined in 21 NCAC 36.0225 (d).

The continuum of the process of immunization begins with the initiation of the immunization order based on client need and ends with the re-evaluation of the client's needs related to the immunization regimen. The immunization order shall be a valid **Standing Order** from the identified medical authority for the mass immunization event, usually the local health department Medical Director or the State Health Director.

Collection of screening data using an approved form for the purpose of pre-administration screening and the task of direct immunization administration are the **only** aspects of the continuum that may be carried out by the appropriately qualified UAP according to the policies and procedures of the agency. Within this framework, the actual task of giving immunizations to a client is considered a technical activity that does not require the professional judgment of a licensed nurse. Thus, the performance of this **technical** task may be delegated to an appropriately qualified UAP. **However, any on-going assessment, interpretation, and decision-making required relative to clients receiving immunizations must be carried out by the RN or LPN within their respective Scope of Practice.** Accountability for any professional judgments or decision-making surrounding immunization administration (e.g., deciding when to refer specific client issues to a physician or deciding when to withhold an immunization due to screening "flags") is the responsibility of the **RN or LPN** and may not be delegated to the UAP.

THIS POSITION STATEMENT IS LIMITED FOR USE ONLY IN "DECLARED STATE OR NATIONAL EMERGENCIES OR FEDERAL/STATE DHHS OR CDC INITIATED MASS IMMUNIZATION CAMPAIGNS," NOT FOR USE IN ROUTINE IMMUNIZATION ADMINISTRATION.

For any questions, please contact the Practice Consultants at the North Carolina Board of Nursing at 919-782-3211 ext 244.

Percentage of LHD who complete Profile Questionnaire

North Carolina	98%
National	83%

N(North Carolina)=83

N(National)=2794

Geographic areas served by North Carolina LHDs

County	92%
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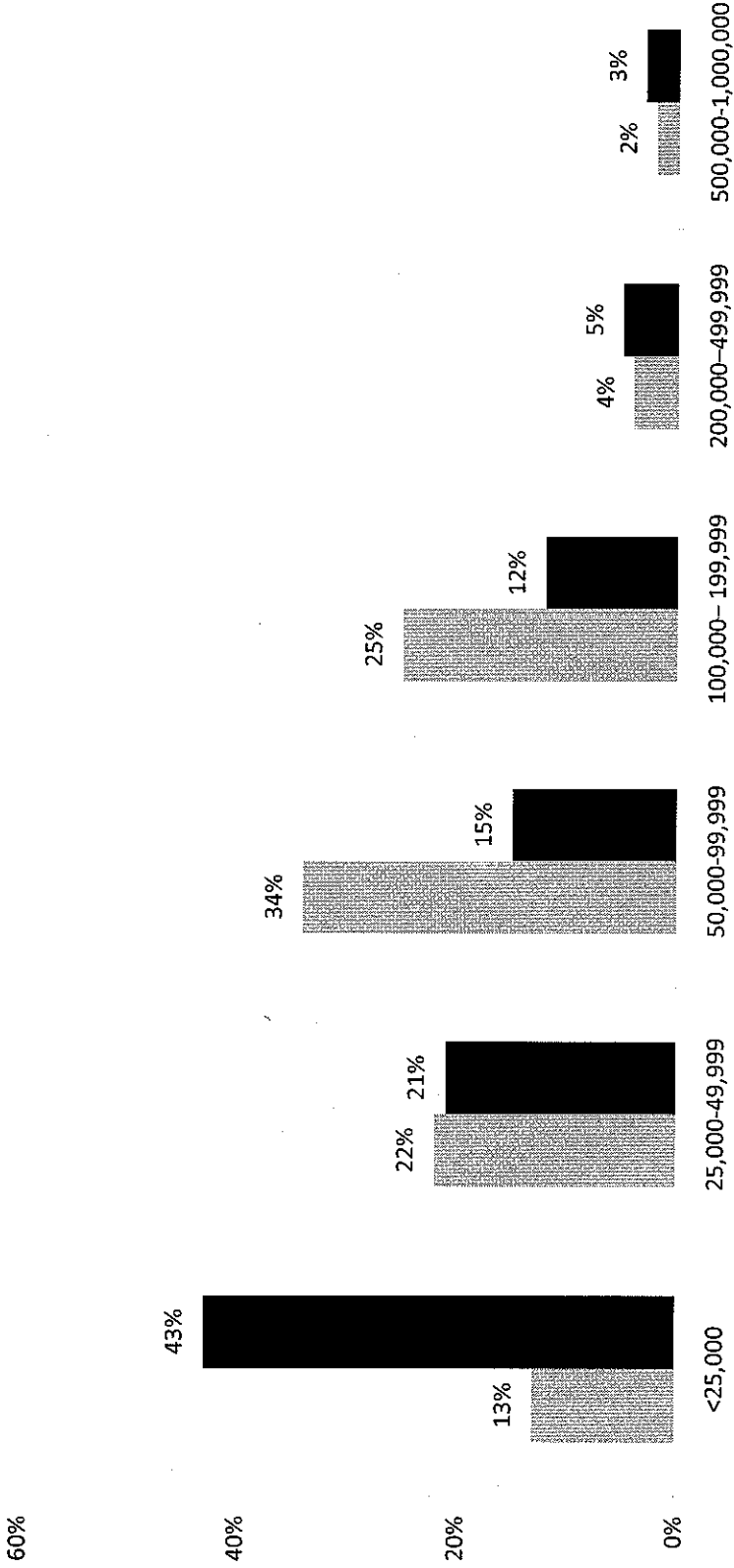
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n(North Carolina)=78

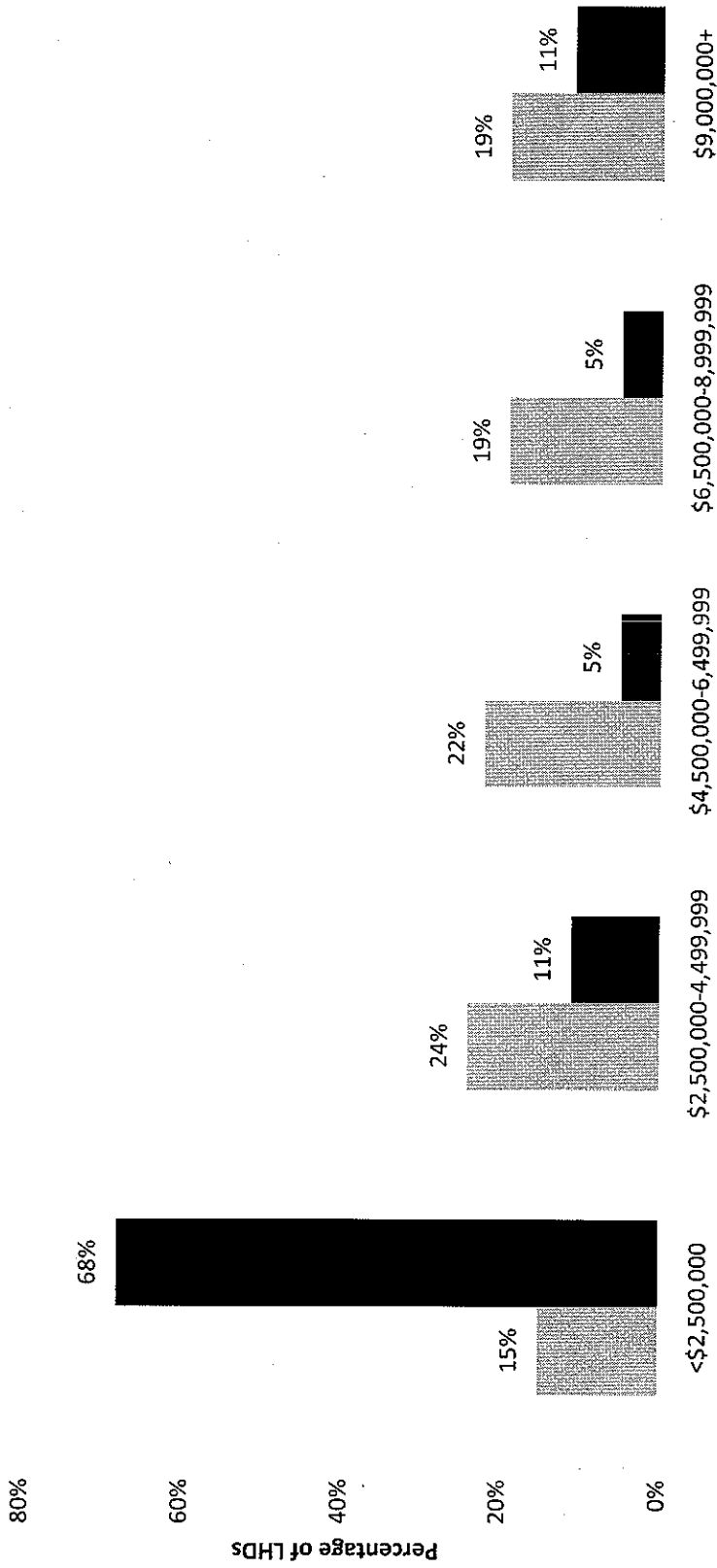
n(National)=2097

North Carolina ■ National



n(North Carolina)=83; n(National)=2332

North Carolina ■ National



Total Annual Expenditures

n(North Carolina)=78; n(National)=2097

Percentage Distribution of LHD Revenues from Various Sources

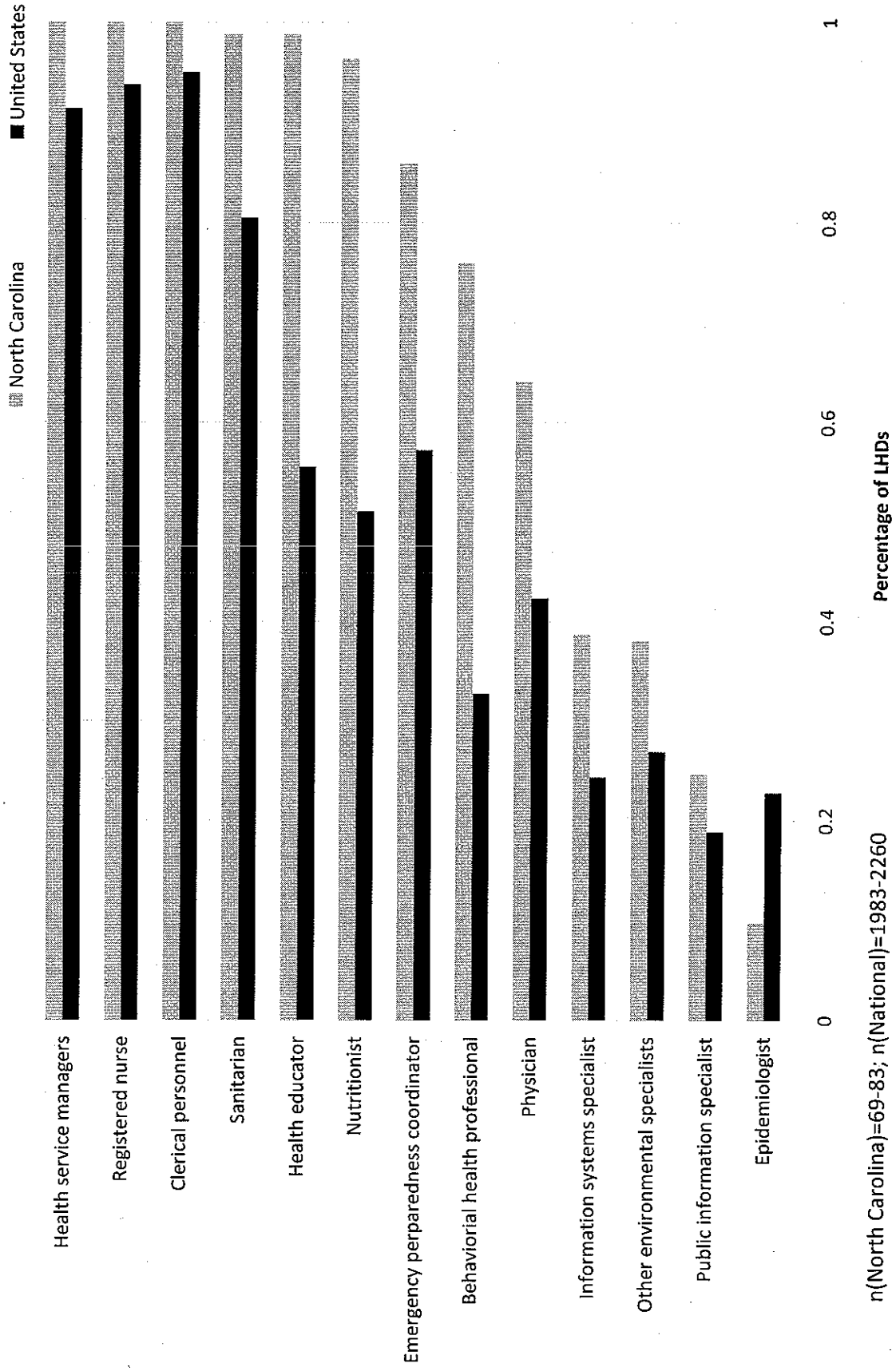
	North Carolina	National
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Characteristics of LHD Top Executives

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**Activities and Services: North Carolina vs National*
Provided More Frequently in North Carolina**

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Hotels/motels regulation	94%	51%	42%

n=76-83 n=2230-2313

Community Health Assessment and Improvement Plan: North Carolina vs. National

	North Carolina	National
Community Health Assessment	88%	63%
Community Health Improvement Plan	77%	49%

n(North Carolina)=82 and 81, respectively

n(National)=2300 and 2220, respectively

AA 513 Discussion Version

III. Scope of Work and Deliverables:

This revised Section III replaces the original Section III in its entirety effective August 10, 2009.

Each of the seven Public Health Regional Surveillance Teams (PHRSTs) shall maintain the following activities for the period August 10, 2009 through May 31, 2010:

A. Administrative

Each member shall attend no less than 75% of annual quarterly meetings
Each member shall attend no less than 75% of team calls

B. Program Management

The Host Health Department will:

- In coordination with PHP&R, recruit experienced and qualified staff and maintain team positions.
- Fill at least four (4) positions on each team with a medical specialist (preferably a physician), epidemiology specialist (this may be a nurse-epi), environmental scientist (preferably an industrial hygienist) and an administrative assistant.
- Provide office space, one (1) work station, and essential support (IT, etc.) per full-time equivalent on the team.
- Provide supervision for the team in partnership with PHP&R Branch Head.
- Provide programmatic assistance by acting as liaison with other Health Directors in the region for quality control and accountability.
- Designate one (1) full-time member of the team to act as Team Leader/Program Manager.
- Participate as active member of NCALHD Preparedness Liaison Committee.

The PHRST will:

- Will develop and implement annual objectives with timeline and monitor activity toward this on a monthly basis (per template) as planned with LHDs in the region and PHP&R.

Epi/Surveillance

- Lead or coordinate Epidemiology Team training with the Communicable Disease Branch and provide quarterly reports on schedule and summary descriptions.
- Monitor NC DETECT at minimum three times per week and produce, at minimum, weekly reports to LHDs, their region, and PHP&R.

Training and Exercise

- Develop and implement a rolling three-year public health exercise plan for the region, in conjunction with LHDs and integrate into PHP&R exercise plan.
- Deliver and implement HSEEP training program for all PCs in the region.
- Assist LHDs as requested in documentation of exercises and real-life incidents to accomplish continuous corrective actions and preparedness goals, including conducting after action reviews (AAR), conducting training on completion of AARs and CAPs, and posting completed reports in designated file sharing areas.

Support to Local Health Departments

- Provide support to LHDs as requested:
 - In case/cluster investigations, especially suspected category A agents or public health emergencies, chemical and radiologic incidents and natural hazard emergencies.
 - By coordinating with PHP&R activities required by the Agreement Addendum with LHDs
 - By providing subject matter expertise, multi-agency coordination capacity or in incident management system capacity.
- Conduct airborne infection isolation room (AIIR) measurements annually by request of LHDs according to the CDC's "Environmental Infection Control for Health Care Facilities" guidelines to ensure compliance with engineering specifications.
- Provide support for Respiratory Protection Programs through fit testing training as needed in accordance with 29 CFR 1910.134.
- Conduct, at minimum, monthly meetings with region's preparedness coordinators.
- Conduct, at minimum, semi-annual meetings with region's health directors.
- Conduct at least one annual on-site visit to each LHD.
- Conduct and report equipment checklist quarterly.
- Provide subject matter expertise to the Regional Response Teams (RRT). Two members must be EPI-X users; two members of RRT or PHRST.
 - Meet with RRT on at least a quarterly basis.
 - Ensure PHRST members are knowledgeable of RRT operations.

- Provide the PC Orientation Package to newly assigned LHD preparedness coordinators
- Coordinate NC HAN registration.
- Coordinate GETS card registration.
- Coordinate PHP&R WebEOC access.
- Conduct regularly scheduled communications exercises and radio checks.

Support of the Public Health Coordination Center (PHCC)

- Conduct daily calls with PCs to coordinate response activity and provide situational awareness both "down" to locals and "up" to PHCC, as directed by PHCC.
- Provide daily situational reports to PHCC of regional status via public health management software (currently WebEOC).
- Participate in public health conference calls as conducted by the PHCC.
- Support, as requested, LHDs in case investigations, implementation of guidance, incident management teams, etc.
- Anticipate deployment, as requested, to the PHCC or outside of region as coordinated through the PHCC. (No more than one team member at a time, other than a regional pharmacist, for a period not longer than one week unless circumstances demand or allow otherwise.

The PHRST Leader will:

- Act as program manager within host health department structure and provide direct supervision of the remainder of the team.
- Serve as direct point of contact for PHP&R for team activities.

The Regional Pharmacist will:

- Be coordinated by the Team Leader in conjunction with the SNS Coordinator in PHP&R.

AA 849 Discussion Version

III. Scope of Work and Deliverables:

The Health Department/District shall:

A. Hire temporary epidemiology staff to develop, update and revise plans to comply with the benchmarks in "D" below. Position descriptions and/or documentation must be submitted upon request to support the use of temporary epidemiology staff and/or re-assignment of staff including start/stop dates, time spent, work plan with timeline and outputs measured to assure accountability and demonstrate that no supplantation is occurring.

B. Allow for training for staff to include acquisition of training, time spent in training and facility costs for training venues. Target audience will be temporary epidemiology staff and may include both Health Department staff and non-Health Department staff. Training will address CDC H1N1 guidances, epidemiologic response, enhancing Epi Teams, cross training Health Department staff and others, and developing/updating/revising epidemiologic response plans.

C. Fulfill requirements related to completing this benchmark: equipment and supplies for the planners performing this activity, travel expenses incurred during planning, printing and copying of information packets for training, etc.

D. Develop the following (benchmarks):

1. Pandemic Influenza response plans that include epidemiologic response plans and provide surge capacity to investigate cases and clusters in their community.
2. These plans shall include enhancement of Epi Teams, cross training of current staff and identification and recruitment of non-Health Department staff.
3. Other H1N1 activities/documentation as directed by PHER guidance.

IV. Performance Measures/Reporting Requirements:

All H1N1 epidemiologic response plans and other documents must be available for review by PHP&R staff as needed during the period August 17, 2009 – May 31, 2010. Plans and other documents must be consistent with state and federal requirements and must be specific to your local public health area. Reporting requirements include:

- A. Submit monthly Expenditure Monitoring Reports (EMRs).
- B. Submit Quarterly Narrative Reports (QNRs). QNRs are due four (4) times per year.
- C. Submit After Action Reports (AARs) within 45 days of completing H1N1 incident/event.
- D. Report the aggregate number of H1N1 trained epidemiology staff (both newly trained and total trained).

V. Performance Monitoring and Quality Assurance:

PHP&R will provide technical support to the LHD in H1N1 planning. Templates, best practices, and meetings/conferences will be provided on an ongoing basis. PHP&R staff will maintain open communication with the LHD and will therefore, receive and respond to all questions related to preparedness and response, SNS, exercises, telecommunication, and communication.

PHP&R's Subrecipient Grants Monitor or PHP&R Program Manager's designee may schedule and conduct on-site visits with the LHD to assess compliance with Center for Disease Control (CDC) grant and Agreement Addendum requirements, financials, and/or provide consultative assistance.

Reasonable efforts will be recognized as attempts to complete the Scope of Work and to achieve the work performance as outlined above. However, inadequate performance on the part of the LHD directly impacts the capacity of North Carolina's ability in overall preparedness. In the event that performance is deemed inadequate or non-compliant, PHP&R reserves the right to identify the county as "high risk."

While not necessarily an indicator of inadequate performance, a LHD's inability to spend allocated funds will result in an assessment and potential recall of funds for re-allocation to other local health departments.

including requirements for corrective action.

All plans and documents must be available for review by PHP&R staff as needed during the period August 10, 2009 – May 31, 2010. Plans and other documents must be consistent with state and federal requirements and must be specific to your local public health area. Reporting requirements include:

A. At Risk Populations

1. Documentation from Community Health Assessment of populations identified as “at risk” during a public health emergency.
2. Documentation from Emergency Operations Plans that reflects the provision of essential public health preparedness target capabilities specifically for those populations. The three major target capabilities for Public Health are: Emergency Communications, Mass Prophylaxis and Vaccination, Community Containment.
3. Provide to PHP&R upon request educational materials related to preparedness functions (SNS, community containment, emergency communications, etc.).
4. Submit as part of annotated LTAR Section 5.7 a Public Information Plan for at-risk populations.

B. Communications

1. Copy of Notification Protocol from local Public Health Preparedness and Response Plan (or equivalent), OR written policies and procedures regarding after-hours calls, AND current after-hours call list.
2. Documentation of quarterly update to these lists.
3. Performed quarterly: one drill or portion of an exercise where the notification procedure was tested with an After Action Report (AAR) and Corrective Action Plan (CAP) OR reference as a function in a larger AAR or CAP.
4. Health Alert Communication Plan
5. Medical provider contact list (to include pharmacists and veterinarians)
6. If applicable, proof of dissemination of advisories or alerts by multiple methods (e.g. phone, fax, & email).
7. Agency Crisis Communication Plan, or Communication/Media Plan AND, if applicable, examples of threats, alerts, or advisories appearing in/on news media.
8. Documentation (meeting agenda, attendance and minutes) or agency participation in or coordination of a Local Information Team.
9. Documentation of agency participation in ICCE-NET as demonstrated by established group in Web EOC ICCE-NET.

C. Planning

1. Where applicable, provide documentation of plans that indicate specific response components for Category A agents, chemicals, and radiologic threats. For example, Suspicious Substance Response Protocol, Radiologic/Nuclear Response Protocol, and BioDetection System (BDS) Plan.
2. Copy of those portions/sections of the County Emergency Operations Plan that reflect the role of the public health agency.
3. Documentation indicating the SNS Plan is part or annex to the county’s all hazard plan or Emergency Operations Plan.
4. Provide documentation, if applicable, that the Local Health Department has collaborated with community health agencies for response to public health emergencies. This could be in areas of training, equipment, surge capacity, etc.

5. Provide documentation regarding the specific plans: Local SNS Distribution Plan, Pandemic Flu COOP
6. Minutes or documents confirming agency involvement in Local Emergency Planning (LEPC) Committee (or equivalent).
7. Documentation of SNS specific activities of the LEPC. If separate, documentation must be provided as outlined in Section 1.3 of the LTAR.
8. Minutes or notes from two or more meetings per year OR evidence of Health Director's and/or designee's ongoing communications (letters, memos, emails, phone log) with local emergency manager.

D. Training and Exercises

1. If the Local Health Department participates in a regional exercise the Local Health Department must submit a county-specific Corrective Action Plan (CAP) from exercise.
2. After Action Report (AAR) and CAP from all exercises and/or incidents will be submitted to PHP&R within 60 days of completion or exercise/incident.
3. The Local Health Department will submit a three-year exercise plan developed through HSEEP guidelines. This plan will be updated annually and will include current year and two years forward and will include operational based exercises. This plan will also reflect exercise requirements of the SNS program in that each of 12 elements must be exercised over the three year planning cycle.

E. PH Workforce Development for Preparedness and Response

1. Provide a list of team member names, titles, and designated roles.
2. Documentation of training either within the Local Health Department or from another source (UNC, PHRST, etc.)
3. AAR and CAP following an incident(s) OR exercise(s).
4. Provide upon request the portion of Staff Development Plan that specifically addresses preparedness capabilities: ICS training, Preparedness Coordinator training, staff training for preparedness topics, etc.
5. Maintain records of who received ICS training and what level. The level of training is dependent on the expected role the individual will play during a public health emergency.

F. Submit monthly Expenditure Monitoring Reports (EMRs).

G. Submit Quarterly Narrative Reports (QNRs). QNRs are due four (4) times per year. (September, December, March, June)

H. Submit After Action Reports (AARs) within 60 days of completing the exercise/drill.

AA 514 Discussion Version

The Scope of Work and Deliverables has been changed to add the following:

Specifically, funds are awarded to Local Health Departments (LHD) with this Agreement Addendum to provide Public Health Preparedness & Response activities, primarily to be used to support the work and/or function of the Public Health All Hazards Preparedness Planner/Coordinator to accomplish, at a minimum, the following activities for the period August 10, 2009 through May 31, 2010:

F. At Risk Populations

The local health department shall conduct a comprehensive community health assessment every 48 months. The community health assessment must fulfill the following requirement:

- Identify population groups at risk for health problems during a public health emergency.

The local health department shall carry out or assist other agencies in the development, implementation and evaluation of health promotion/disease prevention programs and educational materials targeted to groups identified as at-risk in the community health assessment.

G. Communications

The local health department shall have a system in place to receive reports of communicable diseases or other public health threats on a 24-hour-a-day, 7-day-a-week basis.

The local health department shall use two or more methods to disseminate health alerts and other advisories on real or potential disease threats, as they occur, to the local medical community, including pharmacists and veterinarians.

The local health department shall provide health alerts or advisories to the news media to inform the public when disease outbreaks or other potential public health threats occur.

H. Planning

The local health department shall have epidemiological case investigation protocols in place that specifically refer to cases of public health emergency significance including CDC Category A agents and pandemics.

The local health department shall have a public health preparedness and response plan that:

- is NIMS compliant
- corresponds to existing local and state emergency and Bioterrorism plans
- establishes roles and responsibilities of plan participants
- identifies training for participants in those roles
- establishes a chain of command among plan participants
- describes a system of emergency notification to local and state public health staff and other key decision makers based upon the nature of the event
- is available to staff on site

The local health department shall have a defined role in the county Emergency Operations Plan to protect the public's health.

Specific Plans that are required:

- 1) County All Hazards Emergency Operations Plan that includes public health components
- 2) Communications Plan
- 3) Local SNS Distribution Plan
- 4) Local Health Department Pandemic Flu Continuity of Operations Plan (COOP)

The local health department shall collaborate with community health care providers to provide personal and preventive health services.

The local health department shall be involved in a local emergency planning committee.

The local health director shall maintain periodic communication with local emergency managers.

I. Training and Exercises

The local health department shall annually test or implement the local public health preparedness and response plan.

The local health department shall participate in regional emergency preparedness exercises and activities.

J. PH Workforce Development for Preparedness and Response

The Local Health Department shall have one of the following:

- A Public Health Preparedness and Response Coordination Team with an environmental health member and a public health preparedness response coordinator, or
- An Epidemiology Team with an environmental health member and an epidemiology team coordinator.

The Local Health Department shall have a staff development plan that includes identifying and addressing the training and continuing education needs of the staff.

K. Strategic National Stockpile (SNS) Deliverable

Maintain an updated SNS plan and updated Technical Assistance Review (TAR) tool.

IV. Performance Measures/Reporting Requirements:

The Performance Measures/Reporting Requirements have been changed to add the following:

The local health department shall comply with laws, rules, and contractual requirements for programs and services provided pursuant to the local health department's consolidated agreement and agreement addendum,

AA 850 Discussion Version

III. Scope of Work and Deliverables:

The PHRST shall:

- A. Provide technical support to LHDs in revising plans for pandemic influenza.
- B. Fulfill requirements related to completing this benchmark: equipment and supplies for the planners performing this activity, travel expenses incurred during planning, printing and copying of information packets for training, etc.
- C. Support work by LHDs to develop the following (benchmarks):
 1. Updated vaccination plans that demonstrate how vaccination will be performed in Local Health Department facilities, where applicable.
 2. Updated plans that explain how the Local Health Department will coordinate and communicate with providers in the county who will be administering vaccine.
 3. Updated policies and procedures to ensure cold chain security for vaccine transport and storage.
 4. Updated plans for data entry in NC IR.
 5. Updated plans for training surge staff on data entry in NC IR.
 6. Other H1N1 activities/documentation as directed by PHER guidance.

IV. Performance Measures/Reporting Requirements:

All H1N1 plans and other documents must be available for review by PHP&R staff as needed during the period August 17, 2009 – May 31, 2010. Plans and other documents must be consistent with state and federal requirements and must be specific to your local public health area. Reporting requirements include:

- A. Submit monthly Expenditure Monitoring Reports (EMRs).
- B. Submit Quarterly Narrative Reports (QNRs). QNRs are due four (4) times per year.
- C. Submit After Action Reports (AARs) within 45 days of completing H1N1 incident/event.
- D. Report the aggregate number of H1N1 trained staff (both newly trained and total trained).

V. Performance Monitoring and Quality Assurance:

PHP&R will provide technical support to the LHD in H1N1 planning. Templates, best practices, and meetings/conferences will be provided on an ongoing basis. PHP&R staff will maintain open communication with the LHD and will therefore, receive and respond to all questions related to preparedness and response, SNS, exercises, telecommunication, and communication.

PHP&R's Subrecipient Grants Monitor or PHP&R Program Manager's designee may schedule and conduct on-site visits with the LHD to assess compliance with Center for Disease Control (CDC) grant and Agreement Addendum requirements, financials, and/or provide consultative assistance.

Reasonable efforts will be recognized as attempts to complete the Scope of Work and to achieve the work performance as outlined above. However, inadequate performance on the part of the LHD directly impacts the capacity of North Carolina's ability in overall preparedness. In the event that performance is deemed inadequate or non-compliant, PHP&R reserves the right to identify the county as "high risk."

While not necessarily an indicator of inadequate performance, a LHD's inability to spend allocated funds will result in an assessment and potential recall of funds for re-allocation to other local health departments.

- Serve at the Receipt, Stage, and Store (RSS) during times of RSS activation and/or serve as the SNS SME at the PHCC.
- Work with the North Carolina Association of Pharmacists and the North Carolina Board of Pharmacy to recruit, train, and credential local pharmacists for disaster response.
- Maintain open and ongoing communication with counties in all aspects of Strategic National Stockpile (SNS) programs in conjunction with team leaders and PHP&R.
- Provide consultation and technical support related to SNS programs and activities.
- Participate in the statewide review of local SNS plans.
- Participate in SNS trainings offered by the state both within the designated regions and across the state when necessary.

IV. Performance Measures/Reporting Requirements:

This revised Section IV replaces the original Section IV in its entirety effective August 10, 2009.

- Submit monthly Expenditure Monitoring Reports (EMRs).
- Submit Quarterly Narrative Reports (QNRs). QNRs are due four (4) times per year. (September, December, March, June)

AA 848 Discussion Version

III. Scope of Work and Deliverables:

The Health Department/District shall:

A. Hire temporary staff to develop, update and revise pandemic influenza plans to comply with the benchmarks in "D." below. Position descriptions and/or documentation must be submitted upon request to support the use of temporary staff and/or re-assignment of staff including start/stop dates, time spent, work plan with timeline and outputs measured to assure accountability and demonstrate that no supplantation is occurring.

B. Allow additional work hours for staff that are re-directed or temporarily assigned to this task.

C. Fulfill requirements related to completing this benchmark: equipment and supplies for the planners performing this activity, travel expenses incurred during planning, printing and copying of information packets for training, etc.

D. Develop the following (benchmarks):

1. Updated vaccination plans that demonstrate how vaccination will be performed in Local Health Department facilities, where applicable.
2. Updated plans that explain how the Local Health Department will coordinate and communicate with providers in the county who will be administering vaccine.
3. Updated policies and procedures to ensure cold chain security for vaccine transport and storage.
4. Updated plans for data entry in NC IR.
5. Updated plans for training surge staff on data entry in NC IR.
6. Other H1N1 activities/documentation as directed by PHER guidance.

IV. Performance Measures/Reporting Requirements:

All H1N1 plans and other documents must be available for review by PHP&R staff as needed during the period August 17, 2009 – May 31, 2010. Plans and other documents must be consistent with state and federal requirements and must be specific to your local public health area. Reporting requirements include:

- A. Submit monthly Expenditure Monitoring Reports (EMRs).
- B. Submit Quarterly Narrative Reports (QNRs). QNRs are due four (4) times per year.

C. Submit After Action Reports (AARs) within 45 days of completing H1N1 incident/event.

D. Report the aggregate number of H1N1 trained staff (both newly trained and total trained).

V. Performance Monitoring and Quality Assurance:

PHP&R will provide technical support to the LHD in H1N1 planning. Templates, best practices, and meetings/conferences will be provided on an ongoing basis. PHP&R staff will maintain open communication with the LHD and will therefore, receive and respond to all questions related to preparedness and response, SNS, exercises, telecommunication, and communication.

PHP&R's Subrecipient Grants Monitor or PHP&R Program Manager's designee may schedule and conduct on-site visits with the LHD to assess compliance with Center for Disease Control (CDC) grant and Agreement Addendum requirements, financials, and/or provide consultative assistance.

Reasonable efforts will be recognized as attempts to complete the Scope of Work and to achieve the work performance as outlined above. However, inadequate performance on the part of the LHD directly impacts the capacity of North Carolina's ability in overall preparedness. In the event that performance is deemed inadequate or non-compliant, PHP&R reserves the right to identify the county as "high risk."

While not necessarily an indicator of inadequate performance, a LHD's inability to spend allocated funds will result in an assessment and potential recall of funds for re-allocation to other local health departments.

Summary of data to be requested from NC Local Health Departments

Project	Research objective	LHD sample	Sampling strategy	Method & Burden	Data collection dates
Project 1 Accreditation	To understand the preparedness of accredited and non-accredited health depts. 1) Broad preparedness measures 2) H1N1 measures	1) Health Director or Preparedness Coordinator (PC) 2) PC or other LHD staff and response partners	1) All 85 NC LHDs 2) 10 LHDs (50% accredited, 50% non-accredited)	1) Web survey (30-60 min) 2) Preparation calls and in-person interviews with LHD staff (3-4 hrs) plus focus group with response partners (2-3 hrs)	1) 10/09 to 3/10 2) 8/09 to 9/09 with 9 LHDs participating
Project 2 Surveillance	To understand how users are currently interacting with surveillance systems and what needs are not being met	Health director and daily surveillance system user	Random sample of 7 LHDs from each of 2 strata (large & small)	In-person interviews (2 hrs)	6/09 to 9/09 with 14 LHDs participating
Project 3 PHRSTs	To determine: 1) the structural capacity of the PHRST teams 2) what public health preparedness support and services PHRST teams deliver to their customers (including for H1N1 response)	1a) All PHRST teams 1b) Individual PHRST team members 2) Preparedness Coordinator (or other staff)	1) All members of 7 PHRSTs 2) All LHDs	1a) Paper survey (team) (2-3 hrs) 1b) Paper survey (individual) (30 min) 1c) Site visits to PHRSTs (2-3 hrs) 2) Web survey (20 min)	1) 8/09 to 9/09 with all PHRSTs participating 2) 7/09 to 8/09 with 84 LHDs participating
Project 4 NCHAN	To understand NCHAN alerts and the decision-making behind the alerts by looking at 2004 State Fair E coli, H1N1, and other events	Health directors and other staff who use NCHAN	8 LHDs (2 people in each LHD, selected based on stratified size and NCHAN use)	In-person interviews (2 hrs)	8/09 to 10/09

Note: Research projects descriptions are on the Web Site <http://nccphp.sph.unc.edu/ncperrc/>

Preliminary findings -- None to report at this time; expect to report some preliminary findings next month.

Summary of data to be requested from NC Local Health Departments

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Preliminary findings -- None to report at this time; expect to report some preliminary findings next month.

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Preliminary findings -- None to report at this time; expect to report some preliminary findings next month.

NC Preparedness & Emergency Response Research Center (NCPERRC) Update Report to NCALHD -- Sept. 2009

Summary of data to be requested from NC Local Health Departments

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Preliminary findings -- None to report at this time; expect to report some preliminary findings next month.

NC Preparedness & Emergency Response Research Center (NCPERRC) Update Report to NCALHD -- Sept. 2009

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Note: Research projects descriptions are on the Web Site <http://nccphp.spb.unc.edu/nccpercc/>

Preliminary findings -- None to report at this time; expect to report some preliminary findings next month.

NC Preparedness & Emergency Response Research Center (NCPERRC) Update Report to NCALHD -- Sept. 2009

Summary of data to be requested from NC Local Health Departments

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Preliminary findings -- None to report at this time; expect to report some preliminary findings next month.

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North Carolina Preparedness and Emergency Response Research Center

University of North Carolina at Chapel Hill

Email: NCPERRC@unc.edu -- Web: <http://ncceph.sph.unc.edu/ncperrc/>

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NCPERRC news

The newsletter of the
North Carolina Preparedness and Emergency Response Research Center

**Issue 04
September
2009**

**Synergy
&
Translation
Committee**

Advises on research translation to practice, provides oversight of the research program, and facilitates communication and information sharing across the Center and its projects.

**Principal
Investigators**

**University
of North
Carolina at
Chapel Hill:**

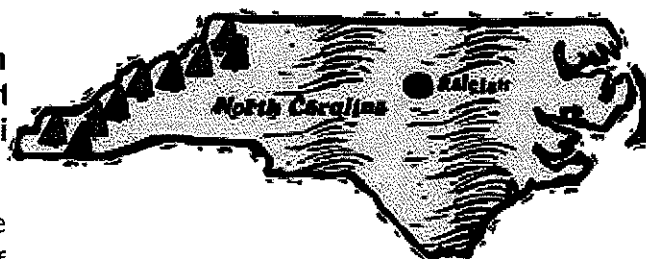
Edward
Baker, MD,
MPH
Pia
MacDonald,
PhD, MPH
Anna Waller,
ScD

In this issue

**NC
health
depart
partici**

This
summe
98% of

North Carolina health departments participated in research conducted by the North Carolina Preparedness and Emergency Response Research Center (NCPERRC). Five different NCPERRC research studies gathered information on the initial response to the H1N1 outbreak, the use of NC DETECT and NCHAN, and the support and services provided to local health departments by the PHRSTs. [More...](#)



Surveillance system gets fresh look

Following the terrorist attacks on September 11, 2001, unprecedented funding was given to state and local public health departments to improve their infrastructure to prepare for and respond to terrorism and other emerging health threats. North Carolina spent part of the allocated federal public health preparedness funds on improving the North Carolina Disease Event Tracking and Epidemiologic Collection Tool which had been collecting emergency department data since 1999. Now, through the NCPERRC, researchers have the opportunity to systematically assess the strengths, weaknesses, and areas for improvement of the electronic surveillance systems that have been in use for years as well as newer systems. [More...](#)

NCPERRC projects

The overall theme of the Center's research is to **create**

**North
Carolina
State
University:**
Julie Ivy,
PhD
**University
of Arkansas
for Medical
Sciences:**
Glen Mays,
PhD, MPH

Public Health Practitioners

Julie Casani,
MD, MPH
Jeffrey
Engel, MD
Aaron
Fleischauer,
PhD, MPH
Jean-Marie
Maillard, MD,
MSc
Lou Turner,
DrPH
Douglas
Urland, MPA

Research Consultants

Gene
Matthews,
JD
James
Thomas, PhD

and maintain sustainable preparedness and response systems. The Public Health Surveillance Systems project is featured in this issue. [More...](#)

What is systems research?

In previous issues, we have defined PHSR (Issue 1), given an example (Issue 2) and discussed what we learned at a recent conference (Issue 3). Now we will put PHSR in the context of public health performance. [More....](#)

NCPERRC Profile

Meet Anna E. Waller, ScD. [More...](#)

Our pledge to collaborators

We appreciate the contributions of our research collaborators. When we request your participation in one of our research studies, we make the following pledge to you. We will:

- coordinate our requests for information to ensure that there is no duplication of requested information,
- be considerate of your time and priorities,
- acknowledge your contribution to our research by recognizing your organization (to maintain your confidentiality),
- share our research findings with you.

Thanks to research participants

Over 150 NC health department staff have participated in our research. As a thank you, we have sent public health books and had a drawing for expenses paid to attend the NCPHA conference in Asheville. Congratulations to a staff member from Nash County who won this drawing!

We also thank Doug Urland, who serves on the NCPERRC Synergy & Translation Committee, for his assistance with sharing NCPERRC information with his colleagues in the NCAHLD.

Printable version of the complete newsletter

Best printed on 11" x 17" or 8.5" x 14" paper. [Download it now.](#)

Go to the NC PERRC home page

This research was carried out by the **North Carolina Preparedness and Emergency Response Research Center (NCPERRC)** at the University of North Carolina at Chapel Hill's Gillings School of Global Public Health and was supported by the Centers for Disease Control and Prevention (CDC) Grant 1P01 TP 000296-01. The contents are solely the responsibility of the authors and do not necessarily represent the official views of CDC.

North Carolina Preparedness and Emergency Response Research Center

North Carolina Institute for Public Health
Gillings School of Global Public Health
The University of North Carolina at Chapel Hill

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Last updated September 23, 2009 10:47 AM

Association of North Carolina Boards of Health
ANCBH, 3420 Ridge Road Durham, NC 27705-5538
WEB PAGE: <http://www.ancbh.org/>
ANCBH phone #: 704-466-8436 or 704-300-1365 (answering machine)
Health Director's September 29, 2009 Asheville, NC

1. Legislation "If you win, move on. If you lose, learn and move on. That's what our next chore will be" Boston Red Sox Manager

Rep. Young- Joint Legislative Task Force on Obesity has not been appointed as of yesterday". ANCBH will focus on "legislation and creative marketing of public health" during the coming year.

2. Accreditation

You are to receive an update from David Stone on the NCLHDA status. All members of the accreditation board will undergo ethics training to be covered under the NC State Ethics Act. PHAB: Kay Bender, PHAB president and CEO, announced the launch of PHAB'S public health accreditation beta test. Congratulations to The Public Health Authority of Cabarrus Co, Inc. of Kannapolis for being selected as one of the Beta Test sites.

3. NALBOH NEWS, NALBOH Membership

The National Association of Local Boards of Health (NALBOH) Program Committee invites you to submit a proposal for a workshop or concurrent session presentation at our 18th Annual conference - *Journey to the Future: Facing Public Health Challenges Today for a Healthier Tomorrow*. The conference will take place in the heart of the midwest - Omaha, Nebraska from August 5-7, 2010. ANCBH is very pleased with the NALBOH NEWSBRIEF and the special NC insert and their many publications supporting public health. ANCBH encourages you to join and get updates from around the country about the role of boards of health in public health SALBOH NEWS-We participate with all the states to share information and successes.

4. Other Meetings

September 14, Eat Smart Move More Meeting- Wake Med Cary Hospital speaker-Hank Cardello,

Author of Stuffed An Insider's Look at who's (really) making America fat

September 15 Raleigh Healthy Youth Act Collaborative-HB 88

September 23-Conference Call 4-5 NICHQ Application Conference -Alice Ammerman-Grant proposal for UNC and NC Chapter AAP / NC Pediatric Society

September 28 Conference Call AHA Advocacy Committee

Will be attending the 17th Annual Healthy Carolinians Conference & NCIOM

Prevention Summit on October 8, 2009. Speakers include Thomas Freiden, MPH Director, Center for Disease Control and Prevention and Governor Beverly Purdue.

5. Other Information

ANCBH Dues: We appreciate your prompt response to dues request. We have collected dues from 93% of the NC health departments. ANCBH is proud to be one of the sponsors of the 100th Anniversary meeting this week.

6. Important Date 2010 NALBOH 18th Annual Conference, August 5-7,2010, Omaha, Nebraska