Division of Emergency Preparedness

April 2025

Public Health and Healthcare Readiness Assessment

Indiana Department of Health

Table of Contents

Executive Summary 4

State of Indiana Public Health and Healthcare Readiness Assessments 6

- Hospital Preparedness Program and Healthcare Coalitions 7
- Public Health Emergency Preparedness and Local Health Departments 8

HCC Capability: Foundation for Health Care and Medical Readiness 11

- LHD Capability: Community Preparedness 14
  - Foundation for Health Care and Medical Response and Community Preparedness crosswalk 17

HCC Capability: Health Care and Medical Response Coordination 20

- LHD Capability: Emergency Operations Coordination 23
  - Health Care and Medical Response Coordination and Emergency Operations Coordination crosswalk 25

HCC Capability: Continuity of Health Care Service Delivery 29

- LHD Capability: Public Health Laboratory Testing 32
  - Continuity of Healthcare Service Delivery and Public Health Laboratory Testing crosswalk 35

HCC Capability: Medical Surge 38

- LHD Capability: Fatality Management 41
  - Medical Surge and Fatality Management crosswalk 44

HCC Capability: Incident Management and Coordination 47

- LHD Capability: Public Health Surveillance and Epidemiological Investigation 50
  - Incident Management and Coordination and Public Health Surveillance and Epidemiology 53

HCC Capability: Information Management 57

- LHD Capability: Emergency Public Information and Warning 59
- LHD Capability: Information Sharing 62
  - Information Management, Emergency Public Information and Warning, and Information Sharing crosswalks 65

HCC Capability: Patient Movement and Distribution 69

- LHD Capability: Medical Surge 72
  - Patient Movement and Distribution and Medical Surge Capability crosswalk 75

HCC Capability: Workforce 78

LHD Capability: Responder Safety and Health 81
LHD Capability: Volunteer Management 84
Workforce, Responder Safety and Health, and Volunteer Management Capability crosswalk 86
HCC Capability: Resources 91
LHD Capability: Medical Countermeasure Dispensing and Administration 94
LHD Capability: Medical Material Management and Distribution 97
Resources, Medical Countermeasure Dispensing, and Medical Material Management capabilities crosswalk 100
HCC Capability: Operational Continuity 105
LHD Capability: Mass Care 107
Operational Continuity and Mass Care crosswalk 110
HCC Capability: Specialty Care 114
LHD Capability: Nonpharmaceutical Interventions 117
Specialty Care and Nonpharmaceutical Interventions capability crosswalk 119
HCC Capability: Community Integration 123
LHD Capability: Community Recovery 126
Community Integration and Community Recovery capability crosswalk 129
Whole Community Health Capability 133
HCC and LHD Comparison 136
Next Steps 137

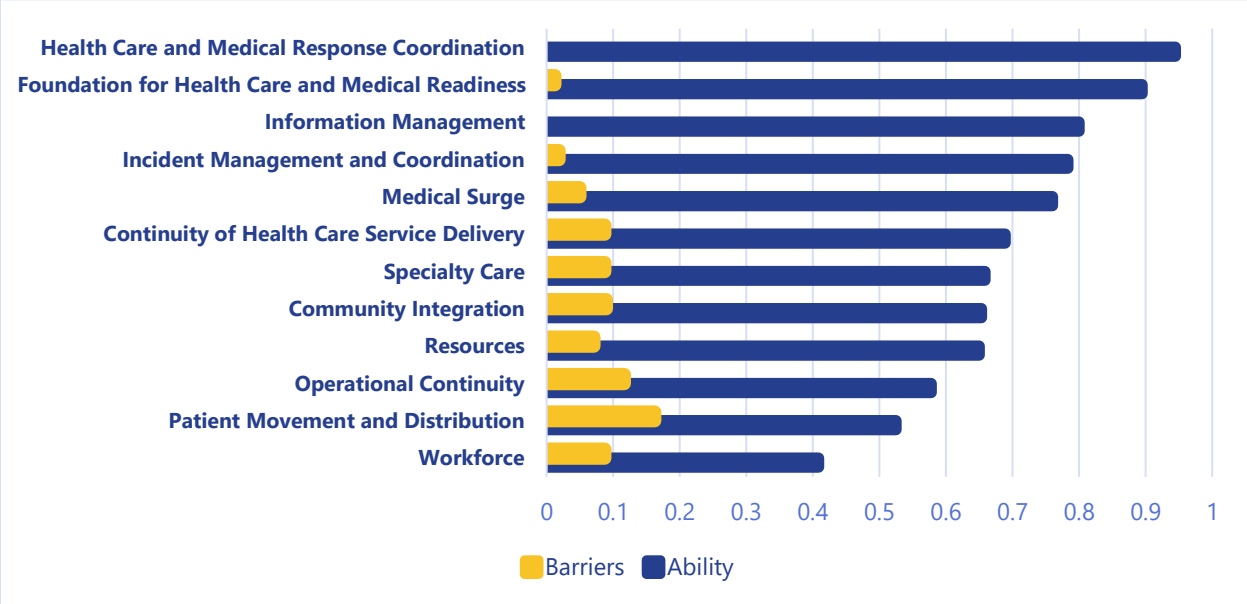
Executive Summary

The Public Health and Healthcare Readiness Assessment (PHHRA) tool assesses healthcare readiness based on the CDC PHEP Capabilities, ASPR Hospital Preparedness Program (HPP) Capabilities and whole community health capabilities. It aims to provide the local health departments (LHDs) and Healthcare Coalitions (HCCs) of Indiana with data on current hazard response capabilities, perceived preparedness, gaps in healthcare capabilities, and insight into strategies for collaboration between the LHDs and HCCs. Results from PHHRA assessments, along with tools like the Jurisdictional Risk Assessment (JRA) and Hazard Vulnerability Analysis (HVA), will enhance public health and healthcare preparedness throughout the state of Indiana.

The PHHRA tool built for this report assesses healthcare readiness based on four sections: the CDC Capabilities, the ASPR Response Readiness Framework 10 Priorities, ASPR HPP Capabilities and whole community health capabilities.

The PHHRA HCC assessment results of the ability of the HCCs to perform the capabilities is shown in the figure below with the highest capability rate to the one with the lowest capability rate. In the State of Indiana Health Care Coalition's indicated they have the most ability to perform the Healthcare and Medical Response Coordination capability and the least ability to perform the Workforce capability. Additionally, the figure below also shows in orange the barrier rate to performing the capability.

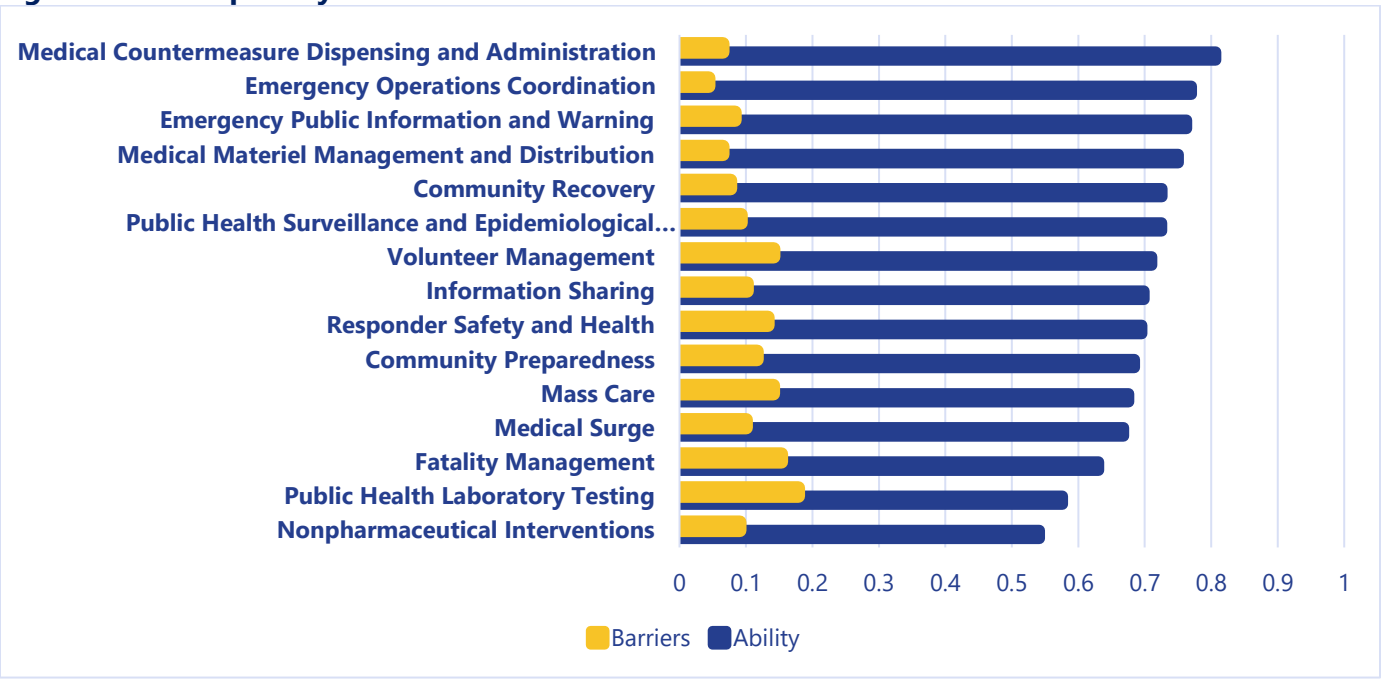
Figure 1: HCC Capability and Barrier Results



The following figure shows the PHHRA LHD assessment results in order of capability with the highest capability rate to the lowest capability rate. In the State of Indiana Local Health Departments indicated the most ability to perform the Medical Countermeasure Dispensing and Administration and the least ability to perform the Nonpharmaceutical Interventions Capability.

Additionally, the figure below also shows in orange the barrier rate to performing the capability that was identified by the respondents.

Figure 2: LHD Capability and Barrier Results



State of Indiana Public Health and Healthcare Readiness Assessments

For public health emergency response efforts to be the most effective collaboration between the HCC's and LHD's must occur. Though the capabilities that were rated by each were different there exists an overlap between the functions that allows for a comparison of the responses submitted by the HCC's and LHD's. The following table shows how the assessed capabilities of each can overlap with one another for the purpose of comparing the two.

Figure 3: HCC and LHD Capability Crosswalk

HCC Capability	LHD Capability
Foundation for Health Care and Medical Readiness	Capability 1: Community Preparedness
Health Care and Medical Coordination	Capability 3: Emergency Operations Coordination
Continuity of Health Care Service Delivery	Capability 12: Public Health Laboratory Testing
Medical Surge	Capability 5: Fatality Management
Incident Management and Coordination	Capability 13: Public Health Surveillance and Epidemiological Investigation
Information Management	Capability 4: Emergency Public Information and Warning Capability 6: Information Sharing
Patient Movement and Distribution	Capability 10: Medical Surge
Workforce	Capability 14: Responder Safety and Health Capability 15: Volunteer Management
Resources	Capability 8: Medical Countermeasure Dispensing and Administration Capability 9: Medical Material Management and Distribution
Operational Continuity	Capability 7: Mass Care

Specialty Care	Capability 11: Nonpharmaceutical Interventions
Community Integration	Capability 2: Community Recovery

This report will provide insight into the state level responses to the PHHRA for both the HCC's and LHD's and will then show a comparison of how each related capability scored at the HCC and LHD level.

Hospital Preparedness Program and Healthcare Coalitions

The U.S. Department of Health and Human Services Office of the Assistant Secretary for Preparedness and Response (ASPR) provides high-level guidelines to improve health and emergency response programs throughout the United States. ASPR developed the 2017-2022 Health Care Preparedness and Response Capabilities guidance to describe what the health care delivery system, including HCCs, hospitals, and emergency medical services (EMS), must do to effectively prepare for and respond to emergencies that impact the public's health. There are 4 critical functions that support the capacity of healthcare systems to plan for and respond to emergencies. These include:

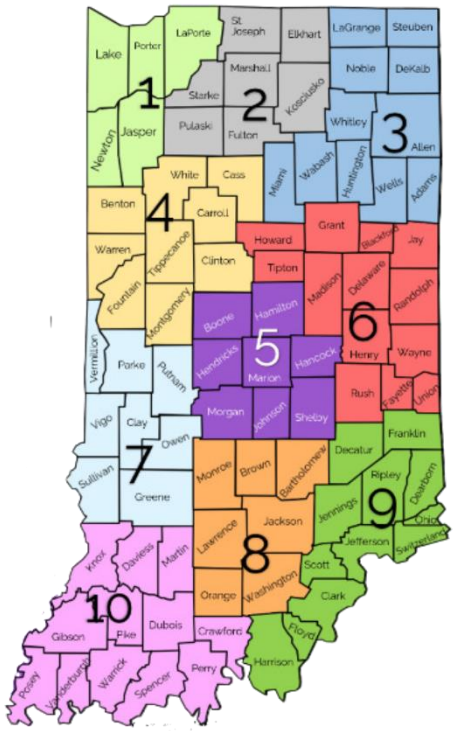
1. Foundation for Health Care and Medical Readiness
2. Health Care and Medical Response Coordination
3. Continuity of Health Care Service Delivery
4. Medical Surge

In addition to these four existing Health Care Preparedness and Response Capabilities, ASPR has proposed eight new pre-decisional capabilities:

1. Incident Management and Coordination
2. Information Management
3. Patient Movement and Distribution
4. Workforce
5. Resources
6. Operational Continuity
7. Specialty Care
8. Community Integration

The capabilities listed above were used to assess the Public Health and Health care readiness of the 10 Healthcare Coalitions in the state. A Healthcare Coalition (HCC) is a network of individual public and private organizations in a defined state or sub-state geographic area that partner to prepare health care systems to respond to emergencies and disasters, ultimately increasing local and regional resilience. HCCs are composed of diverse, and sometimes competitive organizations who, during a disaster, become interdependent on one another for supplies, transportation, personnel, and more. Figure 1: HCC Capability and Barrier Results displays the results of the HCC PHHRA.

Figure 4: Indiana Preparedness District's Map



Public Health Emergency Preparedness and Local Health Departments

In 2011, the CDC introduced the Public Health Preparedness Capabilities: National Standards for State and Local Planning. The standards create a national framework that helps public health agencies structure their emergency preparedness planning and formalize their Emergency Support Function-8 (ESF-8) roles in collaboration with emergency management agencies. The capability standards support routine public health activities, enhancing day-to-day effectiveness and preparation for emergencies. There are 15 capability standards described in that report, and the capability standards are designed to enhance the emergency preparedness and response capacity of state and local public health systems. The most recent 15 PHEP capabilities are:

1. Community Preparedness
2. Community Recovery
3. Emergency Operations Coordination
4. Emergency Public Information and Warning
5. Fatality Management
6. Information Sharing
7. Mass Care
8. Medical Countermeasure Dispensing and Administration
9. Medical Material Management and Distribution
10. Medical Surge
11. Nonpharmaceutical Interventions
12. Public Health Laboratory Testing
13. Public Health Surveillance and Epidemiological Investigation
14. Responder Safety Health
15. Volunteer Management

Figure 2: LHD Capability and Barrier Results displays the results of the LHD PHHRA.

A total of 81 respondents in the state of Indiana completed the PHHRA. Only the LHD sub-recipients of PHEP in budget period 1(July 1, 2024-June 30, 2025) were required to submit a response therefore not every health department in the state of Indiana is represented in the results. Representatives from the following organizations submitted a response. Respondents with an asterisk next to their name are jurisdictions that encompass the Cities Readiness Initiative (CRI) program, a federally funded program that enhances preparedness in the nation's largest population centers.

1. Adams County Health Department
2. Bartholomew County Health Department
3. Benton County Health Department
4. Blackford County Health Department
5. *Boone County Health Department
6. *Brown County Health Department
7. Carroll County Health Department
8. Cass County Health Department
9. *City of East Chicago Health Department
10. *City of Fishers Health Department
11. *City of Gary Health Department
12. Clark County Health Department
13. Clay County Health Department
14. Daviess County Health Department
15. *Dearborn County Health Department
16. Decatur County Health Department
17. Dekalb County Health Department
18. Delaware County Health Department
19. Dubois County Health Department
20. Elkhart County Health Department
21. Fayette County Health Department
22. *Floyd County Health Department
23. Fountain-Warren County Health Department
24. Franklin County Health Department
25. Gibson County Health Department
26. Grant County Health Department
27. Greene County Health Department
28. *Hamilton County Health Department
29. *Hancock County Health Department
30. *Harrison County Health Department
31. *Health and Hospital Corporation of Marion County
32. *Hendricks County Health Department
33. Henry County Health Department
34. Howard County Health Department
35. Jackson County Health Department
36. *Jasper County Health Department
37. Jay County Health Department
38. Jefferson County Health Department
39. Jennings County Health Department
40. *Johnson County Health Department
41. Knox County Health Department
42. LaGrange County Health Department
43. *Lake County Health Department
44. LaPorte County Health Department
45. Lawrence County Health Department
46. *Madison County Health Department
47. Marshall County Health Department
48. Miami County Health Department
49. Monroe County Health Department
50. Montgomery County Health Department
51. *Morgan County Health Department
52. *Newton County Health Department

53. Noble County Health Department
54. *Ohio County Health Department
55. Owen County Health Department
56. Parke County Health Department
57. Perry County Health Department
58. Pike County Health Department
59. *Porter County Health Department
60. Posey County Health Department
61. Pulaski County Health Department
62. *Putnam County Health Department
63. Randolph County Health Department
64. Ripley County Health Department
65. Rush County Health Department
66. *Scott County Health Department
67. *Shelby County Health Department
68. St Joseph County Health Department
69. Steuben County Health Department
70. Sullivan County Health Department
71. Switzerland County Health Department
72. Tippecanoe County Health Department
73. Tipton County Health Department
74. Union County Health Department
75. Vanderburgh County Health Department
76. Vermillion County Health Department
77. Warren County Health Department
78. Warrick County Health Department
79. Wells County Health Department
80. White County Health Department
81. Whitley County Health Department

HCC Capability: Foundation for Health Care and Medical Readiness

Respondents were asked to rank their ability/capacity to perform each of the functions associated with this capability by selecting one of the following ability levels: "No Ability" (0), "Limited Ability" (1), "Moderate Ability" (2), and "Full Ability" (3). A total of 6 functions and 7 activities associated with this capability were assessed through the PHHRA. The figure below displays the average capability score of all responses.

Definition: The community's health care organizations and other stakeholders, coordinated through a sustainable HCC, have strong relationships, identify hazards and risks, and prioritize and address gaps through planning, training, exercising, and managing resources.

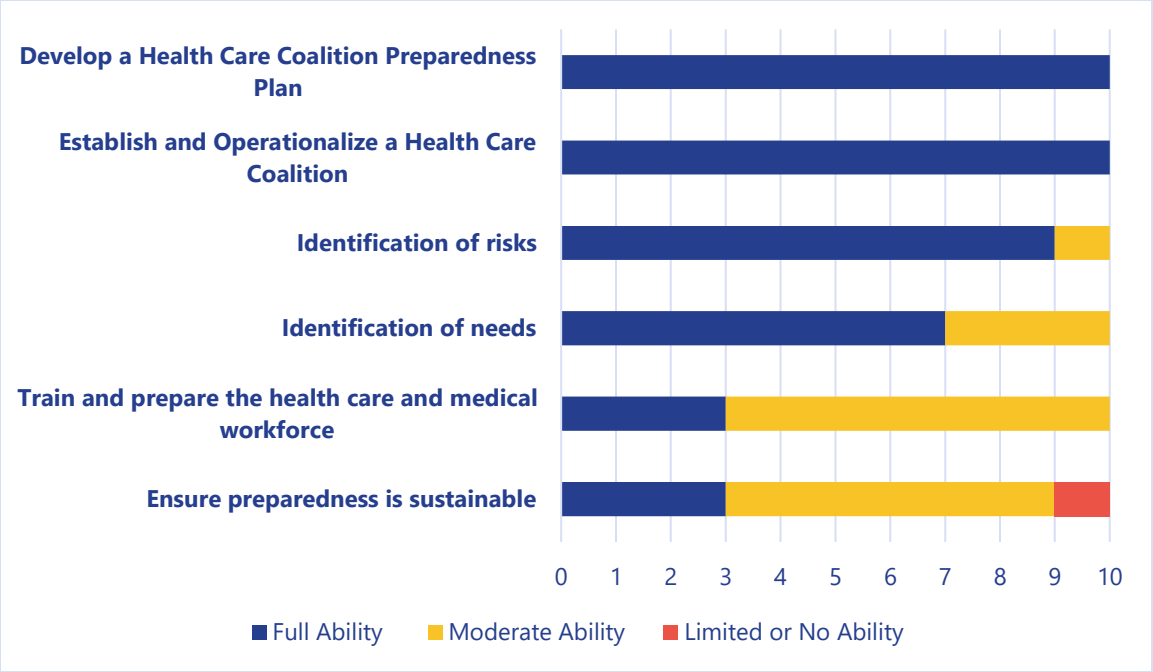
Figure 5: Foundation for Healthcare and Medical Readiness Results

Functions	Average Rating	Average Score
Establish and Operationalize a Health Care Coalition	**Full Ability**	**3**
Develop a Health Care Coalition Preparedness Plan	**Full Ability**	**3**
Identification of risks	**Full Ability**	**2.9**
Identification of needs	**Full Ability**	**2.7**
Train and prepare the health care and medical workforce	**Moderate Ability**	**2.3**
Ensure preparedness is sustainable	**Moderate Ability**	**2.2**

To provide a more detailed look at the unique capability of each HCC the following figure shows the HCCs that selected which ability level for the functions associated with the Foundation for Health Care and Medical Readiness capability.

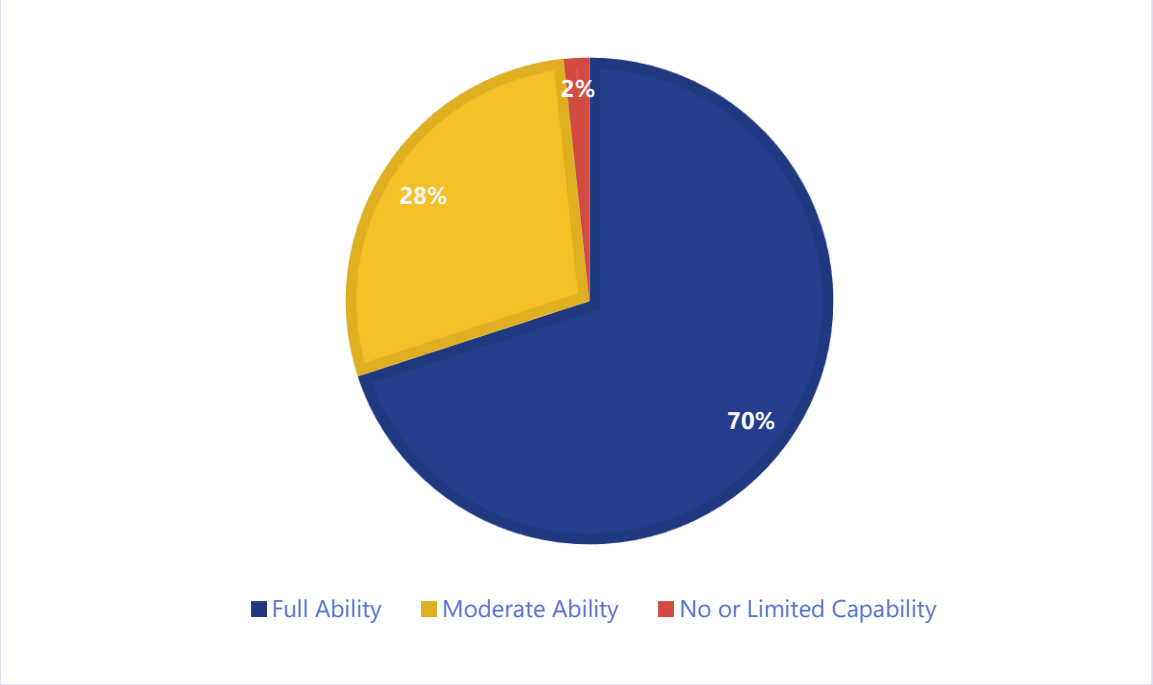
HCCs indicated that they were most capable of performing the "develop a Health Care Coalition Preparedness Plan" function with 10 or 10 HCC's responding that they are "full ability". HCCs indicated they were least capable of performing the "ensure preparedness is scalable" function with 3 HCC's responding, "full ability", 6 responding they have "moderate ability", and 1 HCC responding, "Limited or No Ability".

Figure 6: Foundation for Healthcare and Medical Readiness Functions Capability Results by number of HCCs



In addition to assessing the capability of the HCCs to perform each of the functions, this report also assesses the ability to perform the capability as a whole. When assessing this capability 70% of the responses indicated "Full ability" to perform the functions, 28% indicated "Moderate ability", and 2% indicated "No or Limited ability".

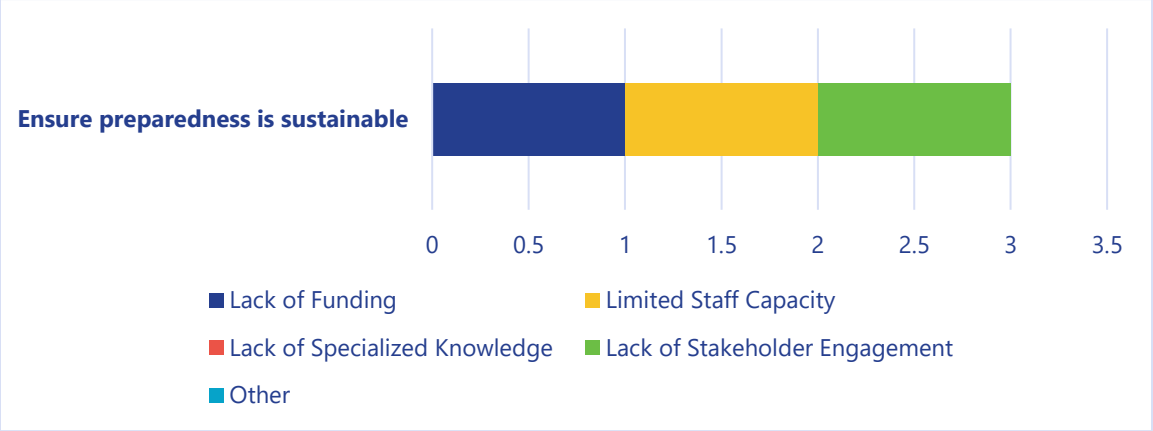
Figure 7: Foundation for Healthcare and Medical Readiness Capability Results



Identified Barriers to Foundation for Health Care and Medical Readiness

Respondents were asked to indicate what barriers they experience when they selected that they had "No or Limited Capability" to perform a function. The figure below shows the identified barriers by associated function. Functions that had no barriers identified are not displayed.

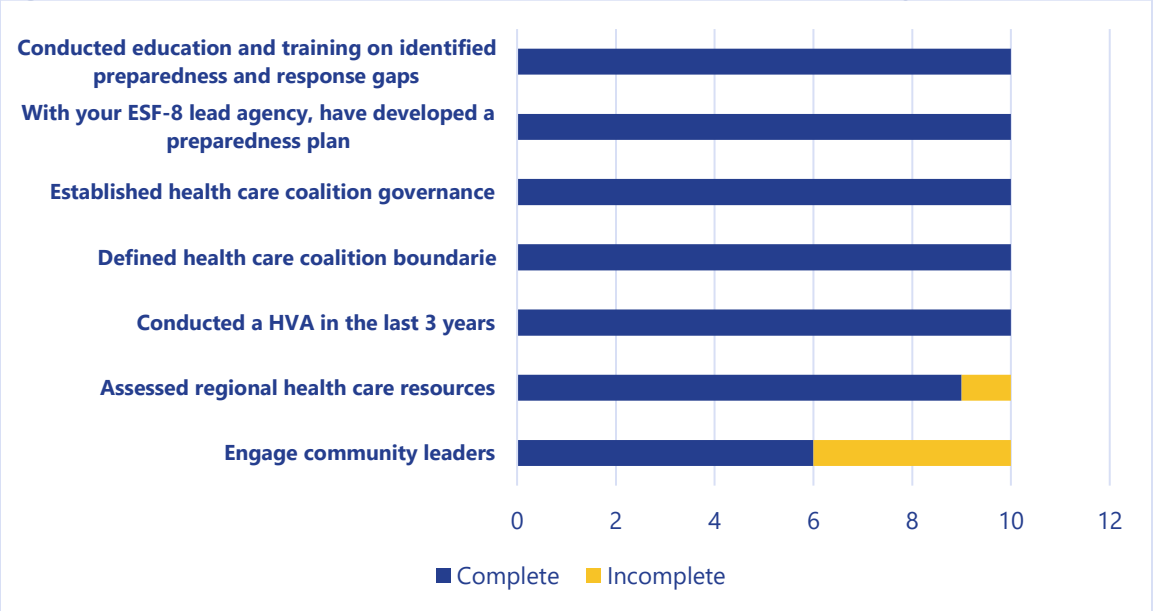
Figure 8: Foundation for Healthcare and Medical Readiness Barriers



Activity Completion

The National Health Care Preparedness and Response Capabilities document identifies specific activities that should be completed for a capability to be met. The following figure shows the completion status of each of the activities associated with this capability by number of HCC respondents.

Figure 9:Foundation for Healthcare and Medical Readiness Activity Completion Results



LHD Capability: Community Preparedness

Definition: Community preparedness is the ability of communities to prepare for, withstand, and recover from public health incidents in both the short and long term.

Respondents were asked to rank their capability to perform each of the functions associated with this capability by selecting one of the following ability levels: "No Ability" (0), "Limited Ability" (1), "Moderate Ability" (2), and "Full Ability" (3). A total of 6 functions associated with this capability were assessed through the PHHRA. The following figure displays the average capability score of all responses.

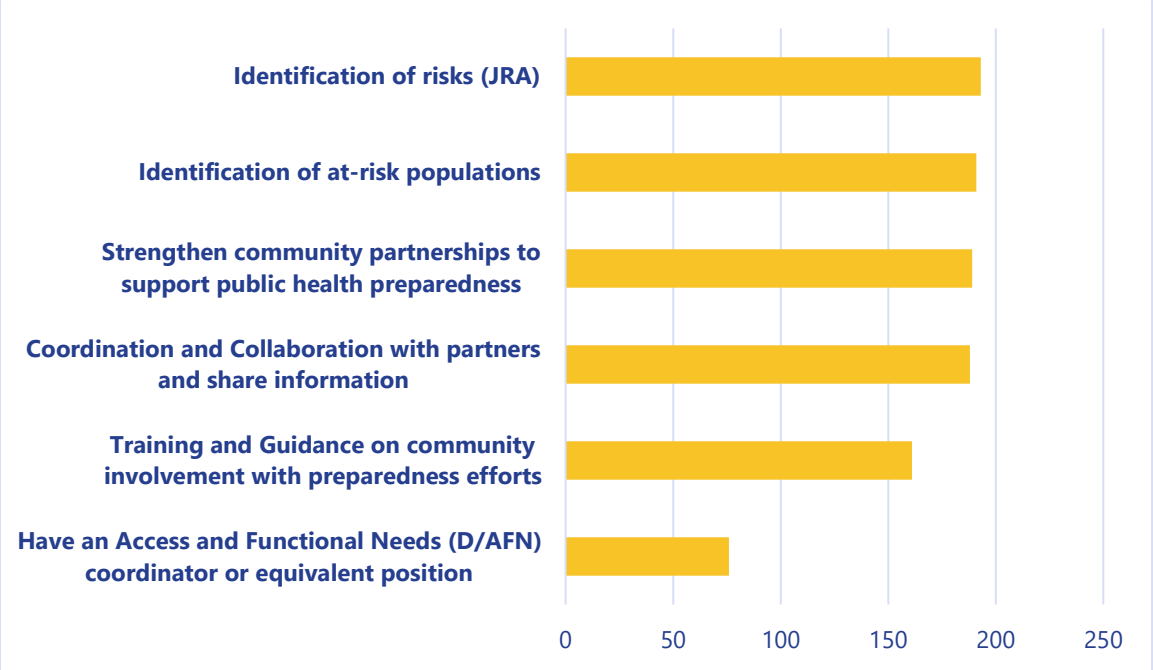
Figure 10: Community Preparedness Results

Functions	Average Rating	Average Score
Identification of risks (JRA)	**Moderate Capability**	**2.4**
Identification of at-risk populations	**Moderate Capability**	**2.3**
Strengthen community partnerships to support public health preparedness	**Moderate Capability**	**2.3**
Coordination and Collaboration with partners and share information	**Moderate Capability**	**2.3**
Training and Guidance on community involvement with preparedness efforts	**Moderate Capability**	**2**
Have a Disability/Access and Functional Needs (D/AFN) coordinator or equivalent position	**Limited Capability**	**1**

To provide a more detailed look at the unique score submitted by each respondent the following figure shows the total score for each function. A total of 246 points were possible for each function. (3 points possible * 82 respondents). This chart provides a visual of the overall capability of the state to perform each function.

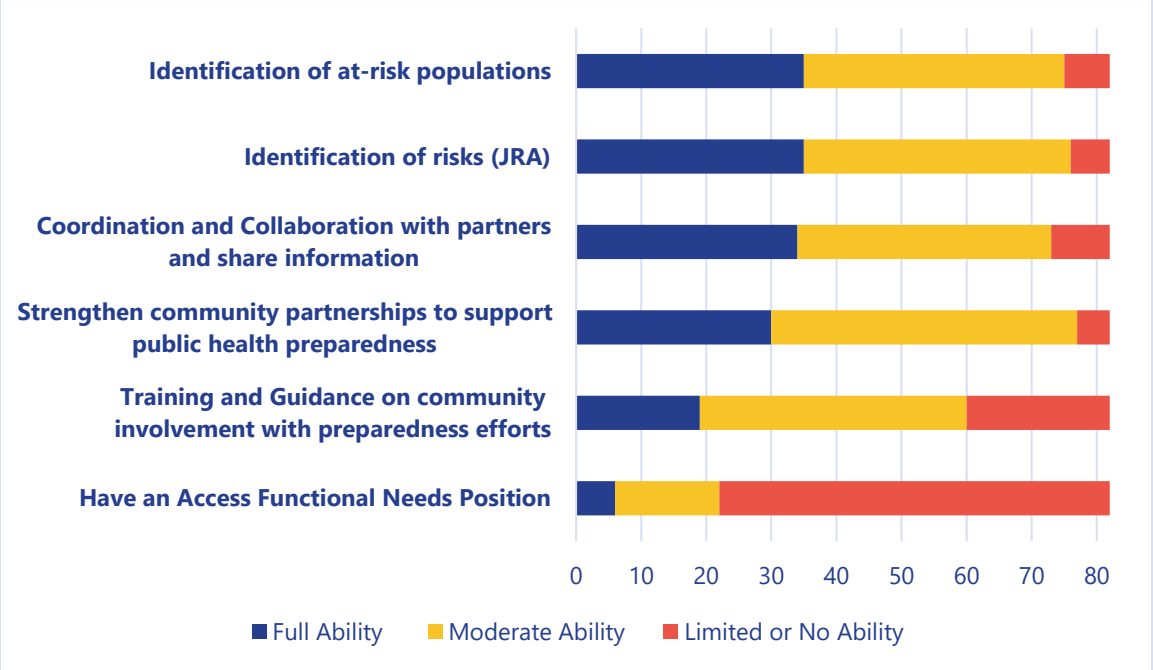
The function "identification of risks" had the highest cumulative score from the responses submitted by the LHD's with 193 of 246 possible points. The function "have an access and functional needs coordinator" had the lowest cumulative score from the responses submitted by the LHD's with 76 of 246 possible points.

Figure 11: Community Preparedness Functions Capability Ranking



The figures below represent the responses submitted by each Local Health Department regarding their level of capability to perform each function. A total of 81 LHD's submitted responses.

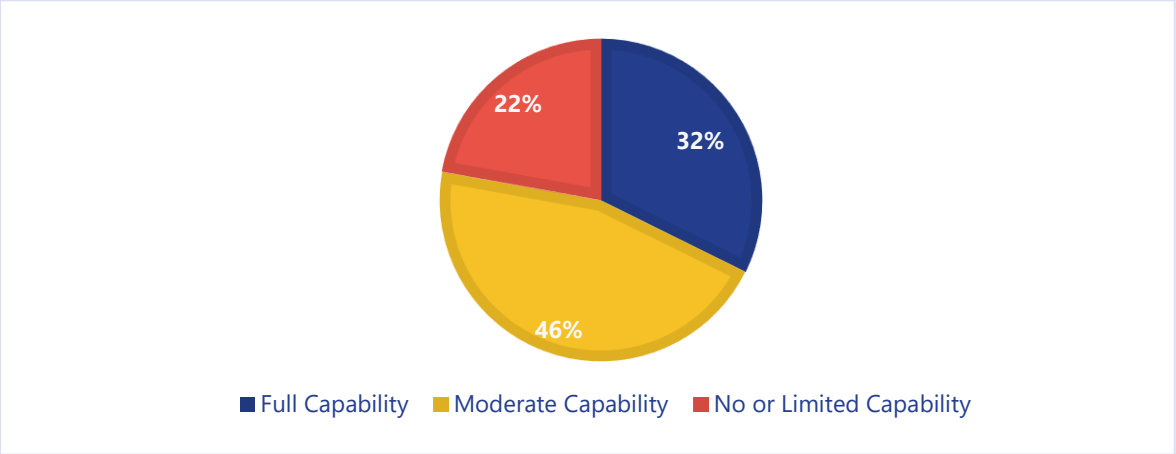
Figure 12: Community Preparedness Functions Results by number of LHDs



In addition to assessing the ability to perform each of the functions, this report also assesses the ability to perform the capability as a whole. The scores associated with the Community

Preparedness capability indicated that 32% of respondents had "Full Capability", 46% indicated "Moderate Capability", and 22% indicated "No or Limited Capability".

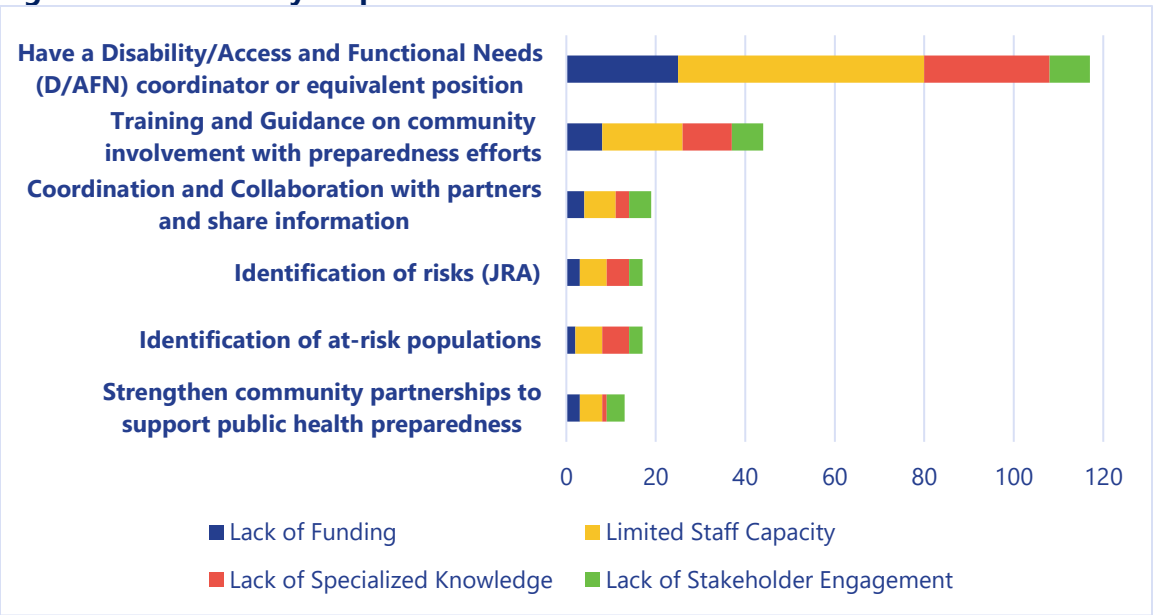
Figure 13: Community Preparedness Capability Results



Identified Barriers to Community Preparedness

Respondents were asked to identify what barriers they've encountered when they selected that they had "No" or "Limited" capability to perform a function. The figure below displays he barriers that were identified by the LHDs that responded, "No or Limited Capability" to the Community Preparedness capability. The figure below shows the identified barriers by associated function. Functions that had no barriers identified are not displayed.

Figure 14: Community Preparedness Barriers



Foundation for Health Care and Medical Response and Community Preparedness crosswalk

The table below provides insight into how the HCC functions related to Foundations for Healthcare and Medical Readiness correspond to the LHD functions related to Community Preparedness. In the event of an emergency impacting the health of a jurisdiction, a solid Foundation for Healthcare and Medical Readiness strengthens Community Preparedness. The column titled "interoperability of functions" provides an example of how the HCC function supports the LHD function and vice versa.

Figure 15: Foundations for Healthcare and Medical Readiness and Community Preparedness Crosswalk

Foundations for Health Care and Medical Readiness	Community Preparedness	Interoperability of Functions
HCC Functions	**LHD Functions**	
Establish and Operationalize a Health Care Coalition	Strengthen community partnerships to support public health preparedness	LHD's active participation in the HCC strengthens community partnerships. HCC's being operational supports LHD's partnership building.
Develop a Health Care Coalition Preparedness Plan	Coordination and Collaboration with partners and share information	The HCC's Preparedness Plan includes information regarding how LHD's will coordinate and collaborate with partners in a response.
Identification of risks	Identification of risks (JRA)	Identification of risks at the district (HCC) as well as county (LHD) levels provides multiple vantage points to view the possible risk to a jurisdiction.
Identification of needs	Identification of at-risk populations	The LHD's identification of at-risk populations supports HCC's ability to identify the diverse needs of the district's population.
Train and prepare the health care and medical workforce	Training and Guidance on community involvement with preparedness efforts	HCC's can provide training to the healthcare workforce, including those at the LHD's. LHD's can use that training and further the reach by providing training opportunities to community members.

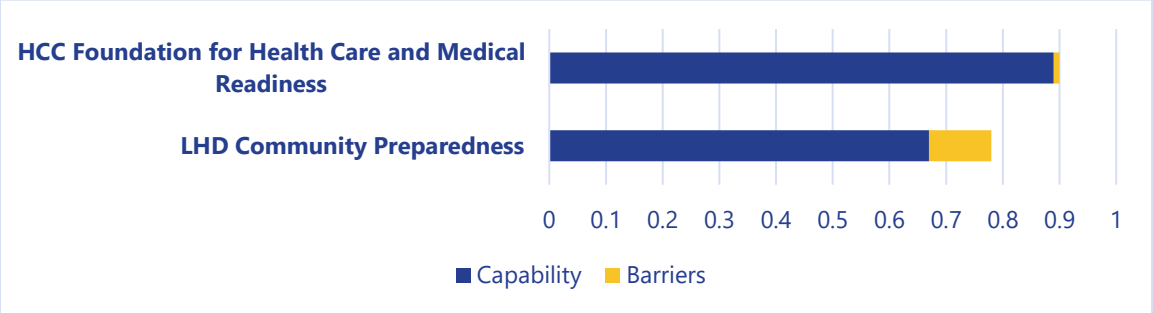
Ensure preparedness is sustainable	Have a Disability/Access and Functional Needs (D/AFN) coordinator or equivalent position	An LHD having a Disability/Access and Functional Needs (D/AFN) coordinator or equivalent position supports the HCC's ability to ensure preparedness is sustainable.

Local public health professionals are encouraged to expand upon this information to capture the specific ways in which the function of the HCC and LHD collaborate within their jurisdiction.

HCC and LHD Capability and Barrier Score Comparison

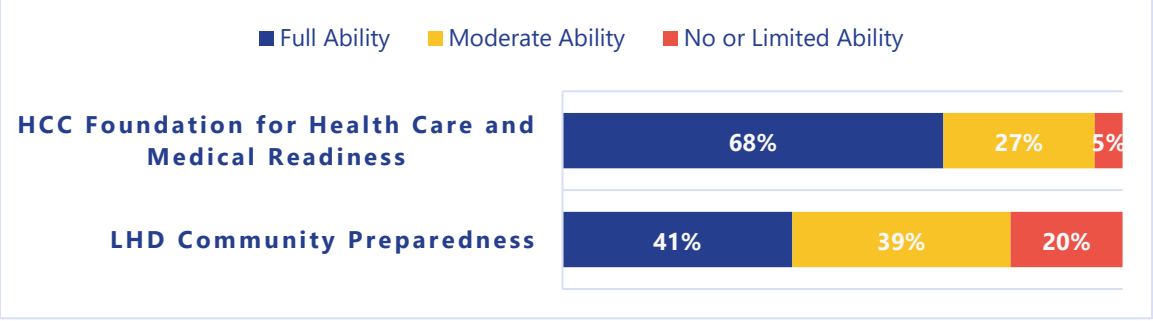
To compare the HCC and LHD capabilities ratings of the respondents a total possible score for each capability was calculated. Then the total of the scores given by the respondents was calculated. Finally, the total score was divided by the total possible score to find the capability rate. The HCC's indicated more of an ability to perform the Foundation for Healthcare and Medical Readiness capability with a rate of .89 compared to the LHDs ability to perform the Community Preparedness capability with a rate of .67. Additionally, HCCs identified fewer barriers with a rate of .01 compared to the LHD barrier rate of .11.

Figure 16: Foundation for Healthcare and Medical Readiness and Community Preparedness Capability and Barriers Comparison



HCC's rated themselves at "full ability" 68% of the time compared to the LHD's who rated themselves at a "full ability" 41%.

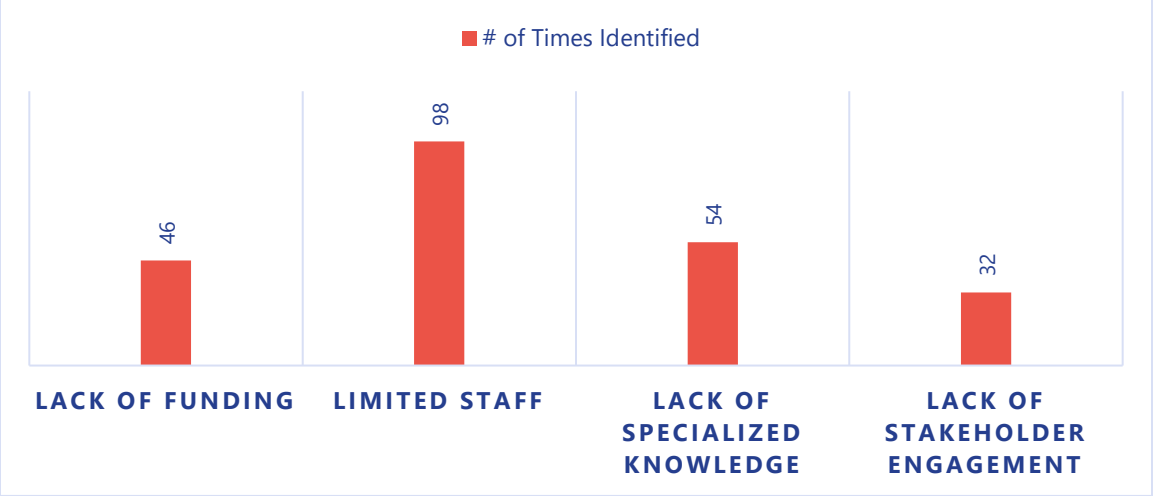
Figure 17: Foundation for Healthcare and Medical Readiness and Community Preparedness Ability Rating Comparison



Identified barriers comparison

HCCs and LHDs were both asked to identify barriers they encounter to achieving "full" or "moderate" ability ratings for their respective capabilities. The chart below shows the number of times an HCC or LHD selected that they experienced each barrier to their respective capability. Limited staff capacity was the most frequently identified with 98 respondents selecting this as a barrier.

Figure 18: HCC and LHD Barriers



HCC Capability: Health Care and Medical Response Coordination

Respondents were asked to rank their ability/capacity to perform each of the functions associated with this capability by selecting one of the following ability levels: "No Ability" (0), "Limited Ability" (1), "Moderate Ability" (2), and "Full Ability" (3). A total of 3 functions and 6 activities associated with this capability were assessed through the PHHRA. The figure below displays the average capability score of all district responses.

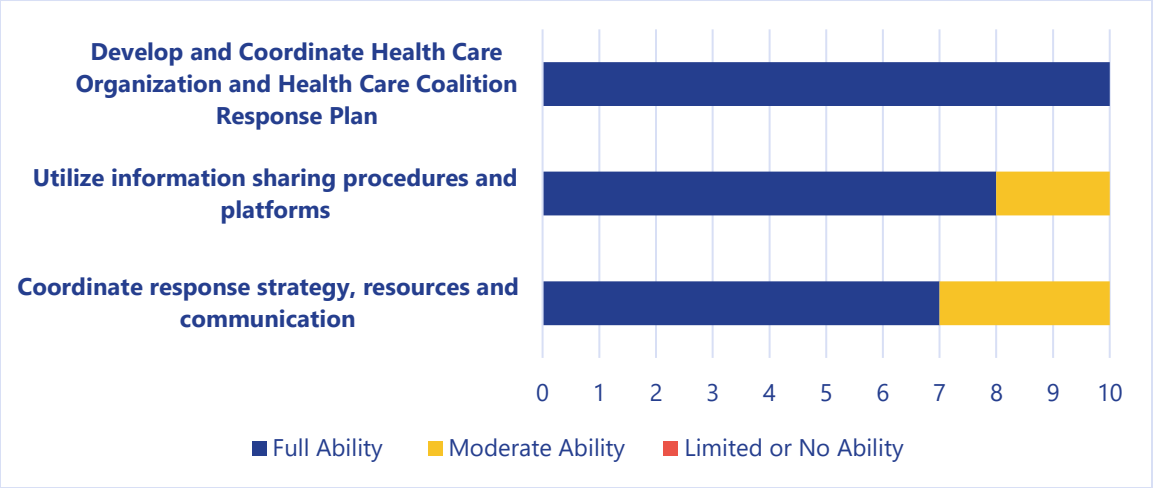
Definition: Health care organizations, the HCC, their jurisdiction(s), and the state's/jurisdiction's Emergency Support Function-8 (ESF-8) lead agency plan and collaborate to share and analyze information, manage and share resources, and coordinate strategies to deliver medical care to all populations during emergencies and planned events

Figure 19: Healthcare and Medical Response Coordination Results

Functions	Average Rating	Average Score
Develop and Coordinate Health Care Organization and Health Care Coalition Response Plan	**Full Ability**	**3**
Utilize information sharing procedures and platforms	**Full Ability**	**2.8**
Coordinate response strategy, resources and communication	**Full Ability**	**2.7**

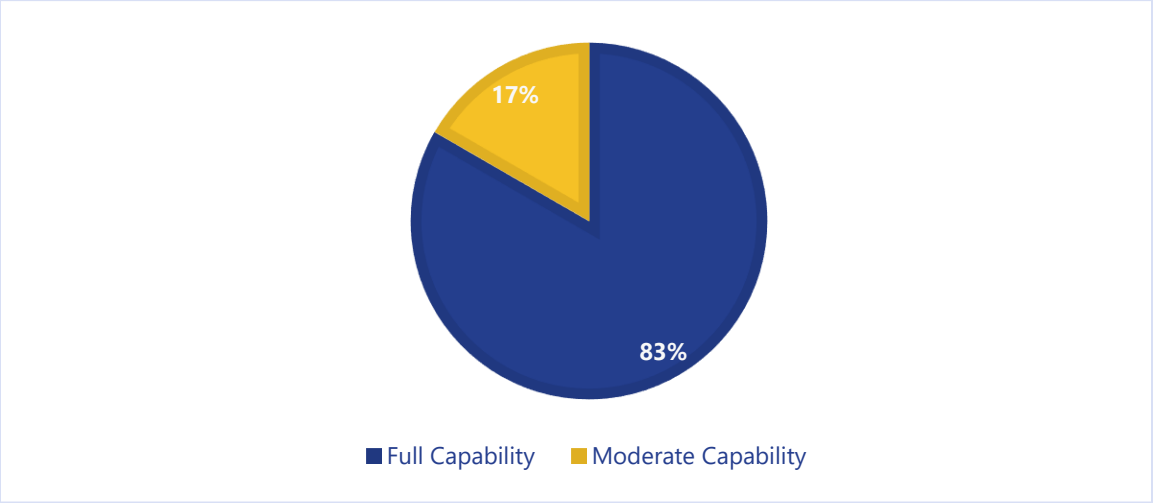
To provide a more detailed look at the unique capability of each HCC the following figure shows the HCCs that selected which ability level for each function.

Figure 20: Healthcare and Medical Response Coordination Functions Capability Results by number of HCCs



In addition to assessing the capability of the district to perform each of the functions, this report also assesses the district's ability to perform the HCC Capability as a whole. When assessing the 83% of the responses indicated "Full Capability", and 17% indicated "Moderate Capability".

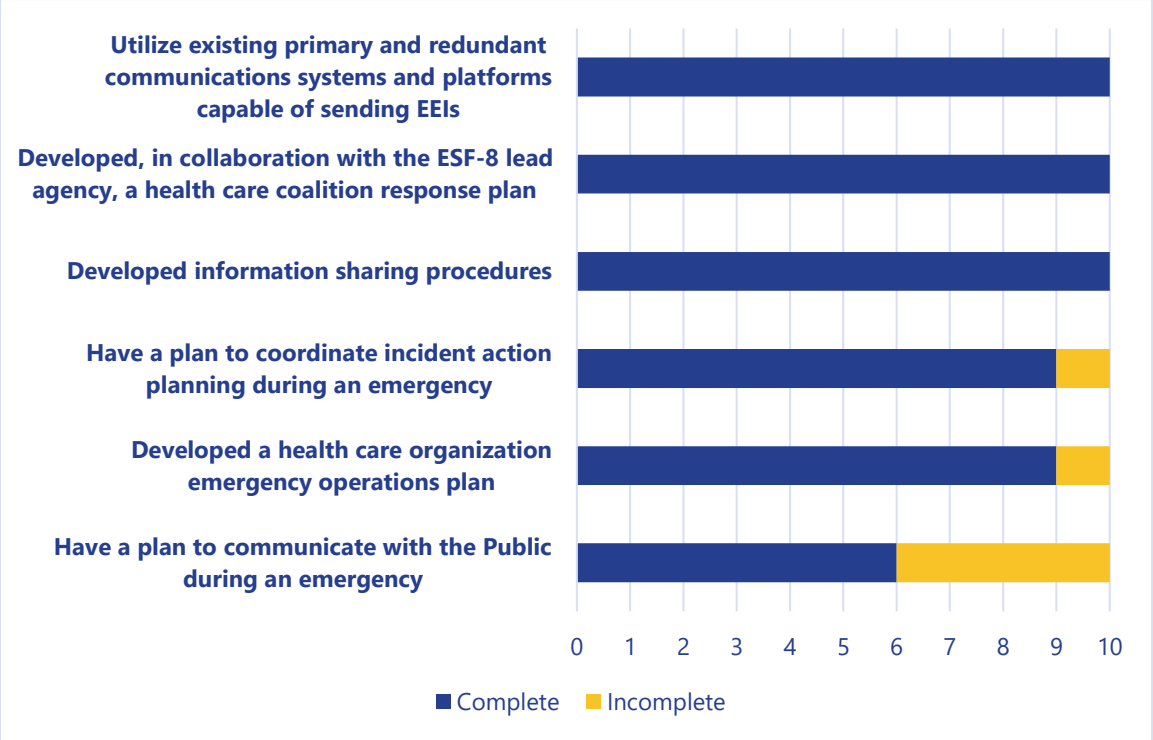
Figure 21:Healthcare and Medical Response Coordination Capability Response



Activity Completion

The National Health Care Preparedness and Response Capabilities document identifies specific activities that should be completed for a capability to be met. The following figure shows the completion status of each of the associated activities by number of HCC respondents.

Figure 22: Healthcare and Medical Response Coordination Activity Completion Results



Identified Barriers to Healthcare and Medical Response Coordination

No barriers were identified for this capability

LHD Capability: Emergency Operations Coordination

Respondents were asked to rank their ability/capacity to perform each of the functions associated with this capability by selecting one of the following ability levels: "No Ability" (0), "Limited Ability" (1), "Moderate Ability" (2), and "Full Ability" (3). A total of 6 functions associated with this capability were assessed through the PHHRA. The figure below displays the average capability score of all district responses.

Definition: The ability to coordinate with emergency management and to direct and support an incident or event with public health or health care implications by establishing a standardized, scalable system of oversight, organization, and supervision that is consistent with the National Incident Management System (NIMS).

Figure 23: Emergency Operations Coordination Results

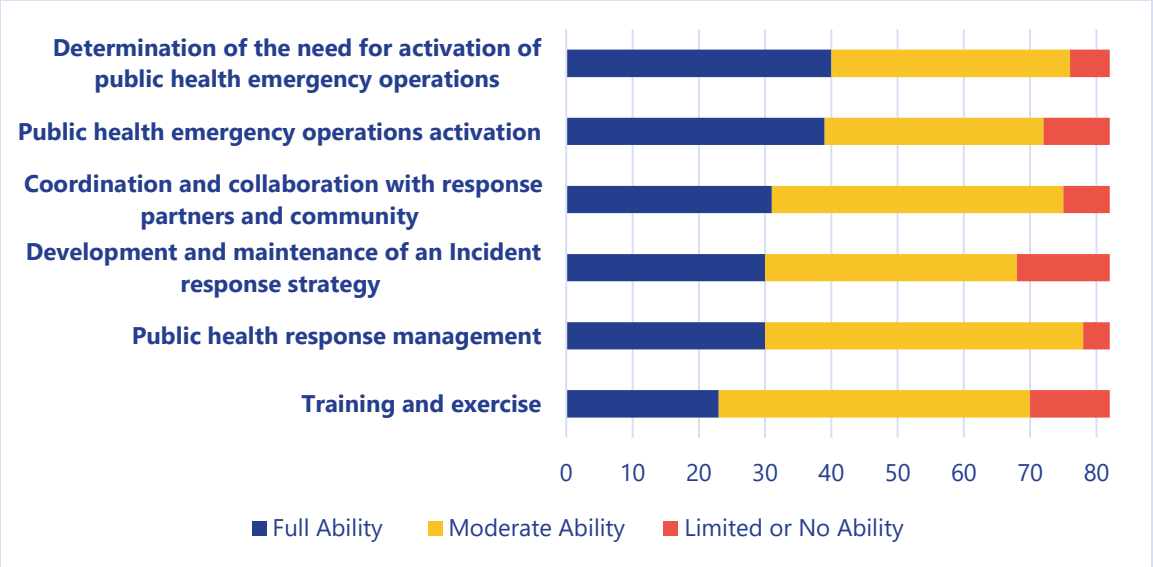
Functions	Average Rating	Average Score
Determination of the need for activation of public health emergency operations	**Moderate Ability**	**2.4**
Public health emergency operations activation	**Moderate Ability**	**2.4**
Public health response management	**Moderate Ability**	**2.3**
Coordination and collaboration with response partners and community	**Moderate Ability**	**2.3**
Development and maintenance of an Incident response strategy	**Moderate Ability**	**2.2**
Training and exercise	**Moderate Ability**	**2.1**

To provide a more detailed look at the unique score submitted by each respondent in the district the following figure shows the total score for each function. A total of 246 points were possible for each function. (3 points possible * 82 respondents). This chart provides a visual of the overall capability of the state to perform each function.

Figure 24: Emergency Operations Coordination Functions Capability Ranking

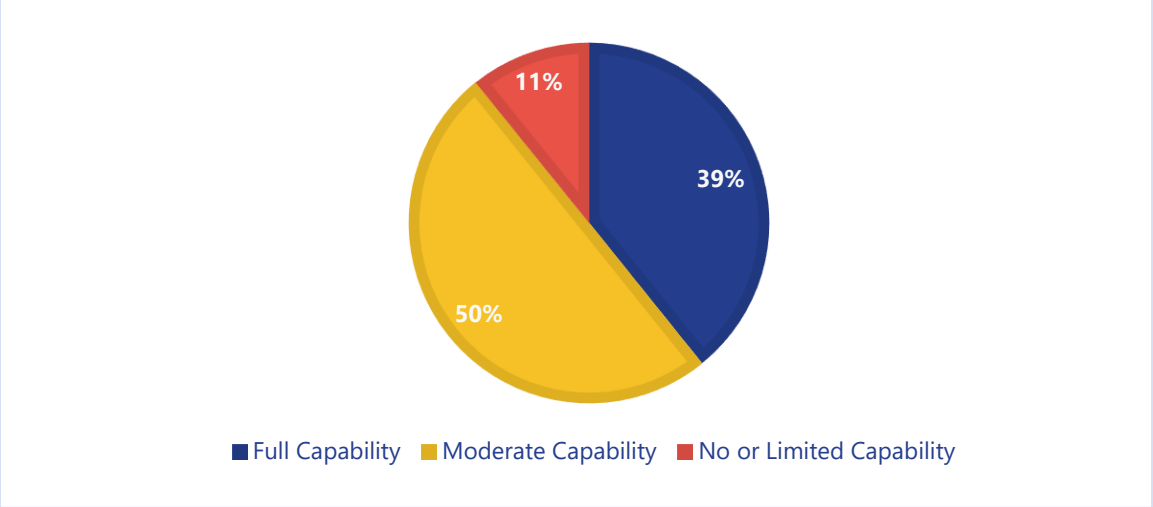
The figures below represent the responses submitted by each Local Health Department regarding their level of capability to perform each function.

Figure 25: Emergency Operations Coordination Functions Results by number of LHDs



In addition to assessing the capability of the district to perform each of the functions, this report also assesses the district's ability to perform the LHD Capability as a whole. When assessing the Emergency Operations Coordination capability 39% of the responses indicated "Full Capability", 50% indicated "Moderate Capability", and 11% of respondents indicated "No or Limited Capability".

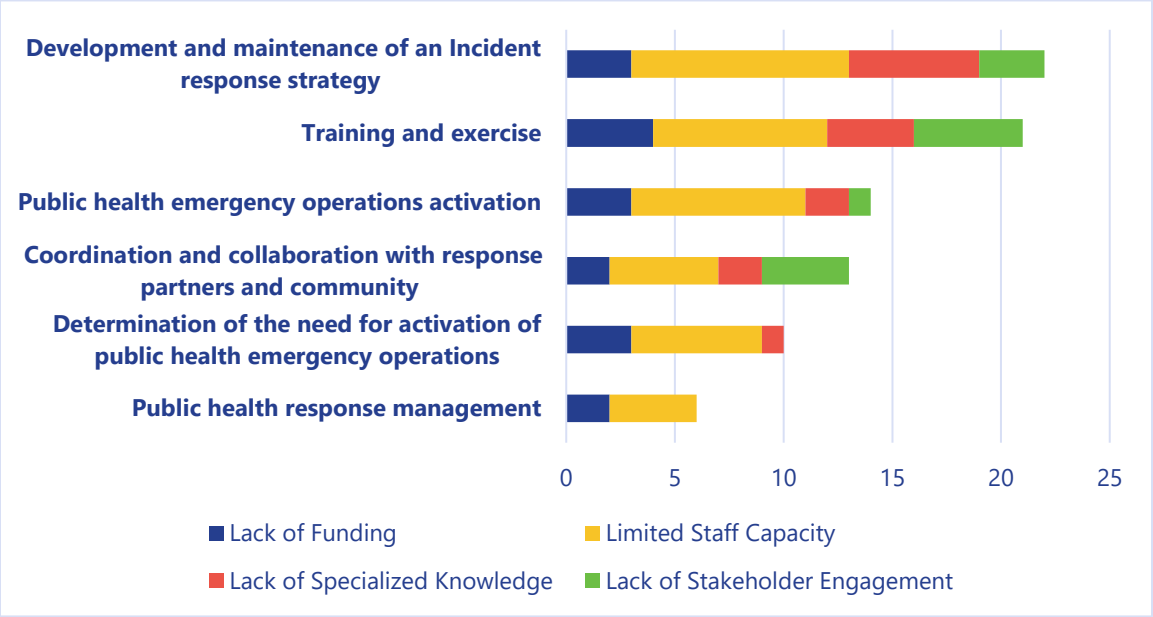
Figure 26: Emergency Operations Coordination Capability Results



Identified Barriers to Emergency Operations Coordination

The figure below shows the identified barriers by associated function. Functions that had no barriers identified are not displayed.

Figure 27: Emergency Operations Coordination Barriers



Health Care and Medical Response Coordination and Emergency Operations Coordination crosswalk

The table below provides insight into how the HCC functions related to Health Care and Medical Response Coordination correspond to the LHD functions related to Emergency Operations Coordination. In the event of an emergency impacting the health of a jurisdiction, coordination of all aspects of health-related operations is needed. The column titled "interoperability of

functions" provides an example of how the HCC function supports the LHD function and vice versa.

Figure 28: Healthcare and Medical Response Coordination and Emergency Operations Coordination Crosswalk

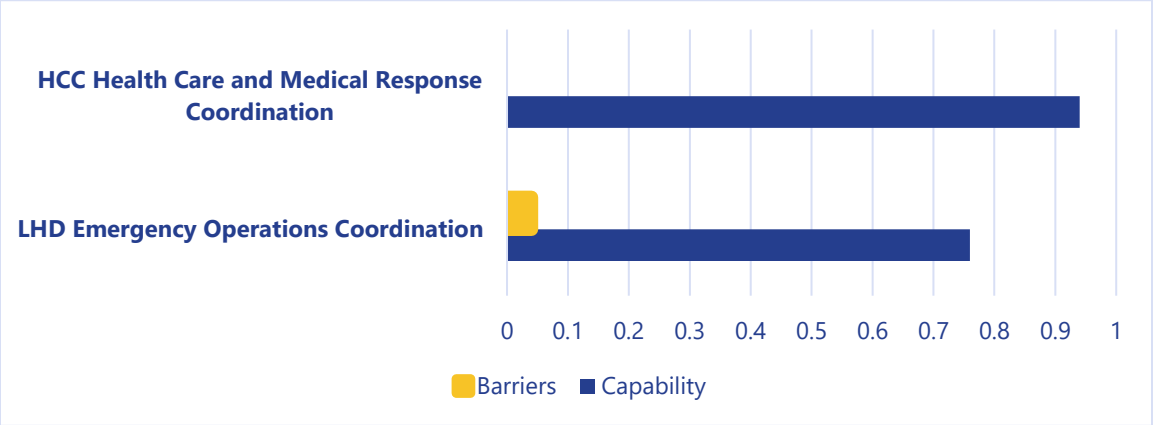
Health Care and Medical Response Coordination	Emergency Operations Coordination	Interoperability of Functions
HCC Functions	**LHD Functions**	
Develop and Coordinate Health Care Organization and Health Care Coalition Response Plan	Determination of the need for activation of public health emergency operations	The HCC's development of a response plan would incorporate the need for activation determined by the LHDs in the district. The LHD's ability to maintain the incident response strategy is strengthened through integration with the HCC's response plan as this expands the strategies beyond that of the LHD.
	Development and maintenance of an Incident response strategy	
Utilize information sharing procedures and platforms	Coordination and collaboration with response partners and community	Coordination and collaboration between LHD's and HCC's to develop and implement information sharing procedures and platforms supports creation of a shared understanding and responsibility for these systems.
Coordinate response strategy, resources and communication	Public health response management	A coordinated response strategy requires the HCCs and LHDs to collaborate on public health response management, emergency operations activation plans, and training and exercises at the district and county level.
	Public health emergency operations activation	
	Training and exercise	

Local public health professionals are encouraged to expand upon this information to capture the specific ways in which the function of the HCC and LHD collaborate within their jurisdiction.

HCC and LHD Capability and Barrier Score Comparison

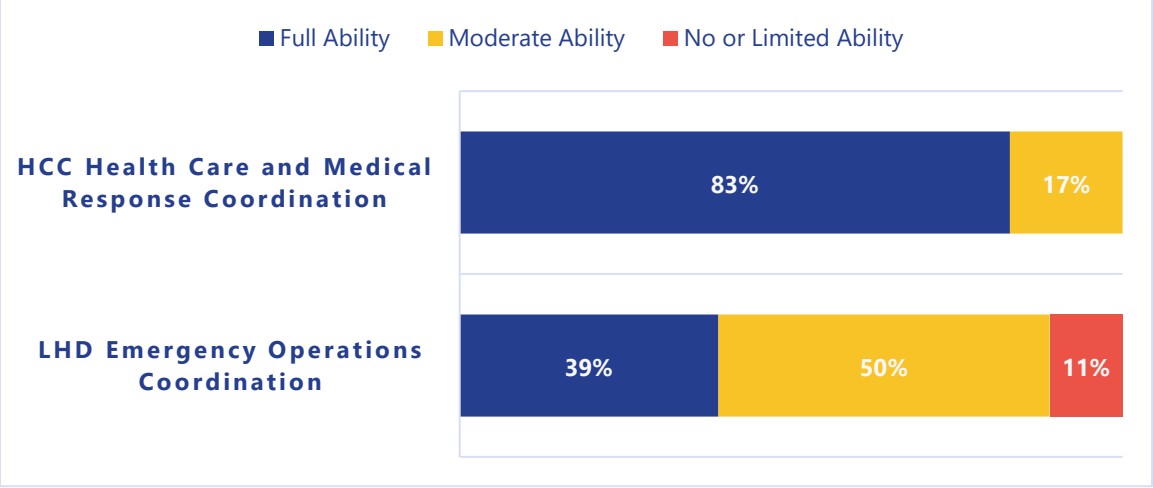
To compare the HCC and LHD capabilities ratings of the respondents a total possible score for each capability was calculated. Then the total of the scores given by the respondents was calculated. Finally, the total score was divided by the total possible score to find the capability rate.

Figure 29: Healthcare and Medical Readiness Coordination and Emergency Operations Coordination Capability and Barrier Comparison



The following figure shows the % of respondents that selected each ability level for their respective capabilities.

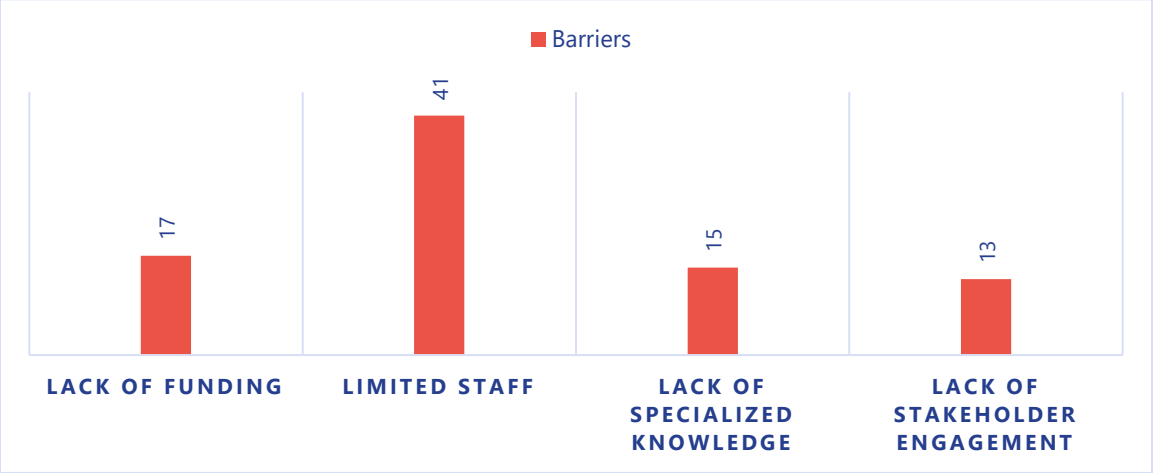
Figure 30: Healthcare and Medical Readiness Coordination and Emergency Operations Coordination Ability Rating Comparison



Identified barrier comparison

HCCs and LHDs were both asked to identify barriers they encounter to achieving "full" or "moderate" ability ratings for their respective capabilities. The chart below shows the number of times an HCC or LHD selected that they experienced each barrier to their respective capability. Limited staff capacity was the most frequently identified with 41 respondents selecting this as a barrier.

Figure 31: Healthcare and Medical Response Coordination and Emergency Operations Coordination Barriers



HCC Capability: Continuity of Health Care Service Delivery

Respondents were asked to rank their ability/capacity to perform each of the functions associated with this capability by selecting one of the following ability levels: "No Ability" (0), "Limited Ability" (1), "Moderate Ability" (2), and "Full Ability" (3). A total of 6 functions and 6 activities associated with this capability were assessed through the PHHRA. The following figure displays the average capability score of all district responses.

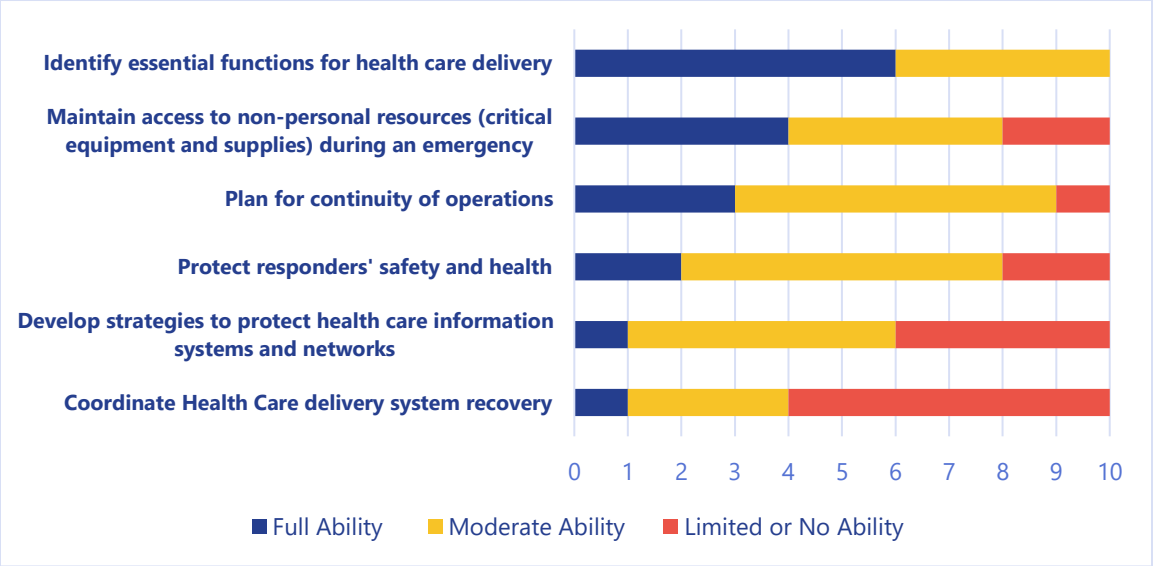
Definition: Health care organizations, with support from the HCC and the state's/jurisdiction's ESF-8 lead agency, provide uninterrupted, optimal medical care to all populations in the face of damaged or disabled health care infrastructure. Health care workers are well-trained, well-educated, and well-equipped to care for patients during emergencies.

Figure 32: Continuity of Healthcare Service Delivery Results

Functions	Average Rating	Average Score
Identify essential functions for health care delivery	**Full Ability**	**2.6**
Plan for continuity of operations	**Moderate Ability**	**2.2**
Maintain access to non-personal resources (critical equipment and supplies) during an emergency	**Moderate Ability**	**2.2**
Protect responders' safety and health	**Moderate Ability**	**2**
Coordinate Health Care delivery system recovery	**Moderate Ability**	**1.8**
Develop strategies to protect health care information systems and networks	**Moderate Ability**	**1.6**

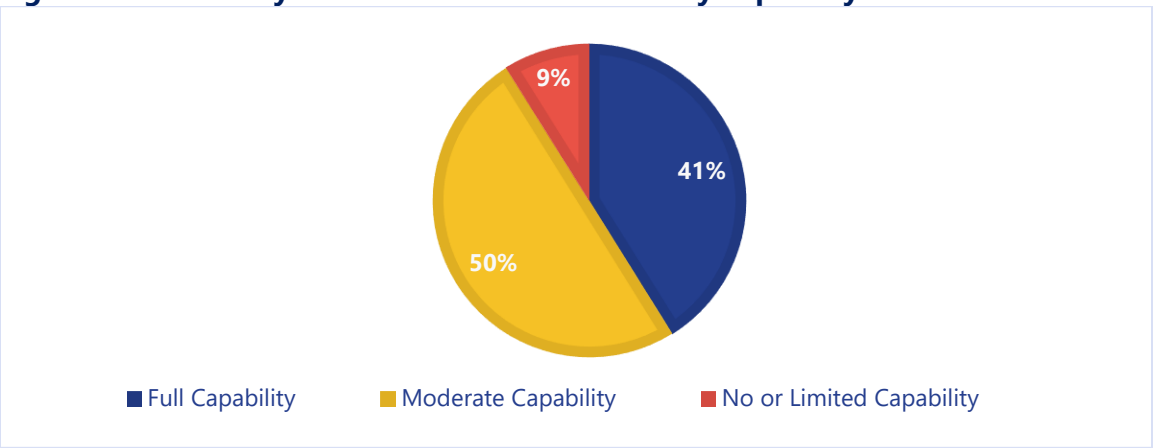
To provide a more detailed look at the unique capability of each HCC the following figure shows the HCCs that selected which ability level for each function.

Figure 33: Continuity of Healthcare Service Delivery Functions Capability Results by number of HCCs



In addition to assessing the capability of the district to perform each of the functions, this report also assesses the district's ability to perform the HCC Capability as a whole. When assessing the 41% of the responses indicated "Full Capability", and 50% indicated "Moderate Capability". 9% indicated "No or Limited Capability"

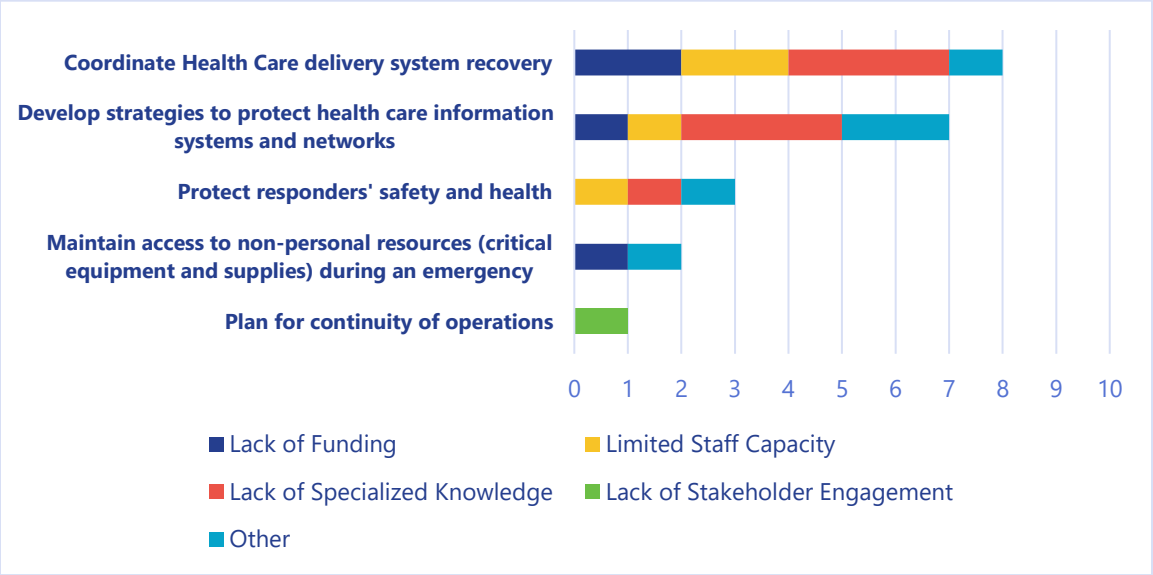
Figure 34: Continuity of Healthcare Service Delivery Capability Results



Identified barriers to Continuity of Healthcare Service Delivery

The figure below shows the identified barriers by associated function. Functions that had no barriers identified are not displayed.

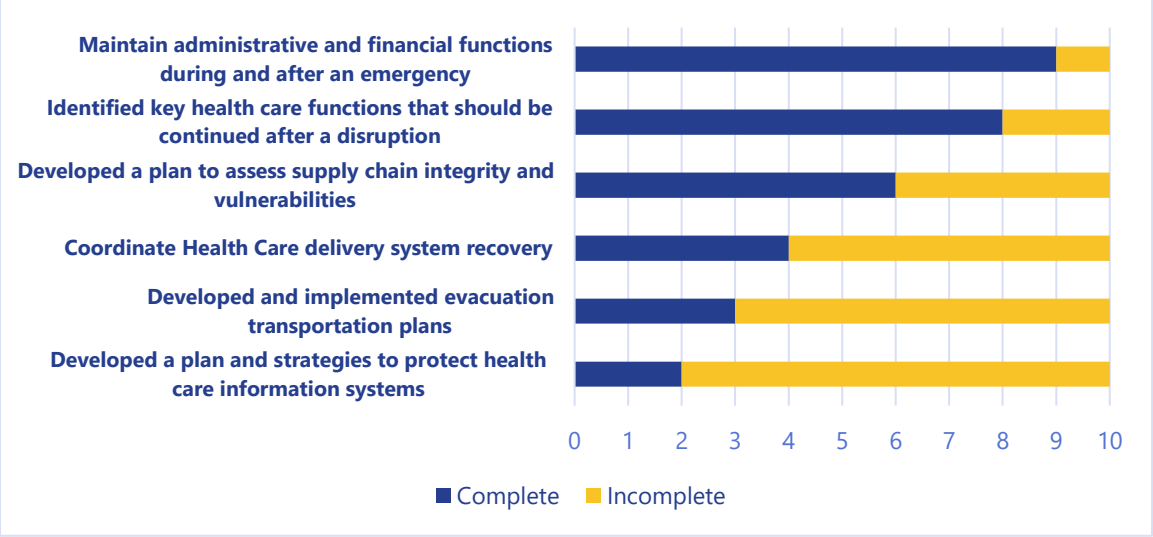
Figure 35: Continuity of Healthcare Service Delivery Barriers



Activity Completion

The National Health Care Preparedness and Response Capabilities document identifies specific activities that should be completed for a capability to be met. The following figure shows the completion status of each of the associated activities by number of HCC respondents.

Figure 36: Continuity of Healthcare Service Delivery Activity Completion Results



LHD Capability: Public Health Laboratory Testing

Definition: The ability to implement and perform methods to detect, characterize, and confirm public health threats.

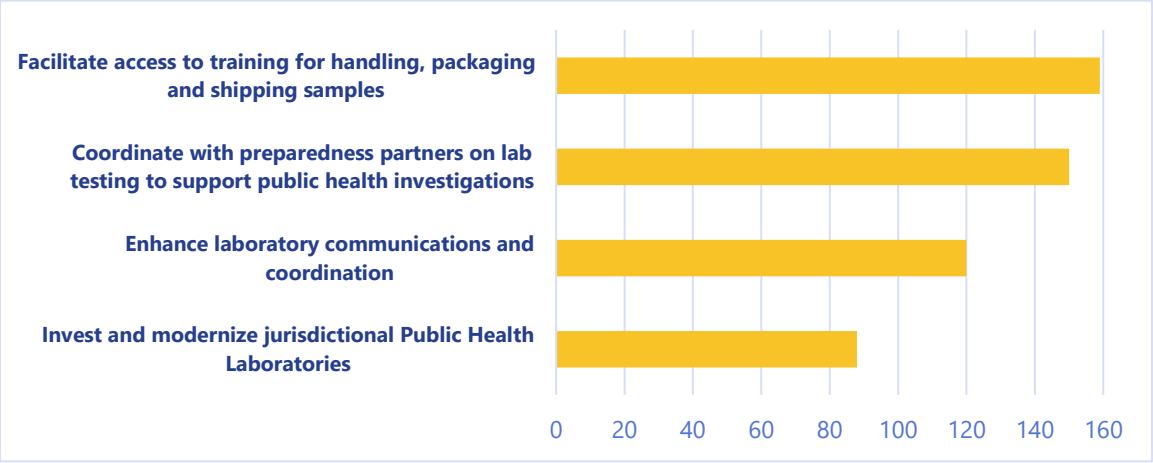
Respondents were asked to rank their ability/capacity to perform each of the functions associated with this capability by selecting one of the following ability levels: "No Ability" (0), "Limited Ability" (1), "Moderate Ability" (2), and "Full Ability" (3). A total of 4 functions associated with this capability were assessed through the PHHRA. The figure below displays the average capability score of all district responses.

Figure 37: Public Health Laboratory Testing Results

Functions	Average Rating	Average Score
Facilitate access to training for handling, packaging and shipping samples	**Moderate Ability**	**1.9**
Coordinate with preparedness partners on lab testing to support public health investigations	**Moderate Ability**	**1.8**
Enhance laboratory communications and coordination	**Limited Ability**	**1.4**
Invest and modernize jurisdictional Public Health Laboratories	**Limited Ability**	**1**

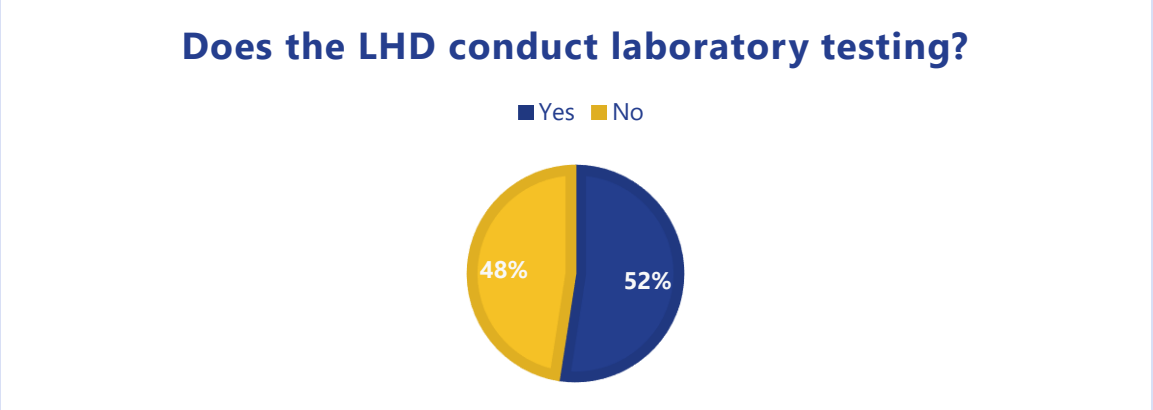
To provide a more detailed look at the unique score submitted by each respondent in the district the following figure shows the total score for each function. A total of 246 points were possible for each function. (3 points possible * 82 respondents). This chart provides a visual of the overall capability of the state to perform each function.

Figure 38: Public Health Laboratory Testing Capability Ranking



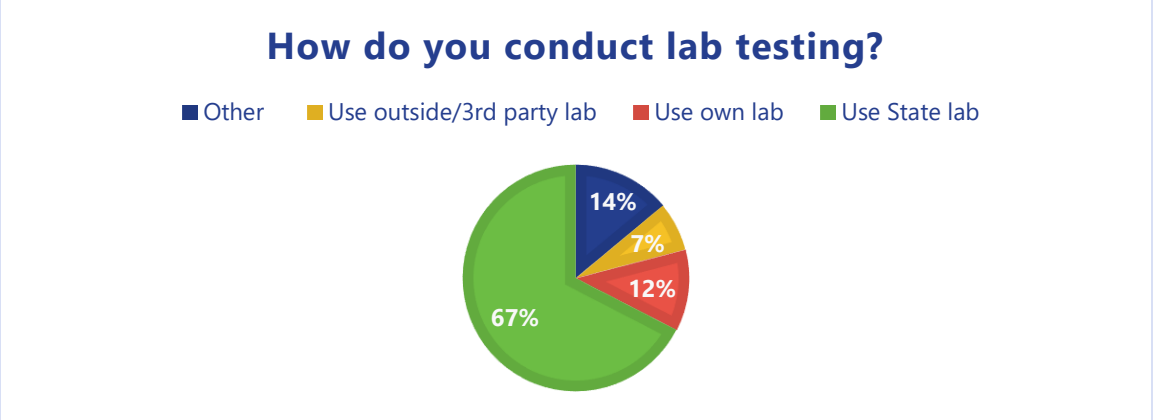
Not every LHD in Indiana conducts laboratory testing and reports results. Prior to answering questions regarding this capability respondents were asked if their LHD performs laboratory testing. The responses to this question are shown in the figure below.

Figure 39: LHD Laboratory Testing



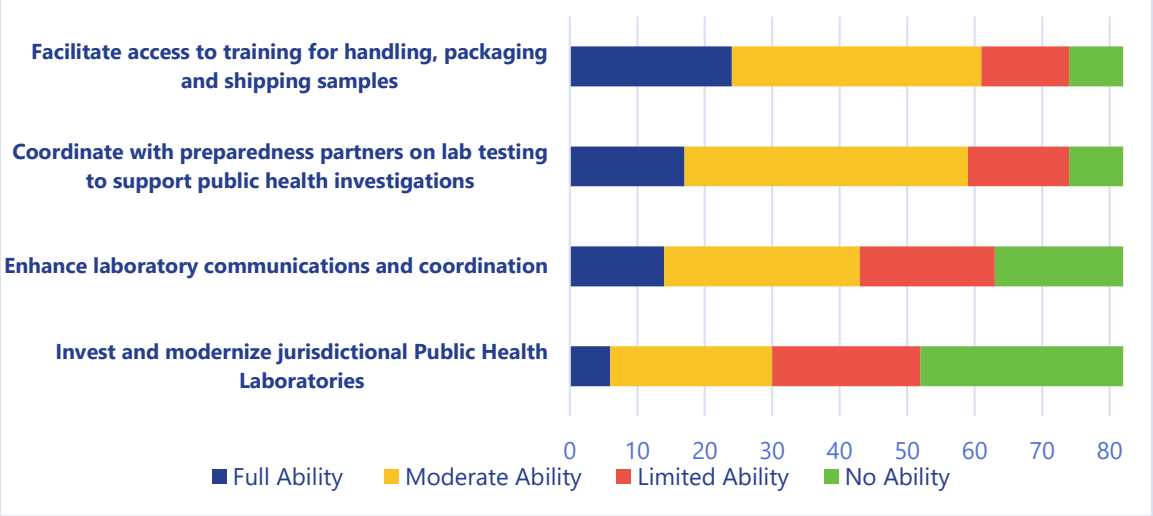
For respondents that answered "yes" to this question. They were then prompted to specify how this is done. A breakdown of those responses is shown below:

Figure 40: How Laboratory Testing is Conducted



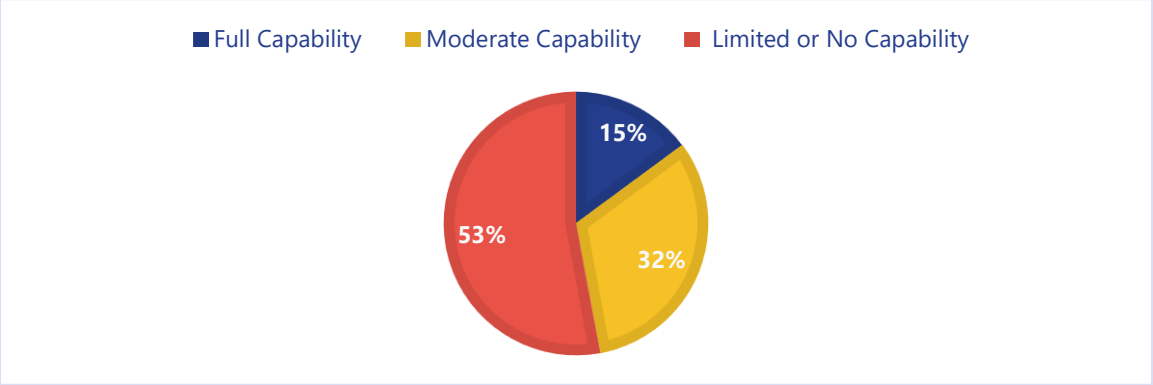
To provide a more detailed look at the unique score submitted by each respondent in the following figures represent the responses submitted by each Local Health Department regarding their level of capability to perform each function.

Figure 41: Public Health Laboratory Testing Functions Capability by number of LHDs



In addition to assessing the capability of the district to perform each of the functions, this report also assesses the district's ability to perform the LHD Capability as a whole. When assessing the Public Health Laboratory Testing capability 15% of the responses indicated "Full Capability", 32% indicated "Moderate Capability", and 53% indicated "Limited or No Capability".

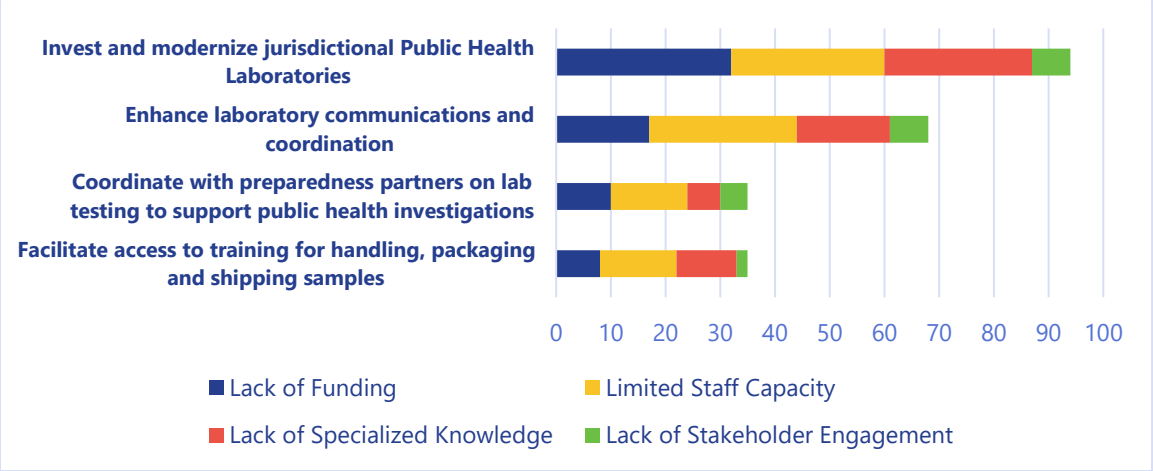
Figure 42: Public Health Laboratory Testing Capability Results



Identified Barriers to Public Health Laboratory Testing

Additionally, respondents were asked to indicate what barriers they experience when they selected that they had "No or Limited Capability" to perform a function. The figure below shows the identified barriers by associated function. Functions that had no barriers identified are not displayed.

Figure 43: Public Health Laboratory Testing Barriers



Continuity of Healthcare Service Delivery and Public Health Laboratory Testing crosswalk

The table below provides insight into how the HCC functions related to Continuity of Healthcare Service Delivery correspond to the LHD functions related to Public Health Laboratory Testing. The column titled "interoperability of functions" provides an example of how the HCC function supports the LHD function and vice versa.

Figure 44: Continuity of Healthcare Service Delivery and Public Health Laboratory Testing crosswalk

Continuity of Health Care Service Delivery	Public Health Laboratory Testing	Interoperability of Functions
HCC Functions	**LHD Functions**	
Plan for continuity of operations	Invest and modernize jurisdictional Public Health Laboratories	Investment and modernization of public health laboratories by LHDs will support the ability of the HCCs to plan for continuity of operations as it relates to laboratory services.
Maintain access to non-personal resources (critical equipment and supplies) during an emergency	Coordinate with preparedness partners on lab testing to support public health investigations	The LHD's support with lab testing for public health investigations assists the HCCs to maintain access to non-personal resources during an emergency.
Protect responders' safety and health	Facilitate access to training for handling,	LHD's facilitation of access to training for handling, packaging, and shipping of samples directly supports the function of the HCC's to protect responders safety and health. Lack of

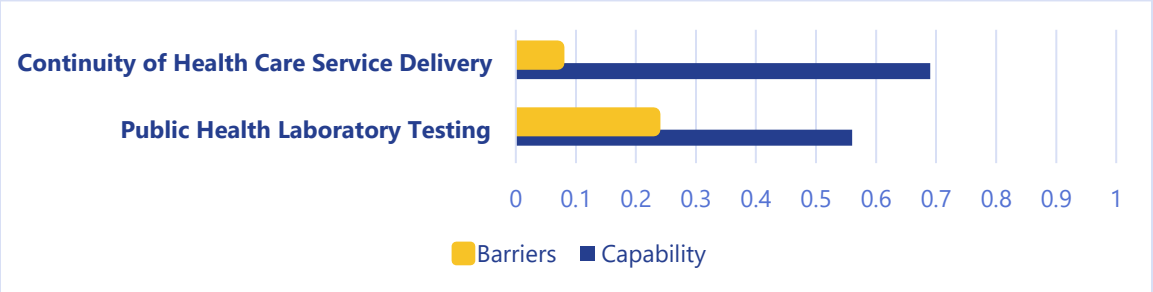
	packaging and shipping samples	training regarding safe handling of samples can lead to adverse impacts on the health of responders.
Develop strategies to protect health care information systems and networks	Enhance laboratory communications and coordination	The strategies developed by the HCC's to protect health care information systems can be used in collaboration with the LHD's to enhance laboratory communications and coordination.
Identify essential functions for health care delivery		
Coordinate Health Care delivery system recovery	ALL	The HCC's coordination of Healthcare Delivery system recovery supports the continued ability of the LHD to perform all functions related to this capability.

Local public health professionals are encouraged to expand upon this information to capture the specific ways in which the function of the HCC and LHD collaborate within their jurisdiction.

HCC and LHD Capability and Barrier Scores

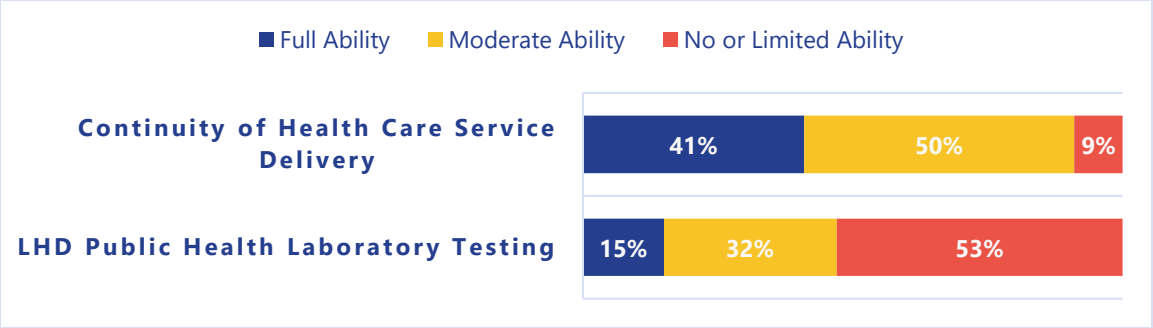
To compare the HCC and LHD capabilities ratings of the respondents a total possible score for each capability was calculated. Then the total of the scores given by the respondents was calculated. Finally, the total score was divided by the total possible score to find the capability rate.

Figure 45: Continuity of Healthcare Service Delivery and Public Health Laboratory Testing Capability and Barrier Comparison



The following figure shows the % of respondents that selected each ability level for their respective capabilities.

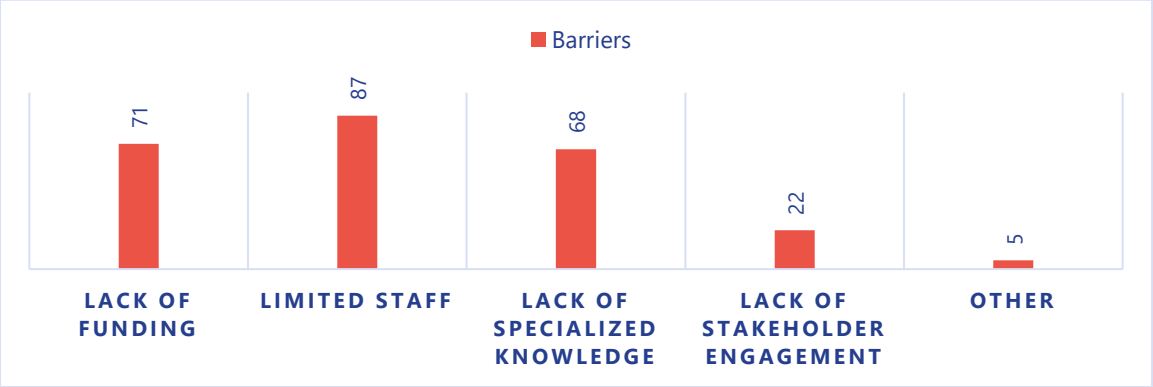
Figure 46: Continuity of Healthcare Service Delivery and Public Health Laboratory Testing Ability Rating Comparison



Identified barriers comparison

HCCs and LHDs were both asked to identify barriers they encounter to achieving "full" or "moderate" ability ratings for their respective capabilities. The chart below shows the number of times an HCC or LHD selected that they experienced each barrier to their respective capability. Limited staff capacity was the most frequently identified with 87 respondents selecting this as a barrier.

Figure 47:Continuity of Healthcare Service Delivery and Public Health Laboratory Testing Barriers



HCC Capability: Medical Surge

Respondents were asked to rank their ability/capacity to perform each of the functions associated with this capability by selecting one of the following ability levels: "No Ability" (0), "Limited Ability" (1), "Moderate Ability" (2), and "Full Ability" (3). A total of 10 functions and 5 activities associated with this capability were assessed through the PHHRA. The following figure displays the average capability score of all district responses.

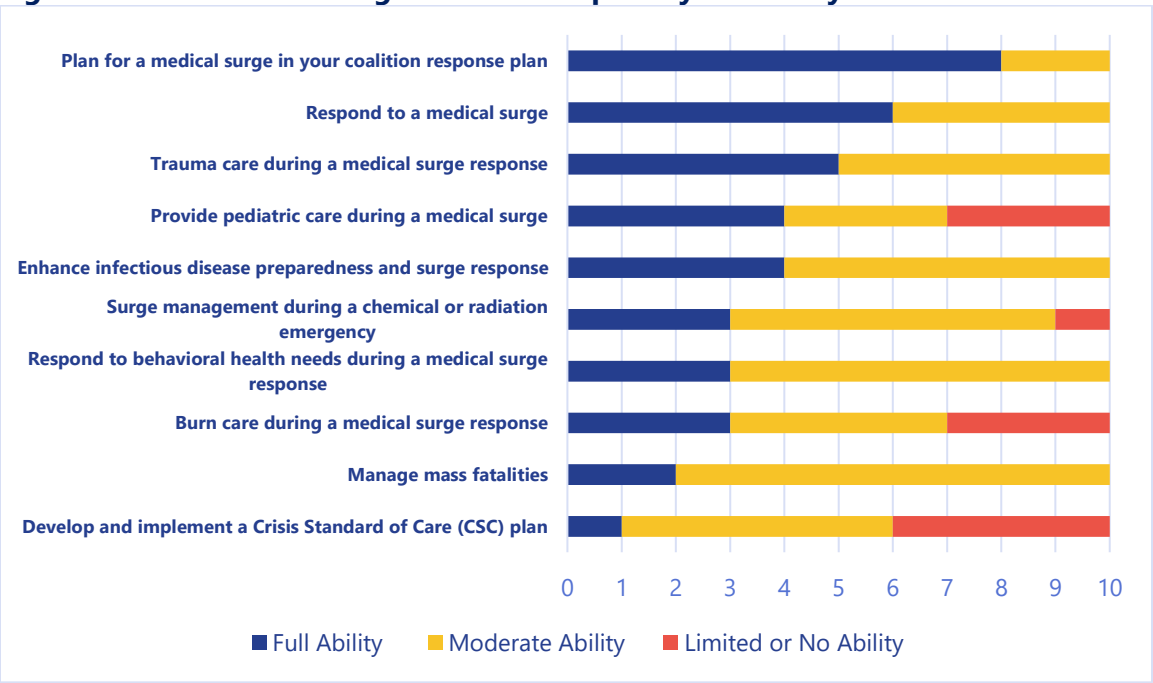
Definition: Health care organizations—including hospitals, EMS, and out-of-hospital providers—deliver timely and efficient care to their patients even when the demand for health care services exceeds available supply.

Figure 48: HCC Medical Surge Results

Functions	Average Rating	Average Score
Plan for a medical surge in your coalition response plan	**Full Ability**	**2.8**
Respond to a medical surge	**Full Ability**	**2.6**
Trauma care during a medical surge response	**Full Ability**	**2.5**
Enhance infectious disease preparedness and surge response	**Moderate Ability**	**2.4**
Respond to behavioral health needs during a medical surge response	**Moderate Ability**	**2.3**
Surge management during a chemical or radiation emergency	**Moderate Ability**	**2.2**
Manage mass fatalities	**Moderate Ability**	**2.2**
Provide pediatric care during a medical surge	**Moderate Ability**	**2.1**
Burn care during a medical surge response	**Moderate Ability**	**2**
Develop and implement a Crisis Standard of Care (CSC) plan	**Moderate Ability**	**1.7**

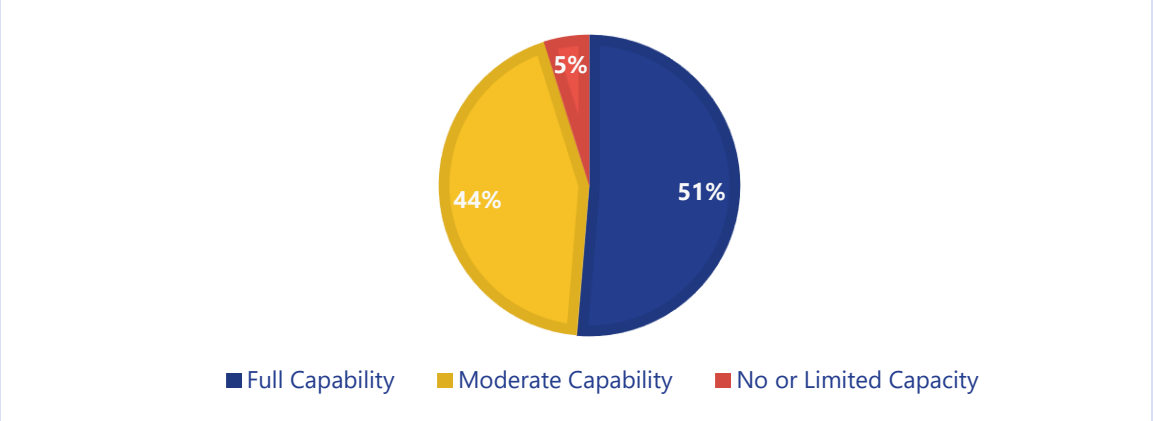
To provide a more detailed look at the unique capability of each HCC the following figure shows the number of HCC's that selected which ability level for each function.

Figure 49: HCC Medical Surge Functions Capability Results by number of HCCs



In addition to assessing the capability of the HCCs to perform each of the functions, this report also assesses the district's ability to perform the HCC Capability as a whole. When assessing this capability 51% of the responses indicated "Full Capability", and 44% indicated "Moderate Capability". 5% indicated "No or Limited Capability".

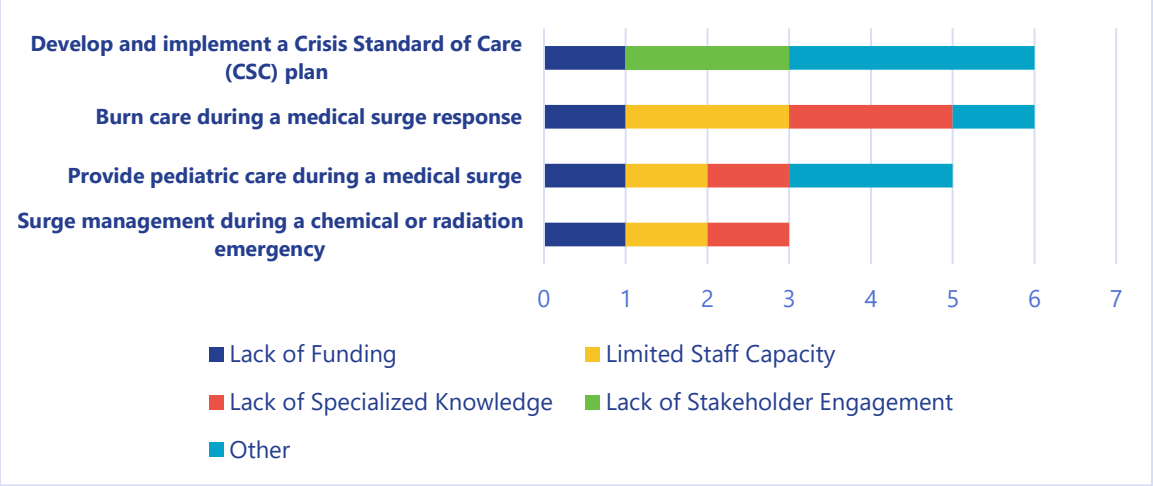
Figure 50: HCC Medical Surge Capability Results



Identified Barriers to Medical Surge

The figure below shows the identified barriers by associated function. Functions that had no barriers identified are not displayed.

Figure 51: HCC Medical Surge Barriers



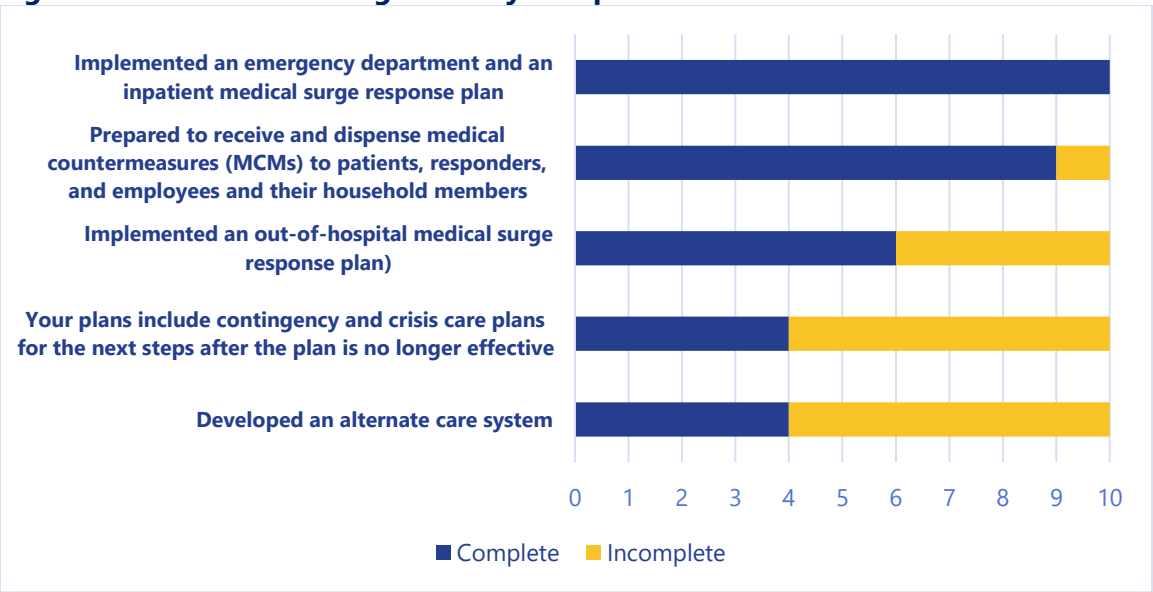
Other Response Narratives:

- No dedicated pediatric beds in D9
- We can do immediate care of pediatric, however D1 does not have a pediatric trauma hospital
- No dedicated burn beds in D9
- No state plan
- It is up to each healthcare facility to use their own CSC plan in the case of emergency. The HCC has no control or authority to implement a CSC plan
- This activity is in progress.

Activity Completion

The National Health Care Preparedness and Response Capabilities document identifies specific activities that should be completed for a capability to be met. The following figure shows the completion status of each of the associated activities by number of HCC respondents.

Figure 52: HCC Medical Surge Activity Completion Results



LHD Capability: Fatality Management

Definition: The ability to coordinate with organizations and agencies to provide fatality management services.

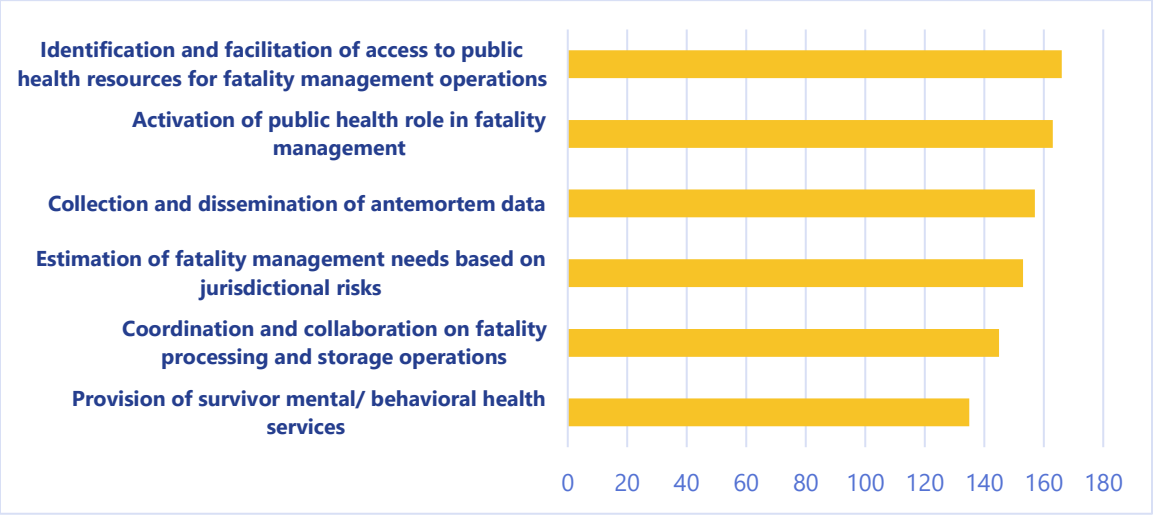
Respondents were asked to rank their ability/capacity to perform each of the functions associated with this capability by selecting one of the following ability levels: "No Ability" (0), "Limited Ability" (1), "Moderate Ability" (2), and "Full Ability" (3). A total of 6 functions associated with this capability were assessed through the PHHRA. The following figure displays the average capability score of all district responses.

Figure 53: Fatality Management Results

Functions	Average Rating	Average Score
Identification and facilitation of access to public health resources for fatality management operations	**Moderate Ability**	**2**
Activation of public health role in fatality management	**Moderate Ability**	**2**
Collection and dissemination of antemortem data	**Moderate Ability**	**1.9**
Estimation of fatality management needs based on jurisdictional risks	**Moderate Ability**	**1.8**
Coordination and collaboration on fatality processing and storage operations	**Moderate Ability**	**1.8**
Provision of survivor mental/ behavioral health services	**Moderate Ability**	**1.6**

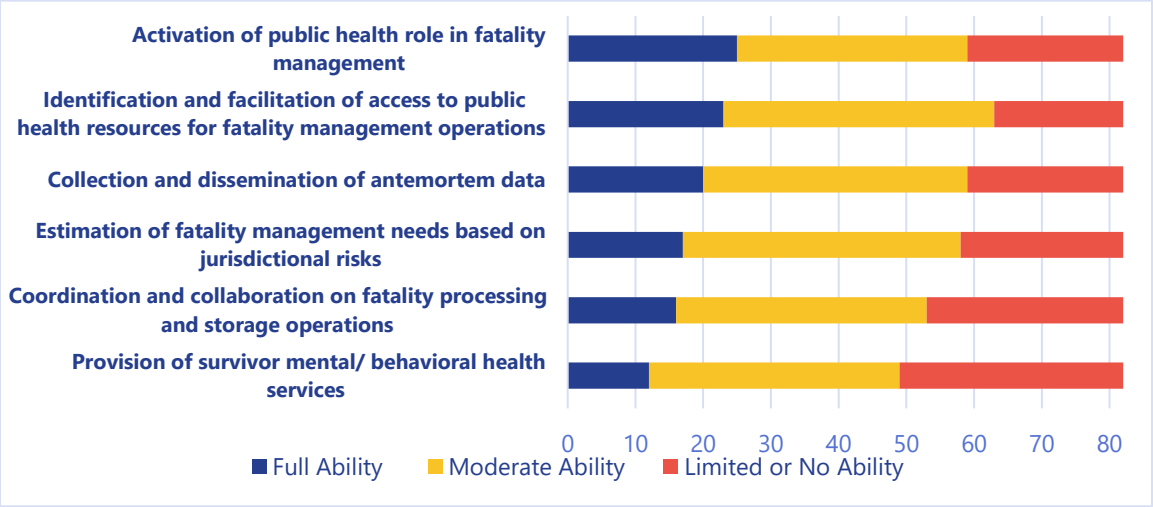
To provide a more detailed look at the unique score submitted by each respondent in the district the following figure shows the total score for each function. A total of 246 points were possible for each function. (3 points possible * 82 respondents). This chart provides a visual of the overall capability of the state to perform each function.

Figure 54: Fatality Management Functions Capability Rankings



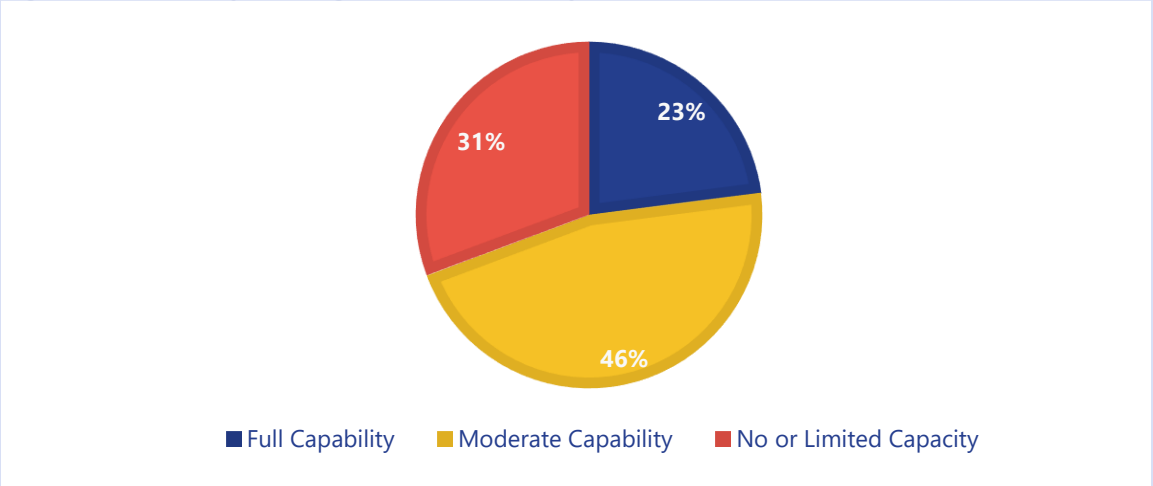
To provide a more detailed look at the unique score submitted by each respondent in the district the following figures represent the responses submitted by each Local Health Department regarding their level of capability to perform each function.

Figure 55: Fatality Management Functions Results by number of LHDs



In addition to assessing the capability of the district to perform each of the functions, this report also assesses the district's ability to perform the LHD Capability as a whole. When assessing the Fatality Management capability 23% of the responses indicated "Full Capability", 46% indicated "Moderate Capability", and 31% indicated "No or Limited Capability".

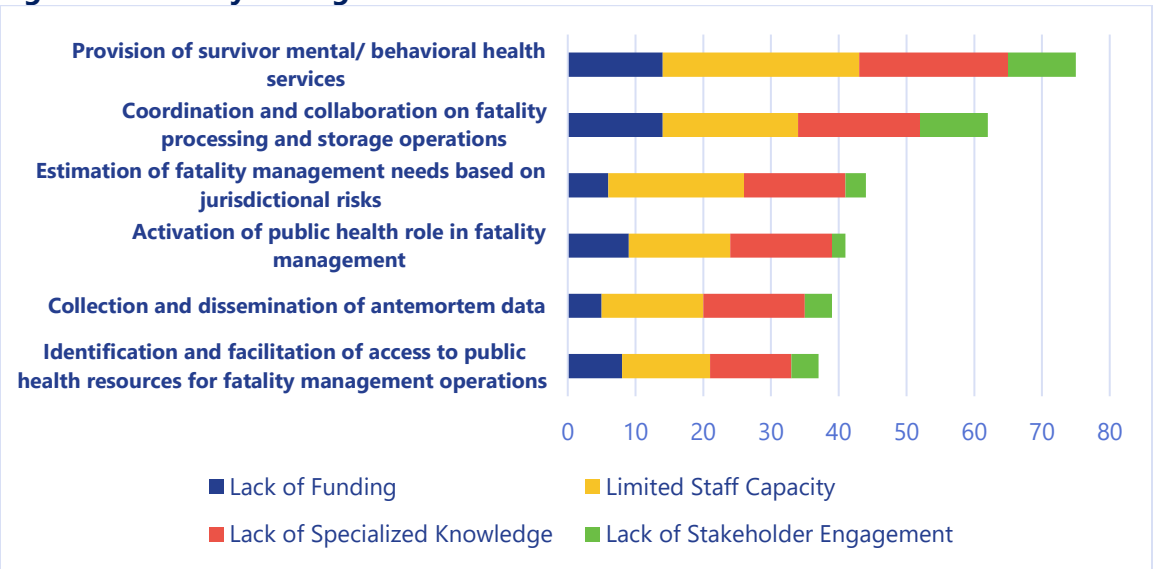
Figure 56: Fatality Management Capability Results



Identified Barriers to Fatality Management

Additionally, respondents were asked to indicate what barriers they experience when they selected that they had "No or Limited Capability" to perform a function. The figure below shows the identified barriers by associated function. Functions that had no barriers identified are not displayed.

Figure 57: Fatality Management Barriers



Medical Surge and Fatality Management crosswalk

The table below provides insight into how the HCC functions related to Medical Surge correspond to the LHD functions related to Fatality Management. The column titled "interoperability of functions" provides an example of how the HCC function supports the LHD function and vice versa.

Figure 58: Medical Surge and Fatality Management crosswalk

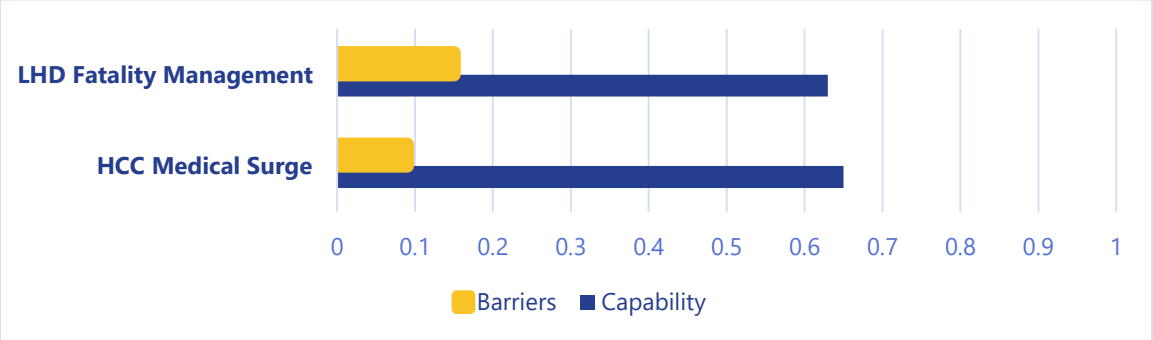
Medical Surge	Fatality Management	Interoperability of Functions
HCC Functions	**LHD Functions**	
Plan for a medical surge in your coalition response	Activation of public health role in fatality management	The HCC's plan for a medical surge should include the LHD's definition of the role of the public health agency in fatality management and their roles and responsibilities.
Enhance infectious disease preparedness and surge response	Collection and dissemination of antemortem data	The collection and dissemination of antemortem data by LHD's assists HCC's to make data driven decisions regarding how to enhance infectious disease preparedness and surge response.

Respond to a medical surge, to include the following: During a chemical or radiation emergency Burn care Trauma care Pediatric care Behavioral health needs	Estimation of fatality management needs based on jurisdictional risks	The estimation of need by the LHD's could be compiled by the HCC's to gain a clearer picture of the medical surge needs of the district during any event.
Manage mass fatalities	Identification and facilitation of access to public health resources for fatality management operations	The LHD's facilitation of access to public health resources for fatality management supports the HCC's management of mass fatalities. The HCC's should have awareness of the public health resources from the LHD as well as from other partners in the district and throughout the state.

HCC and LHD Capability and Barrier Score Comparison

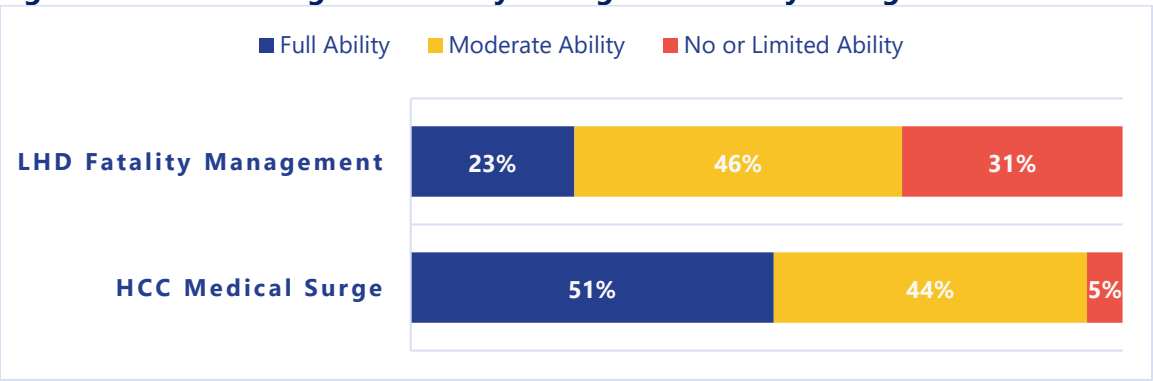
To compare the HCC and LHD capabilities ratings of the respondents a total possible score for each capability was calculated. Then the total of the scores given by the respondents was calculated. Finally, the total score was divided by the total possible score to find the capability rate.

Figure 59: Medical Surge and Fatality Management Capability and Barriers Comparison



The following figure shows the % of respondents that selected each ability level for their respective capabilities.

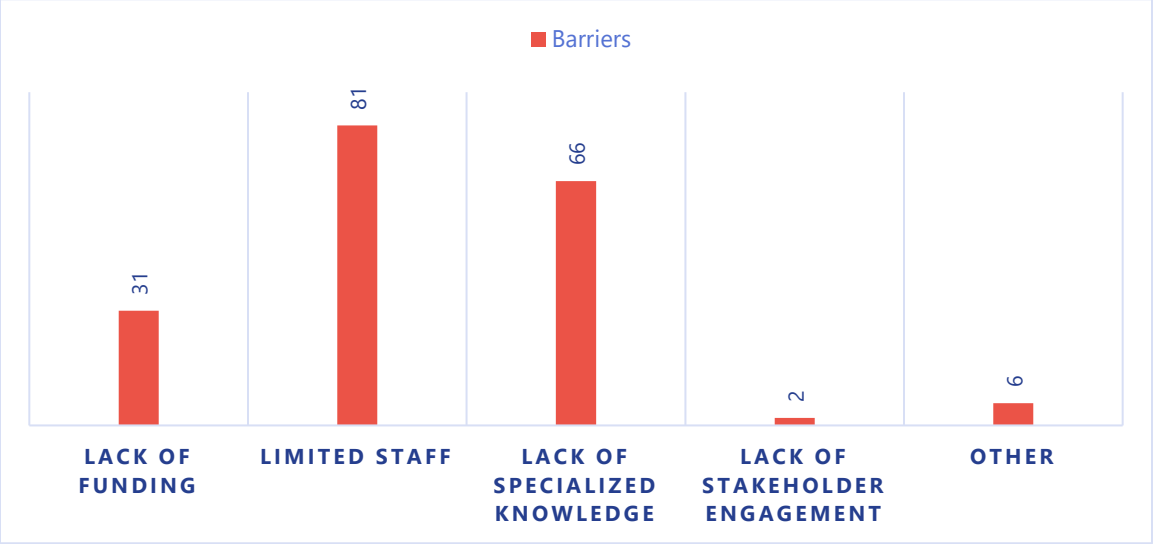
Figure 60: Medical Surge and Fatality Management Ability Rating Results



Identified barriers comparison

HCCs and LHDs were both asked to identify barriers they encounter to achieving "full" or "moderate" ability ratings for their respective capabilities. The chart below shows the number of times an HCC or LHD selected that they experienced each barrier to their respective capability. Limited staff capacity was the most frequently identified with 81 respondents selecting this as a barrier.

Figure 61: Medical Surge and Fatality Management Barriers



HCC Capability: Incident Management and Coordination

Respondents were asked to rank their ability/capacity to perform each of the functions associated with this capability by selecting one of the following ability levels: "No Ability" (0), "Limited Ability" (1), "Moderate Ability" (2), and "Full Ability" (3). A total of 4 functions and 5 activities associated with this capability were assessed through the PHHRA. The figure below displays the average capability score of all district responses.

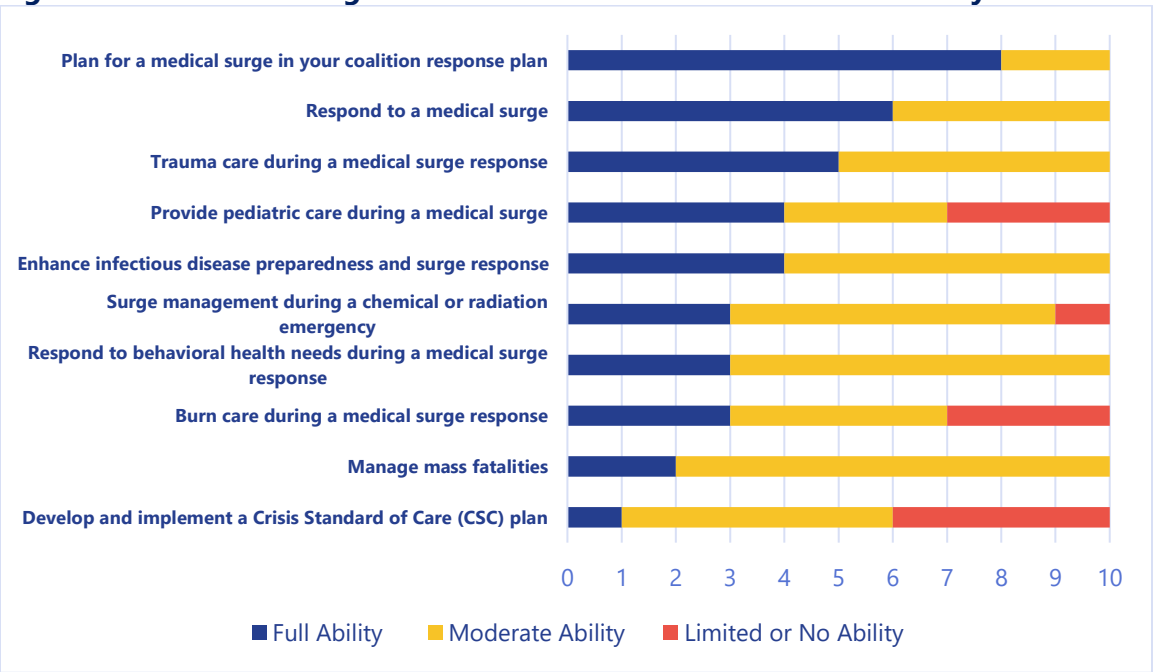
Definition: This capability focuses on coordinating organizations during a health care response and integrating clinical expertise into incident operations and decision-making.

Figure 62: Incident Management and Coordination Results

Functions	Average Rating	Average Score
Use incident management principles and practices across all facilities and agencies and maintain equity and access to care as operational priorities	**Full Ability**	**2.5**
Integrate health care, including clinical and operational experts, into all levels of incident management and emergency management for situational awareness, resource allocation and load-balancing	**Moderate Ability**	**2.4**
Integrate health care into recovery planning and functions	**Moderate Ability**	**2.4**
Develop an integrated approach to command and coordination that involves providers, health care organizations and state and local public health and emergency management authorities during resource-constrained or crisis situations	**Moderate Ability**	**2.1**

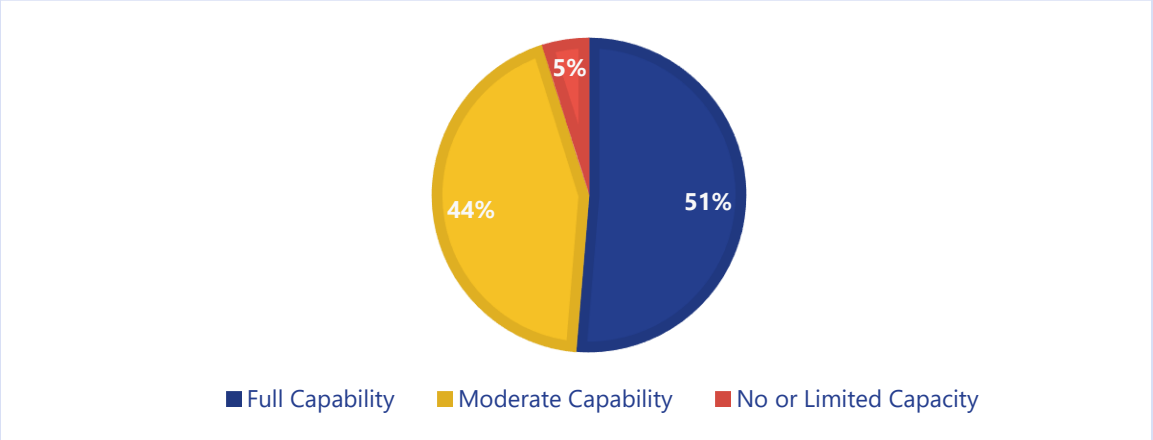
To provide a more detailed look at the unique capability of each HCC the following figure shows the HCCs that selected which ability level for each function.

Figure 63: Incident Management and Coordination Functions Results by number of HCCs



In addition to assessing the capability of the district to perform each of the functions, this report also assesses the district's ability to perform the HCC Capability as a whole. When assessing the 51% of the responses indicated "Full Capability", and 44% indicated "Moderate Capability". 5% indicated "Limited or No Capability".

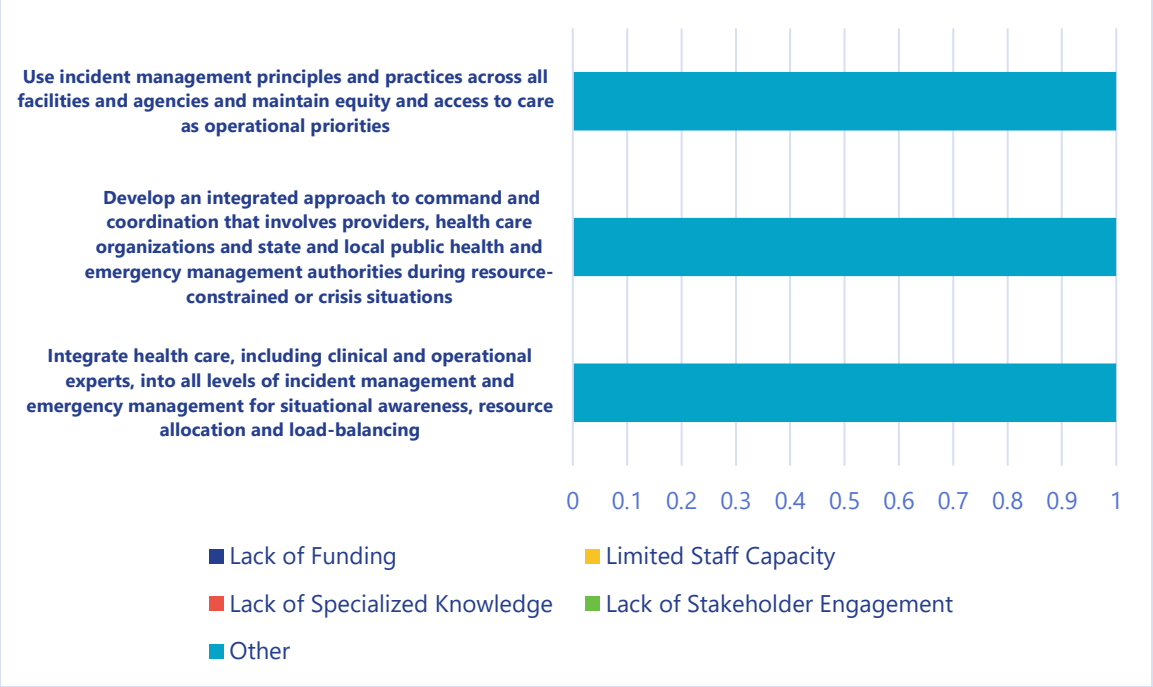
Figure 64: Incident Management and Coordination Capability Results



Identified Barriers to Incident Management and Coordination

The figure below shows the identified barriers by associated function. Functions that had no barriers identified are not displayed.

Figure 65: Incident Management and Coordination Barriers



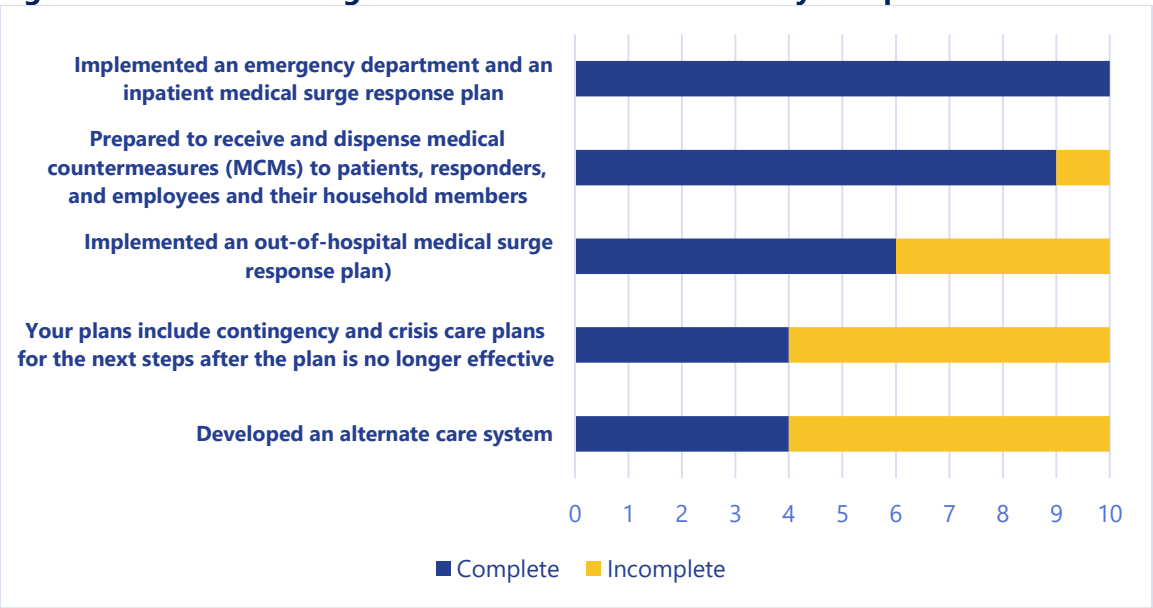
Other Response Narratives:

- This is in progress with training on going.
- In progress

Activity Completion

The National Health Care Preparedness and Response Capabilities document identifies specific activities that should be completed for a capability to be met. The following figure shows the completion status of each of the associated activities by number of HCC respondents.

Figure 66: Incident Management and Coordination Activity Completion Results



LHD Capability: Public Health Surveillance and Epidemiological Investigation

Definition: The ability to create, maintain, support, and strengthen routine surveillance and detection systems and epidemiological investigation processes.

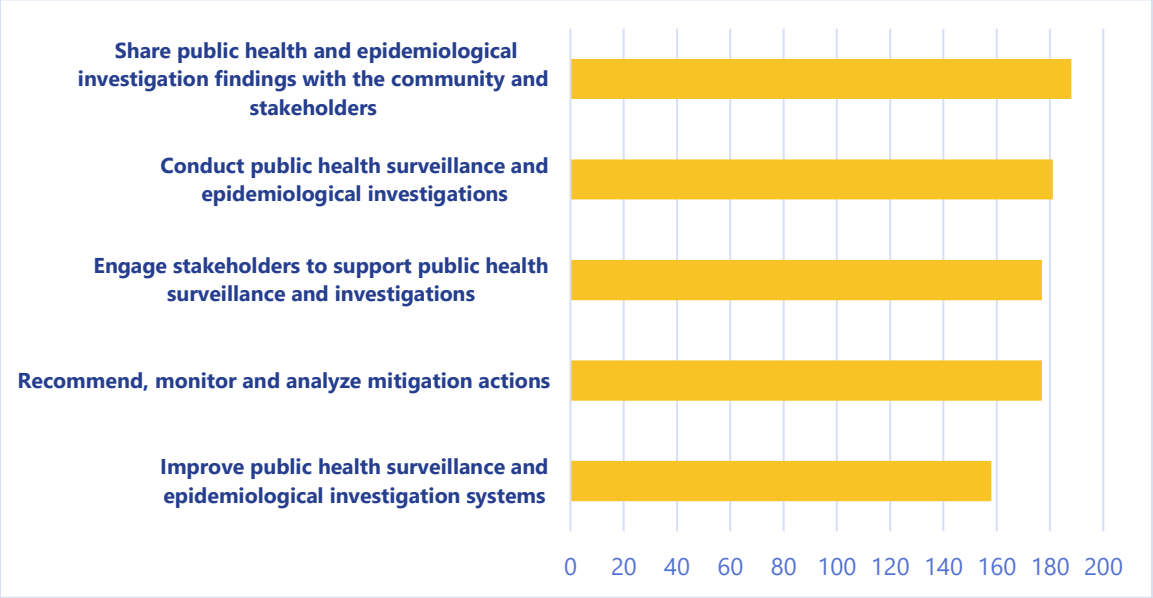
Respondents were asked to rank their ability/capacity to perform each of the functions associated with this capability by selecting one of the following ability levels: "No Ability" (0), "Limited Ability" (1), "Moderate Ability" (2), and "Full Ability" (3). A total of 5 functions associated with this capability were assessed through the PHHRA. The following figure displays the average capability score of all district responses.

Figure 67: Public Health Surveillance and Epidemiological Investigation Results

Functions	Average Rating	Average Score
Share public health and epidemiological investigation findings with the community and stakeholders	**Moderate Ability**	**2.3**
Conduct public health surveillance and epidemiological investigations	**Moderate Ability**	**2.2**
Recommend, monitor and analyze mitigation actions	**Moderate Ability**	**2.2**
Engage stakeholders to support public health surveillance and investigations	**Moderate Ability**	**2.2**
Improve public health surveillance and epidemiological investigation systems	**Moderate Ability**	**1.9**

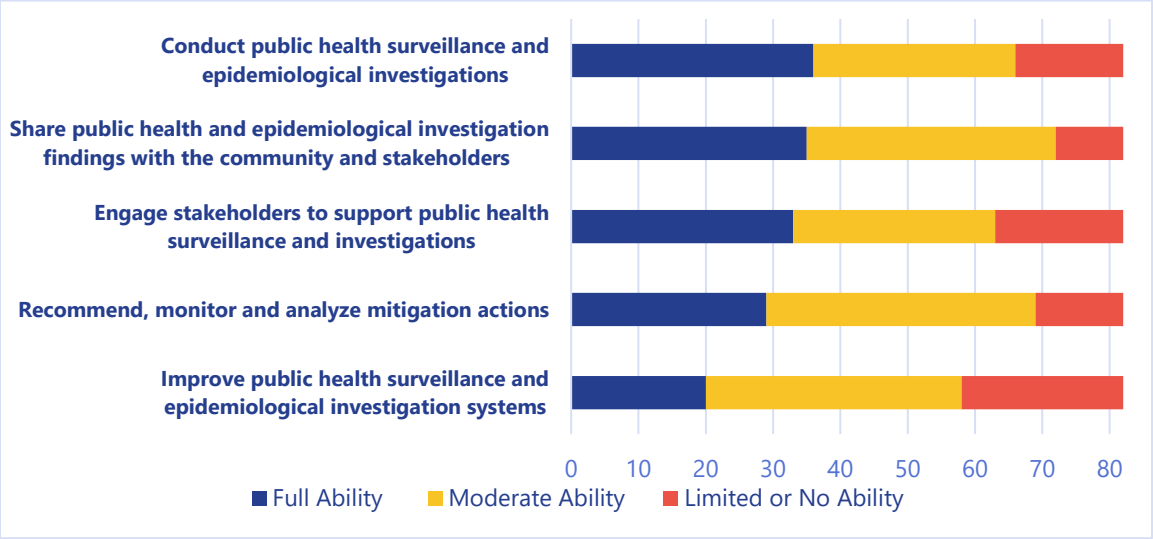
To provide a more detailed look at the unique score submitted by each respondent in the district the following figure shows the total score for each function. A total of 246 points were possible for each function. (3 points possible * 82 respondents). This chart provides a visual of the overall capability of the state to perform each function.

Figure 68: Public Health Surveillance and Epidemiological Investigation Capability Ranking



The figures below represent the responses submitted by each Local Health Department regarding their level of capability to perform each function.

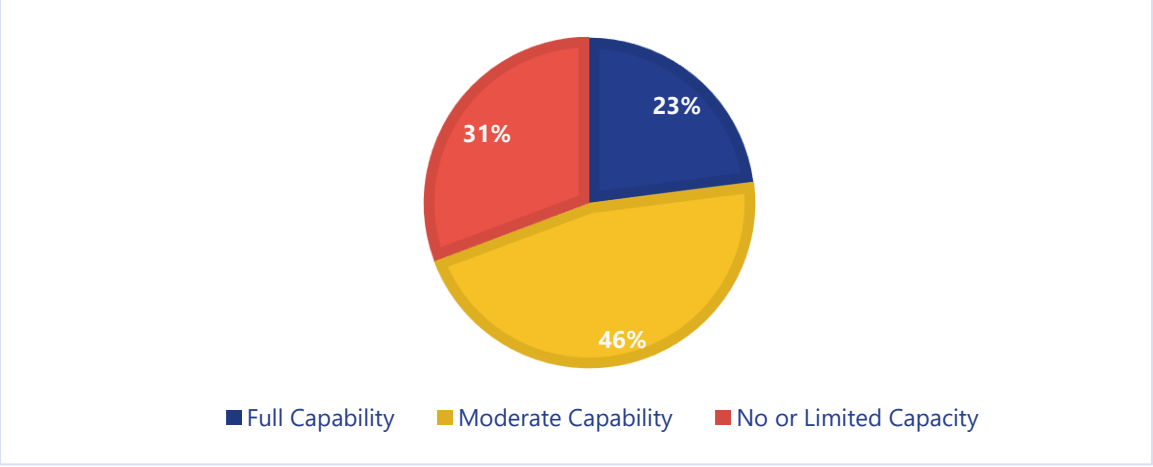
Figure 69: Public Health Surveillance and Epidemiological Investigation Functions Capability Ranking



In addition to assessing the capability of the district to perform each of the functions, this report also assesses the district's ability to perform the LHD Capability as a whole.

When assessing the Public Health Surveillance and Epidemiological Investigation capability 73% of the responses indicated "Full Capability", 26% indicated "Moderate Capability", and 1% indicated "No or Limited Capability".

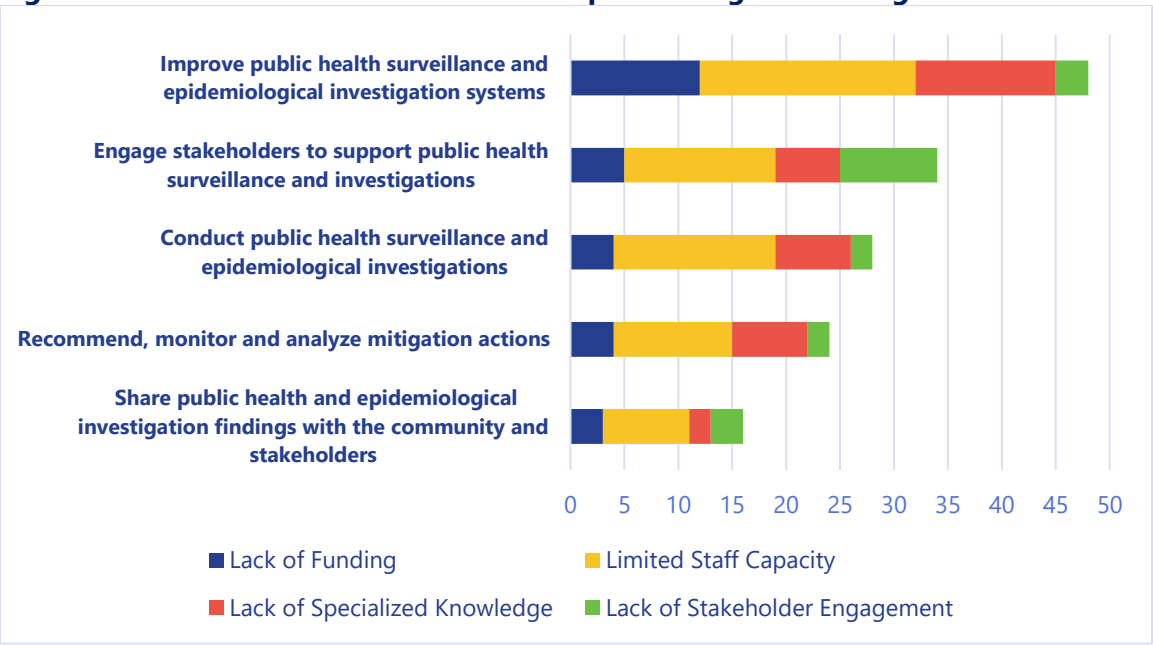
Figure 70: Public Health Surveillance and Epidemiological Investigation Capability Results



Identified Barriers to Public Health Surveillance and Epidemiological Investigations

Additionally, respondents were asked to indicate what barriers they experience when they selected that they had "No or Limited Capability" to perform a function. The figure below shows the identified barriers by associated function. Functions that had no barriers identified are not displayed.

Figure 71: Public Health Surveillance and Epidemiological Investigation Barriers



Incident Management and Coordination and Public Health Surveillance and Epidemiology

The table below provides insight into how the HCC functions related to Incident Management and Coordination correspond to the LHD functions related to Public Health Surveillance and Epidemiology. In the event of an emergency impacting the health of a jurisdiction, Public Health Surveillance and Epidemiology is a key aspect of Incident Management and Coordination. The column titled "interoperability of functions" provides an example of how the HCC function supports the LHD function and vice versa.

Figure 72: Incident Management and Coordination and Public Health Surveillance and Epidemiology Crosswalk

Incident Management and Coordination	Public Health Surveillance and Epidemiology	Interoperability of Functions
HCC Functions	**LHD Functions**	
Use incident management principles and	Improve public health surveillance and	The use of incident management principles and practices by the HCCs and LHDs provides an evidence-based foundation to improve public

practices across all facilities and agencies and maintain equity and access to care as operational priorities	epidemiological investigation systems	health surveillance and epidemiological investigation systems.
Integrate health care into recovery planning and functions	Recommend, monitor and analyze mitigation actions	Integration of health care into recovery planning by HCCs can include LHD's recommendations, monitoring, and analysis of mitigation actions.
Develop an integrated approach to command and coordination that involves providers, health care organizations and state and local public health and emergency management authorities during resource-constrained or crisis situations	Conduct public health surveillance and epidemiological investigations	The integrated approach developed by the HCCs would include the work of the LHDs to conduct public health surveillance and epidemiological investigations.
Integrate health care, including clinical and operational experts, into all levels of incident management and emergency management for situational awareness, resource allocation and load-balancing	Engage stakeholders to support public health surveillance and investigations	The work of the LHD's to engage stakeholders furthers the integration of healthcare experts into all levels of incident management by the HCCs. The HCC's integration of LHD's stakeholder engagement findings supports the integration of experts into the district response.
	Share public health and epidemiological investigation findings with the	HCC's integration of LHD's epidemiological investigation findings supports inclusion of clinical and operational experts into all levels of incident management.

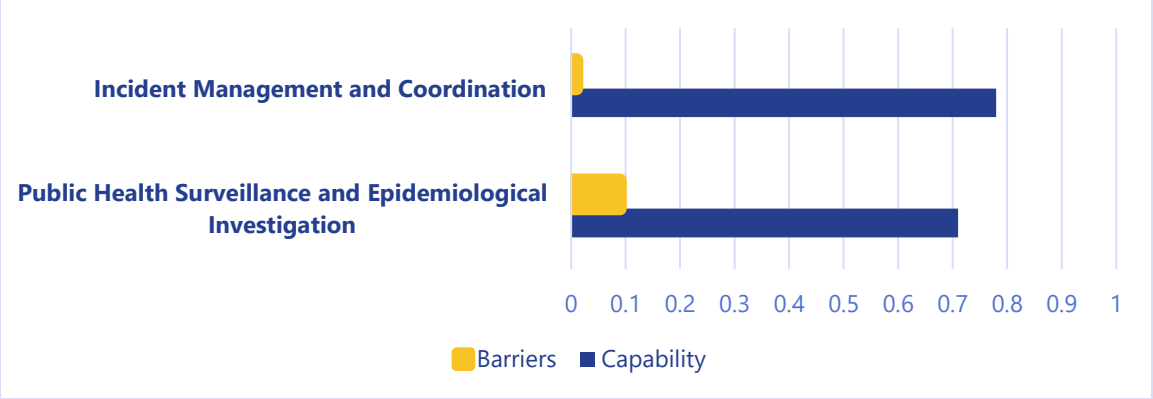
	community and stakeholders	

Local public health professionals are encouraged to expand upon this information to capture the specific ways in which the function of the HCC and LHD collaborate within their jurisdiction.

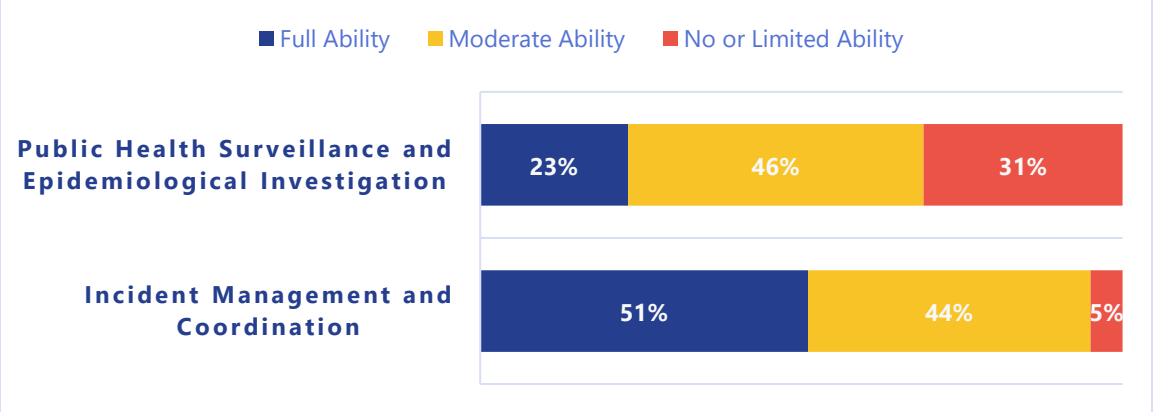
HCC and LHD Capability and Barrier Score Comparison

To compare the HCC and LHD capabilities ratings of the respondents a total possible score for each capability was calculated. Then the total of the scores given by the respondents was calculated. Finally, the total score was divided by the total possible score to find the capability rate.

Figure 73: Incident Management and Coordination and Public Health Surveillance and Epidemiology Capability and Barriers Comparison



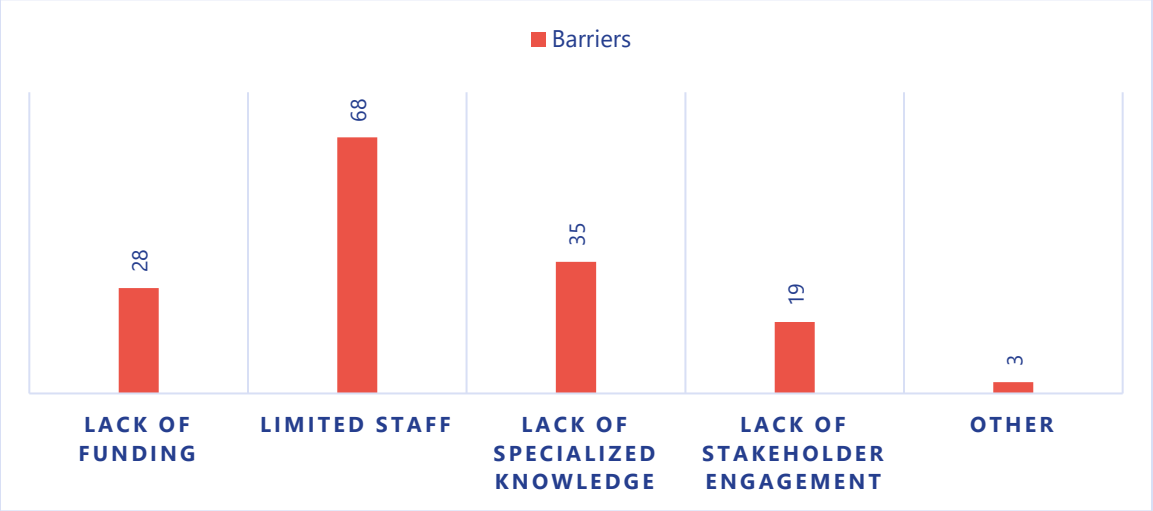
The following figure shows the % of respondents that selected each ability level for their respective capabilities.



Identified barriers comparison

HCCs and LHDs were both asked to identify barriers they encounter to achieving "full" or "moderate" ability ratings for their respective capabilities. The chart below shows the number of times an HCC or LHD selected that they experienced each barrier to their respective capability. Limited staff capacity was the most frequently identified with 68 respondents selecting this as a barrier.

Figure 74: Incident Management and Coordination and Public Health Surveillance and Epidemiology Barriers



HCC Capability: Information Management

Respondents were asked to rank their ability/capacity to perform each of the functions associated with this capability by selecting one of the following ability levels: "No Ability" (0), "Limited Ability" (1), "Moderate Ability" (2), and "Full Ability" (3). A total of 4 functions and 4 activities associated with this capability were assessed through the PHHRA. The following figure displays the average capability score of all district responses.

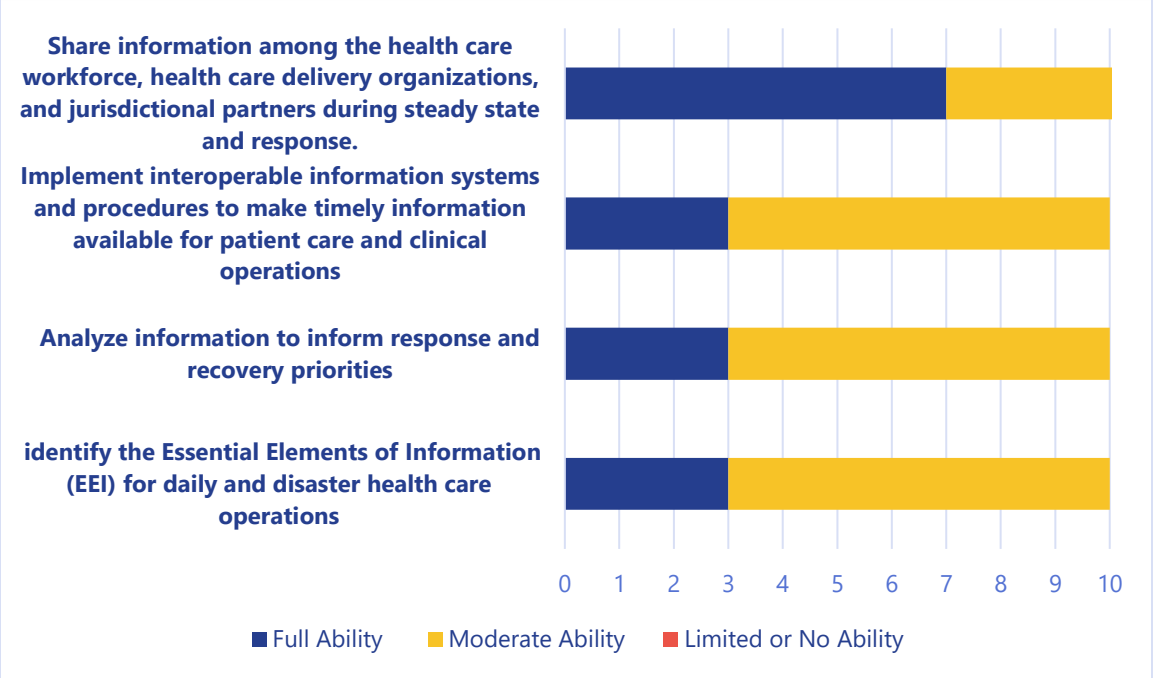
Definition: Information management includes sharing baseline (day-to-day) information to determine the degree of strain on health care resources and predict capacity to respond to an incident.

Figure 75: Information Management Results

Functions	Average Rate	Average Score
Share information among the health care workforce, health care delivery organizations, and jurisdictional partners during steady state and response.	**Full Ability**	**2.7**
Implement interoperable information systems and procedures to make timely information available for patient care and clinical operations	**Moderate Ability**	**2.3**
identify the Essential Elements of Information (EEI) for daily and disaster health care operations	**Moderate Ability**	**2.3**
Analyze information to inform response and recovery priorities	**Moderate Ability**	**2.3**

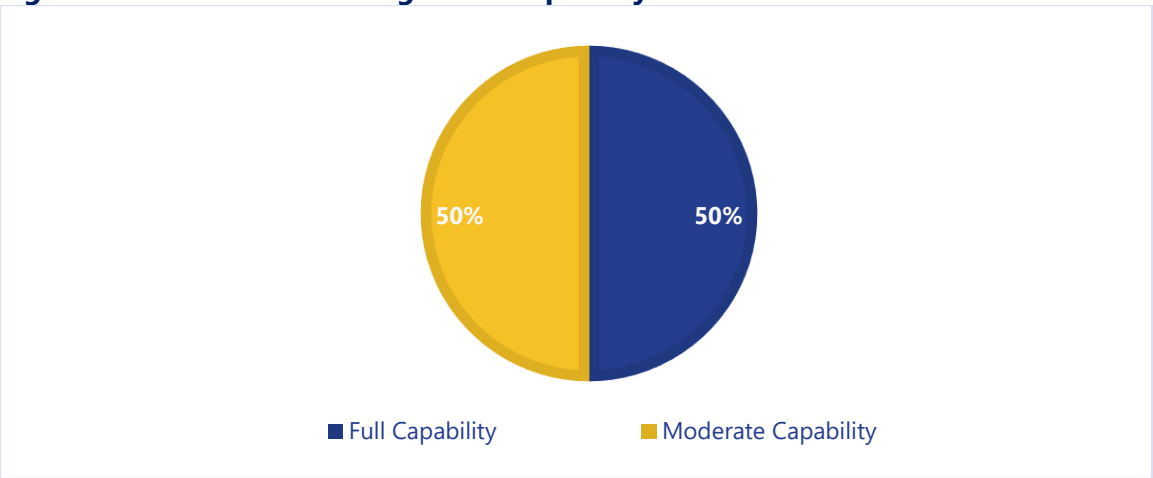
To provide a more detailed look at the unique capability of each HCC the following figure shows the number of HCC's that selected which ability level for each function.

Figure 76: Information Management Functions Capability Results by number of HCCs



In addition to assessing the capability of the district to perform each of the functions, this report also assesses the district's ability to perform the HCC Capability as a whole. When assessing the Information Management capability 50% of the responses indicated "Full Capability", and 50% indicated "Moderate Capability".

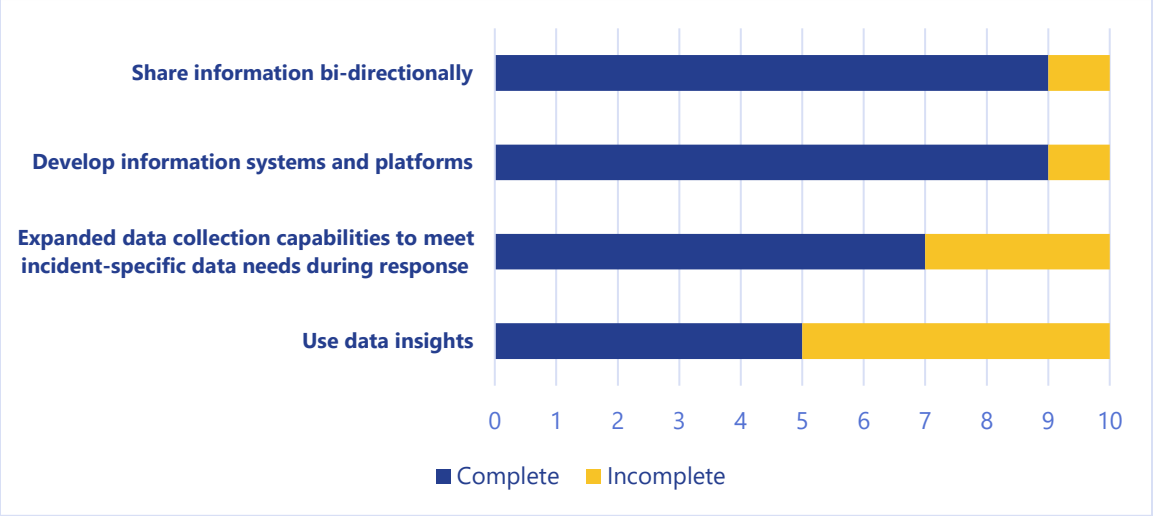
Figure 77: Information Management Capability Results



Activity Completion

The National Health Care Preparedness and Response Capabilities document identifies specific activities that should be completed for a capability to be met. The following figure shows the completion status of each of the associated activities by number of HCC respondents.

Figure 78: Information Management Activity Completion Results



Identification of Barriers Information Management

No barriers to information management have been identified.

LHD Capability: Emergency Public Information and Warning

Definition: The ability to develop, coordinate, and disseminate information, alerts, warnings, and notifications to the public and incident management personnel.

Respondents were asked to rank their ability/capacity to perform each of the functions associated with this capability by selecting one of the following ability levels: "No Ability" (0), "Limited Ability" (1), "Moderate Ability" (2), and "Full Ability" (3). A total of 6 functions associated with this capability were assessed through the PHHRA. The following figure displays the average capability score of all district responses.

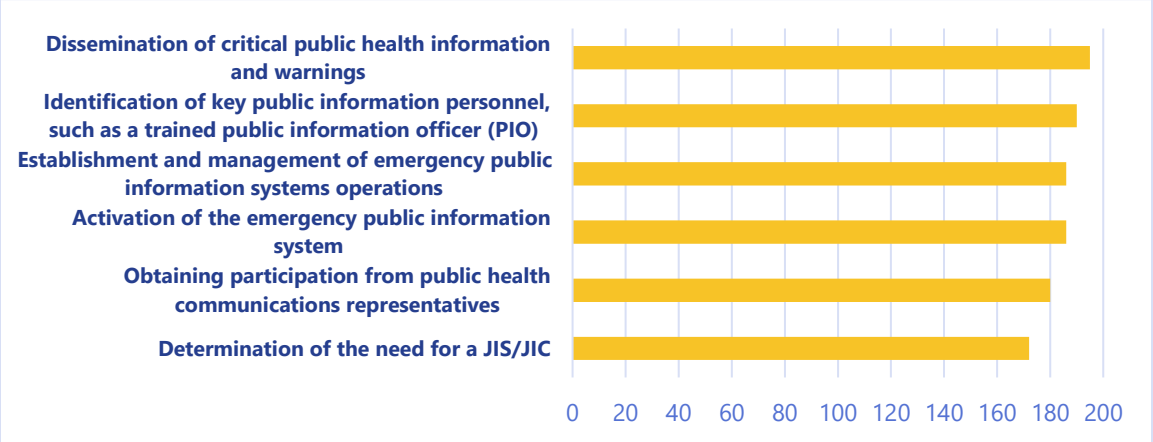
Figure 79: Emergency Public Information and Warning Results

Functions	Average Rating	Average Score
Dissemination of critical public health information and warnings	**Moderate Ability**	**2.4**
Identification of key public information personnel, such as a trained public information officer (PIO)	**Moderate Ability**	**2.3**
Activation of the emergency public information system	**Moderate Ability**	**2.3**
Establishment and management of emergency public information systems operations	**Moderate Ability**	**2.3**

Obtaining participation from public health communications representatives	**Moderate Ability**	**2.2**
Determination of the need for a JIS/JIC	**Moderate Ability**	**2**

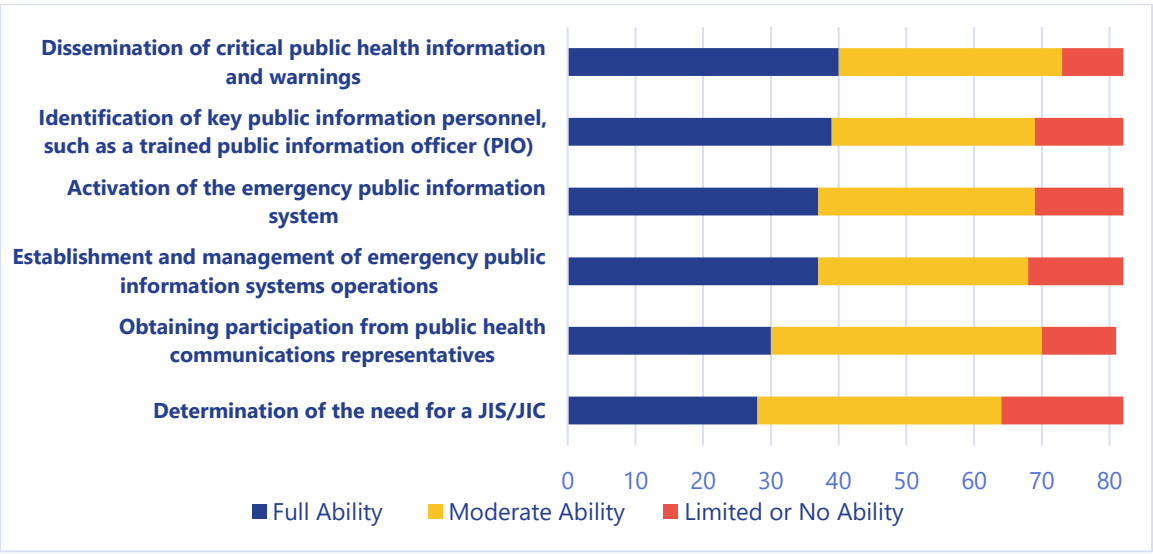
To provide a more detailed look at the unique score submitted by each respondent in the district the following figure shows the total score for each function. A total of 246 points were possible for each function. (3 points possible * 82 respondents). This chart provides a visual of the overall capability of the state to perform each function.

Figure 80: Emergency Public Information and Warning Functions Capability Ranking



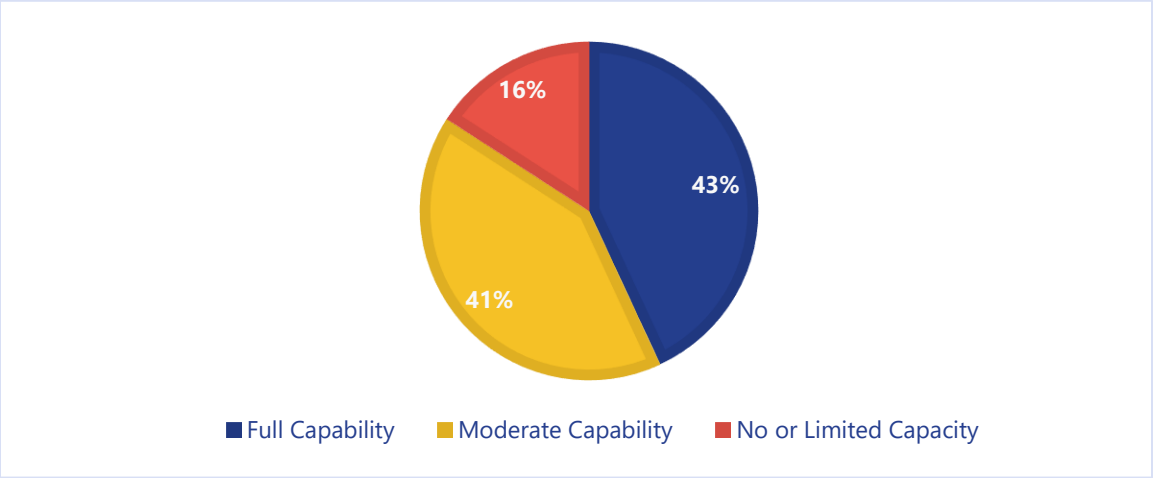
The following figures represent the responses submitted by each Local Health Department regarding their level of capability to perform each function.

Figure 81: Emergency Public Information and Warning Functions Results by number of LHDs



In addition to assessing the capability of the district to perform each of the functions, this report also assesses the district's ability to perform the LHD Capability as a whole. When assessing the Emergency Public Information and Warning capability 43% of the responses indicated "Full Capability", 41% indicated "Moderate Capability", and 16% indicated "No or Limited Capability".

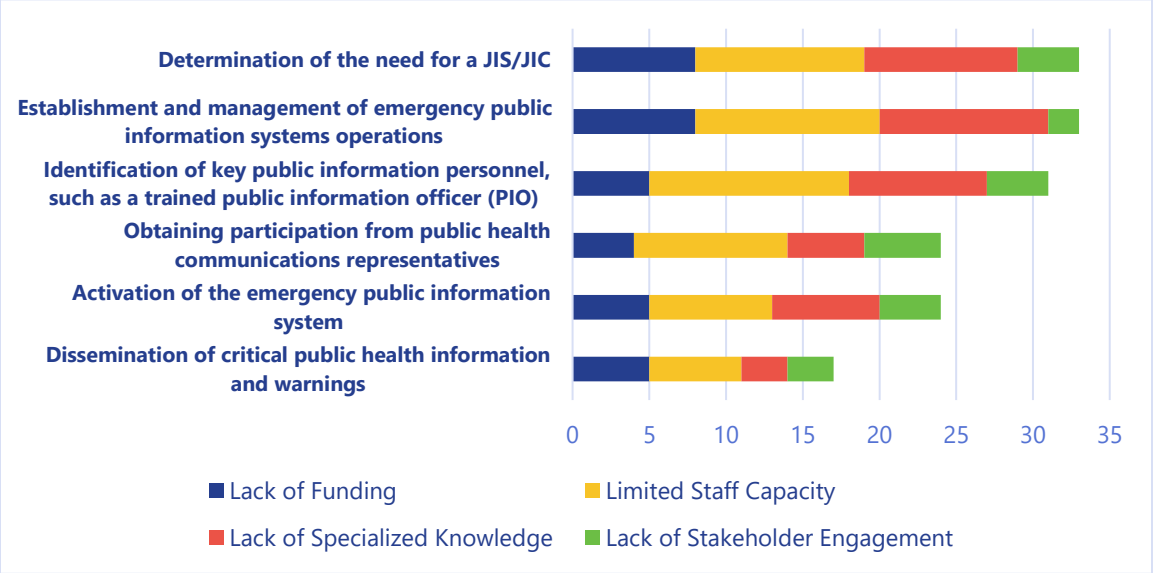
Figure 82: Emergency Public Information and Warning Capability Results



Emergency Public Information and Warning Identified Barriers

Additionally, respondents were asked to indicate what barriers they experience when they selected that they had "No or Limited Capability" to perform a function. The figure below shows the identified barriers by associated function. Functions that had no barriers identified are not displayed.

Figure 83: Emergency Public Information and Warning Barriers



LHD Capability: Information Sharing

Respondents were asked to rank their ability/capacity to perform each of the functions associated with this capability by selecting one of the following ability levels: "No Ability" (0), "Limited Ability" (1), "Moderate Ability" (2), and "Full Ability" (3). A total of 6 functions associated with this capability were assessed through the PHHRA. The following figure displays the average capability score of all district responses.

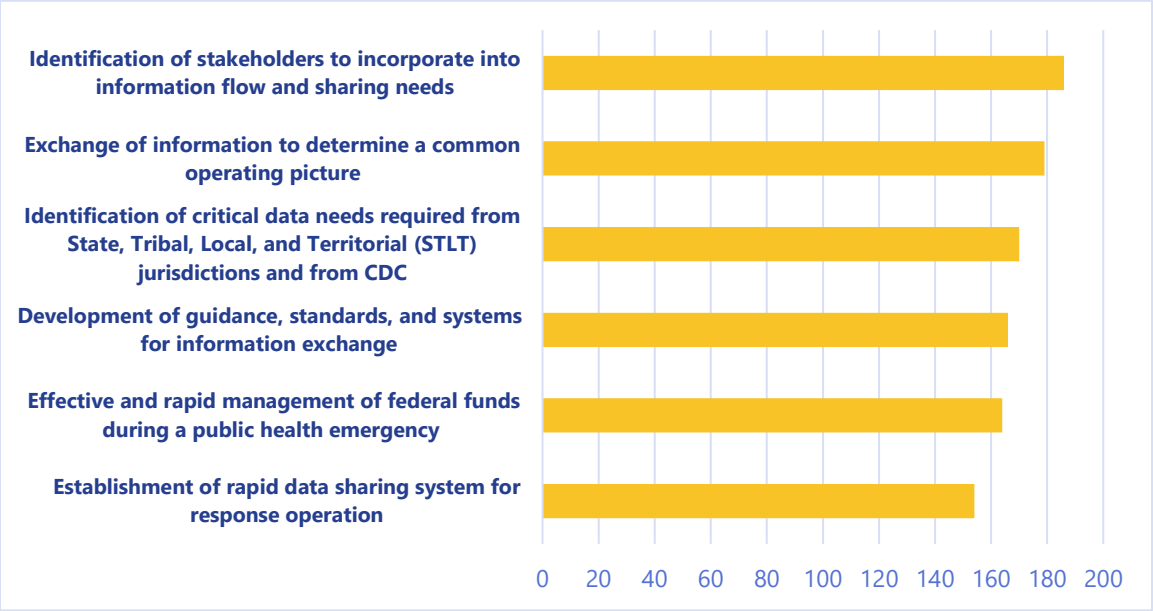
Definition: The ability to conduct multijurisdictional and multidisciplinary exchange of health-related information and situational awareness data among federal, state, local, tribal, and territorial levels of government and the private sector.

Figure 84: Information Sharing Results

Functions	Average Rating	Average Score
Identification of stakeholders to incorporate into information flow and sharing needs	**Moderate Ability**	**2.3**
Exchange of information to determine a common operating picture	**Moderate Ability**	**2.2**
Identification of critical data needs required from State, Tribal, Local, and Territorial (STLT) jurisdictions and from CDC	**Moderate Ability**	**2**
Development of guidance, standards, and systems for information exchange	**Moderate Ability**	**2**
Effective and rapid management of federal funds during a public health emergency	**Moderate Ability**	**2**
Establishment of rapid data sharing system for response operation	**Moderate Ability**	**1.9**

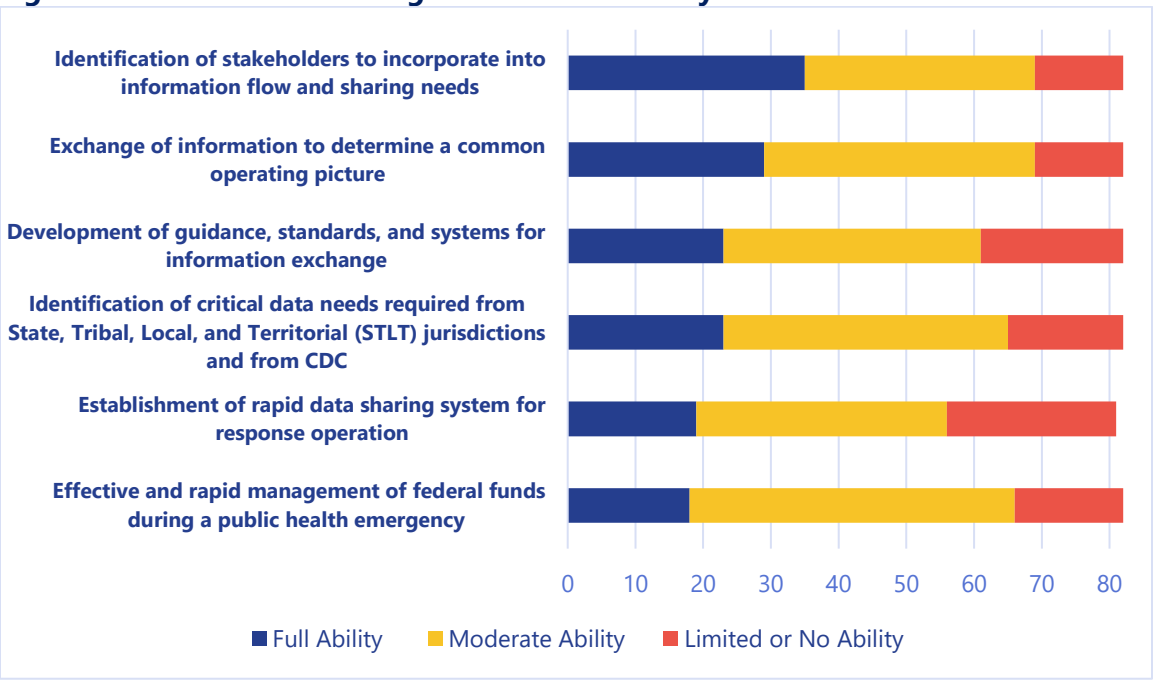
To provide a more detailed look at the unique score submitted by each respondent in the district the following figure shows the total score for each function. A total of 246 points were possible for each function. (3 points possible * 82 respondents). This chart provides a visual of the overall capability of the state to perform each function.

Figure 85: Information Sharing Functions Capability Ranking



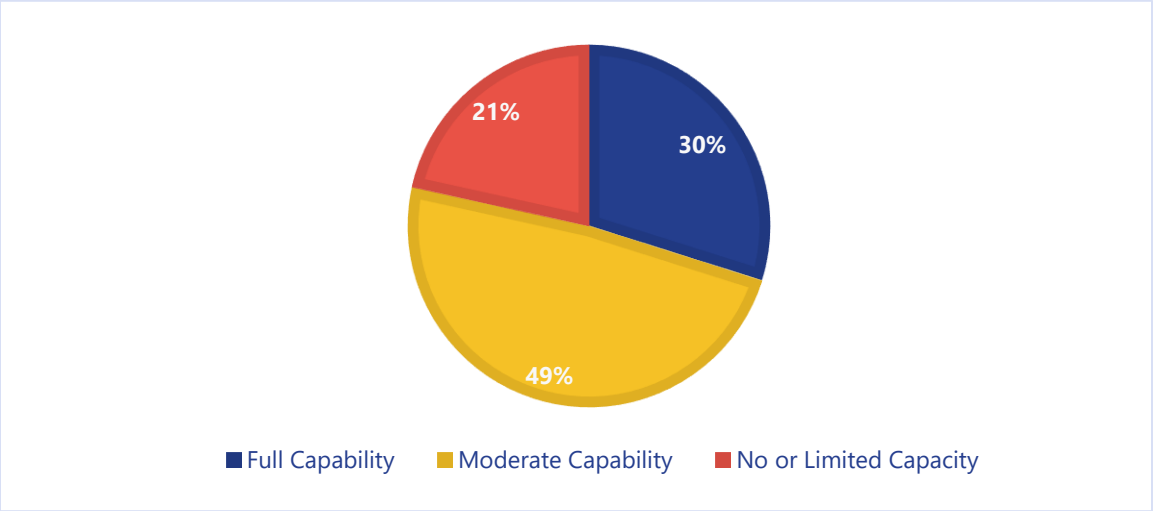
The following figures represent the responses submitted by each Local Health Department regarding their level of capability to perform each function.

Figure 86: Information Sharing Functions Results by number of LHDs



In addition to assessing the capability of the district to perform each of the functions, this report also assesses the district's ability to perform the LHD Capability as a whole. When assessing the Information Sharing capability 30% of the responses indicated "Full Capability", 49% indicated "Moderate Capability", and no respondents indicated "No or Limited Capability".

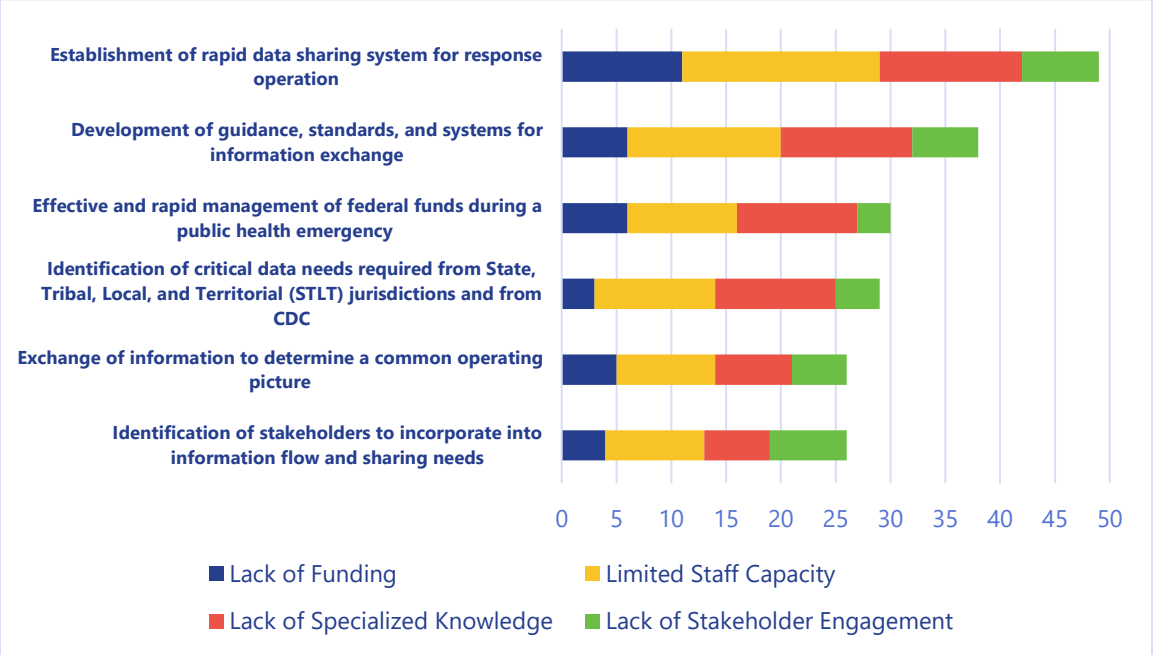
Figure 87: Information Sharing Capability Results



Identified Barriers to Information Sharing

Additionally, respondents were asked to indicate what barriers they experience when they selected that they had "No or Limited Capability" to perform a function. The figure below shows the identified barriers by associated function. Functions that had no barriers identified are not displayed.

Figure 88: Information Sharing Barriers



Information Management, Emergency Public Information and Warning, and Information Sharing crosswalks

The table below provides insight into how the HCC functions related to Incident Management and Coordination correspond to the LHD functions related to Public Health Surveillance and Epidemiology. In the event of an emergency impacting the health of a jurisdiction, Public Health Surveillance and Epidemiology is a key aspect of Incident Management and Coordination. The column titled "interoperability of functions" provides an example of how the HCC function supports the LHD function and vice versa.

Figure 89: Information Management, Emergency Public Information and Warning crosswalk

Information Management	Emergency Public Information and Warning	Interoperability of Functions
HCC Functions	**LHD Functions**	
Implement interoperable information systems and procedures to make timely information available for patient care and clinical operations	Dissemination of critical public health information and warnings	The HCCs implementation of interoperable information systems would allow LHDs to disseminate information to the public that is developed from the most relevant information available to both HCCs and LHDs.
identify the Essential Elements of Information (EEI) for daily and disaster health care operations	Establishment and management of emergency public information systems operations	The HCCs identification of EEI can be used by LHDs to establish and manage an emergency public information system based on shared language.
Analyze information to inform response and recovery priorities	Obtaining participation from public health communications representatives	Participation obtained from public health communications representatives
Share information among the health care workforce,	Activation of the emergency public information system	LHDs can utilize the HCCs information sharing methods to support activation of the emergency public information system.

health care delivery organizations, and jurisdictional partners during steady state and response.	Determination of the need for a JIS/JIC	Once LHDs determine the need for a JIS/JIC the HCCs can assist with informing the health care workforce, health care delivery organizations, and jurisdictional partners.
	Identification of key public information personnel, such as a trained public information officer (PIO)	The LHDs and HCCs can work collaboratively to identify key public information personnel through sharing information and opportunities to participate with the healthcare workforce.

Figure 90: Information Management and Information Sharing crosswalk

Information Management	Information Sharing	Interoperability of Functions
HCC Functions	**LHD Functions**	
Implement interoperable information systems and procedures to make timely information available for patient care and clinical operations	Development of guidance, standards, and systems for information exchange	HCC procedures for timely information availability and LHD guidance on information exchange can be developed in a collaborative manner that would support implementation of interoperable information systems.
	Effective and rapid management of federal funds during a public health emergency	HCCs implementation of interoperable information systems can include funding information to support the LHD's effective and rapid management of federal funds during a public health emergency.
identify the Essential Elements of Information (EEI) for daily and disaster health care operations	Identification of critical data needs required from State, Tribal, Local, and Territorial (STLT) jurisdictions and from CDC	The identification of EEI by HHCs can be used to assist the LHD's identification of the critical data needs built on a shared language. The critical data needs identified by the LHD's can inform what EEIs are needed for the HCCs.

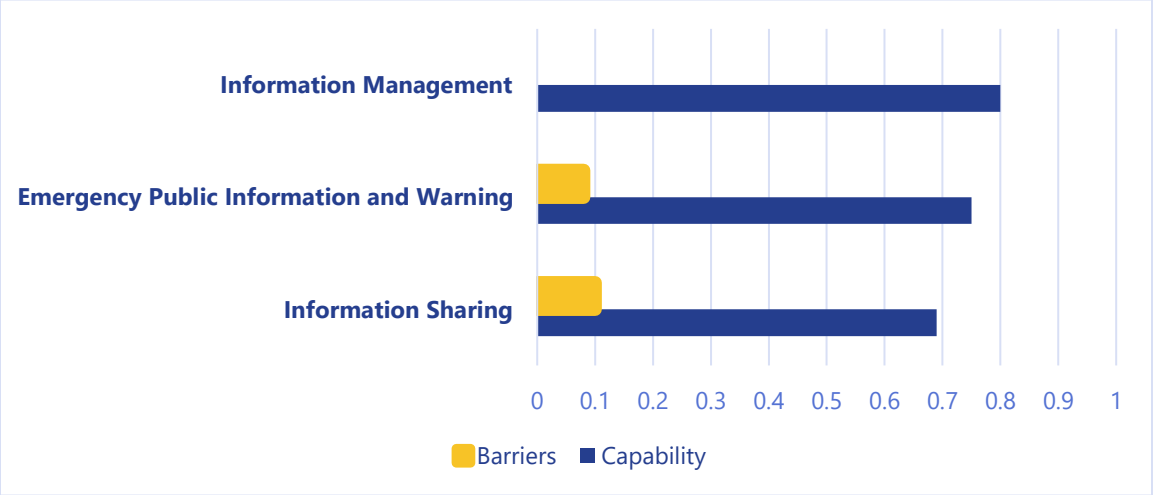
Analyze information to inform response and recovery priorities	Exchange of information to determine a common operating picture	Information exchanged by the LHD should be included in the analysis done by the HCCs.
Share information among the health care workforce, health care delivery organizations, and jurisdictional partners during steady state and response.	Identification of stakeholders to incorporate into information flow and sharing needs	The stakeholders identified by the LHDs would also be relevant to HCCs for information sharing.
	Establishment of rapid data sharing system for response operation	The data sharing systems established by LHDs can be leveraged or incorporated into the information sharing process of the HCCs.

Local public health professionals are encouraged to expand upon this information to capture the specific ways in which the function of the HCC and LHD collaborate within their jurisdiction.

HCC and LHD Capability and Barrier Score Comparison

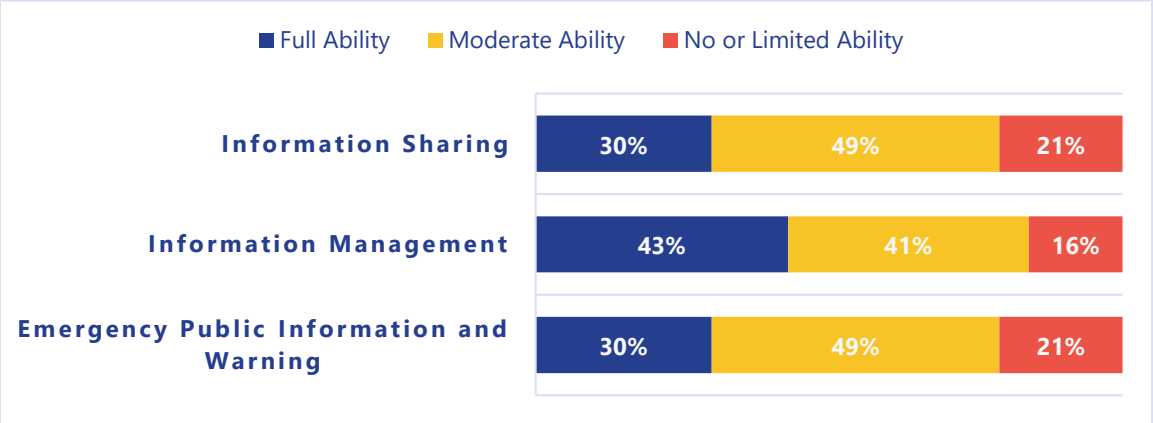
To compare the HCC and LHD capabilities ratings of the respondents a total possible score for each capability was calculated. Then the total of the scores given by the respondents was calculated. Finally, the total score was divided by the total possible score to find the capability rate.

Figure 91: Information Management, Emergency Public Information and Warning, and Information Sharing Capability and Barrier Comparison



The following figure shows the % of respondents that selected each ability level for their respective capabilities.

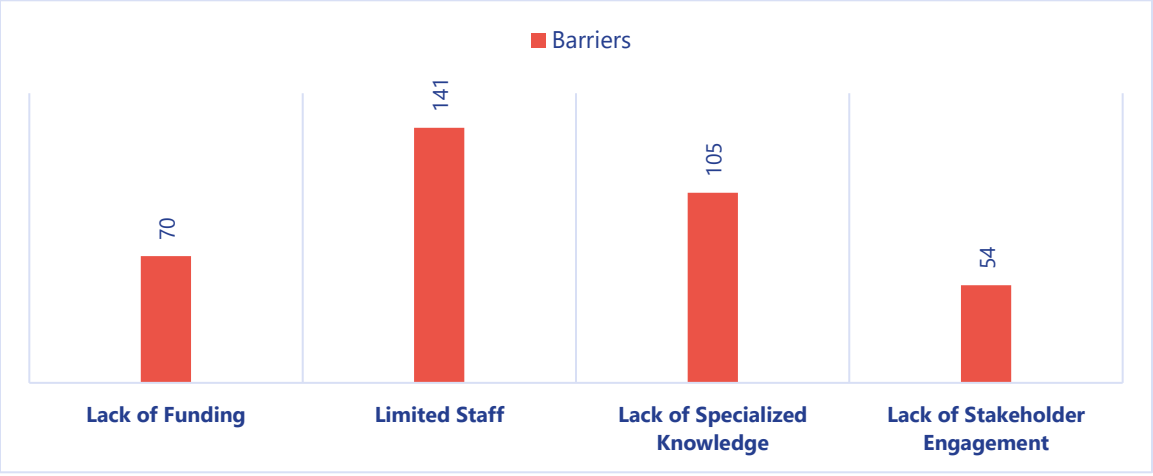
Figure 92: Information Management, Emergency Public Information and Warning, and Information Sharing Ability Rating Comparison



Identified barriers comparison

HCCs and LHDs were both asked to identify barriers they encounter to achieving "full" or "moderate" ability ratings for their respective capabilities. The chart below shows the number of times an HCC or LHD selected that they experienced each barrier to their respective capability. Limited staff capacity was the most frequently identified with 141 respondents selecting this as a barrier.

Figure 93: Information Management, Emergency Public Information and Warning, and Information Sharing Barriers



HCC Capability: Patient Movement and Distribution

Respondents were asked to rank their ability/capacity to perform each of the functions associated with this capability by selecting one of the following ability levels: "No Ability" (0), "Limited Ability" (1), "Moderate Ability" (2), and "Full Ability" (3). A total of 4 functions and 6 activities associated with this capability were assessed through the PHHRA. The following figure displays the average capability score of all district responses.

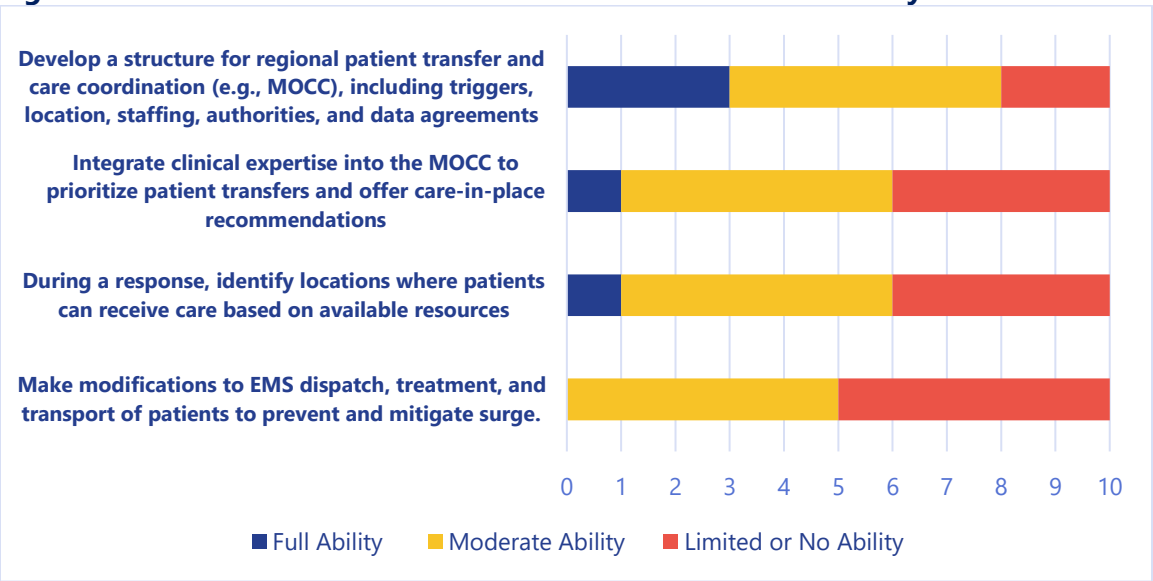
Definition: Patient movement is not only the medical transport of patients to, from, and between facilities, it also includes prioritization of transfers and destinations to provide patients the best possible care.

Figure 94: Patient Movement and Distribution Results

Functions	Average Rating	Average Score
During a response, identify locations where patients can receive care based on available resources	**Moderate Ability**	**2.1**
Develop a structure for regional patient transfer and care coordination (e.g., MOCC), including triggers, location, staffing, authorities, and data agreements	**Moderate Ability**	**1.5**
Integrate clinical expertise into the MOCC to prioritize patient transfers and offer care-in-place recommendations	**Moderate Ability**	**1.5**
Make modifications to EMS dispatch, treatment, and transport of patients to prevent and mitigate surge.	**Limited Ability**	**1.2**

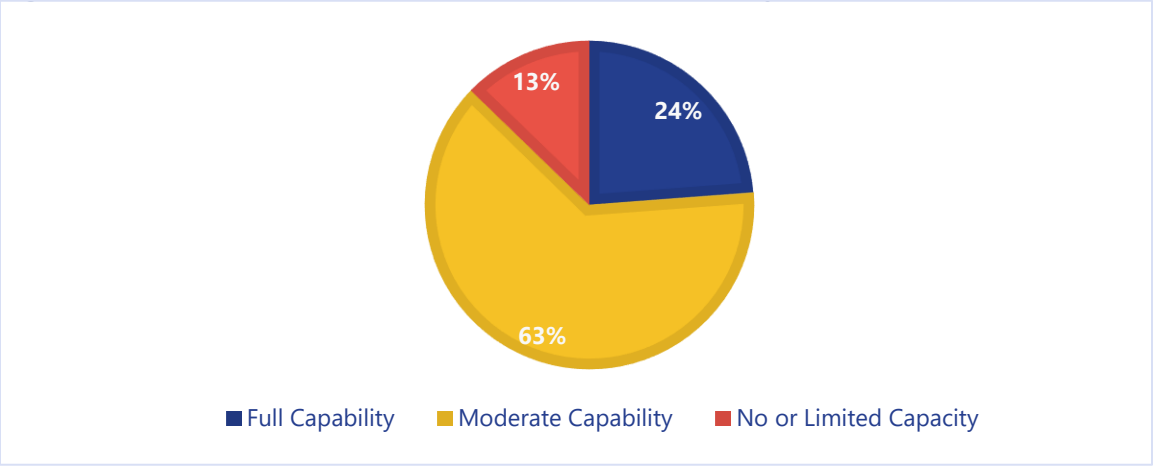
To provide a more detailed look at the unique capability of each HCC the following figure shows the number of HCC's that selected which ability level for each function.

Figure 95: Patient Movement and Distribution Functions Results by number of HCCs



In addition to assessing the capability of the district to perform each of the functions, this report also assesses the district's ability to perform the HCC Capability as a whole. When assessing the Patient Movement and Distribution capability 24% of the responses indicated "Full Capability", and 63% indicated "Moderate Capability" and 13% indicated "Limited or No Capability".

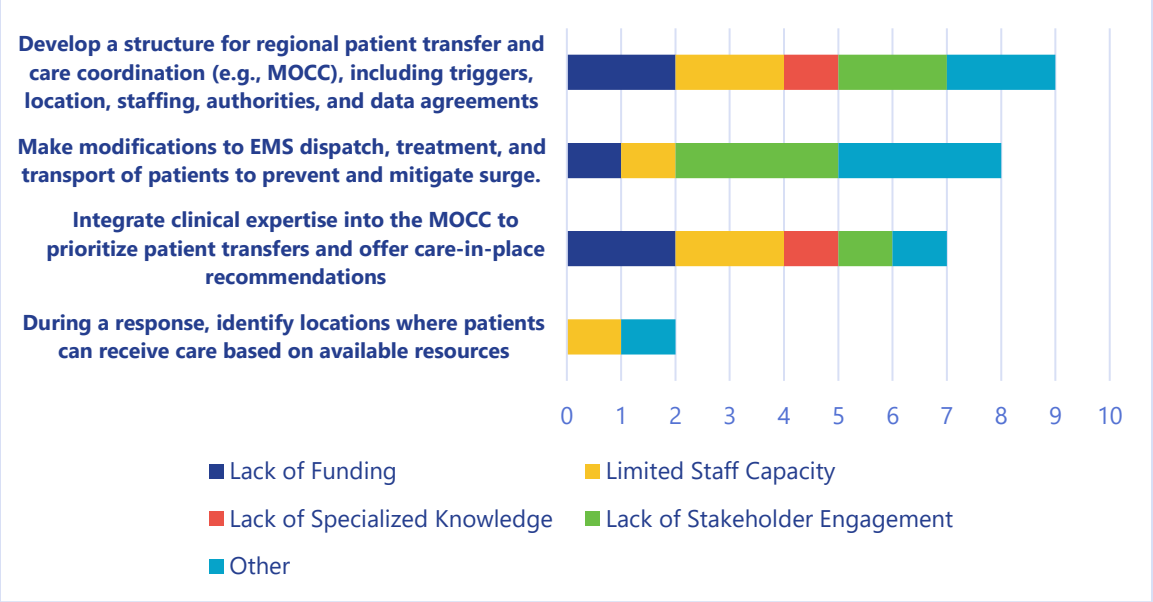
Figure 96: Patient Movement and Distribution Capability Results



Identified Barriers to Patient Movement and Distribution

The figure below shows the identified barriers by associated function. Functions that had no barriers identified are not displayed.

Figure 97: Patient Movement and Distribution Barriers



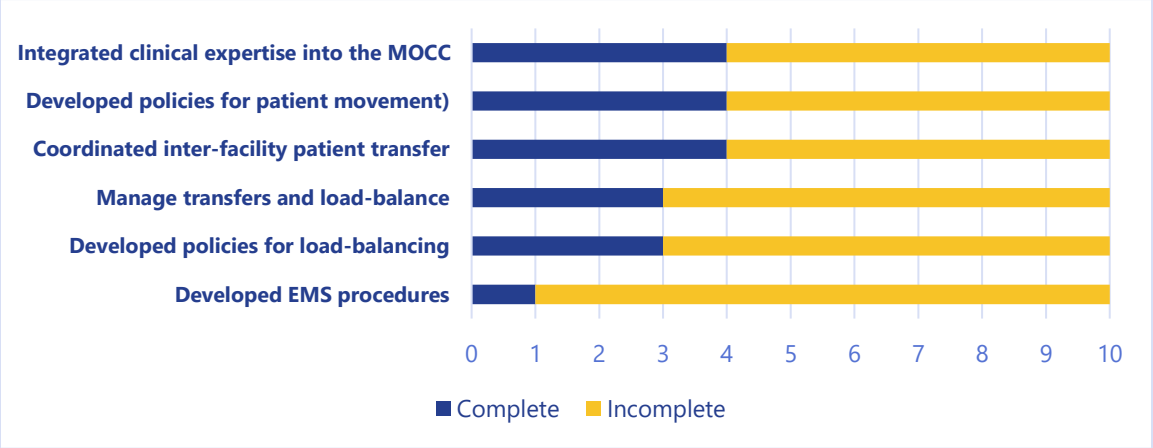
Other Response Narratives:

- No state plan
- Not an HCC function.
- No authority to make modifications
- Geographical challenges

Activity Completion

The National Health Care Preparedness and Response Capabilities document identifies specific activities that should be completed for a capability to be met. The following figure shows the completion status of each of the associated activities by number of HCC respondents.

Figure 98: Patient Movement and Distribution Activity Completion Results



LHD Capability: Medical Surge

Definition: The ability to provide adequate medical evaluation and care during events that exceed the limits of the normal medical infrastructure of an affected community.

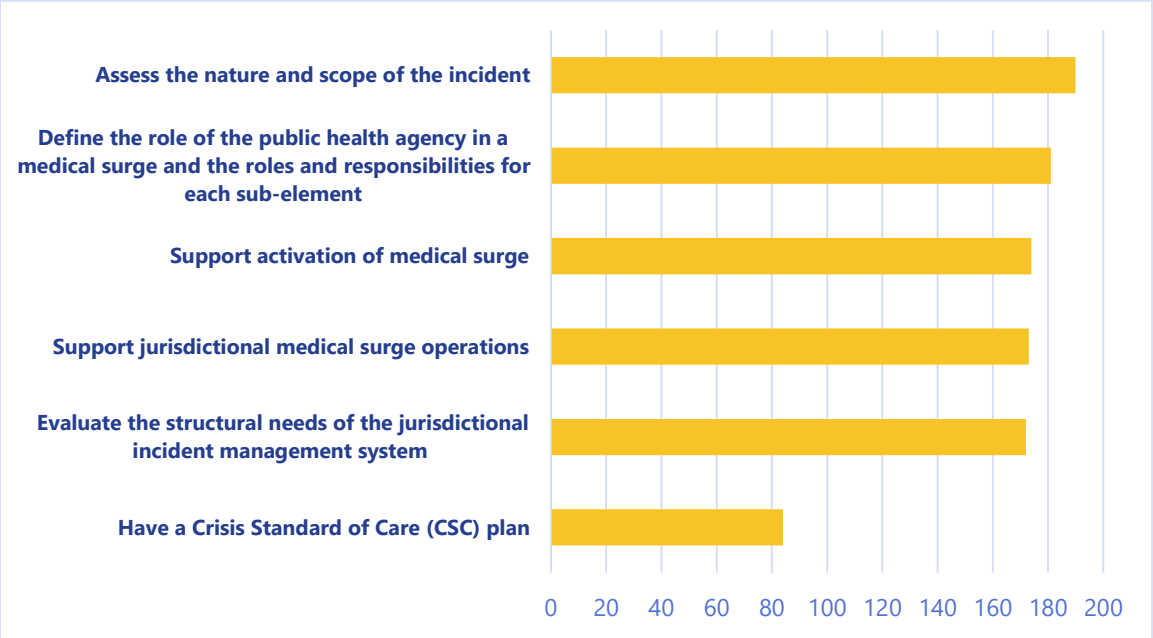
Respondents were asked to rank their ability/capacity to perform each of the functions associated with this capability by selecting one of the following ability levels: "No Ability" (0), "Limited Ability" (1), "Moderate Ability" (2), and "Full Ability" (3). A total of 6 functions associated with this capability were assessed through the PHHRA. The following figure displays the average capability score of all district responses.

Figure 99: LHD Medical Surge Results

Functions	Average Rating	Average Score
Assess the nature and scope of the incident	**Moderate Ability**	**2.3**
Define the role of the public health agency in a medical surge and the roles and responsibilities for each sub-element	**Moderate Ability**	**2.2**
Support activation of medical surge	**Moderate Ability**	**2.1**
Support jurisdictional medical surge operations	**Moderate Ability**	**2.1**
Evaluate the structural needs of the jurisdictional incident management system	**Moderate Ability**	**2**
Have a Crisis Standard of Care (CSC) plan	**Limited Ability**	**1**

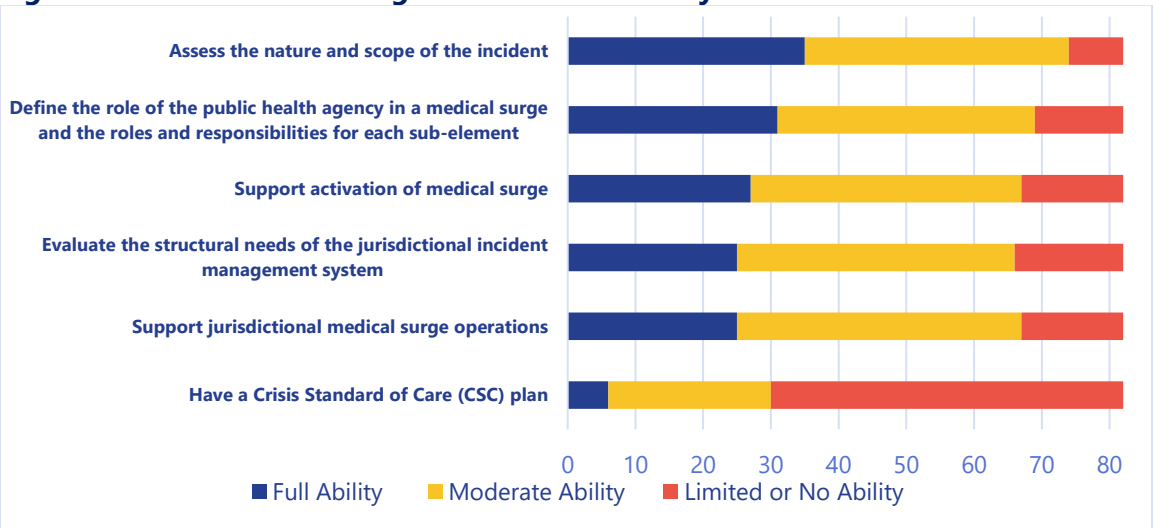
To provide a more detailed look at the unique score submitted by each respondent in the district the following figure shows the total score for each function. A total of 246 points were possible for each function. (3 points possible * 82 respondents). This chart provides a visual of the overall capability of the state to perform each function.

Figure 100: LHD Medical Surge Functions Capability Rankings



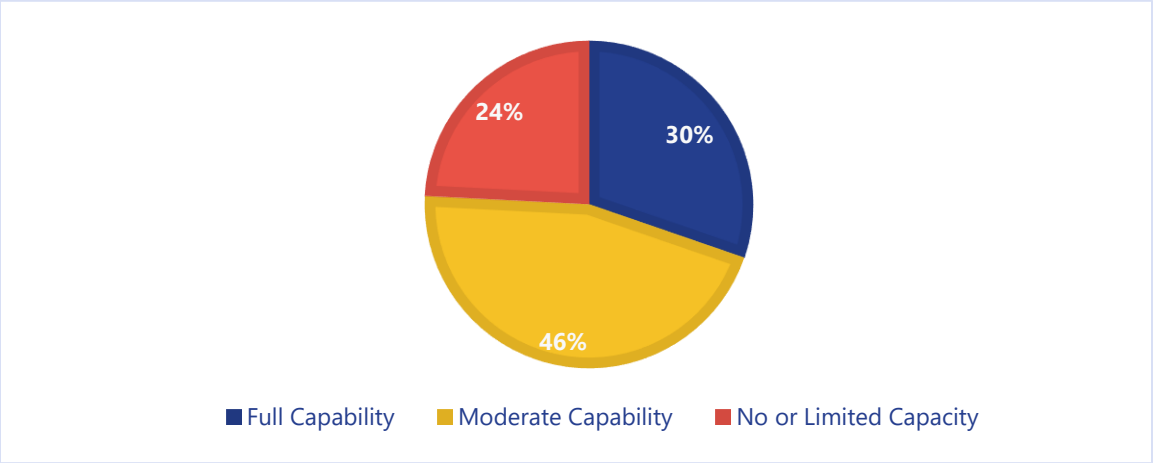
To provide a more detailed look at the unique score submitted by each respondent in the district the following figures represent the responses submitted by each Local Health Department regarding their level of capability to perform each function.

Figure 101: LHD Medical Surge Functions Results by number of LHDs



In addition to assessing the capability to perform each of the functions, this report also assesses the district's ability to perform the LHD Capability as a whole. When assessing the Medical Surge capability 30% of the responses indicated "Full Capability", 46% indicated "Moderate Capability", and 24% indicated "No or Limited Capability".

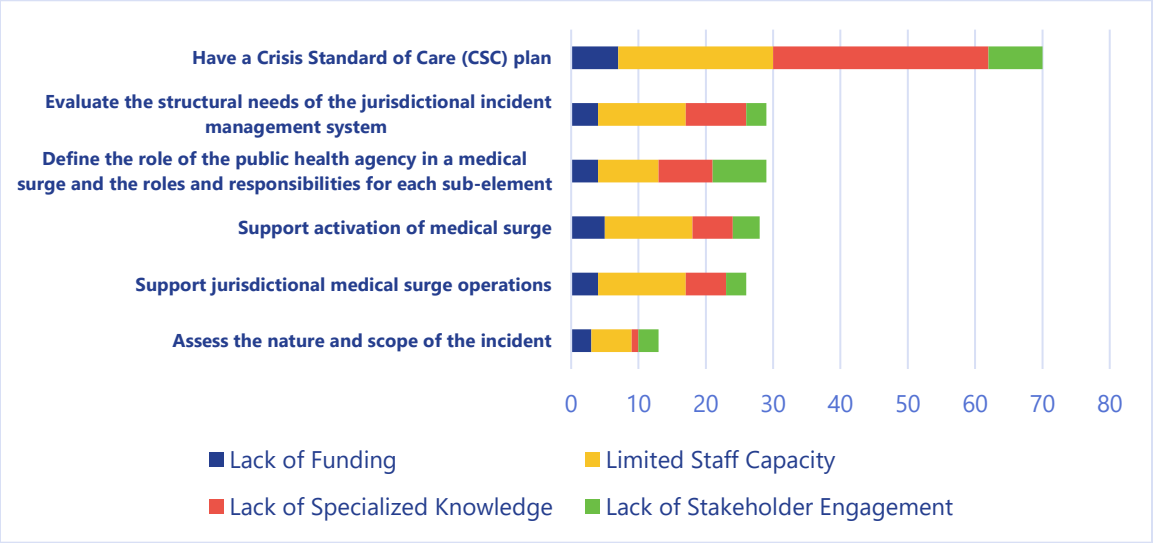
Figure 102: LHD Medical Surge Capability Results



Identified Barriers to Medical Surge

Respondents were asked to indicate what barriers they experience when they selected that they had "No or Limited Capability" to perform a function. The figure below shows the identified barriers by associated function. Functions that had no barriers identified are not displayed.

Figure 103: LHD Medical Surge Barriers



Patient Movement and Distribution and Medical Surge Capability crosswalk

The table below provides insight into how the HCC functions related to Patient Movement correspond to the LHD functions related to Medical Surge. In the event of an emergency impacting the health of a jurisdiction, Public Health Surveillance and Epidemiology is a key aspect of Incident Management and Coordination. The column titled "interoperability of functions" provides an example of how the HCC function supports the LHD function and vice versa. Local public health professionals are encouraged to expand upon this information to capture the specific ways in which the function of the HCC and LHD collaborate within their jurisdiction.

Figure 104: Patient Movement and Distribution and LHD Medical Surge Capability crosswalk

Patient Movement and Distribution	Medical Surge	Interoperability of Functions
HCC Functions	**LHD Functions**	
During a response, identify locations where patients can receive care based on available resources	Assess the nature and scope of the incident	The LHD's assessment of the nature and scope of the incident can be used to inform the HCC's determination of locations where patients can receive care based on available resources. The LHD's can integrate information provided by the HCCs regarding available resources into their assessment of an incident.
Integrate clinical expertise into the MOCC to prioritize patient transfers and offer care-in-place recommendations	Support jurisdictional medical surge operations	The LHDs can support jurisdictional medical surge operations through providing clinical expertise to HCC's as needed.
Make modifications to EMS dispatch, treatment, and transport of patients to prevent and mitigate surge.	Have a Crisis Standard of Care (CSC) plan	The HCCs can use the Crisis Standard of Care (CSC) plan developed by the LHD to inform modifications to EMS dispatch, treatment, and transport of patients to prevent and mitigate surge.
Develop a structure for regional patient transfer and care coordination (e.g., MOCC), including	Define the role of the public health agency in a medical surge and the roles and responsibilities for each sub-element	The LHD's definition of the role of the public health agency in a medical surge can be incorporated into the structure developed by the HCCs.

triggers, location, staffing, authorities, and data agreements	Support activation of medical surge	The structure developed by the HCCs includes triggers which would include the LHD's activation triggers for medical surge.
	Evaluate the structural needs of the jurisdictional incident management system	The LHD's evaluation of the structural needs of the jurisdictional incident management system can be utilized to inform the structure for regional patient transfer and care coordination developed by the HCCs.

HCC and LHD Capability and Barrier Scores

To compare the HCC and LHD capabilities ratings of the respondents a total possible score for each capability was calculated. Then the total of the scores given by the respondents was calculated. Finally, the total score was divided by the total possible score to find the capability rate.

Figure 105: Patient Movement and Distribution and Medical Surge Capability and Barrier Comparison

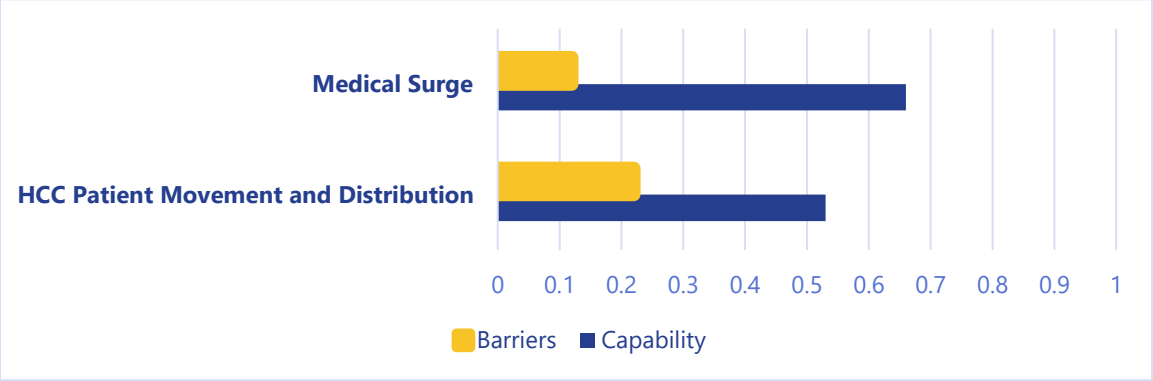
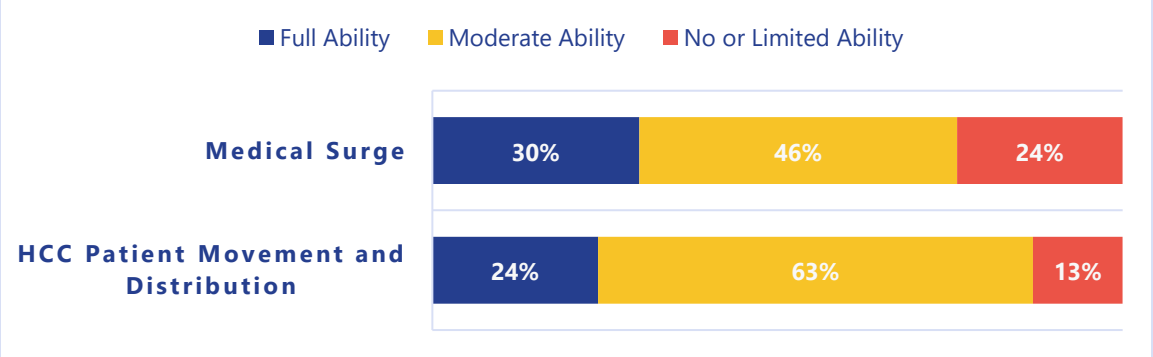


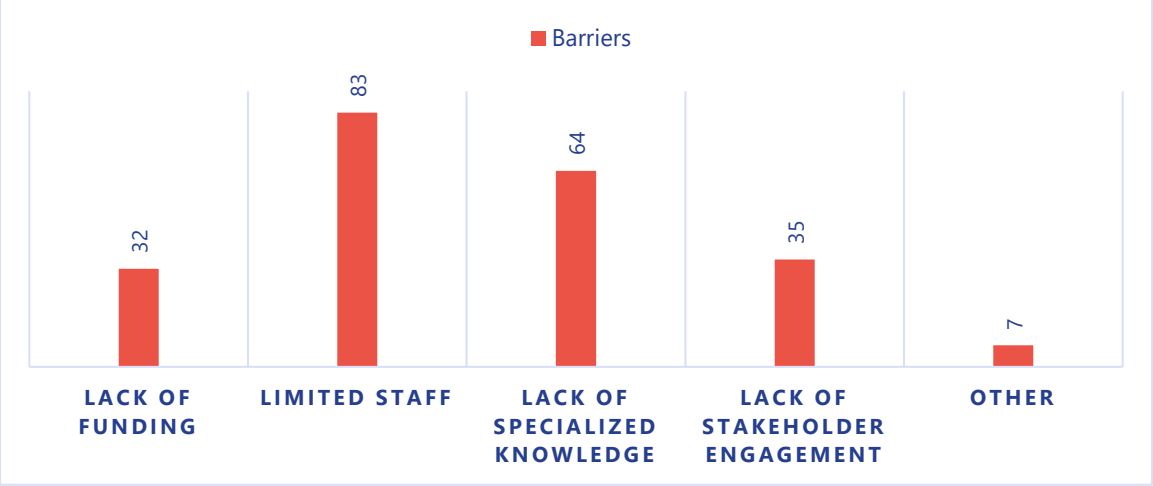
Figure 106: Patient Movement and Distribution and Medical Surge Capability Ability Rating Comparison



Identified barriers comparison

HCCs and LHDs were both asked to identify barriers they encounter to achieving "full" or "moderate" ability ratings for their respective capabilities. The chart below shows the number of times an HCC or LHD selected that they experienced each barrier to their respective capability. Limited staff capacity was the most frequently identified with 141 respondents selecting this as a barrier.

Figure 107: Patient Movement and Distribution and Medical Surge Barriers



HCC Capability: Workforce

Respondents were asked to rank their ability/capacity to perform each of the functions associated with this capability by selecting one of the following ability levels: "No Ability" (0), "Limited Ability" (1), "Moderate Ability" (2), and "Full Ability" (3). A total of 4 functions and 6 activities associated with this capability were assessed through the PHHRA. The following figure displays the average capability score of all district responses.

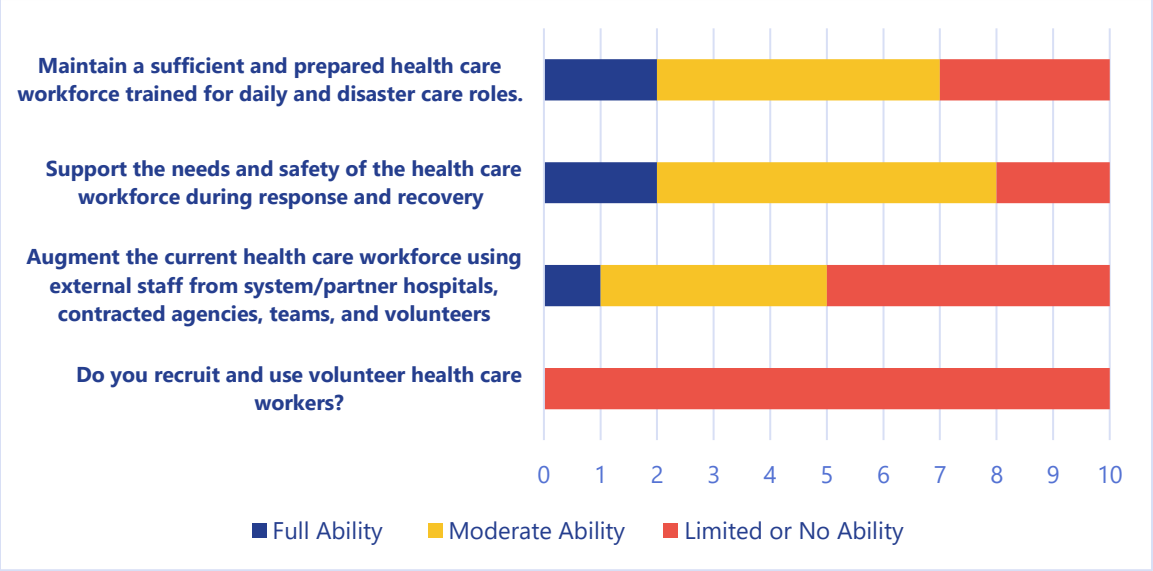
Definition: This capability focuses on activities to build workforce resilience and plan needed changes to staffing during a response

Figure 108: Workforce Results

Functions	Average Rating	Average Score
Support the needs and safety of the health care workforce during response and recovery	**Moderate Ability**	**2**
Maintain a sufficient and prepared health care workforce trained for daily and disaster care roles.	**Moderate Ability**	**1.6**
Augment the current health care workforce using external staff from system/partner hospitals, contracted agencies, teams, and volunteers	**Limited Ability**	**1.3**
Do you recruit and use volunteer health care workers?	**No Ability**	**All HCC's responded "no" to this question**

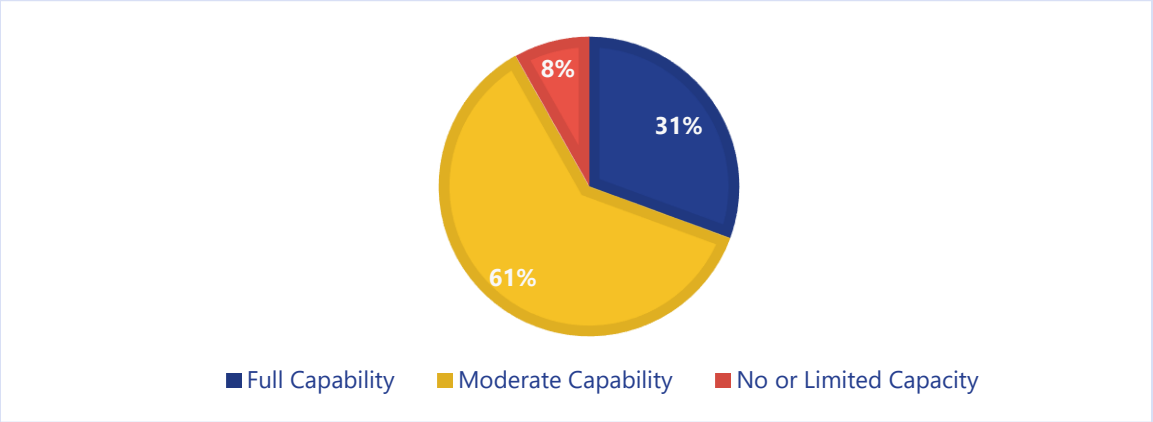
To provide a more detailed look at the unique capability of each HCC the following figure shows the number of HCC's that selected which ability level for each function.

Figure 109: Workforce Functions Results by number of HCCs



In addition to assessing the capability of the district to perform each of the functions, this report also assesses the district's ability to perform the HCC Capability as a whole. When assessing the Workforce capability 31% of the responses indicated "Full Capability", and 61% indicated "Moderate Capability" and 8% indicated "Limited or No Capability".

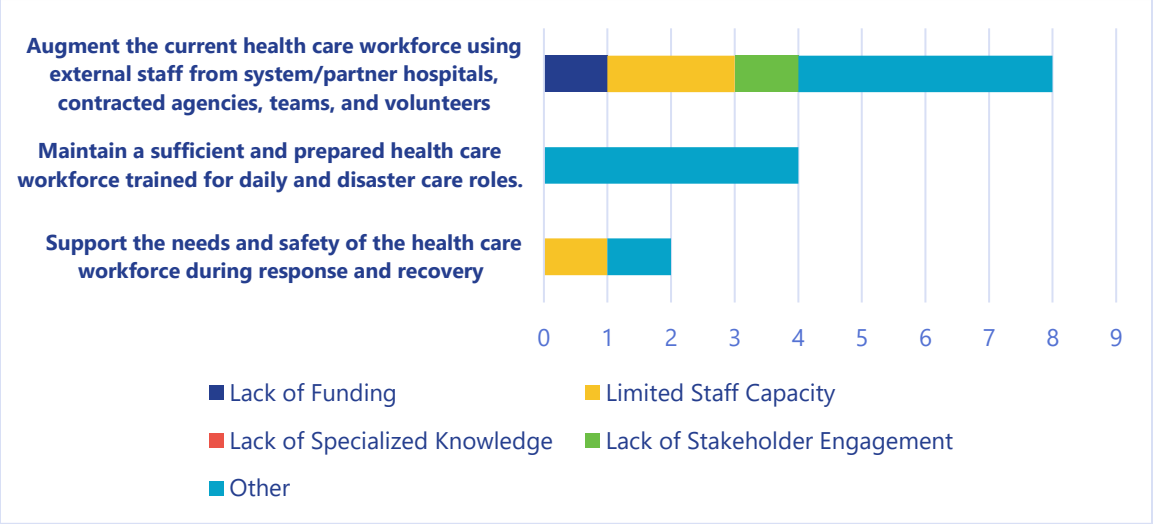
Figure 110: Workforce Capability Results



Identified Barrier to Workforce

The figure below shows the identified barriers by associated function. Functions that had no barriers identified are not displayed.

Figure 111: Workforce Barriers



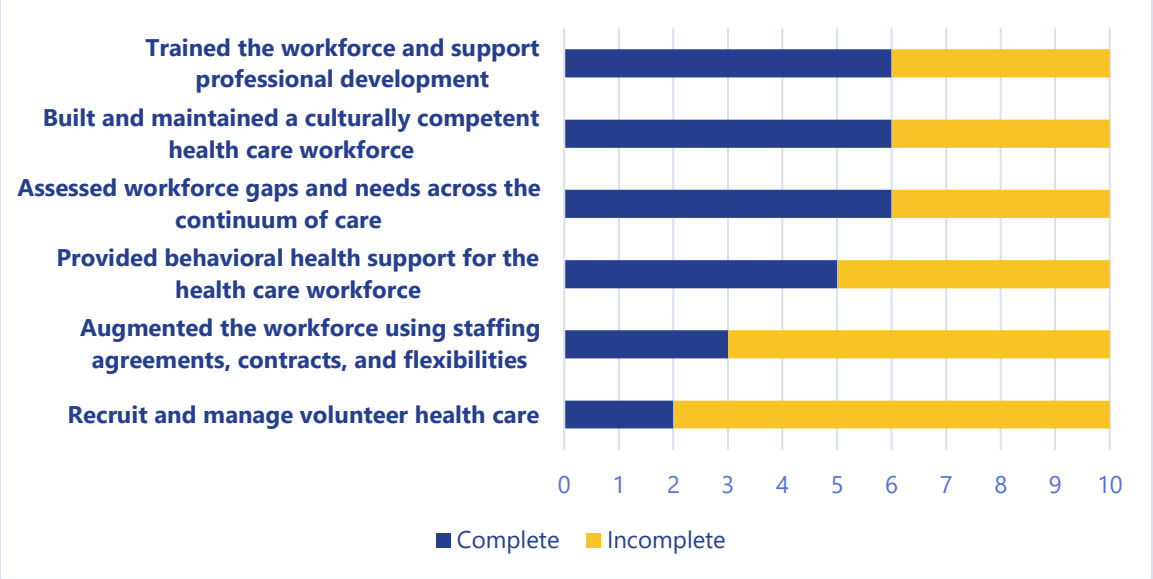
Other Response Narratives:

- Local HCC's do not maintain a workforce
- The HCC does not dictate staffing, credentialing, recruitment, etc.
- Local HCC's do not maintain a workforce
- HCC does not control staffing
- Lack of overall Volunteers and medical staff which was observed during Covid.
- Facility Responsibility
- Workforce turnover is a huge challenge in keeping a trained staff.

Activity Completion

The National Health Care Preparedness and Response Capabilities document identifies specific activities that should be completed for a capability to be met. The following figure shows the completion status of each of the associated activities by number of HCC respondents.

Figure 112: Workforce Activity Completion Results



LHD Capability: Responder Safety and Health

Definition: The ability to protect public health and other emergency responders during pre-deployment, deployment, and post-deployment.

Respondents were asked to rank their ability/capacity to perform each of the functions associated with this capability by selecting one of the following ability levels: "No Ability" (0), "Limited Ability" (1), "Moderate Ability" (2), and "Full Ability" (3). A total of 5 functions associated with this capability were assessed through the PHHRA. The following figure displays the average capability score of all responses.

Figure 113: Responder Safety and Health Results

Functions	Average Rating	Average Score
Identify responder safety and health risks	**Moderate Ability**	**2.2**
Identify and support risk- specific responder safety and health training	**Moderate Ability**	**2.1**
Identify, prioritize, and recommend protection and control measures, medical services and mental/ behavioral health support service for responders	**Moderate Ability**	**2.1**
Monitor responder safety and health during and after incident response	**Moderate Ability**	**2**

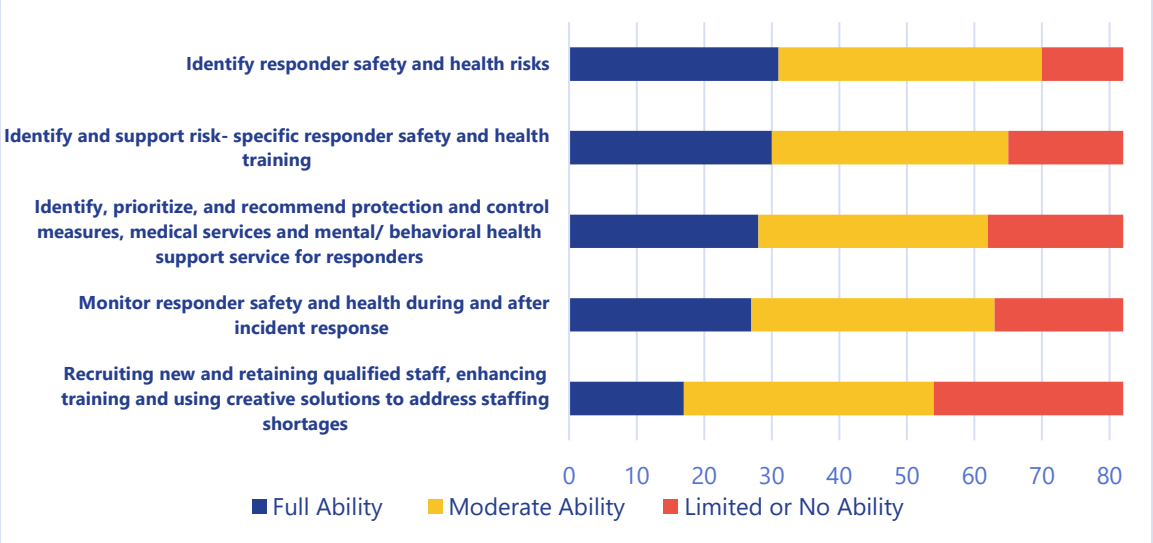
Recruiting new and retaining qualified staff, enhancing training and using creative solutions to address staffing shortages	**Moderate Ability**	**1.8**

To provide a more detailed look at the unique score submitted by each respondent in the district the following figure shows the total score for each function. A total of 246 points were possible for each function. (3 points possible * 82 respondents). This chart provides a visual of the overall capability of the state to perform each function.

Figure 114: Responder Safety and Health Functions Capability Ranking

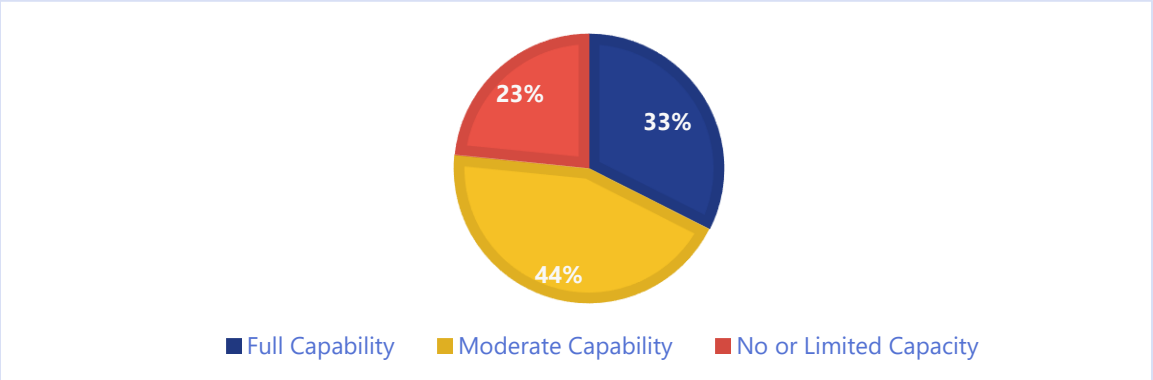
The following figures represent the responses submitted by each Local Health Department regarding their level of capability to perform each function.

Figure 115: Responder Safety and Health Functions Results by number of LHDs



In addition to assessing the capability of the district to perform each of the functions, this report also assesses the district's ability to perform the LHD Capability as a whole. When assessing the Responder Safety and Health capability 33% of the responses indicated "Full Capability", 44% indicated "Moderate Capability", and 23% indicated "No or Limited Capability".

Figure 116: Responder Safety and Health Capability Results



Identified Barriers to Responder Safety and Health

Additionally, respondents were asked to indicate what barriers they experience when they selected that they had "No or Limited Capability" to perform a function. The figure below shows the identified barriers by associated function. Functions that had no barriers identified are not displayed.

Figure 117: Responder Safety and Health Barriers

LHD Capability: Volunteer Management

Respondents were asked to rank their ability/capacity to perform each of the functions associated with this capability by selecting one of the following ability levels: "No Ability" (0), "Limited Ability" (1), "Moderate Ability" (2), and "Full Ability" (3). A total of 5 functions associated with this capability were assessed through the PHHRA. The following figure displays the average capability score of all district responses.

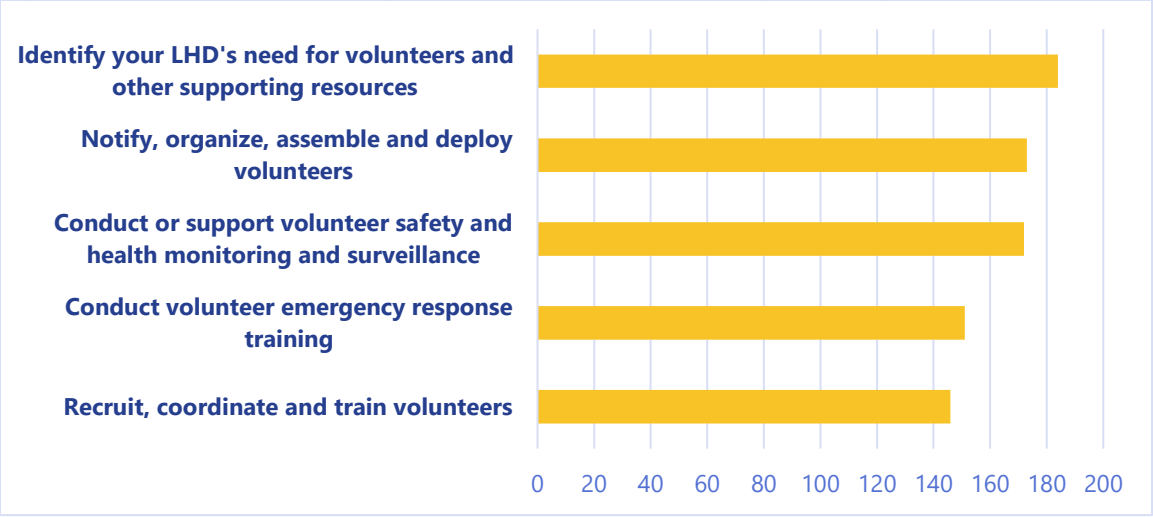
Definition: The ability to coordinate with emergency management and partner agencies to identify, recruit, register, verify, train, and engage volunteers to support the jurisdictional public health agency's preparedness, response, and recovery activities during pre-deployment, deployment, and post deployment.

Figure 118: Volunteer Management Results

Functions	Average Rating	Average Score
Identify your LHD's need for volunteers and other supporting resources	**Moderate Ability**	**2.2**
Notify, organize, assemble and deploy volunteers	**Moderate Ability**	**2.1**
Conduct or support volunteer safety and health monitoring and surveillance	**Moderate Ability**	**2.1**
Conduct volunteer emergency response training	**Moderate Ability**	**1.8**
Recruit, coordinate and train volunteers	**Moderate Ability**	**1.8**

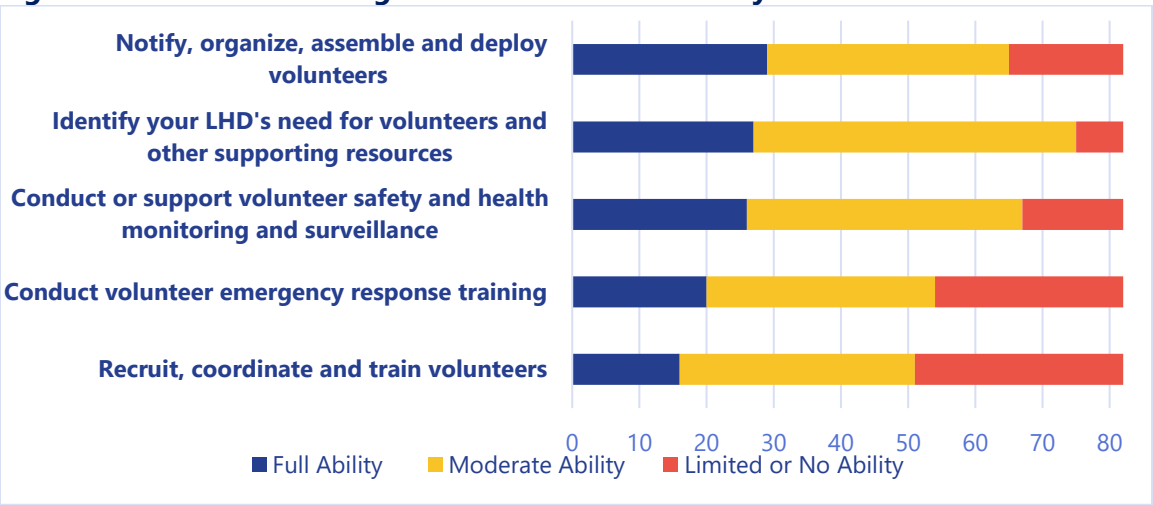
To provide a more detailed look at the unique score submitted by each respondent in the district the following figure shows the total score for each function. A total of 246 points were possible for each function. (3 points possible * 82 respondents). This chart provides a visual of the overall capability of the state to perform each function.

Figure 119: Volunteer Management Functions Capability Ranking



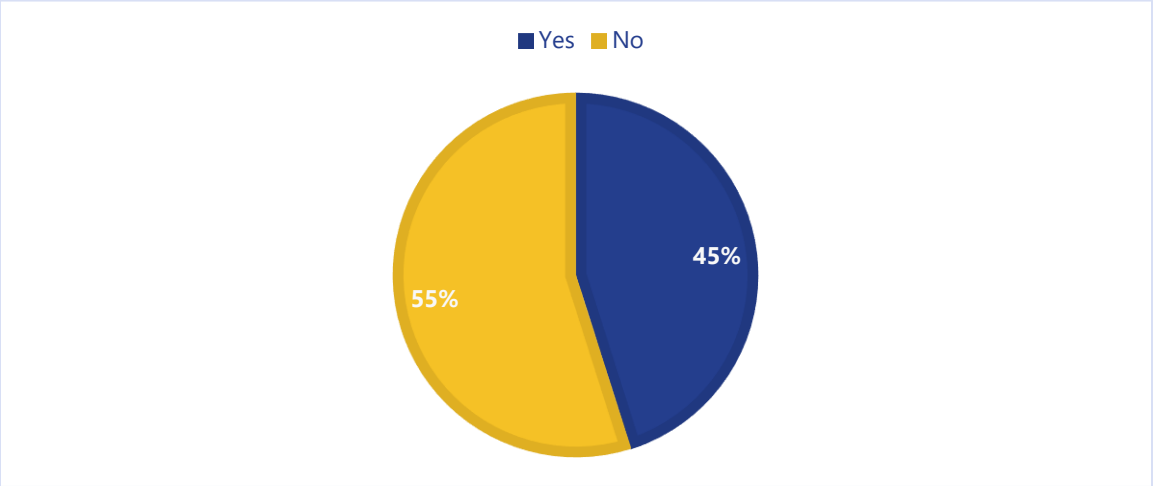
The following figures represent the responses submitted by each Local Health Department regarding their level of capability to perform each function.

Figure 120:Volunteer Management Functions Results by number of LHDs



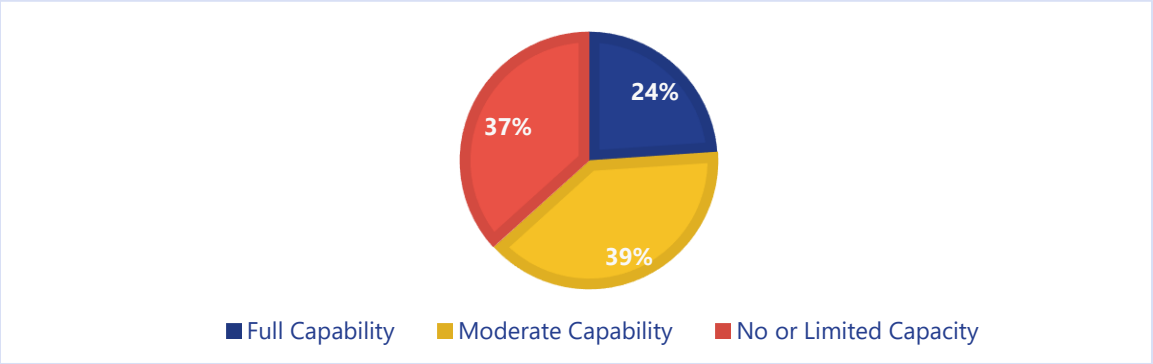
LHD's were also asked if they have liability insurance coverage of volunteers outside of the PREP act during a declared public health emergency. The breakdown of responses is shown below:

Figure 121: Liability Insurance Results



In addition to assessing the capability of the district to perform each of the functions, this report also assesses the district's ability to perform the LHD Capability as a whole. When assessing the Volunteer Management capability 24% of the responses indicated "Full Capability", 39% indicated "Moderate Capability", and 37% indicated "No or Limited Capability".

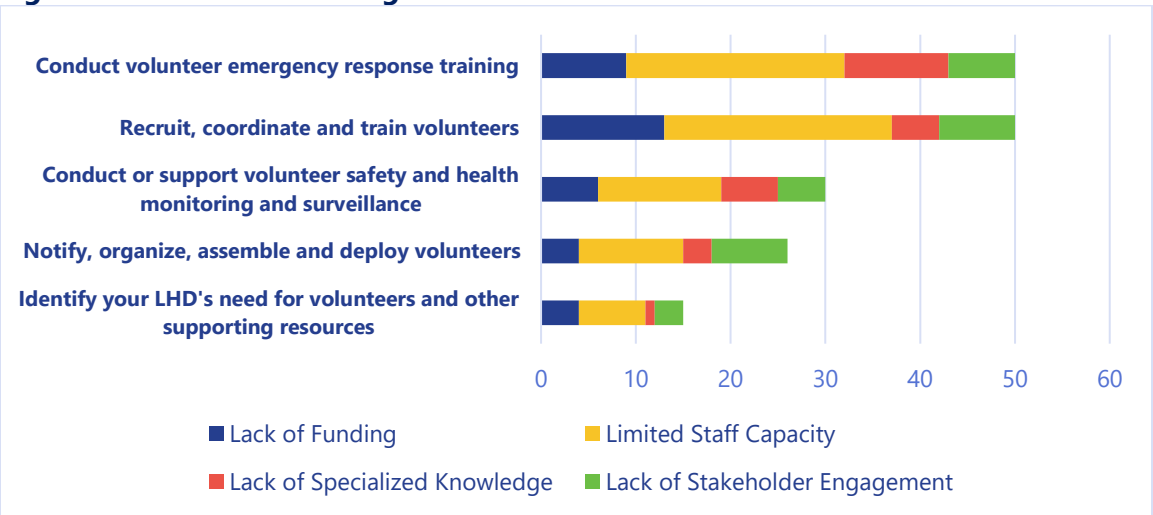
Figure 122: Volunteer Management Capability Results



Identified Barriers to Volunteer Management

Additionally, respondents were asked to indicate what barriers they experience when they selected that they had "No or Limited Capability" to perform a function. The figure below shows the identified barriers by associated function. Functions that had no barriers identified are not displayed.

Figure 123: Volunteer Management Barriers



Workforce, Responder Safety and Health, and Volunteer Management Capability crosswalk

The table below provides insight into how the HCC functions related to Workforce correspond to the LHD functions related to Responder Safety and Health, and Volunteer Management. The column titled "interoperability of functions" provides an example of how the HCC function supports the LHD function and vice versa. Local public health professionals are encouraged to

expand upon this information to capture the specific ways in which the function of the HCC and LHD collaborate within their jurisdiction.

Figure 124: Workforce and Responder Safety and Health Crosswalk

Workforce	Responder Health and Safety	Interoperability of Functions
HCC Functions	**LHD Functions**	
Maintain a sufficient and prepared health care workforce trained for daily and disaster care roles.	Identify and support risk-specific responder safety and health training	The LHD's identification of risk specific responder safety and health training can be used by the HCC to maintain a prepared health care workforce.
Augment the current health care workforce using external staff from system/partner hospitals, contracted agencies, teams, and volunteers	Recruiting new and retaining qualified staff, enhancing training and using creative solutions to address staffing shortages	Collaboration between the HCCs and LHDs to recruit new and retain qualified staff enables both to augment the current health care workforce as needed.
Support the needs and safety of the health care workforce during response and recovery	Identify responder safety and health risks	LHD's identification of responder safety and health risks allows the HCCs to have a targeted approach to support the needs of the workforce.
	Identify, prioritize, and recommend protection and control measures, medical services and mental/ behavioral health support service for responders	The recommendations made by the LHD's regarding protection and control measures, medical services and mental/ behavioral health support service for responders can be incorporated into the methods the HCC uses to support the needs of the workforce.
	Monitor responder safety and health during and after incident response	The monitoring done by the LHD's can be communicated to the HCC's to ensure support provided is effective.

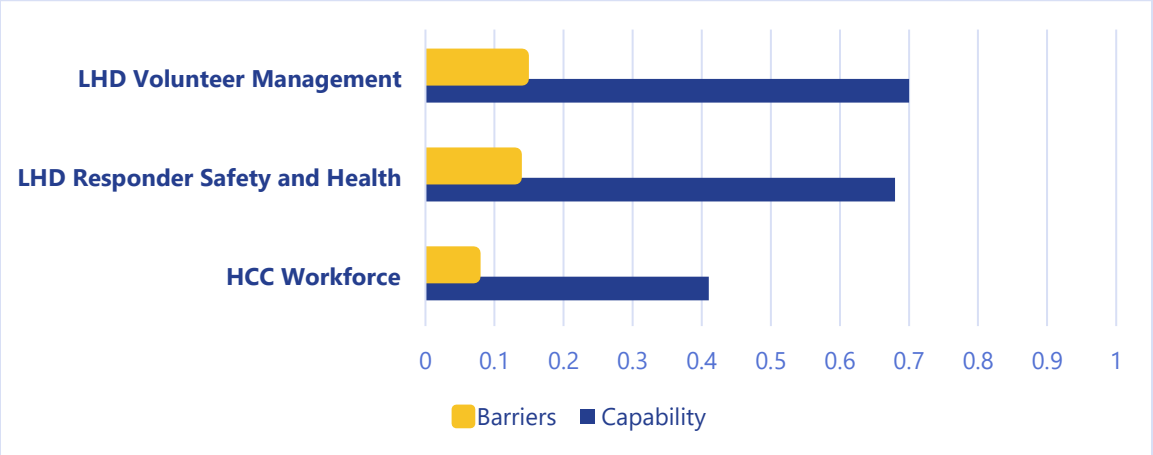
Figure 125: Workforce and Volunteer Management Crosswalk

Workforce	Volunteer Management	Interoperability of Functions
HCC Functions	**LHD Functions**	
Support the needs and safety of the health care workforce during response and recovery	Identify your LHD's need for volunteers and other supporting resources	The HCC's understanding the need for volunteers and other supporting resources identified by the LHD's strengthens the ability of the HCC's to support the workforce needs.
Augment the current health care workforce using external staff from system/partner hospitals, contracted agencies, teams, and volunteers	Notify, organize, assemble and deploy volunteers	LHD's and HCC's can work collaboratively to notify, organize, assemble and deploy volunteers to Augment the current health care workforce as needed.
Maintain a sufficient and prepared health care workforce trained for daily and disaster care roles.	Conduct volunteer emergency response training	The volunteer emergency response training conducted by the LHD's is one avenue that HCC's can use to maintain a sufficient and prepared health care workforce.
	Recruit, coordinate and train volunteers	Collaboration between the LHD's and HCC's to recruit, coordinate and train volunteers enables both to maintain a sufficient and prepared health care workforce.
	Conduct or support volunteer safety and health monitoring and surveillance	The HCC's maintenance of a sufficient and prepared health care workforce is supported by the health monitoring and surveillance of volunteers conducted by LHDs.

HCC and LHD Capability and Barrier Scores

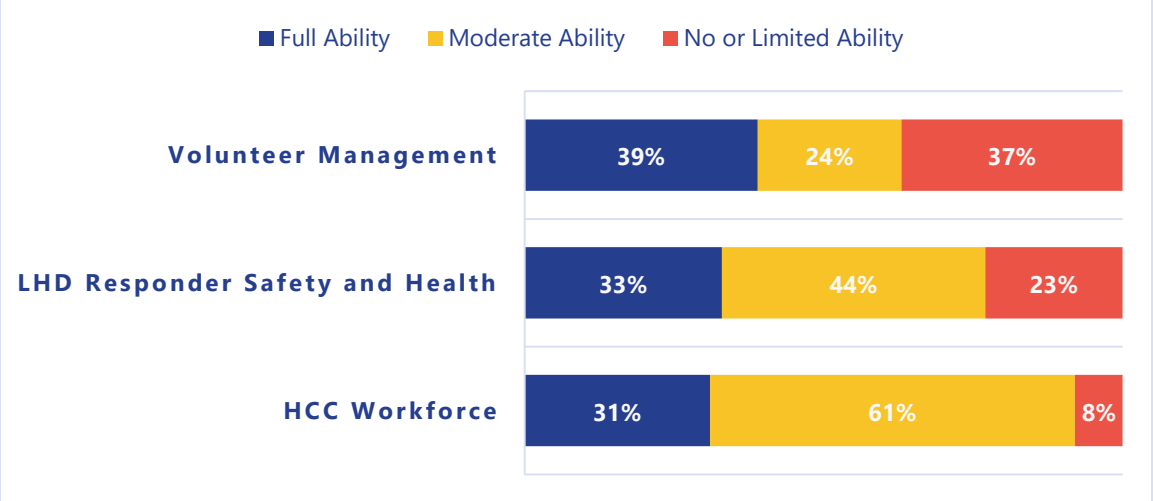
To compare the HCC and LHD capabilities ratings of the respondents a total possible score for each capability was calculated. Then the total of the scores given by the respondents was calculated. Finally, the total score was divided by the total possible score to find the capability rate.

Figure 126: Workforce, Responder Safety and Health, and Volunteer Management Capability and Barriers Comparison



The following figure shows the % of respondents that selected each ability level for their respective capabilities.

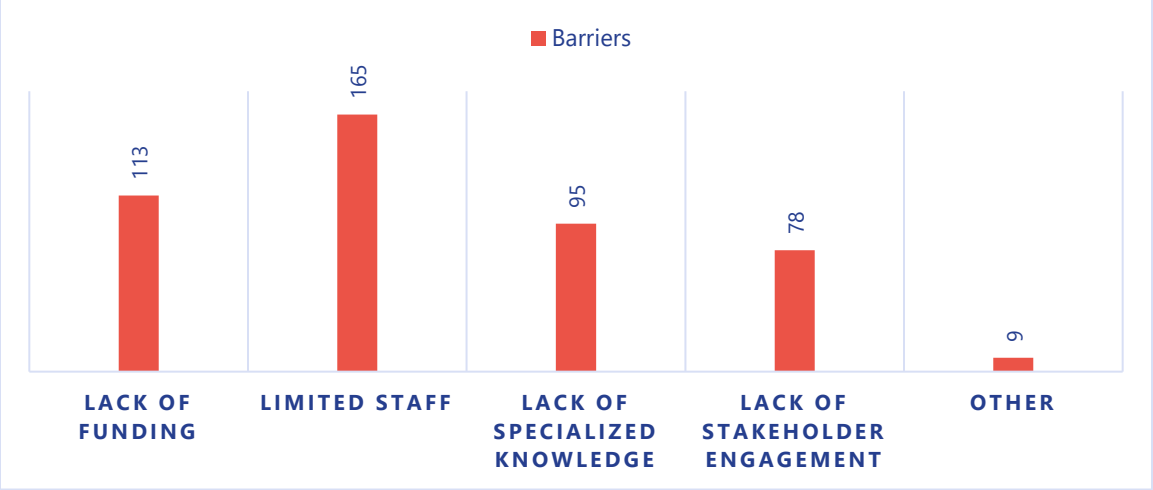
Figure 127: Workforce, Responder Safety and Health, and Volunteer Management Capability Comparison



Identified barriers comparison

HCCs and LHDs were both asked to identify barriers they encounter to achieving "full" or "moderate" ability ratings for their respective capabilities. The chart below shows the number of times an HCC or LHD selected that they experienced each barrier to their respective capability. Limited staff capacity was the most frequently identified with 165 respondents selecting this as a barrier.

Figure 128: Workforce, Responder Safety and Health, and Volunteer Management Barriers



HCC Capability: Resources

Respondents were asked to rank their ability/capacity to perform each of the functions associated with this capability by selecting one of the following ability levels: "No Ability" (0), "Limited Ability" (1), "Moderate Ability" (2), and "Full Ability" (3). A total of 6 functions and 7 activities associated with this capability were assessed through the PHHRA. The following figure displays the average capability score of all district responses.

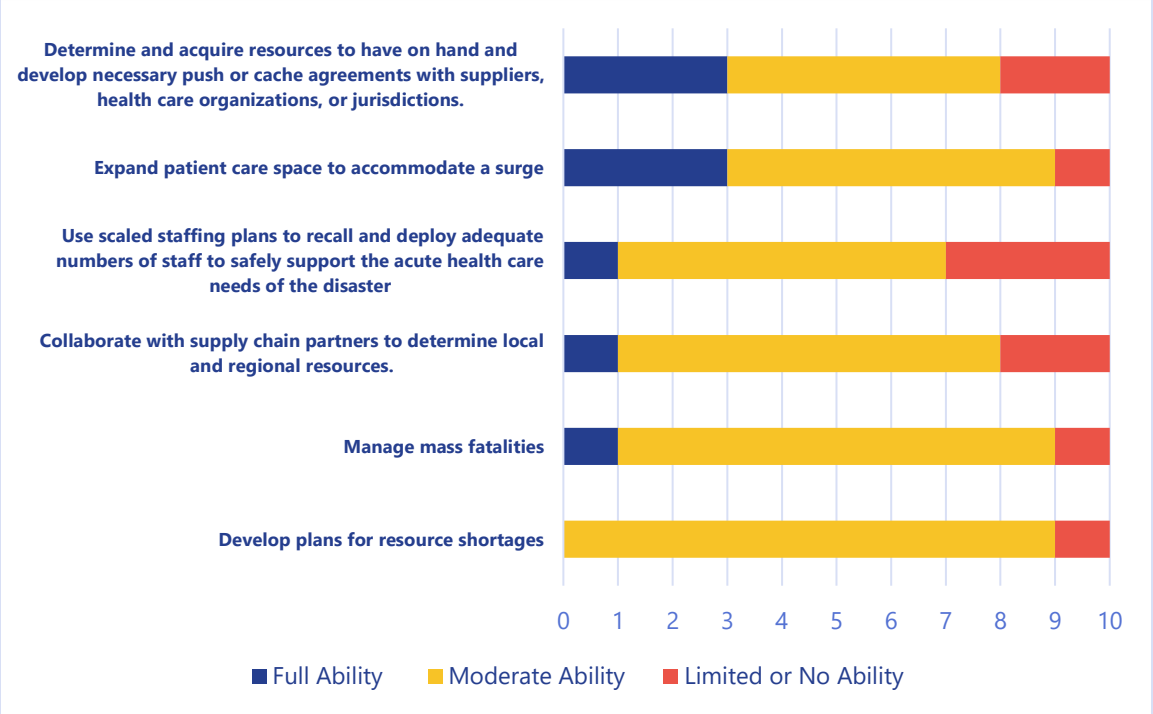
Definition: Resources include staff, space, supplies and equipment, and physical and digital infrastructure systems. To be successful, health care organizations and partners must identify, acquire, cache, and distribute sufficient supplies to meet no-notice and prolonged surge needs, plan to address resource shortages during disasters, prepare adequate space for patient surges, and staff those areas to provide appropriate care.

Figure 129: Resources Results

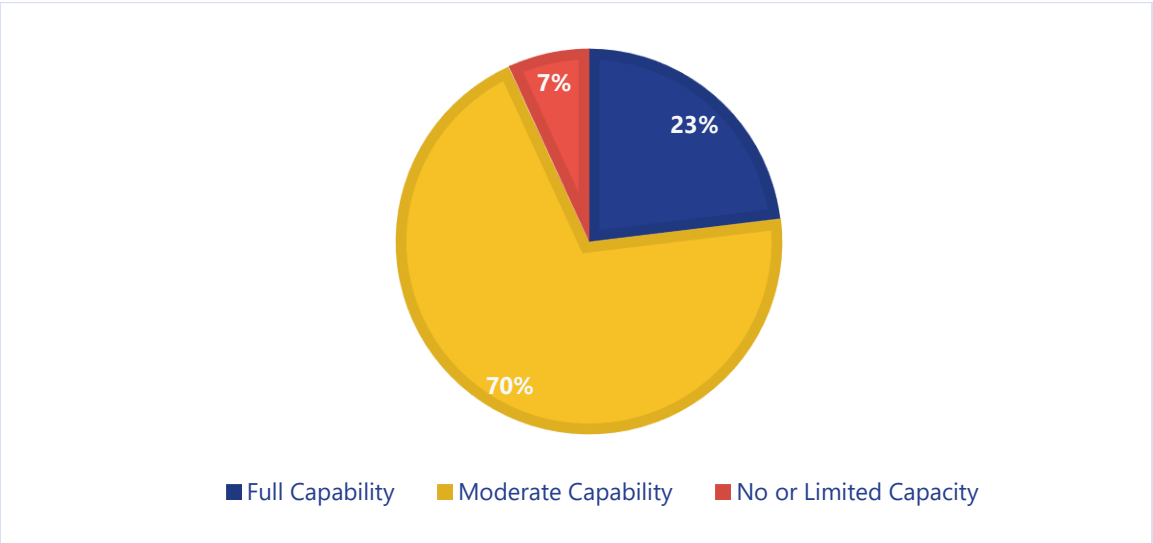
Functions	Average Rating	Average Score
Expand patient care space to accommodate a surge	**Moderate Ability**	**2.2**
Determine and acquire resources to have on hand and develop necessary push or cache agreements with suppliers, health care organizations, or jurisdictions.	**Moderate Ability**	**2.1**
Manage mass fatalities	**Moderate Ability**	**2**
Collaborate with supply chain partners to determine local and regional resources.	**Moderate Ability**	**1.9**
Develop plans for resource shortages	**Moderate Ability**	**1.9**
Use scaled staffing plans to recall and deploy adequate numbers of staff to safely support the acute health care needs of the disaster	**Moderate Ability**	**1.6**

To provide a more detailed look at the unique capability of each HCC the following figure shows the number of HCC's that selected which ability level for each function.

Figure 130: Resources Functions Results by number of HCCs



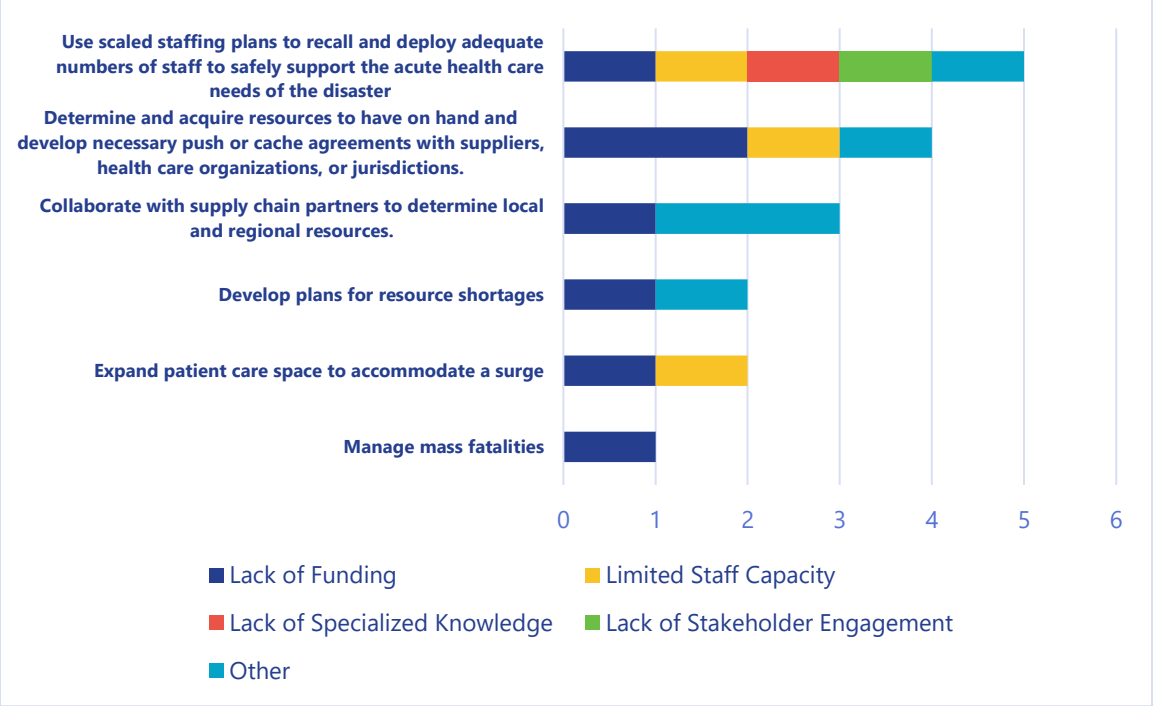
In addition to assessing the capability of the district to perform each of the functions, this report also assesses the district's ability to perform the HCC Capability as a whole. When assessing the Resources capability 23% of the responses indicated "Full Capability", and 70% indicated "Moderate Capability" and 7% indicated "Limited or No Capability".



Identified Barriers to Resources

The figure below shows the identified barriers by associated function. Functions that had no barriers identified are not displayed.

Figure 131: Resources Barriers



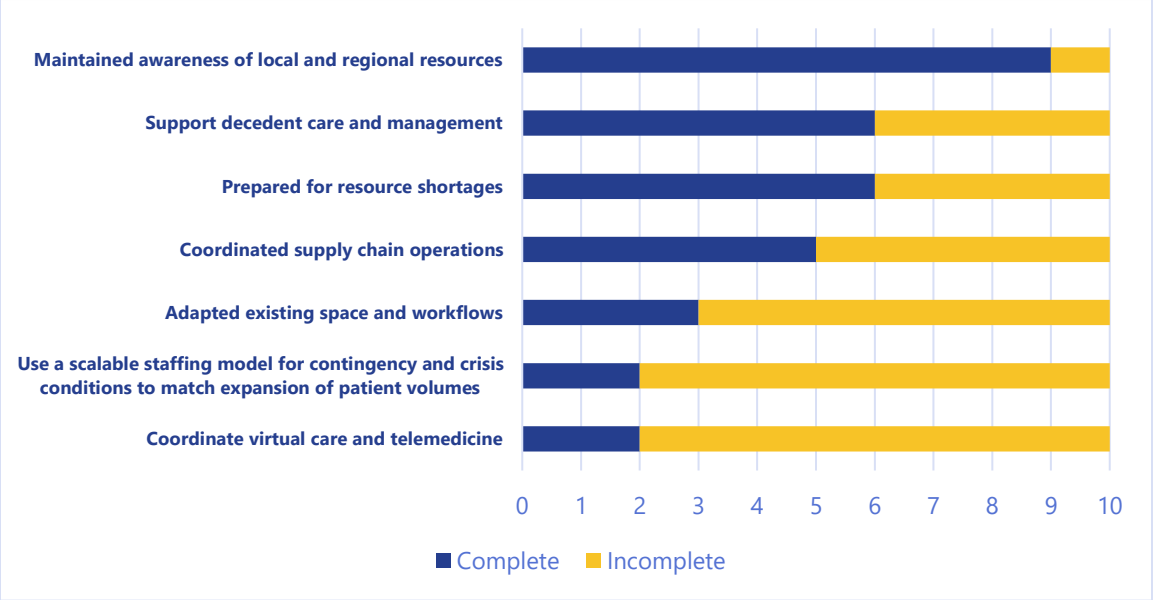
Other Response Narratives:

- In progress
- Supply Chain Assessment Incomplete
- No standardization in supplies across healthcare facilities.
- Facility contractual obligations are a challenge.
- Facility responsibility

Activity Completion

The National Health Care Preparedness and Response Capabilities document identifies specific activities that should be completed for a capability to be met. The following figure shows the completion status of each of the associated activities by number of HCC respondents.

Figure 132: Resources Activity Completion Results



LHD Capability: Medical Countermeasure Dispensing and Administration

Definition: The ability to provide medical countermeasures to targeted population(s) to prevent, mitigate, or treat the adverse health effects of a public health incident.

Respondents were asked to rank their ability/capacity to perform each of the functions associated with this capability by selecting one of the following ability levels: "No Ability" (0), "Limited Ability" (1), "Moderate Ability" (2), and "Full Ability" (3). A total of 4 functions associated with this capability were assessed through the PHHRA. The following figure displays the average capability score of all district responses.

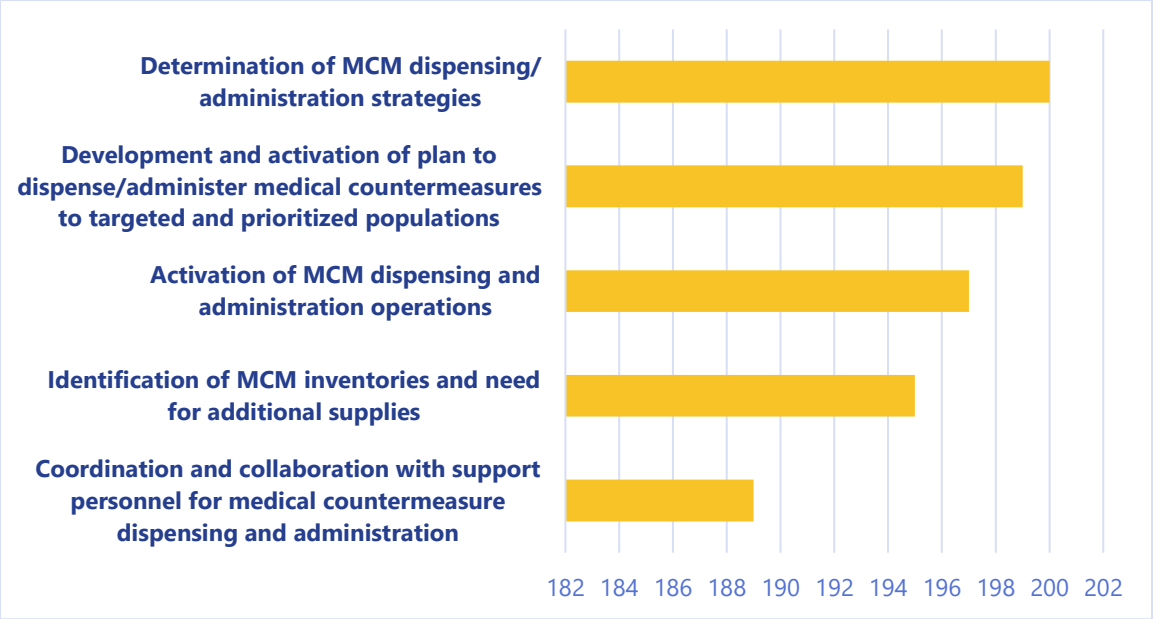
Figure 133: Medical Countermeasure Dispensing and Administration Results

Functions	Average Rating	Average Score
Determination of MCM dispensing/ administration strategies	**Moderate Ability**	**2.4**
Development and activation of plan to dispense/administer medical countermeasures to targeted and prioritized populations	**Moderate Ability**	**2.4**
Activation of MCM dispensing and administration operations	**Moderate Ability**	**2.4**
Identification of MCM inventories and need for additional supplies	**Moderate Ability**	**2.4**

Coordination and collaboration with support personnel for medical countermeasure dispensing and administration	**Moderate Ability**	**2.3**

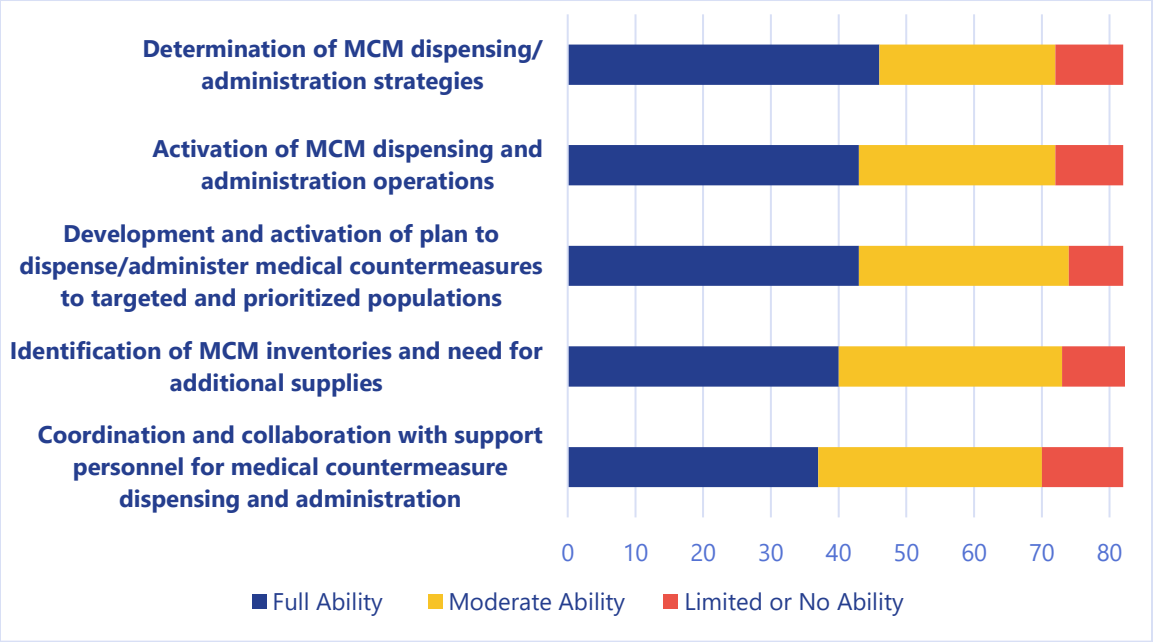
To provide a more detailed look at the unique score submitted by each respondent in the district the following figure shows the total score for each function. A total of 246 points were possible for each function. (3 points possible * 82 respondents). This chart provides a visual of the overall capability of the state to perform each function.

Figure 134: Medical Countermeasure Dispensing and Administration Functions Capability Rankings



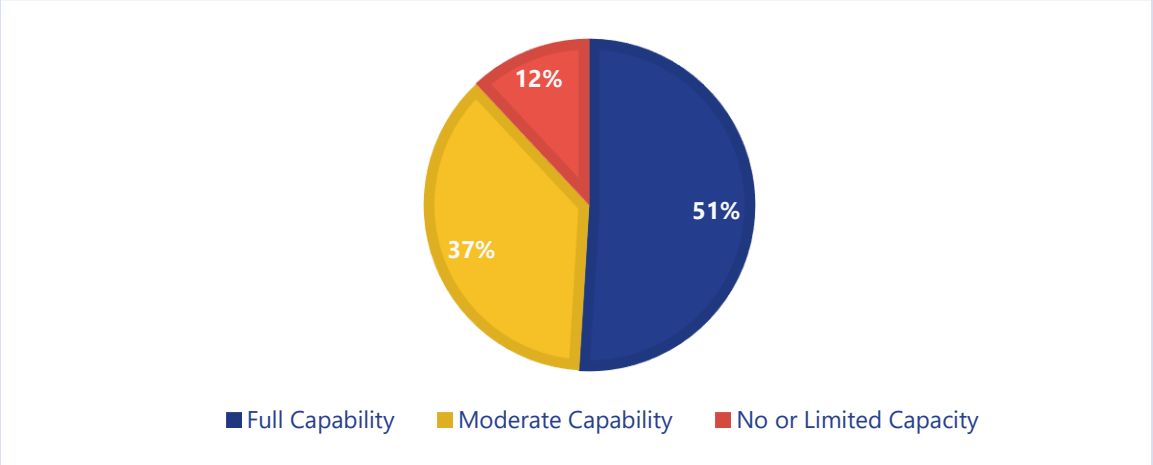
To provide a more detailed look at the unique score submitted by each respondent in the district the following figures represent the responses submitted by each Local Health Department regarding their level of capability to perform each function.

Figure 135: Medical Countermeasure Dispensing and Administration Results by number of LHDs



In addition to assessing the capability of the district to perform each of the functions, this report also assesses the district's ability to perform the LHD Capability as a whole. When assessing the Medical Countermeasure Dispensing and Administration capability 51% of the responses indicated "Full Capability", 37% indicated "Moderate Capability", and 12% indicated "No or Limited Capability".

Figure 136: Medical Countermeasure Dispensing and Administration Capability Results

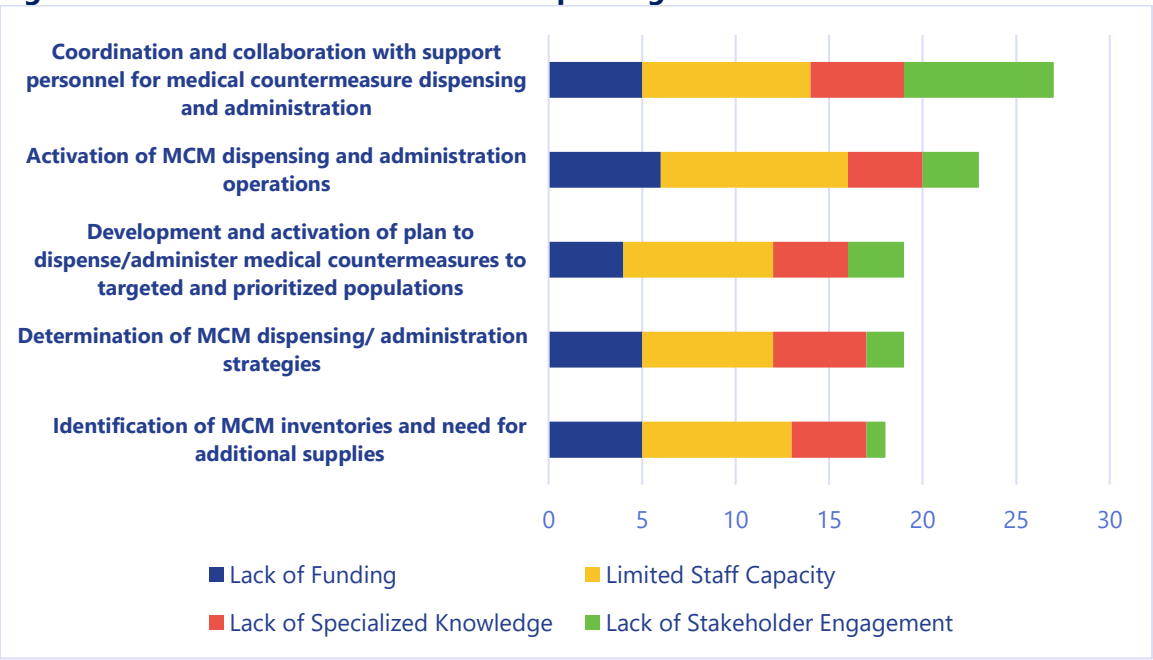


Identified Barriers to Medical Countermeasure Dispensing and Administration

Additionally, respondents were asked to indicate what barriers they experience when they selected that they had "No or Limited Capability" to perform a function. The figure below shows

the identified barriers by associated function. Functions that had no barriers identified are not displayed.

Figure 137: Medical Countermeasure Dispensing and Administration Barriers



LHD Capability: Medical Material Management and Distribution

Respondents were asked to rank their ability/capacity to perform each of the functions associated with this capability by selecting one of the following ability levels: "No Ability" (0), "Limited Ability" (1), "Moderate Ability" (2), and "Full Ability" (3). A total of 6 functions associated with this capability were assessed through the PHHRA. The following figure displays the average capability score of all district responses.

Definition: The ability to acquire, manage, transport, and track medical material during a public health incident or event and the ability to recover and account for unused medical material, such as pharmaceuticals, vaccines, gloves, masks, ventilators, or medical equipment after an incident.

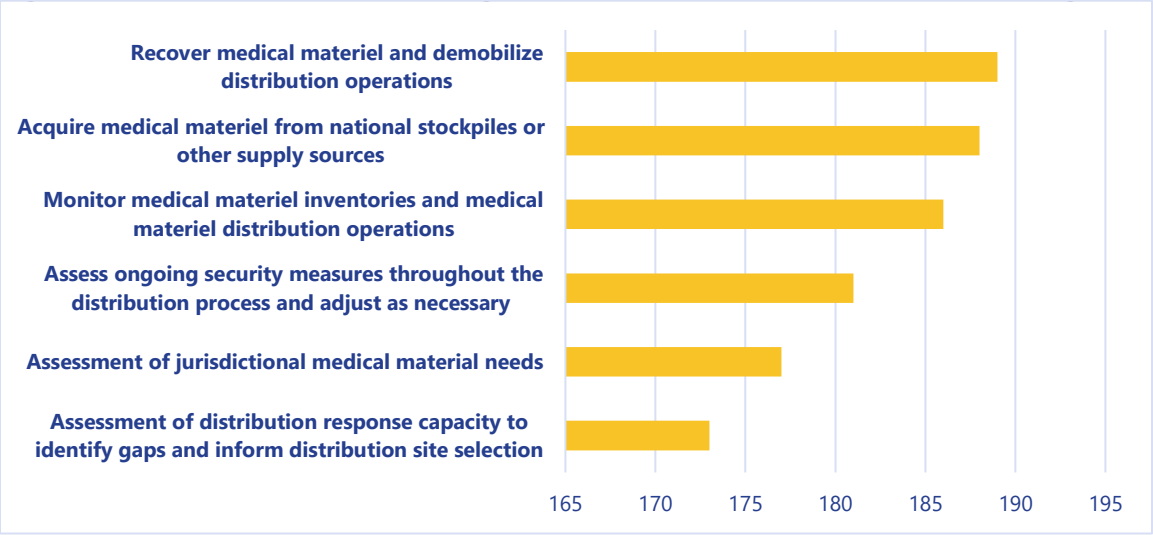
Figure 138: Medical Material Management and Distribution Results

Functions	Average Rating	Average Score
Recover medical material and demobilize distribution operations	**Moderate Ability**	**2.3**
Acquire medical material from national stockpiles or other supply sources	**Moderate Ability**	**2.3**

Monitor medical material inventories and medical material distribution operations	**Moderate Ability**	**2.3**
Assess ongoing security measures throughout the distribution process and adjust as necessary	**Moderate Ability**	**2.2**
Assessment of jurisdictional medical material needs	**Moderate Ability**	**2.2**
Assessment of distribution response capacity to identify gaps and inform distribution site selection	**Moderate Ability**	**2.1**

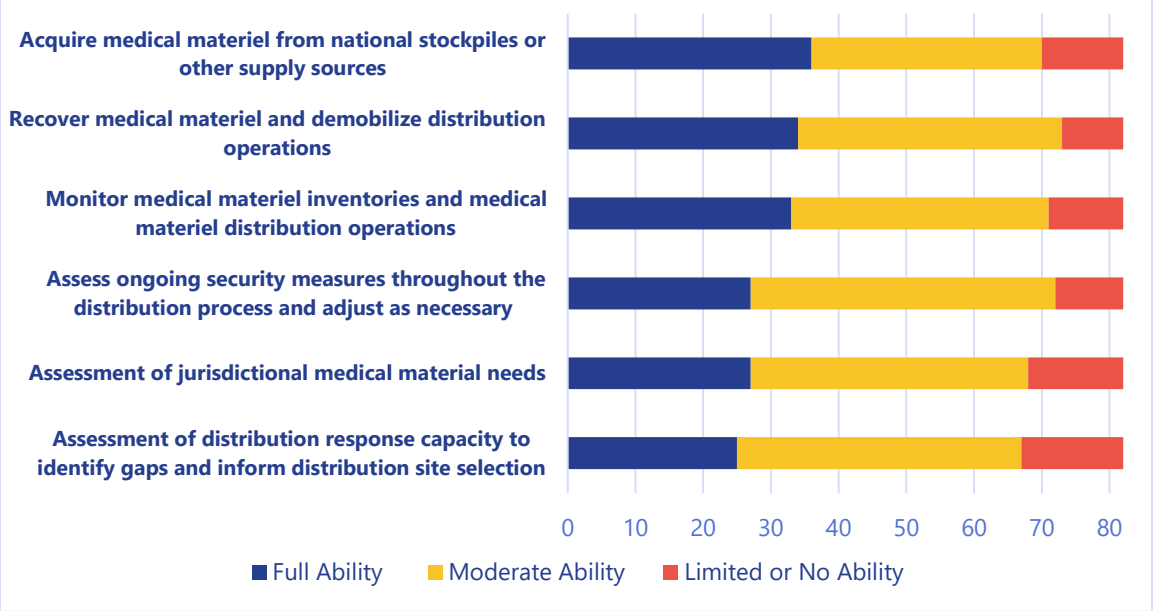
To provide a more detailed look at the unique score submitted by each respondent in the district the following figure shows the total score for each function. A total of 246 points were possible for each function. (3 points possible * 82 respondents). This chart provides a visual of the overall capability of the state to perform each function.

Figure 139: Medical Material Management and Distribution Functions Rankings



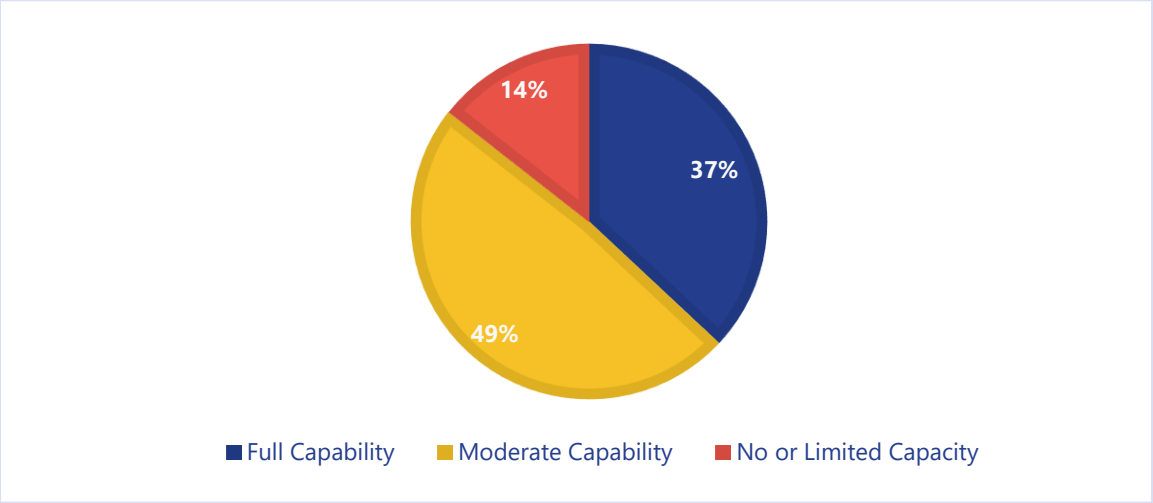
The following figures represent the responses submitted by each Local Health Department regarding their level of capability to perform each function.

Figure 140: Medical Material Management and Distribution Results by number of LHD's



In addition to assessing the capability of the district to perform each of the functions, this report also assesses the district's ability to perform the LHD Capability as a whole. When assessing the Medical Material Management and Distribution capability 37% of the responses indicated "Full Capability", 49% indicated "Moderate Capability", and 14% indicated "No or Limited Capability".

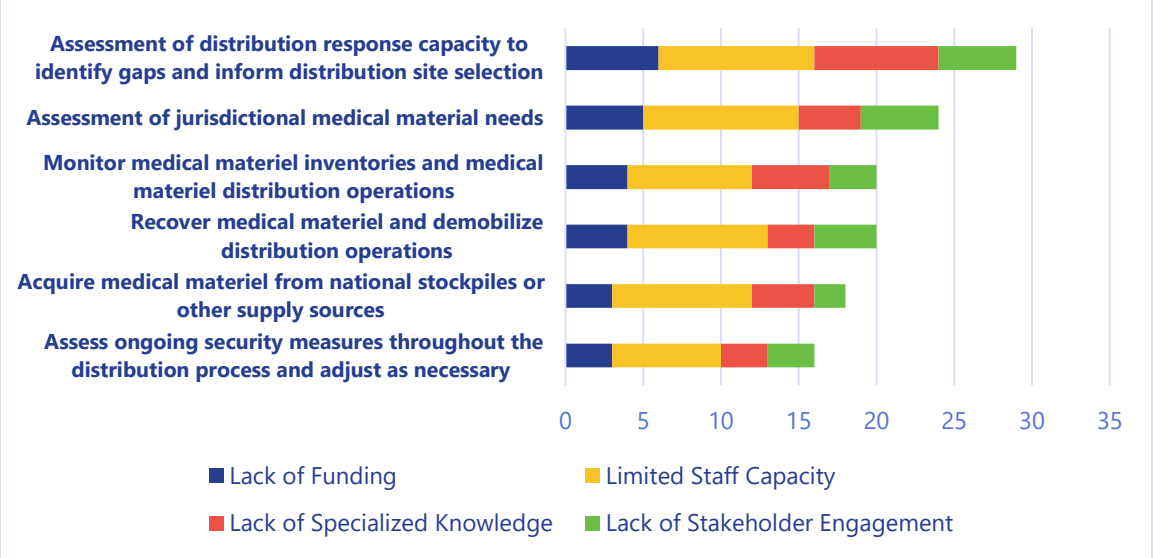
Figure 141: Medical Material Management and Distribution Capability Results



Identified Barriers to Medical Material Management and Distribution

Additionally, respondents were asked to indicate what barriers they experience when they selected that they had "No or Limited Capability" to perform a function. The figure below shows the identified barriers by associated function. Functions that had no barriers identified are not displayed.

Figure 142: Medical Material Management and Distribution Barriers



Resources, Medical Countermeasure Dispensing, and Medical Material Management capabilities crosswalk

The table below provides insight into how the HCC functions related to Incident Management and Coordination correspond to the LHD functions related to Public Health Surveillance and Epidemiology. In the event of an emergency impacting the health of a jurisdiction, Public Health Surveillance and Epidemiology is a key aspect of Incident Management and Coordination. The column titled "interoperability of functions" provides an example of how the HCC function supports the LHD function and vice versa. Local public health professionals are encouraged to expand upon this information to capture the specific ways in which the function of the HCC and LHD collaborate within their jurisdiction.

Figure 143: Resources and Medical Material Management Results

Resources	Medical Material Management	Interoperability of Functions
HCC Functions	**LHD Functions**	
Expand patient care space to accommodate a surge	Monitor medical material inventories and medical material distribution operations	Monitoring of medical material inventories and medical material distribution operations by the LHD's can inform the work of HCC's to accommodate a surge.
Collaborate with supply chain partners to	Assessment of distribution response capacity to identify gaps and	The LHD's assessment of distribution response capacity to identify gaps and inform distribution site selection should be used by the HCC's to determine local and regional resources.

determine local and regional resources.	inform distribution site selection	
Determine and acquire resources to have on hand and develop necessary push or cache agreements with suppliers, health care organizations, or jurisdictions.	Acquire medical material from national stockpiles or other supply sources	LHD's and HCC's should work collaboratively to acquire resources and create processes for cache and stockpile requests.
Develop plans for resource shortages	Assessment of jurisdictional medical material needs	The LHD's assessment of jurisdictional medical material needs should inform the plans for resource shortages developed by HCC's.
	Recover medical material and demobilize distribution operations	The plans developed by the HCC's should include information from the LHD's about recovering medical material and demobilize distribution operations.
	Assess ongoing security measures throughout the distribution process and adjust as necessary	The LHD's assessment of ongoing security measures throughout the distribution process should be incorporated into the HCC's plans.

Figure 144:Resources and Medical Countermeasure Dispensing crosswalk

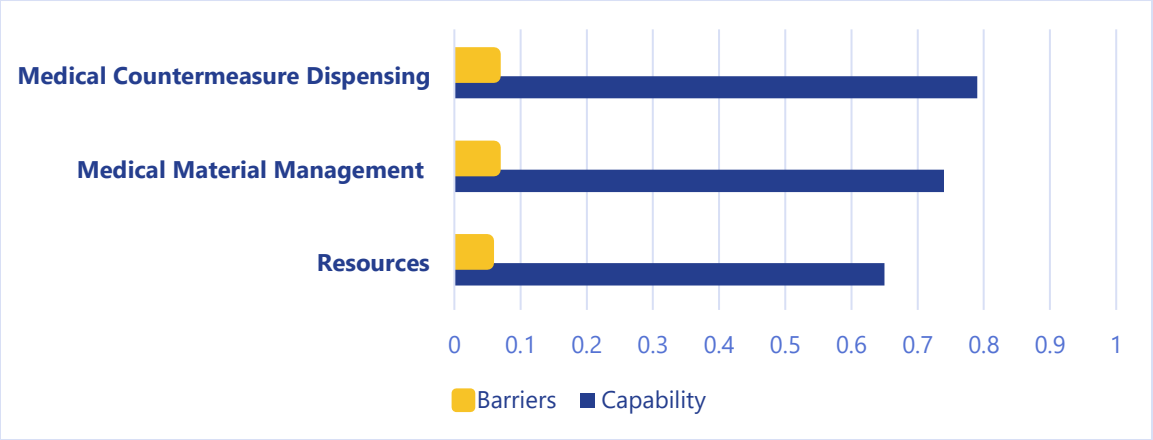
Resources	Medical Countermeasure Dispensing	Interoperability of Functions
HCC Functions	**LHD Functions**	
Expand patient care space to accommodate a surge	Activation of MCM dispensing and administration operations	The LHD's activation of MCM dispensing and administration operations can inform the HCCs of the need to expand patient care space to accommodate a surge.

Determine and acquire resources to have on hand and develop necessary push or cache agreements with suppliers, health care organizations, or jurisdictions.	Determination of MCM dispensing/ administration strategies	Collaboration between the HCCs and LHDs to determine a MCM dispensing/ administration strategies will enable the development of push or cache agreements with suppliers, health care organizations, or jurisdictions.
Collaborate with supply chain partners to determine local and regional resources.	Identification of MCM inventories and need for additional supplies	The HCC's can use the work done by the LHDs to identify MCM inventories and need for additional supplies to inform the collaboration with supply chain partners.
Develop plans for resource shortages	Development and activation of plan to dispense/administer medical countermeasures to targeted and prioritized populations	The HCC's plan for resource shortages should integrate information from the MCM plan developed by the jurisdiction's LHDs.
Use scaled staffing plans to recall and deploy adequate numbers of staff to safely support the acute health care needs of the disaster	Coordination and collaboration with support personnel for medical countermeasure dispensing and administration	The staffing plans used by the HCCs can inform the coordination and collaboration with support personnel conducted by the LHDs.

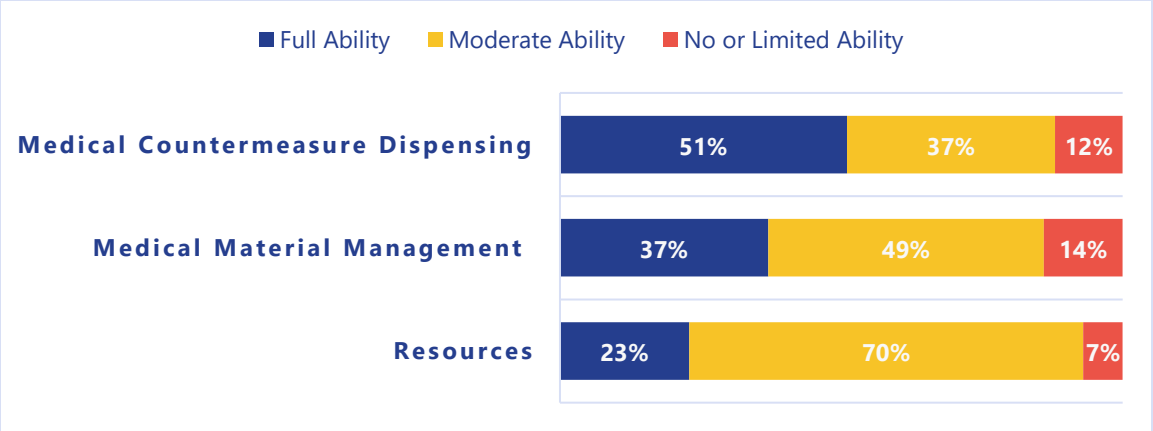
HCC and LHD Capability and Barrier Scores

To compare the HCC and LHD capabilities ratings of the respondents a total possible score for each capability was calculated. Then the total of the scores given by the respondents was calculated. Finally, the total score was divided by the total possible score to find the capability rate.

Figure 145: Resources, Medical Countermeasure Dispensing, and Medical Material Management Capability and Barriers Comparison

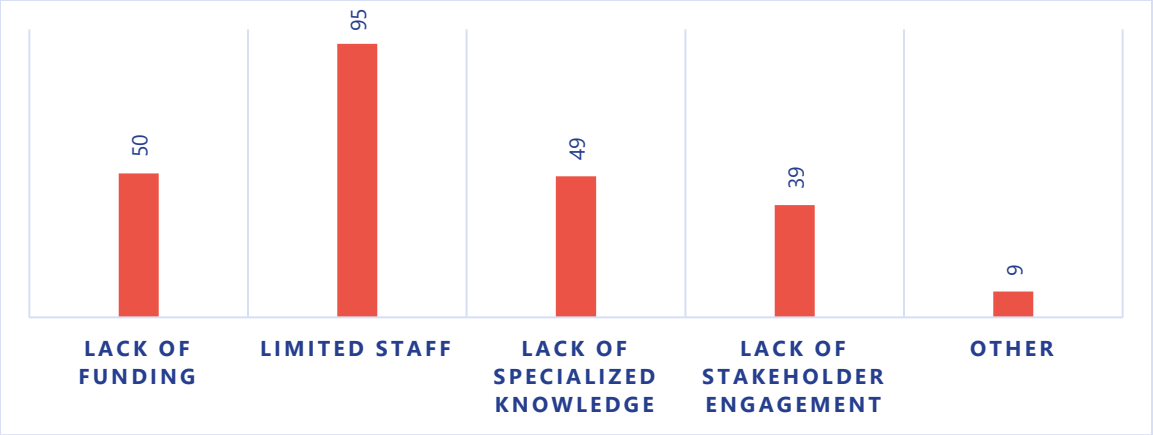


The following figure shows the % of respondents that selected each ability level for their respective capabilities.



Identified barriers comparison

HCCs and LHDs were both asked to identify barriers they encounter to achieving "full" or "moderate" ability ratings for their respective capabilities. The chart below shows the number of times an HCC or LHD selected that they experienced each barrier to their respective capability. Limited staff capacity was the most frequently identified with 165 respondents selecting this as a barrier.


50
95
49
39
9
LACK OF FUNDING
LIMITED STAFF
LACK OF SPECIALIZED KNOWLEDGE
LACK OF STAKEHOLDER ENGAGEMENT
OTHER

HCC Capability: Operational Continuity

Respondents were asked to rank their ability/capacity to perform each of the functions associated with this capability by selecting one of the following ability levels: "No Ability" (0), "Limited Ability" (1), "Moderate Ability" (2), and "Full Ability" (3). A total of 3 functions and 7 activities associated with this capability were assessed through the PHHRA. The following figure displays the average capability score of all district responses.

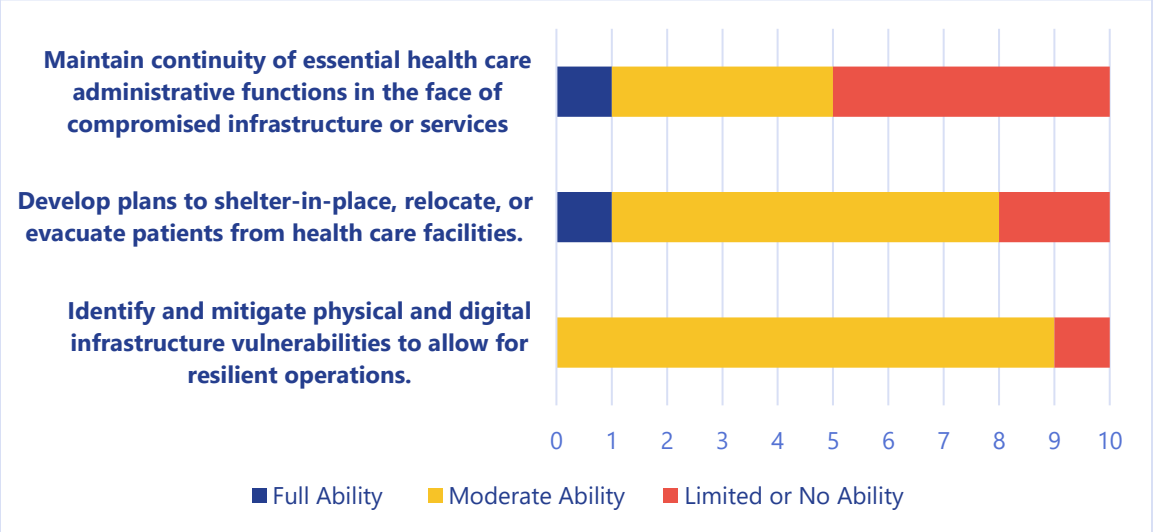
Definition: This capability focuses on what the health care delivery system must do to maintain continuity of daily clinical and administrative operations before, during, and after a disaster.

Figure 146: Operational Continuity Results

Functions	Average Rating	Average Score
Develop plans to shelter-in-place, relocate, or evacuate patients from health care facilities.	**Moderate Ability**	**1.9**
Maintain continuity of essential health care administrative functions in the face of compromised infrastructure or services	**Moderate Ability**	**1.9**
Identify and mitigate physical and digital infrastructure vulnerabilities to allow for resilient operations.	**Limited Ability**	**1.4**

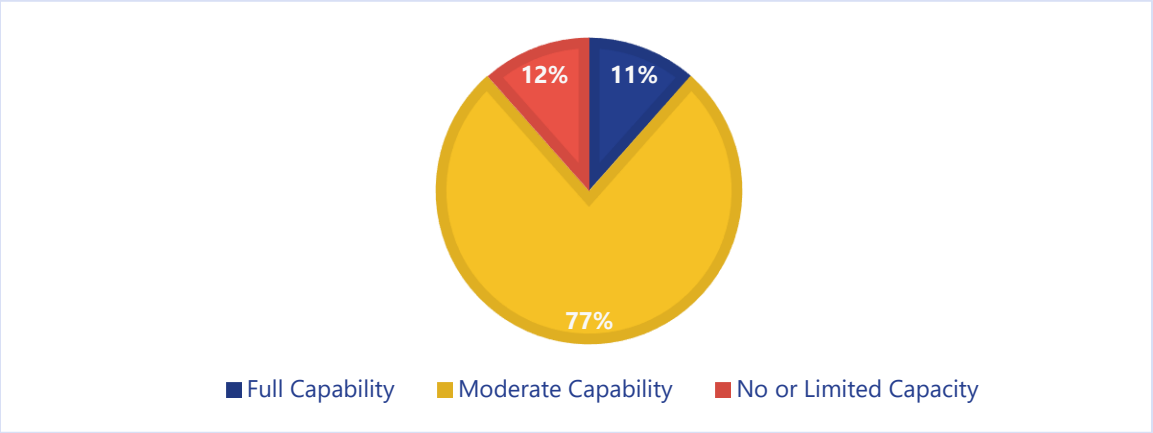
To provide a more detailed look at the unique capability of each HCC the following figure shows the number of HCC's that selected which ability level for each function.

Figure 147: Operational Continuity Results by number of HCCs



In addition to assessing the capability of the district to perform each of the functions, this report also assesses the district's ability to perform the HCC Capability as a whole. When assessing the 11% of the responses indicated "Full Capability", and 77% indicated "Moderate Capability" and 12% indicated "Limited or No Capability".

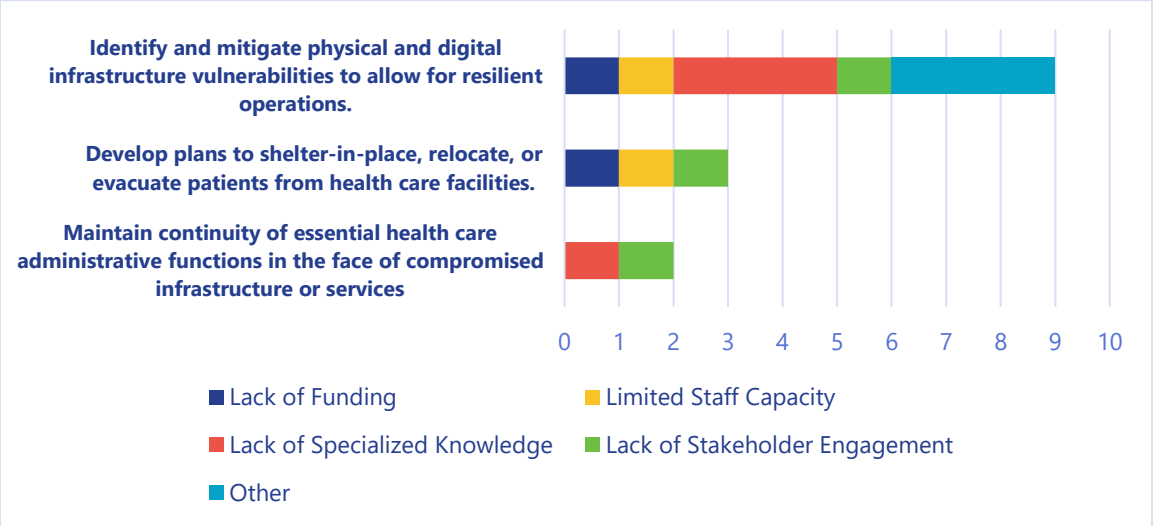
Figure 148: Operational Continuity Capability Results



Identified Barriers to Operational Continuity

The figure below shows the identified barriers by associated function. Functions that had no barriers identified are not displayed.

Figure 149: Operational Continuity Barriers



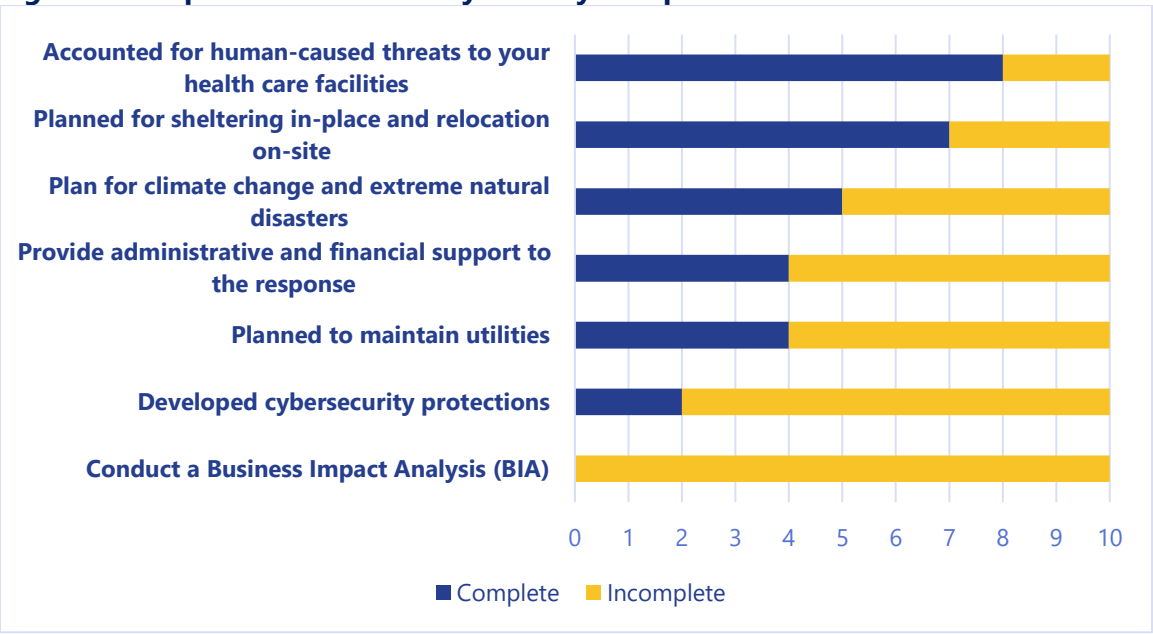
Other Response Narratives:

- Not started
- Expand COOP to be more specific
- Facility responsibility

Activity Completion

The National Health Care Preparedness and Response Capabilities document identifies specific activities that should be completed for a capability to be met. The following figure shows the completion status of each of the associated activities by number of HCC respondents.

Figure 150: Operational Continuity Activity Completion Results



LHD Capability: Mass Care

Respondents were asked to rank their ability/capacity to perform each of the functions associated with this capability by selecting one of the following ability levels: "No Ability" (0), "Limited Ability" (1), "Moderate Ability" (2), and "Full Ability" (3). A total of 6 functions associated with this capability were assessed through the PHHRA. The following figure displays the average capability score of all district responses.

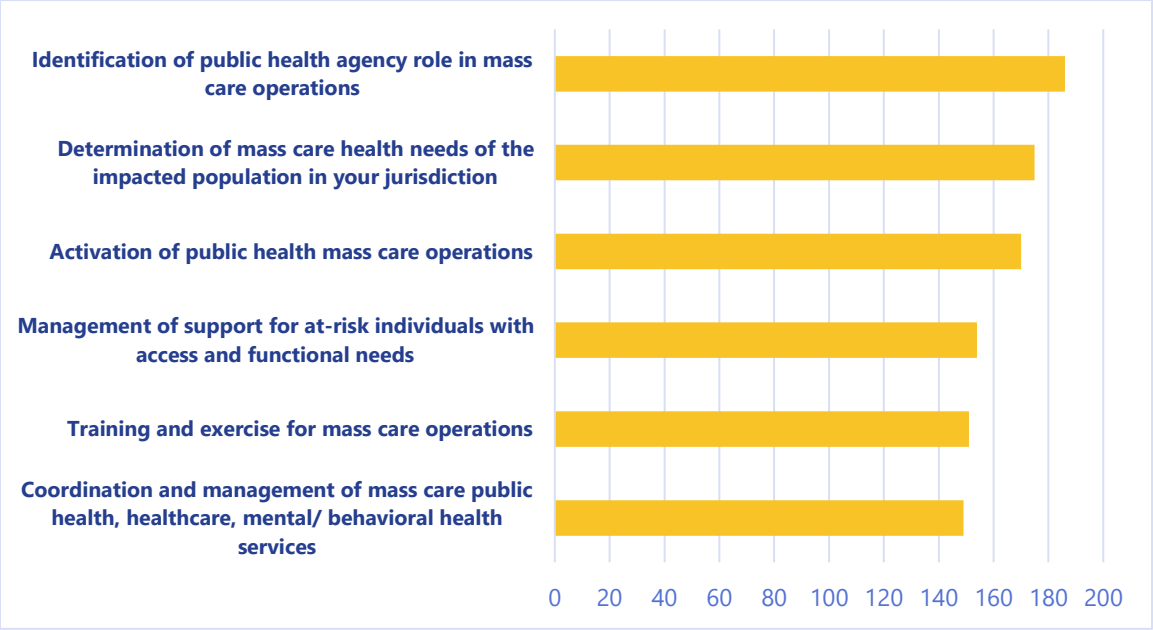
Definition: The ability of public health agencies to coordinate with and support partner agencies to address within a congregate location (excluding shelter-in-place locations) the public health, health care, mental/behavioral health, and human services needs of those impacted by an incident.

Figure 151: Mass Care Results

Functions	Average Rating	Average Score
Identification of public health agency role in mass care operations	**Moderate Ability**	**2.3**
Determination of mass care health needs of the impacted population in your jurisdiction	**Moderate Ability**	**2.1**
Activation of public health mass care operations	**Moderate Ability**	**2.1**
Management of support for at-risk individuals with access and functional needs	**Moderate Ability**	**1.9**
Training and exercise for mass care operations	**Moderate Ability**	**1.8**
Coordination and management of mass care public health, healthcare, mental/ behavioral health services	**Moderate Ability**	**1.8**

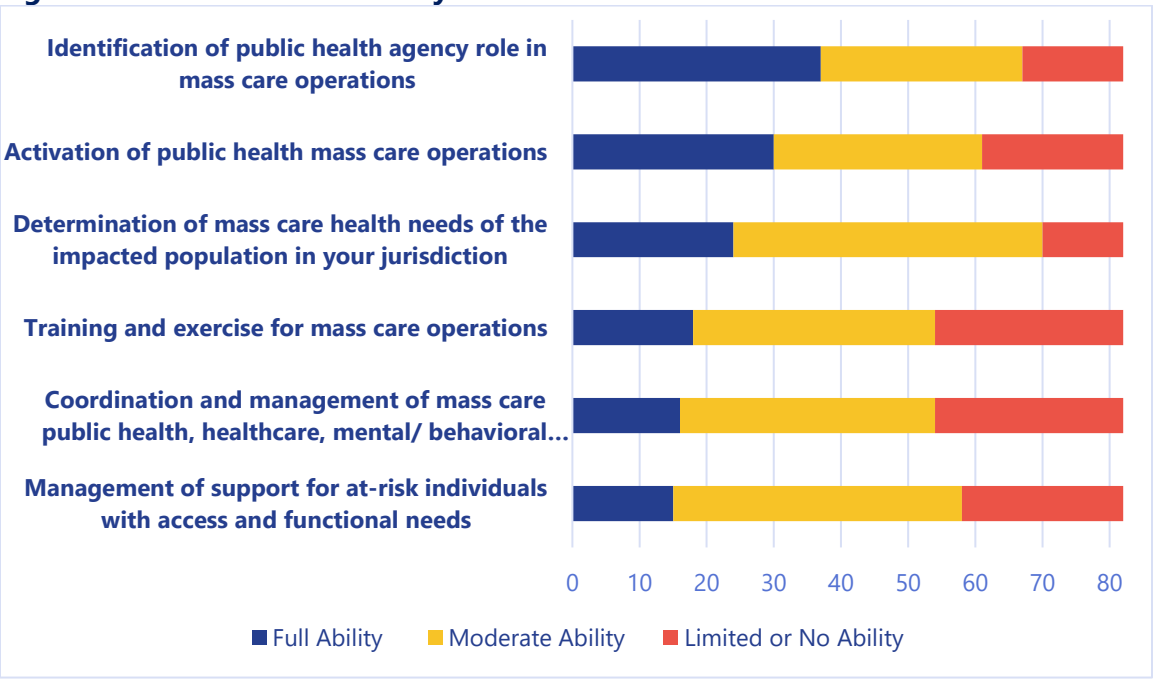
To provide a more detailed look at the unique score submitted by each respondent in the district the following figure shows the total score for each function. A total of 246 points were possible for each function. (3 points possible * 82 respondents). This chart provides a visual of the overall capability of the state to perform each function.

Figure 152: Mass Care Functions Ranking



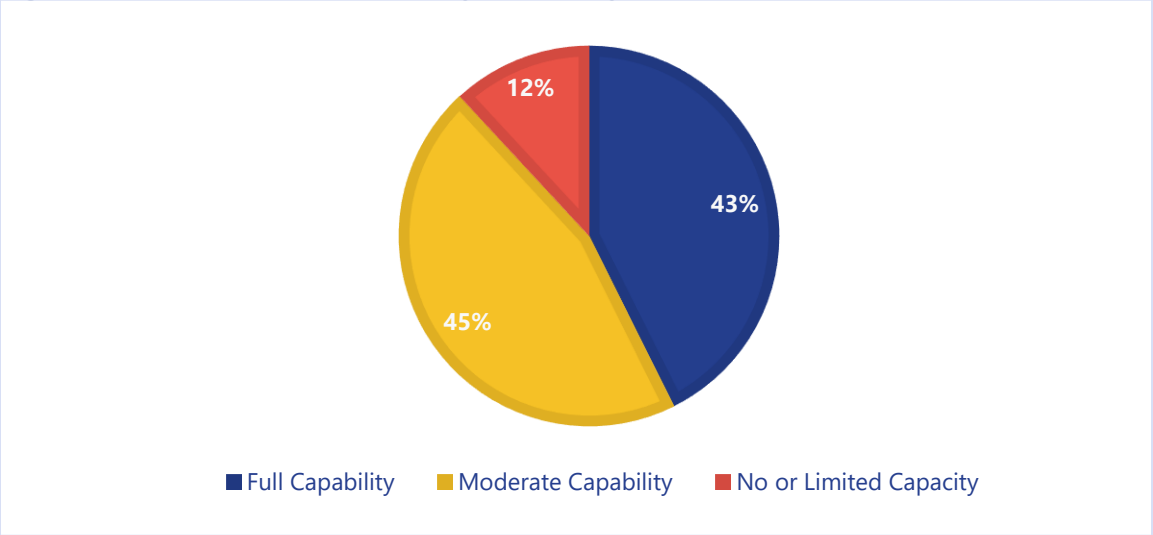
The following figures represent the responses submitted by each Local Health Department regarding their level of capability to perform each function.

Figure 153: Mass Care Results by number of LHDs



In addition to assessing the capability of the district to perform each of the functions, this report also assesses the district's ability to perform the LHD Capability as a whole. When assessing the Mass Care Capability 43% of the responses indicated "Full Capability", and 45% indicated "Moderate Capability" and 12% indicated "Limited or No Capability".

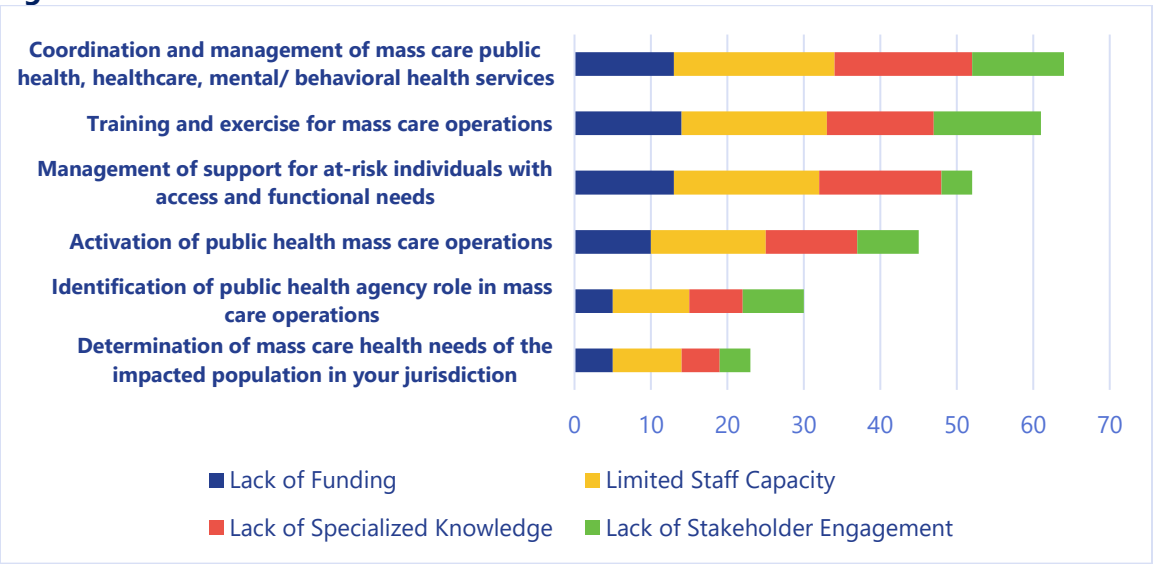
Figure 154: Operational Continuity Capability Results



Identified Barriers to Mass Care

Additionally, respondents were asked to indicate what barriers they experience when they selected that they had "No or Limited Capability" to perform a function. The figure below shows the identified barriers by associated function. Functions that had no barriers identified are not displayed.

Figure 155: Mass Care Barriers



Operational Continuity and Mass Care crosswalk

The table below provides insight into how the HCC functions related to Incident Management and Coordination correspond to the LHD functions related to Public Health Surveillance and Epidemiology. In the event of an emergency impacting the health of a jurisdiction, Public Health Surveillance and Epidemiology is a key aspect of Incident Management and Coordination. The column titled "interoperability of functions" provides an example of how the HCC function supports the LHD function and vice versa.

Figure 156: Operational Continuity and Mass Care crosswalk

Operational Continuity	Mass Care	Interoperability of Functions
HCC Functions	**LHD Functions**	
Identify and mitigate physical and digital infrastructure vulnerabilities to allow for resilient operations.	Training and exercise for mass care operations	Training and exercise conducted by the LHD can be used by HCC's to identify and mitigate physical and digital infrastructure vulnerabilities.

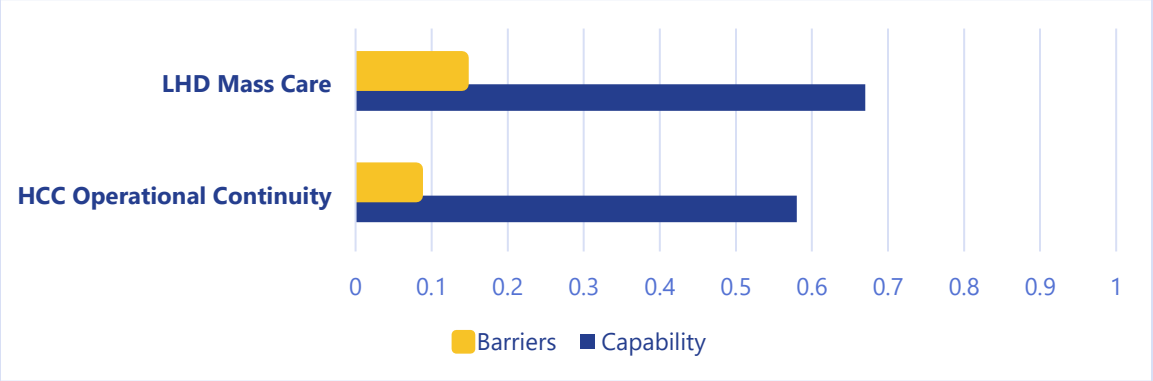
Develop plans to shelter-in-place, relocate, or evacuate patients from health care facilities.	Determination of mass care health needs of the impacted population in your jurisdiction	HCC plans should incorporate the mass care health needs of the LHD's in their district. LHD's can use the HCC's plans to formulate a tiered approach to meeting the needs of their jurisdiction that includes the county as well as district resources.
	Identification of public health agency role in mass care operations	The HCC should use the role defined by the LHD in their plans. The LHD can reference the HCC plan to better define the distinction between each role.
	Activation of public health mass care operations	The plan developed by the HCC should include information from the LHDs about how they will activate public health mass care operations. The LHDs can use the HCC plans to inform their activation procedures.
	Management of support for at-risk individuals with access and functional needs	HCC plans should include information regarding the LHD's management of support for at-risk individuals with access and functional needs, such as how it will be ensured that shelter locations are accessible etc.
	Coordination and management of mass care public health, healthcare, mental/ behavioral health services	HCCs and LHDs can work in collaboration to determine how the coordination of mass care services will work in their district.
Maintain continuity of essential health care administrative functions in the face of compromised infrastructure or services	All functions	HCCs maintenance of continuity of health administrative functions is a key component to ensuring all LHD functions are sustainable in the face of compromised infrastructure.

Local public health professionals are encouraged to expand upon this information to capture the specific ways in which the function of the HCC and LHD collaborate within their jurisdiction.

HCC and LHD Capability and Barrier Scores

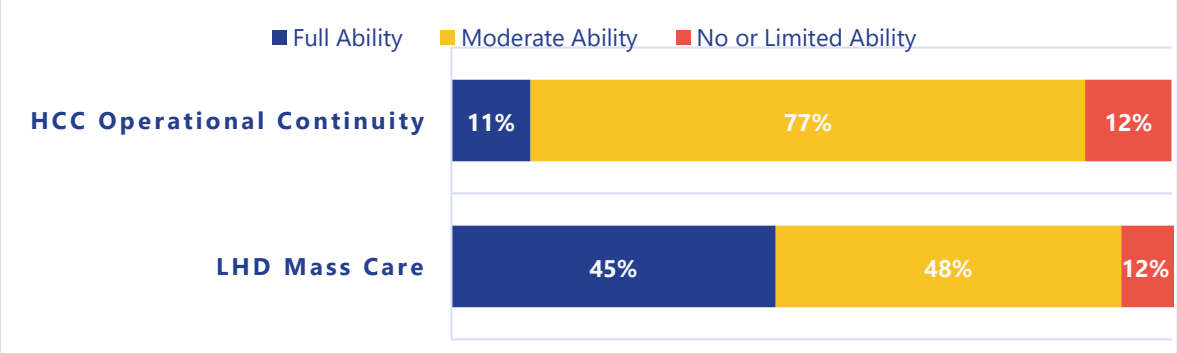
To compare the HCC and LHD capabilities ratings of the respondents a total possible score for each capability was calculated. Then the total of the scores given by the respondents was calculated. Finally, the total score was divided by the total possible score to find the capability rate.

Figure 157: Operational Continuity and Mass Care Capability and Barrier Comparison



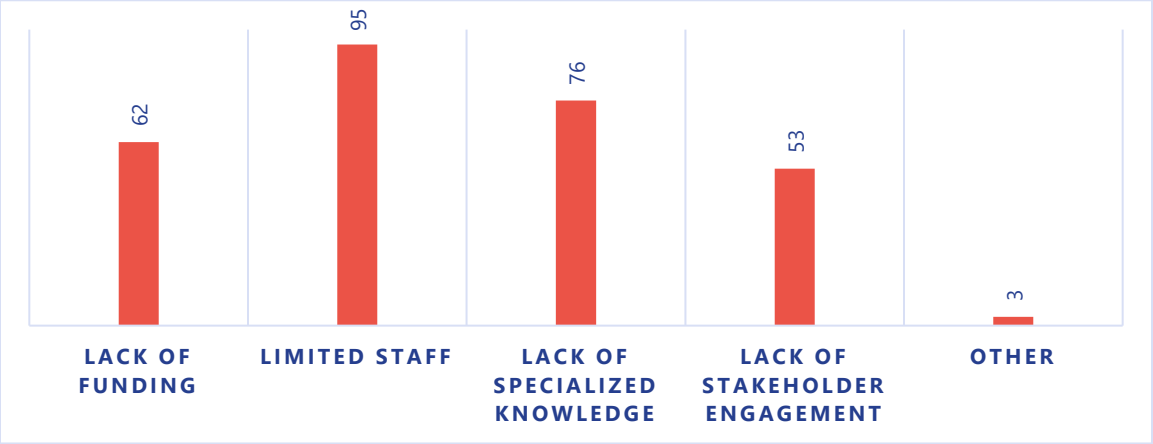
The following figure shows the % of respondents that selected each ability level for their respective capabilities.

Figure 158: Operational Continuity and Mass Care Capability Comparison



Identified barriers comparison

HCCs and LHDs were both asked to identify barriers they encounter to achieving "full" or "moderate" ability ratings for their respective capabilities. The chart below shows the number of times an HCC or LHD selected that they experienced each barrier to their respective capability. Limited staff capacity was the most frequently identified with 95 respondents selecting this as a barrier.



HCC Capability: Specialty Care

Respondents were asked to rank their ability/capacity to perform each of the functions associated with this capability by selecting one of the following ability levels: "No Ability" (0), "Limited Ability" (1), "Moderate Ability" (2), and "Full Ability" (3). A total of 4 functions and 10 activities associated with this capability were assessed through the PHHRA. The following figure displays the average capability score of all district responses.

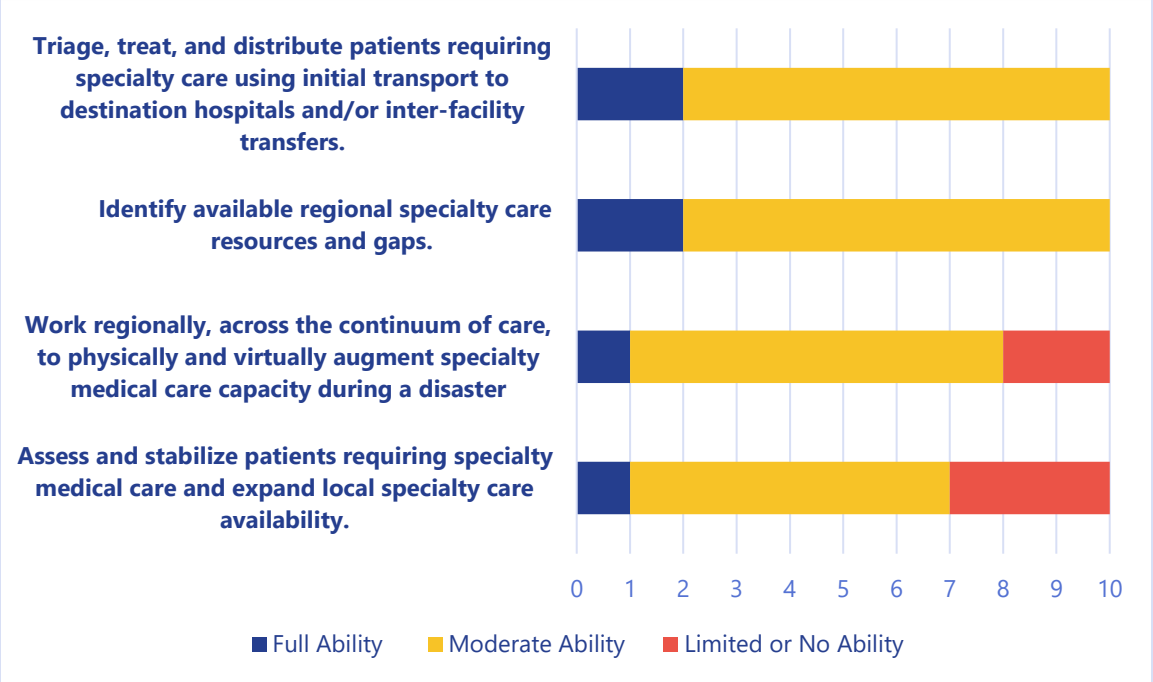
Definition: This capability focuses on specialized care required for mass trauma, burn, radiological, chemical, special pathogens, and pediatric surge events

Figure 159: Specialty Care Results

Functions	Average Rating	Average Score
Triage, treat, and distribute patients requiring specialty care using initial transport to destination hospitals and/or inter-facility transfers.	**Moderate Ability**	**2.2**
Identify available regional specialty care resources and gaps.	**Moderate Ability**	**2.2**
Work regionally, across the continuum of care, to physically and virtually augment specialty medical care capacity during a disaster	**Moderate Ability**	**1.8**
Assess and stabilize patients requiring specialty medical care and expand local specialty care availability.	**Moderate Ability**	**1.7**

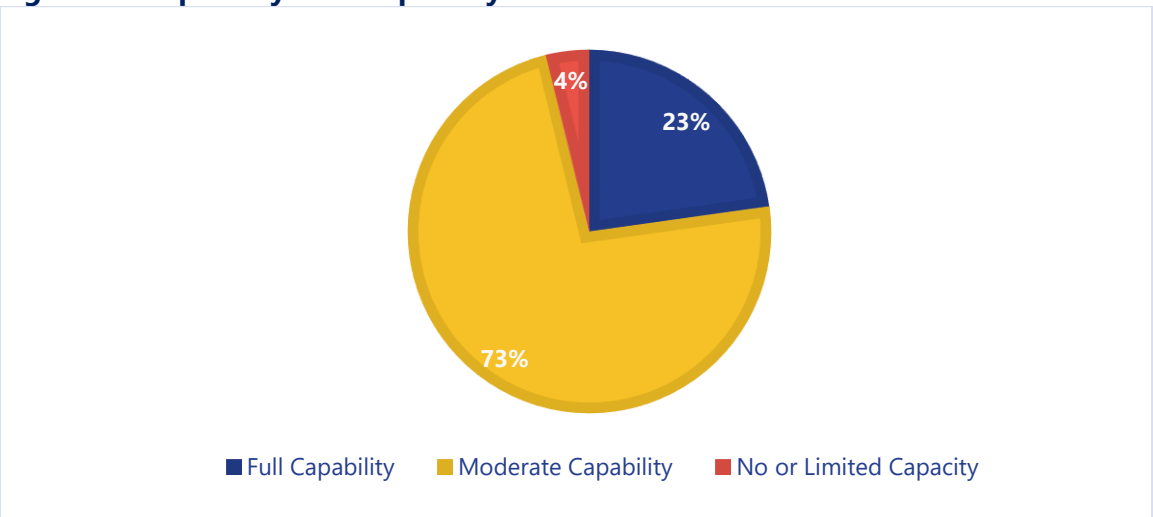
To provide a more detailed look at the unique capability of each HCC the following figure shows the number of HCC's that selected which ability level for each function.

Figure 160: Specialty Care Results by number of HCCs



In addition to assessing the capability of the district to perform each of the functions, this report also assesses the district's ability to perform the HCC Capability as a whole. When assessing the Specialty Care Capability 23% of the responses indicated "Full Capability", and 73% indicated "Moderate Capability" and 4% indicated "Limited or No Capability".

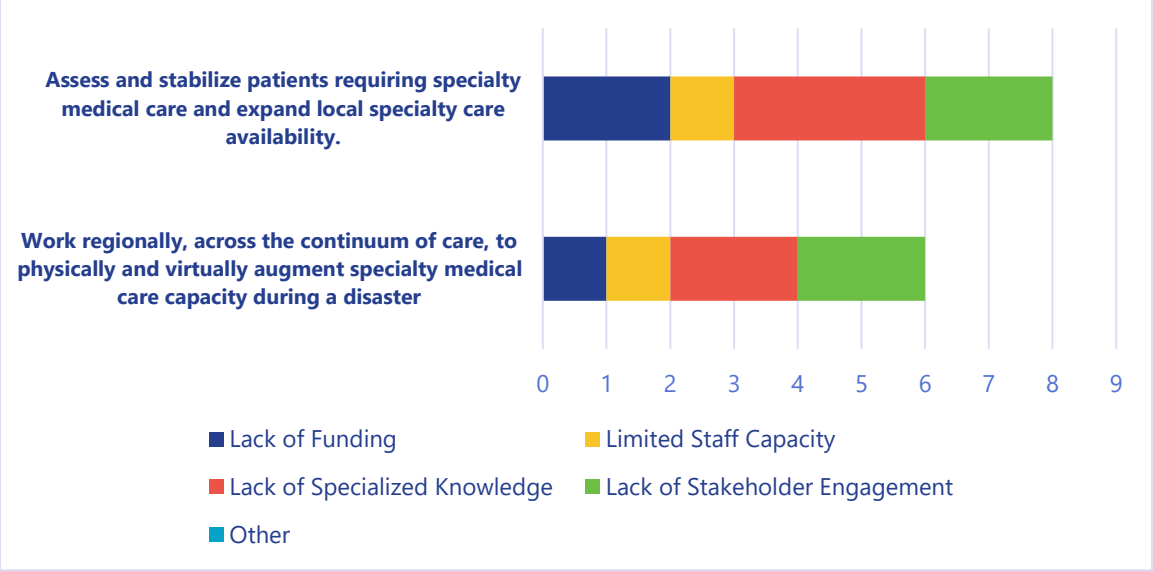
Figure 161: Specialty Care Capability Results



Identified Barriers to Specialty Care

The figure below shows the identified barriers by associated function. Functions that had no barriers identified are not displayed.

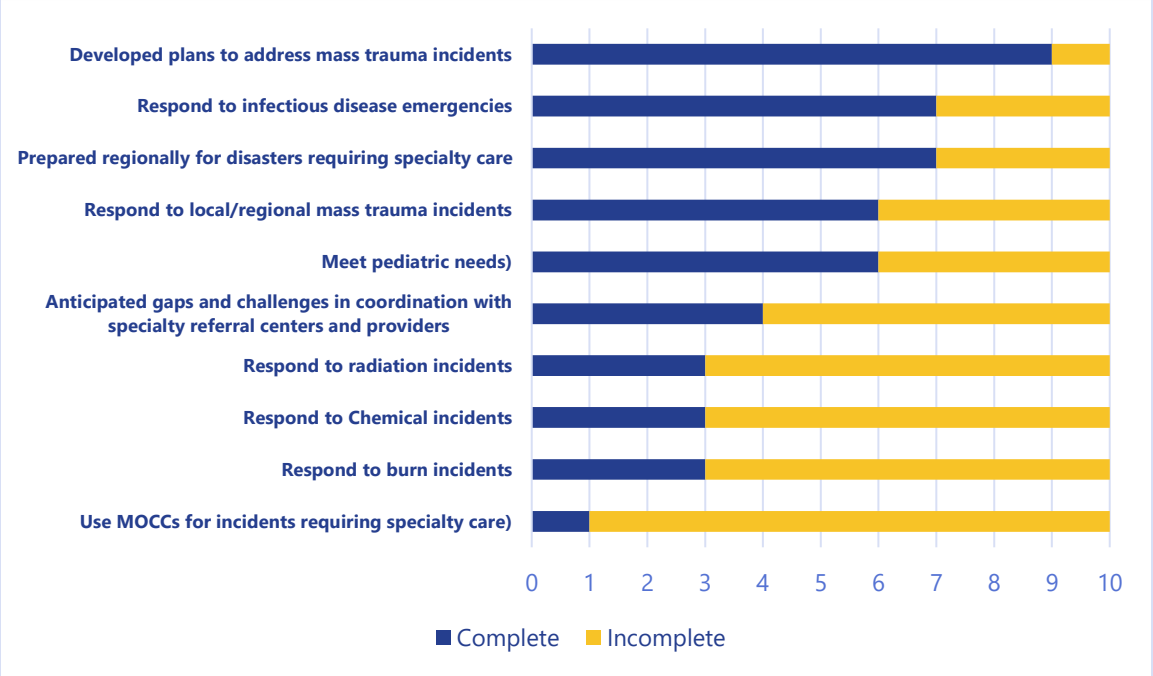
Figure 162: Specialty Care Barriers



Activity Completion

The National Health Care Preparedness and Response Capabilities document identifies specific activities that should be completed for a capability to be met. The following figure shows the completion status of each of the associated activities by number of HCC respondents.

Figure 163: Specialty Care Activity Completion



LHD Capability: Nonpharmaceutical Interventions

Definition: Actions that people and communities can take to help slow the spread of illness or reduce the adverse impact of public health emergencies.

Respondents were asked to rank their ability/capacity to perform each of the functions associated with this capability by selecting one of the following ability levels: "No Ability" (0), "Limited Ability" (1), "Moderate Ability" (2), and "Full Ability" (3). A total of 4 functions associated with this capability were assessed through the PHHRA. The figure below displays the average capability score of all district responses.

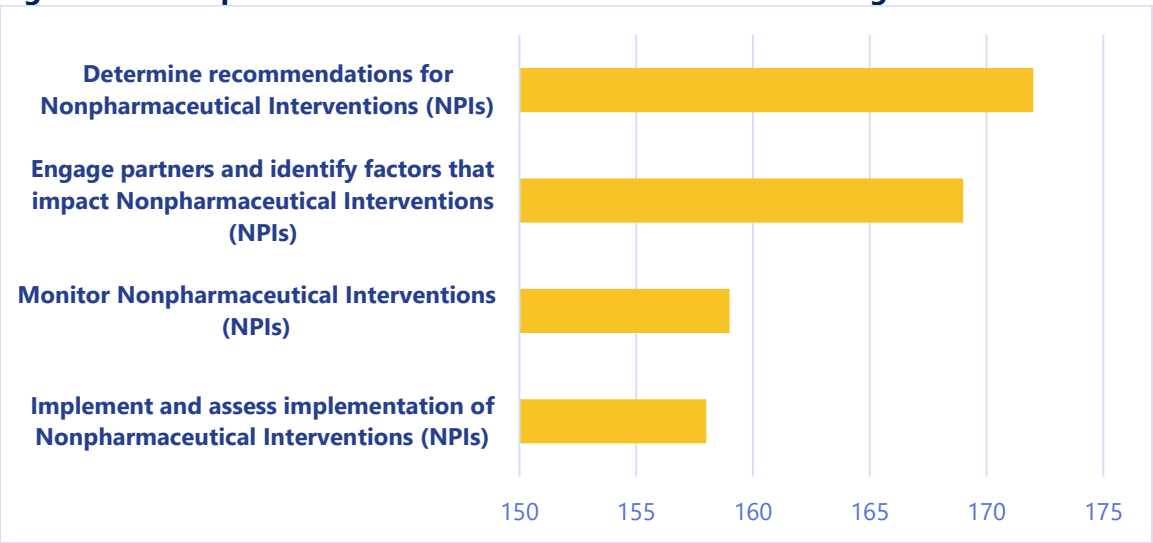
Figure 164: Nonpharmaceutical Interventions Results

Functions	Average Rating	Average Score
Determine recommendations for Nonpharmaceutical Interventions (NPIs)	**Full Ability**	**2.1**
Engage partners and identify factors that impact Nonpharmaceutical Interventions (NPIs)	**Full Ability**	**2.1**
Monitor Nonpharmaceutical Interventions (NPIs)	**Moderate Ability**	**1.9**
Assess implementation of Nonpharmaceutical Interventions (NPIs)	**Moderate Ability**	**1.9**

To provide a more detailed look at the unique score submitted by each respondent in the district the following figure shows the total score for each function. A total of 246 points were

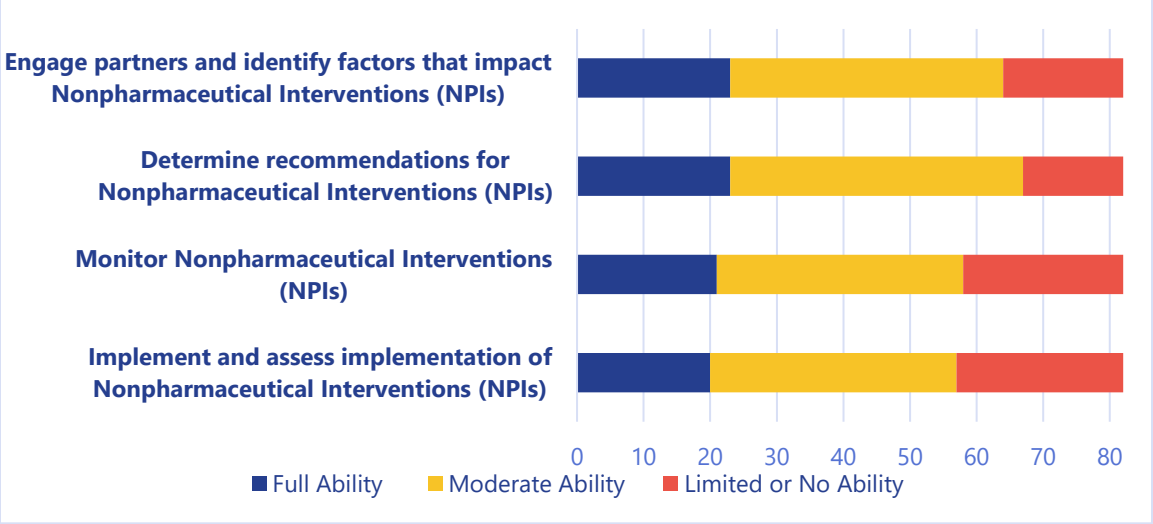
possible for each function. (3 points possible * 82 respondents). This chart provides a visual of the overall capability of the state to perform each function.

Figure 165: Nonpharmaceutical Interventions Functions Ranking



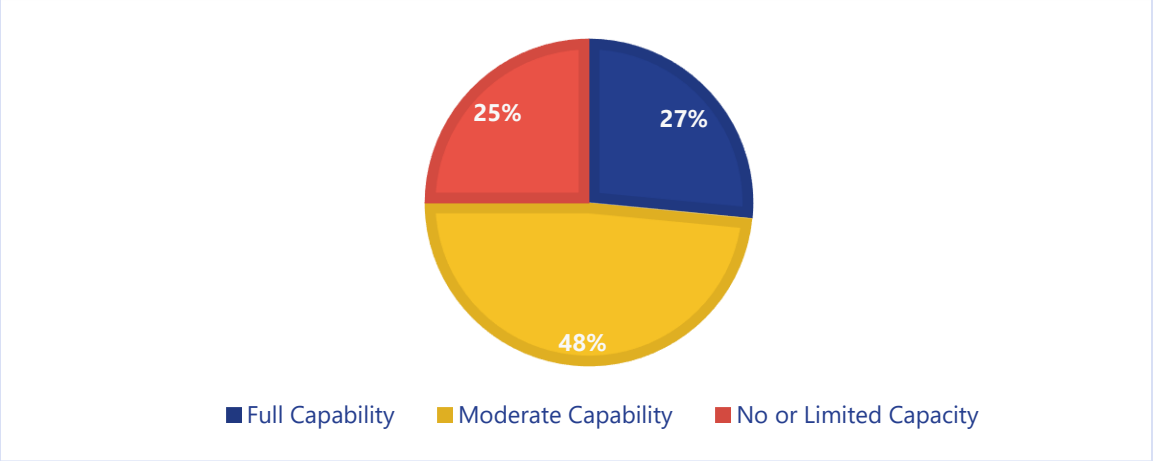
The figures below represent the responses submitted by each Local Health Department regarding their level of capability to perform each function.

Figure 166: Nonpharmaceutical Interventions Results by number of LHDs



In addition to assessing the capability of the district to perform each of the functions, this report also assesses the district's ability to perform the LHD Capability as a whole. When assessing the Nonpharmaceutical Interventions capability 27% of the responses indicated "Full Capability", 48% indicated "Moderate Capability", and 25% indicated "No or Limited Capability".

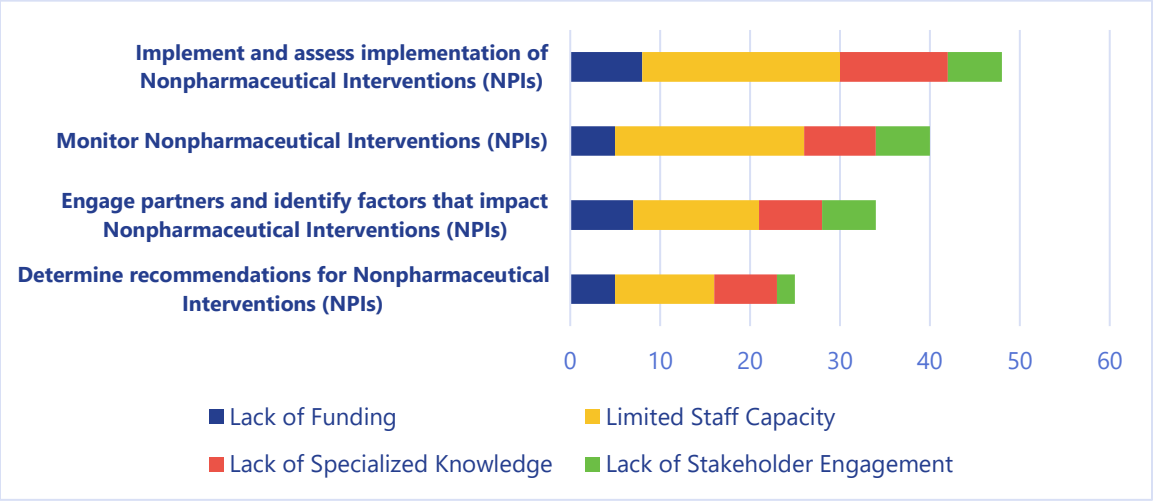
Figure 167: Nonpharmaceutical Interventions Capability Results



Identified Barriers to Nonpharmaceutical Interventions

Additionally, respondents were asked to indicate what barriers they experience when they selected that they had "No or Limited Capability" to perform a function. The figure below shows the identified barriers by associated function. Functions that had no barriers identified are not displayed.

Figure 168: Nonpharmaceutical Interventions Barriers



Specialty Care and Nonpharmaceutical Interventions capability crosswalk

The following table provides insight into how the HCC functions related to Incident Management and Coordination correspond to the LHD functions related to Public Health Surveillance and Epidemiology. In the event of an emergency impacting the health of a jurisdiction, Public Health Surveillance and Epidemiology is a key aspect of Incident Management and Coordination. The column titled "interoperability of functions" provides an example of how the HCC function supports the LHD function and vice versa. Local public health professionals are encouraged to expand upon this information to capture the specific ways in which the function of the HCC and LHD collaborate within their jurisdiction.

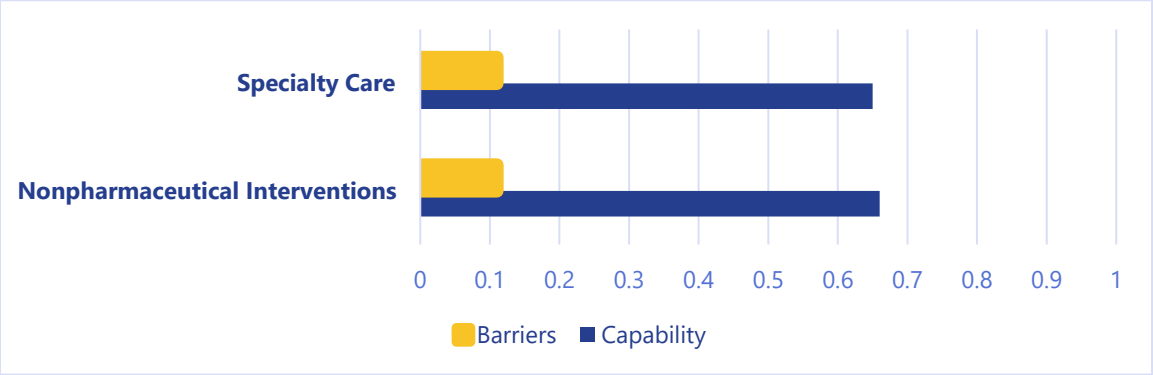
Figure 169: Specialty Care and Nonpharmaceutical Interventions capability crosswalk

Specialty Care	Nonpharmaceutical Interventions	Interoperability of Functions
HCC Functions	**LHD Functions**	
Triage, treat, and distribute patients requiring specialty care using initial transport to destination hospitals and/or inter-facility transfers.	Determine recommendations for Nonpharmaceutical Interventions (NPIs)	The LHD's and HCC's can work in collaboration to determine recommendations on how to triage, treat, and distribute patients requiring specialty care that would be considered an NPI.
Identify available regional specialty care resources and gaps.	Engage partners and identify factors that impact Nonpharmaceutical Interventions (NPIs)	Information gathered through the LHD's engagement with partners can be used by the HCC's to Identify available regional specialty care resources and gaps. When HCC's work to do this identification LHDs and the partners they engage can provide their insight.
Work regionally, across the continuum of care, to physically and virtually augment specialty medical care capacity during a disaster	Monitor Nonpharmaceutical Interventions (NPIs)	The HCCs work to physically and virtually augment specialty medical care capacity can be an aspect that LHD's assist in monitoring.
Assess and stabilize patients requiring specialty medical care and expand local specialty care availability.	Implement and assess implementation of Nonpharmaceutical Interventions (NPIs)	HCCs and LHDs can work in collaboration to assess, implement, and expand local specialty care and NPI availability in their districts.

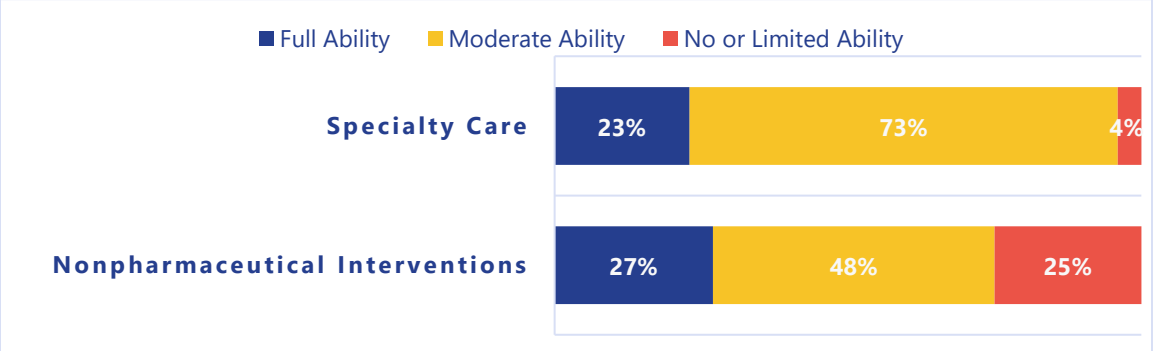
HCC and LHD Capability and Barrier Scores

To compare the HCC and LHD capabilities ratings of the respondents a total possible score for each capability was calculated. Then the total of the scores given by the respondents was calculated. Finally, the total score was divided by the total possible score to find the capability rate.

Figure 170: Specialty Care and Nonpharmaceutical Interventions Capability and Barriers Comparison

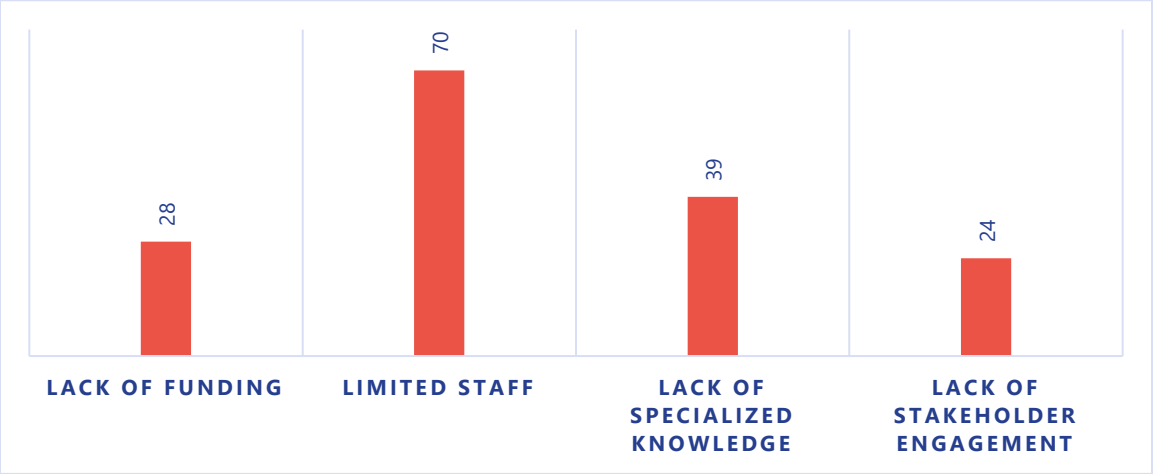


The following figure shows the % of respondents that selected each ability level for their respective capabilities.



Identified barriers comparison

HCCs and LHDs were both asked to identify barriers they encounter to achieving "full" or "moderate" ability ratings for their respective capabilities. The chart below shows the number of times an HCC or LHD selected that they experienced each barrier to their respective capability. Limited staff capacity was the most frequently identified with 70 respondents selecting this as a barrier.



HCC Capability: Community Integration

Respondents were asked to rank their ability/capacity to perform each of the functions associated with this capability by selecting one of the following ability levels: "No Ability" (0), "Limited Ability" (1), "Moderate Ability" (2), and "Full Ability" (3). A total of 5 functions and 9 activities associated with this capability were assessed through the PHHRA. The following figure displays the average capability score of all district responses.

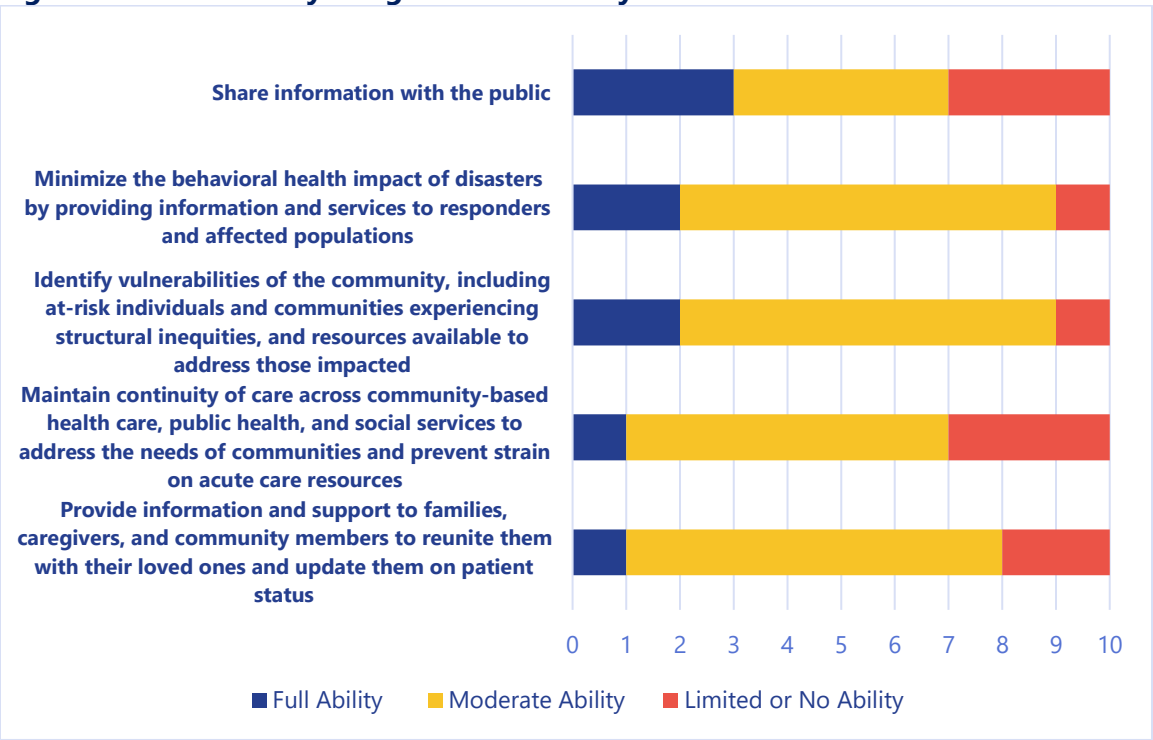
Definition: A health care delivery system that takes a whole community approach, coordinating across the continuum of care, to meet the health needs of its residents in an equitable way before, during, and after disasters.

Figure 171: Community Integration Results

Functions	Average Rating	Average Score
Identify vulnerabilities of the community, including at-risk individuals and communities experiencing structural inequities, and resources available to address those impacted	**Moderate Ability**	**2.1**
Minimize the behavioral health impact of disasters by providing information and services to responders and affected populations	**Moderate Ability**	**2.1**
Share information with the public	**Moderate Ability**	**1.9**
Provide information and support to families, caregivers, and community members to reunite them with their loved ones and update them on patient status	**Moderate Ability**	**1.9**
Maintain continuity of care across community-based health care, public health, and social services to address the needs of communities and prevent strain on acute care resources	**Moderate Ability**	**1.8**

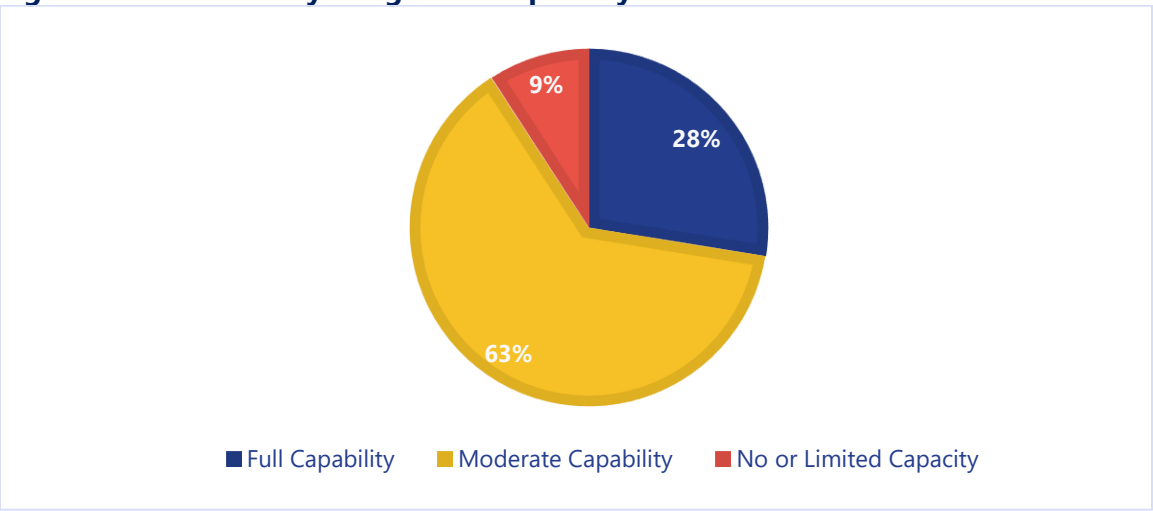
To provide a more detailed look at the unique capability of each HCC the following figure shows the number of HCC's that selected which ability level for each function.

Figure 172: Community Integration Results by number of HCCs



In addition to assessing the capability of the district to perform each of the functions, this report also assesses the district's ability to perform the HCC Capability as a whole. When assessing the Community Integration capability 28% of the responses indicated "Full Capability", and 63% indicated "Moderate Capability" and 9% indicated "Limited or No Capability".

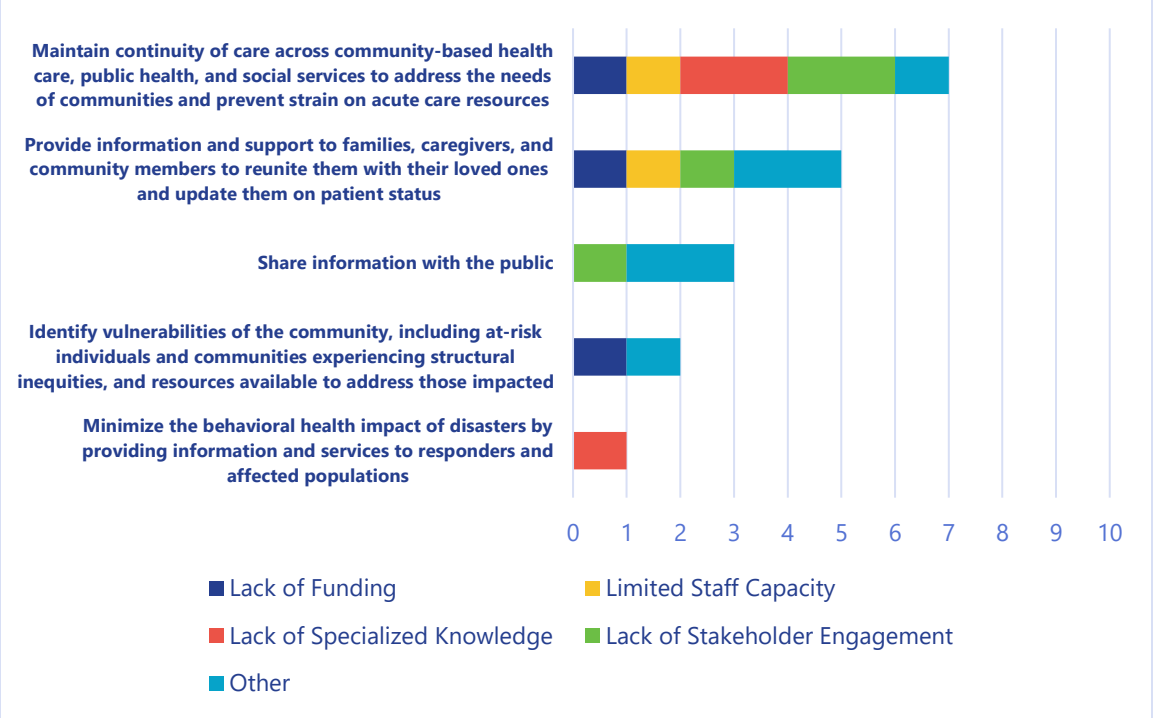
Figure 173: Community Integration Capability Results



Identified Barriers to Community Integration

The figure below shows the identified barriers by associated function. Functions that had no barriers identified are not displayed.

Figure 174: Community Integration Barriers



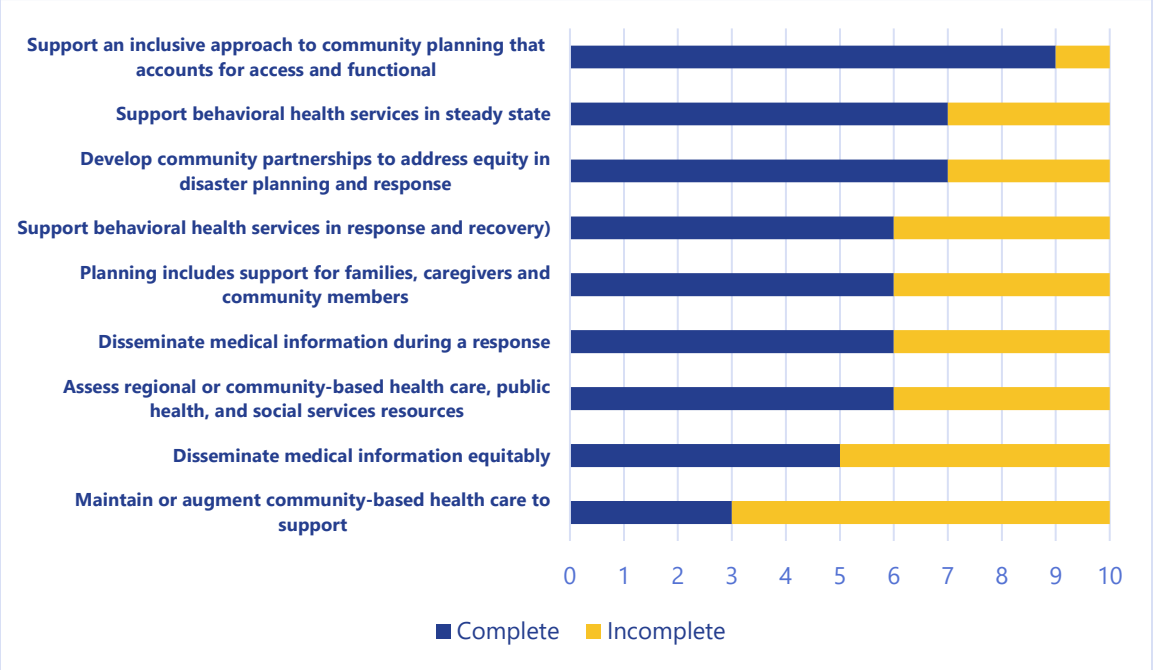
Other Response Narratives:

- In progress
- In progress
- N/A - Public Info Sharing done at the local level
- Lack of state support
- Creating a reunification center plan is something that has been discussed, however, has not been worked on. Plan is to work with LHD's to work on this.
- Facility responsibility

Activity Completion

The National Health Care Preparedness and Response Capabilities document identifies specific activities that should be completed for a capability to be met. The following figure shows the completion status of each of the associated activities by number of HCC respondents.

Figure 175: Community Integration Activity Completion



LHD Capability: Community Recovery

Respondents were asked to rank their ability/capacity to perform each of the functions associated with this capability by selecting one of the following ability levels: "No Ability" (0), "Limited Ability" (1), "Moderate Ability" (2), and "Full Ability" (3). A total of 6 functions associated with this capability were assessed through the PHHRA. The following figure displays the average capability score of all district responses.

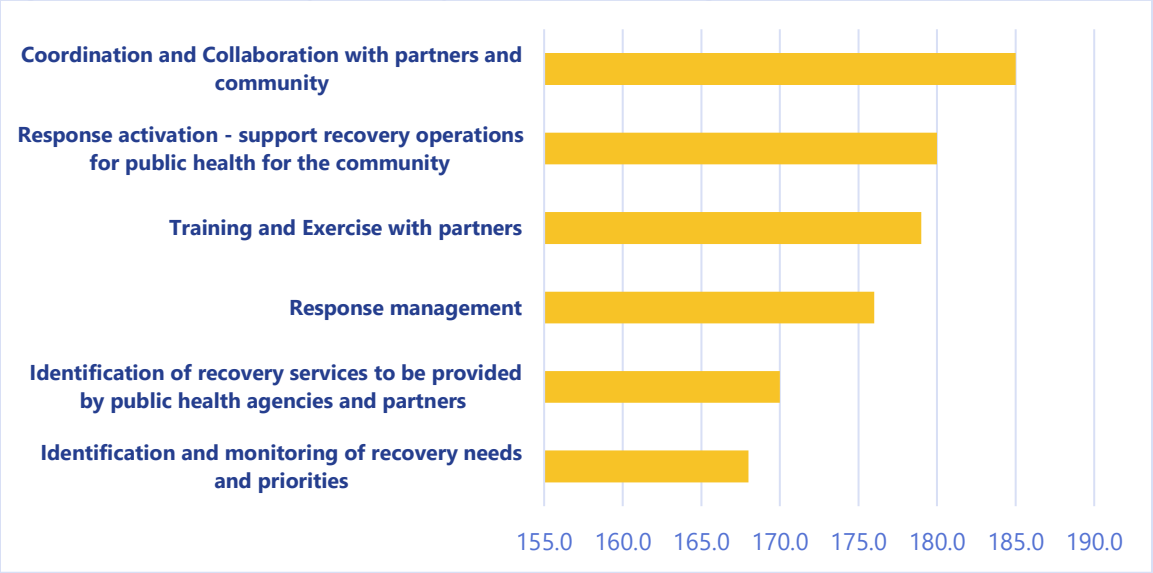
Definition: The ability of communities to identify critical assets, facilities, and other services within public health, emergency management, health care, human services, mental/behavioral health, and environmental health sectors that can guide and prioritize recovery operations.

Figure 176: Community Recovery Results

Functions	Average Rating	Average Score
Coordination and Collaboration with partners and community	**Full Capability**	**2.3**
Response activation - support recovery operations for public health for the community	**Full Capability**	**2.2**
Training and Exercise with partners	**Full Capability**	**2.2**
Response management	**Full Capability**	**2.1**
Identification of recovery services to be provided by public health agencies and partners	**Moderate Capability**	**2.1**
Identification and monitoring of recovery needs and priorities	**Moderate Capability**	**2.0**

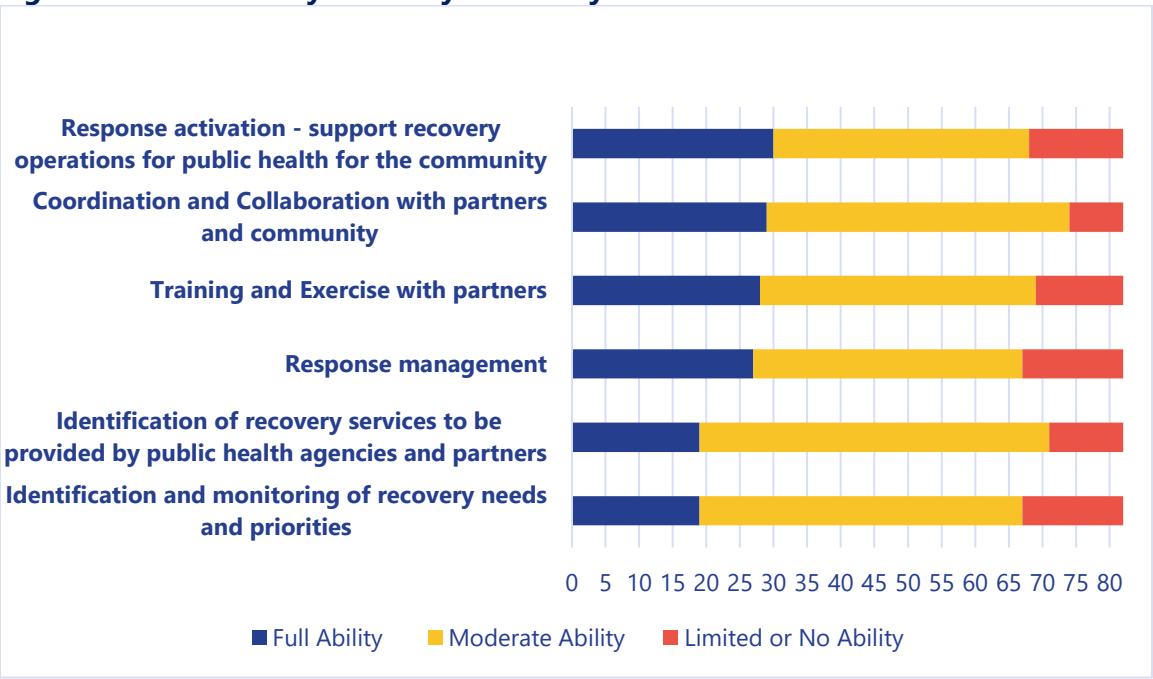
To provide a more detailed look at the unique score submitted by each respondent in the district the following figure shows the total score for each function. A total of 246 points were possible for each function. (3 points possible * 82 respondents). This chart provides a visual of the overall capability of the state to perform each function.

Figure 177: Community Recovery Functions Ranking



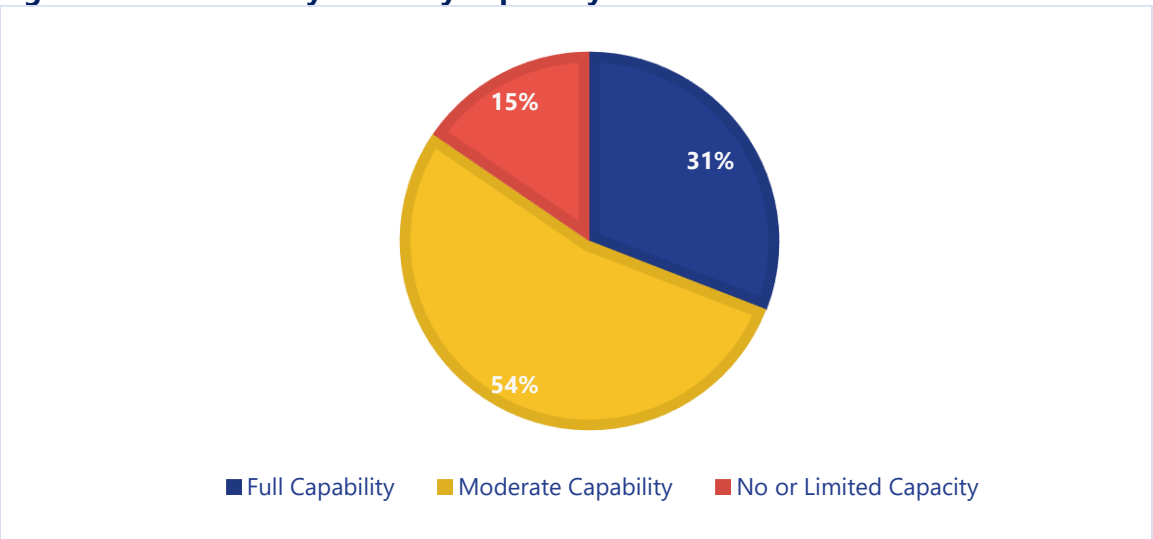
The figures below represent the responses submitted by each Local Health Department regarding their level of capability to perform each function.

Figure 178: Community Recovery Results by number of LHDs



In addition to assessing the capability of the district to perform each of the functions, this report also assesses the district's ability to perform the LHD Capability as a whole. When assessing the Community Recovery capability 69% of the responses indicated "Full Capability", 31% indicated "Moderate Capability", and no respondents indicated "No or Limited Capability".

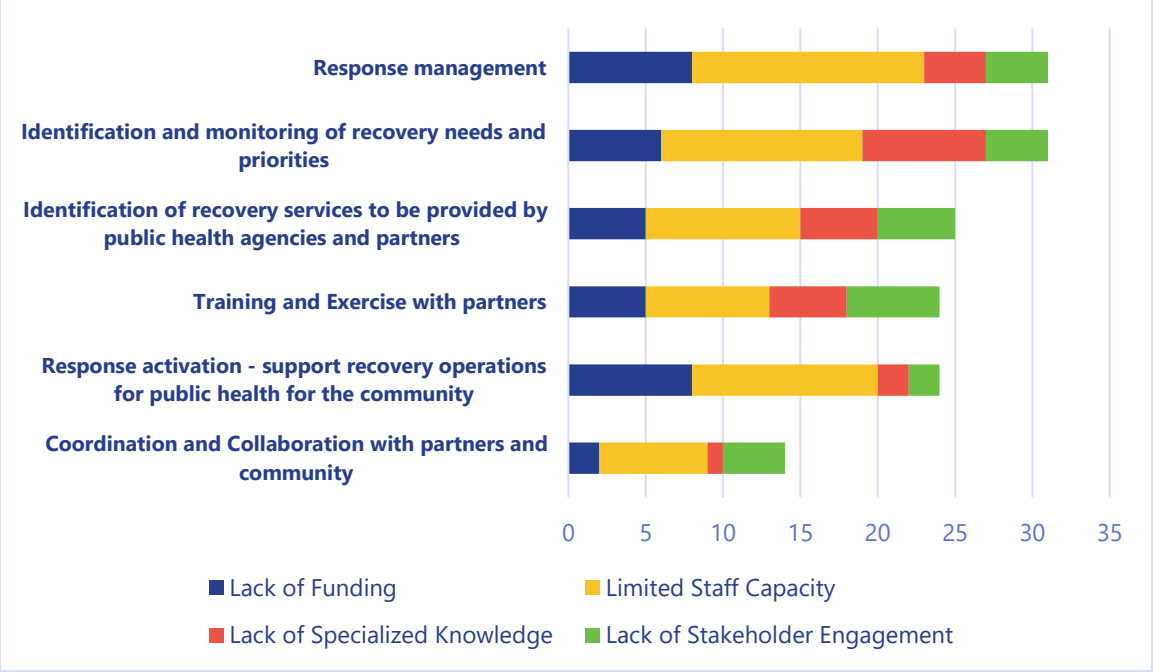
Figure 179: Community Recovery Capability Results



Identified Barriers to Community Recovery

The figure below shows the identified barriers by associated function. Functions that had no barriers identified are not displayed.

Figure 180: Community Recovery Barriers



Community Integration and Community Recovery capability crosswalk

The table below provides insight into how the HCC functions related to Community Integration correspond to the LHD functions related to Community Recovery. The column titled "interoperability of functions" provides an example of how the HCC function supports the LHD function and vice versa.

Figure 181: Community Integration and Community Recovery capability crosswalk

Community Integration	Community Recovery	Interoperability of Functions
HCC Functions	**LHD Functions**	
Minimize the behavioral health impact of disasters by providing information and services to responders and	Response activation - support recovery operations for public health for the community	HCCs and LHDs can collaborate to incorporate behavioral health into the response activation to enhance recovery operations.

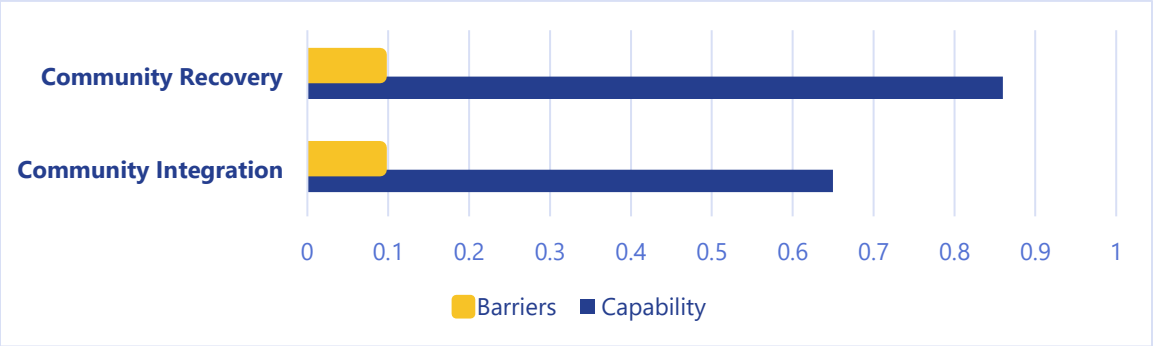
affected populations		
Share information with the public	Training and Exercise with partners	The HCCs can share information with the public regarding training and exercises offered by the LHDs.
Provide information and support to families, caregivers, and community members to reunite them with their loved ones and update them on patient status	Response management	HCCs can work with the LHDs to ensure providing information and support to families and caregivers on patient statuses is included in their response management.
Maintain continuity of care across community-based health care, public health, and social services to address the needs of communities and prevent strain on acute care resources	Identification of recovery services to be provided by public health agencies and partners	HCCs can include the recovery services identified by the LHDs in their strategies to maintain continuity of care.
Identify vulnerabilities of the community, and resources available to address those impacted	Coordination and Collaboration with partners and community	Information gathered through the LHD's collaboration with community partners can be leveraged by HCCs to identify vulnerabilities and resources.
	Identification and monitoring of recovery needs and priorities	LHDs and HCCs can collaborate to identify vulnerabilities, resources, and recovery needs of the communities they serve.

Local public health professionals are encouraged to expand upon this information to capture the specific ways in which the function of the HCC and LHD collaborate within their jurisdiction.

HCC and LHD Capability and Barrier Scores Comparison

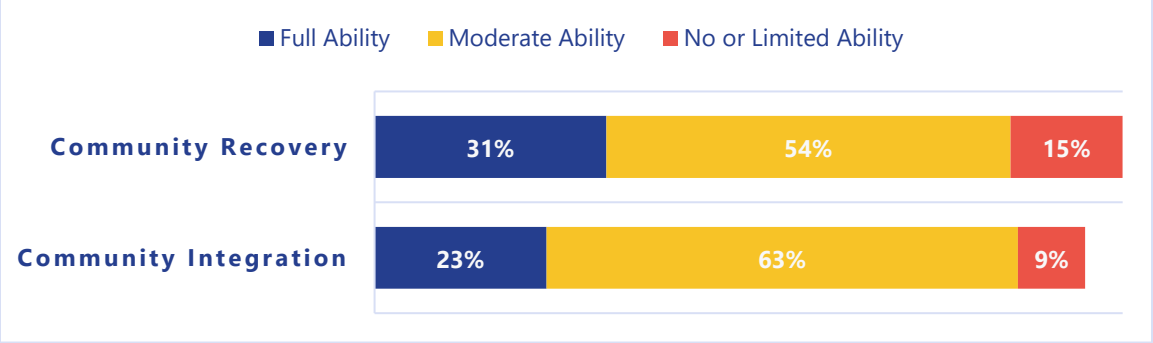
To compare the HCC and LHD capabilities ratings of the respondents a total possible score for each capability was calculated. Then the total of the scores given by the respondents was calculated. Finally, the total score was divided by the total possible score to find the capability rate.

Figure 182: Community Integration and Community Recovery Capability and Barrier Comparison



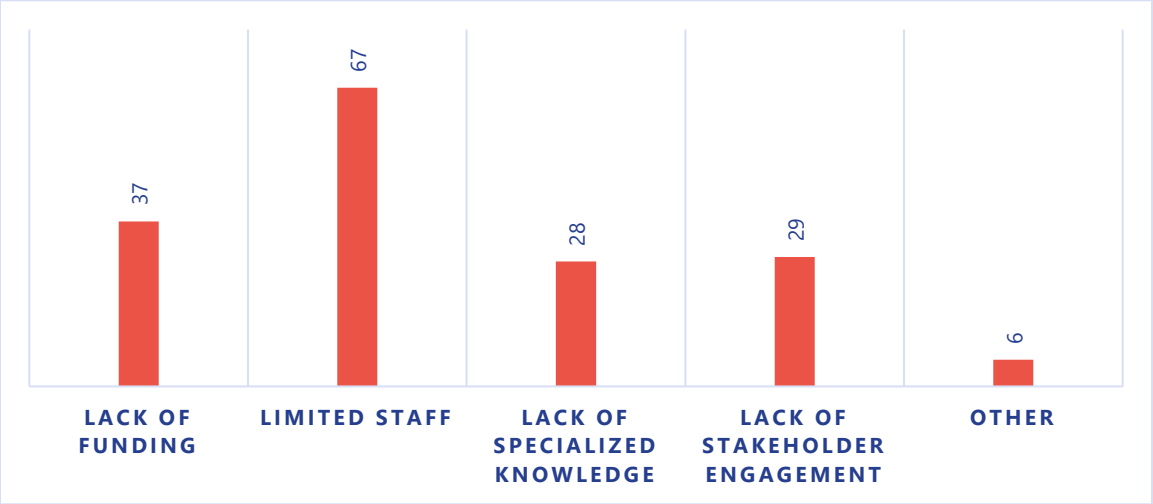
The following figure shows the % of respondents that selected each ability level for their respective capabilities.

Figure 183: Community Integration and Community Recovery Capability Comparison



Identified barriers comparison

HCCs and LHDs were both asked to identify barriers they encounter to achieving "full" or "moderate" ability ratings for their respective capabilities. The chart below shows the number of times an HCC or LHD selected that they experienced each barrier to their respective capability. Limited staff capacity was the most frequently identified with 67 respondents selecting this as a barrier.



Whole Community Health Capability

HCCs and LHDs were asked to indicate what work they have done to integrate a variety of populations into their preparedness and response efforts. They were given the following 12 populations to consider when responding to this section:

1. Individuals with Disabilities
2. Aging Population (65 and older)
3. American Indian and Alaskan Native tribes
4. Homeless Population
5. Limited Access to Transportation
6. Limited English Proficiency
7. Low-income Population
8. Minorities and Other Diverse Populations
9. Pediatric Population (17 and younger)
10. People with Behavioral Health Needs
11. Pregnant Women
12. Rural and Frontier Populations

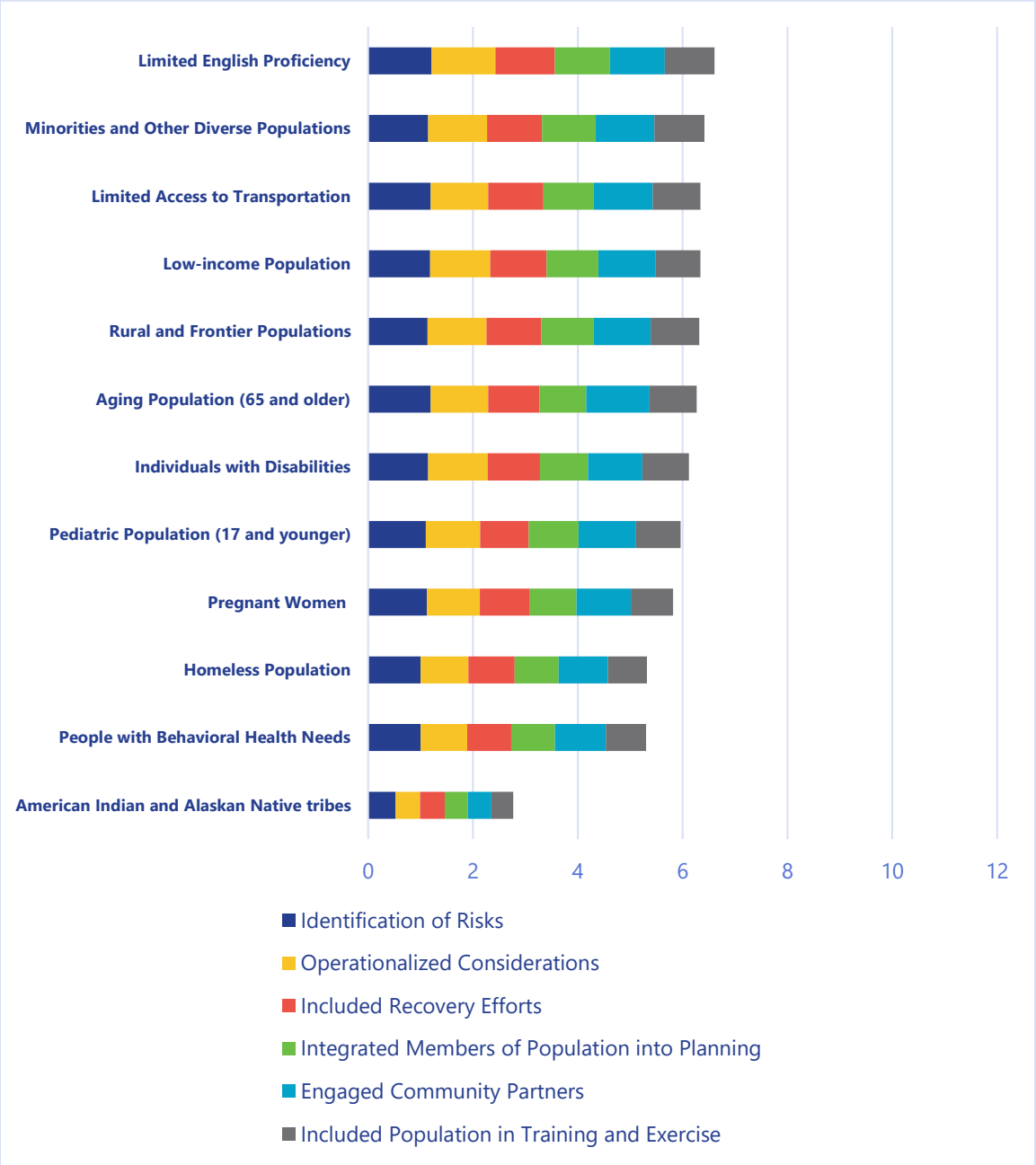
For each of the assessed populations respondents were asked to indicate the level of progress they had made on each of the following activities as it relates to the population:

1. Identification of risks
2. Operationalized Considerations in Response Efforts
3. Included Recovery Efforts into Response Plans
4. Integrated Members of the Population into Planning
5. Engaged Community Partners
6. Included Population in Training and Exercise

The respondents had the option to choose from the following progress levels Not Started [0], In Progress [1], and Fully Integrated into Operations [2]. A total score of 12 was possible for each assessed population.

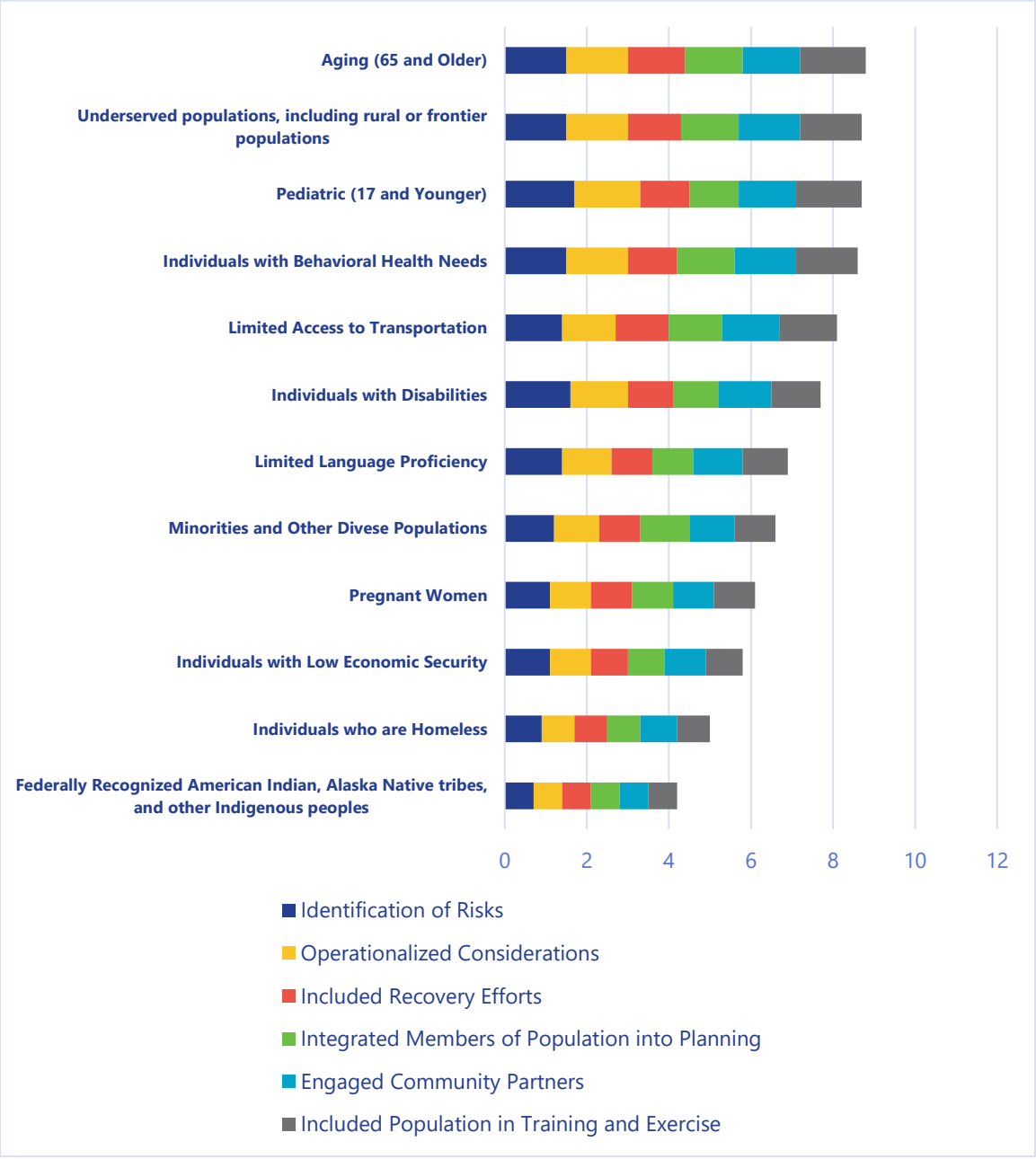
The figure below shows the results of the LHD's responses by population. The LHD's responses indicated that they are most able to fully integrating the "Limited English Proficiency" population, and least able to fully integrating the "American Indian and Alaska Native Tribes".

Figure 184: LHD Whole Community Capability Results



The figure below shows the results of the HCC's responses by population. The HCC's responses indicated that they are most able to fully integrating the "Aging (65 and Older)" population, and least able to fully integrating the "American Indian and Alaska Native Tribes".

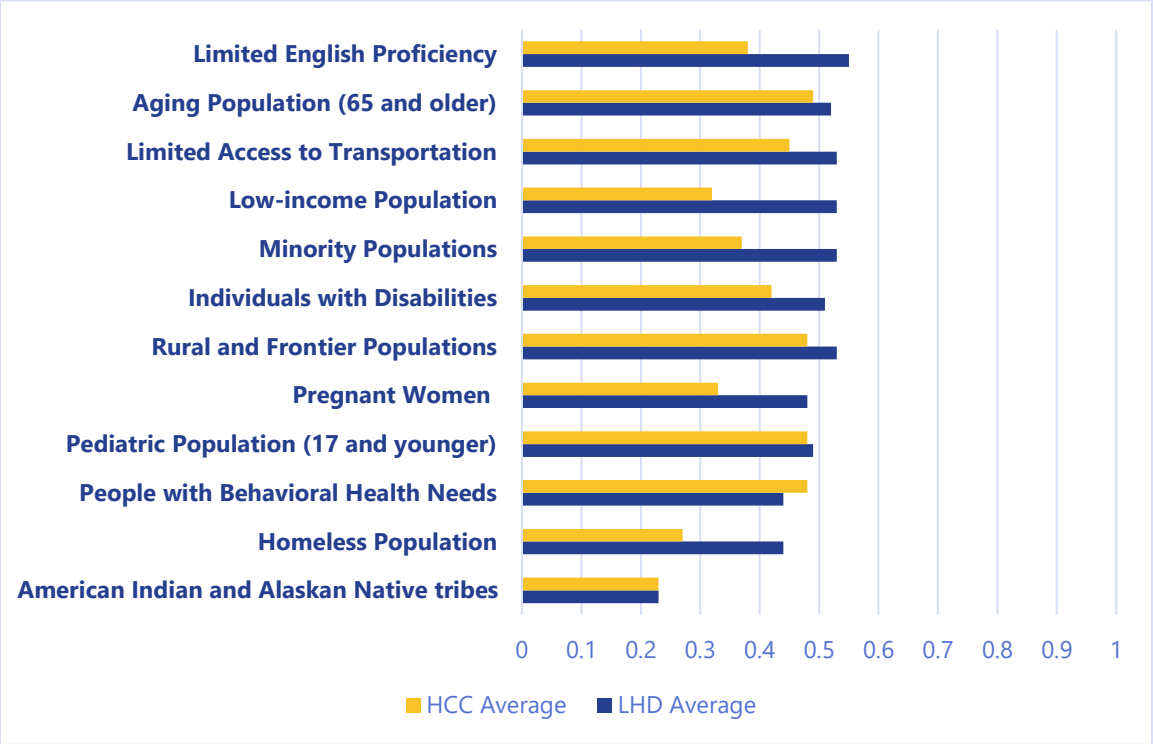
Figure 185: HCC Whole Community Capability Results



HCC and LHD Comparison

The figure below shows a comparison of the results by population for HCCs and the LHDs.

Figure 186: LHD and HCC Whole Community Capability Results Comparison



Next Steps

Locals can utilize this report to guide improvement planning efforts and strengthen collaboration between district and local emergency response. The information and data in this report can be used for the following:

1. Inform of the multiyear integrated preparedness plan for your jurisdiction in conjunction with the JRA and HVA results.
2. Prioritize areas of improvement to enhance the local response capabilities.
3. Identify impacted communities and implement actions to understand how public health emergency response can be developed or updated to address unique preparedness, response, and recovery needs of the communities.
4. Address identified barriers to strengthen ability to perform capabilities.
5. Define Key Performance Indicators (KPIs) for measuring successful attainment of capabilities for the HCCs and LHDs.
6. Identify and document strategies for collaboration between HCCs and LHDs to strengthen response.