Performance Audit: Disaster Preparedness and Readiness Compliance

Public Health Department

Durham County Internal Audit Department

March 5, 2013

COUNTY OF DURHAM

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March 5, 2013

Michael M. Ruffin, County Manager:

Internal Audit has completed its audit of The Public Health Department's compliance with state and federal Preparedness and Readiness requirements. We found the department in satisfactory compliance with all requirements established by the state whose authority it is to administer preparedness programs on behalf of itself and the federal government.

Emergency preparedness and readiness is a cooperative effort by many partners in the County including government as well as private entities. For example, Emergency Management and EMS are partners as are private entities such as hospitals, and other facilities. The Health Department interacts with all entities to meet the state and federal preparedness and readiness capabilities.

This report does not contain recommendations because we did not find areas of non-compliance and the State representative showed satisfaction with Durham County's program. The State's representative believes Durham has a model program and is a leader in the area of preparedness and readiness.

The Health Department was provided a copy of the draft report. The Director expressed her agreement with the report. The Director's comments are included in the report as Appendix 3 on page 10.

I appreciate the courtesy and cooperation provided by Public Health Department during this audit. Brian Welch, Staff Auditor, contributed to this audit.

Richard C. Edwards

Richard Edwards, CIA, CGAP
Internal Audit Director

XC: Gayle Harris, Public Health Director
Audit Oversight Advisory Committee

March 5, 2012

HIGHLIGHTS

Internal Audit report to the County Manager

Why we did this audit

We conducted this audit of the Public Health Department's compliance with State and Federal disaster preparedness and readiness requirements because of the potential risk of non-compliance and because the process had not been audited by the Internal Audit Department in the recent past. The Audit Oversight Committee authorized this audit in July 2012.

Our objective was to determine if the department was in compliance with State and Federal Preparedness and Readiness requirements. We conducted this Performance Audit in accordance with Generally Accepted Government Auditing Standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Recommendations

This audit did not result in recommendations for improvements. We found that the department operates in compliance with State and Federal requirements and that state representatives are pleased with Durham County's progress towards meeting objectives of the enhanced preparedness and readiness program that began in late 2011.

For more information, please contact Richard Edwards, Internal Audit Director, by phone at 919-560-0042 or by email at rcedwards@dconc.gov.

DISASTER PREPAREDNESS AND READINESS COMPLIANCE – PUBLIC HEALTH DEPARTMENT

What We Found

Based upon requirements agreed upon by the department and the State in July 2011, the department meets the established criteria for preparedness and readiness. This conclusion was based upon the status of the four requisite plans the State requires for preparedness. Each plan was in place in permanent or draft form. The status of the communication plan, a plan designed to communicate with the public in case of a disaster event, was in draft form until January 2013. That did not constitute non-compliance because the directions from the State did not require that a document be signed by a specific date. Upon broader review of this requirement, we found that the department's plan for communicating with the public was in place and has been a cooperative effort with the County's Office of Communications to release notices, etc., as needed. The Assistant County Manager for Communications acknowledges this relationship and expects that the relationship will continue.

The department is working towards completion of revised strategies it agreed upon in September 2011. Those revised strategies and requirements resulted from the CDC's desire to provide better definition and enhance efficiency of the program considering the limited funding at its disposal. Those requirements did not replace the program in place but is an effort to improve and clarify. The State and the County are working together to implement those requirements the State believes have the highest priority. The CDC's agreement with the State is a five-year plan and the State and County's goal is to implement the new requirements over that period.

SUMMARY OF AUDIT RESULTS

The department complies with State and Federal guidelines. The preparedness and readiness structure rests upon four plans agreed upon by the State and the County. That agreement document, The Agreement Addendum, describes the functional capacity required in each of the plans. In fiscal year 2012, the agreement addendum set out approximately 42 performance requirements that cut across all four preparedness plans. The specific plans are:

1. All Hazards Emergency operations plan that include public health components.

2. Communications plan to address the media and the public, etc.

3. A Strategic National Stockpile plan that lays out how the department will manage and distribute the medicines and supplies needed in an emergency.

4. Continuity of operations plan.

Audit Objective, Scope, and Methodology

To answer our objective to determine if the County's Public Health Department complies with preparedness and readiness directives set by State and Federal authorities we focused on fiscal year 2012 activity. We chose fiscal year 2012 because that year the CDC revised its model in order to standardize community preparedness efforts across the country.

Our specific review steps consisted of:

1. Conducting online research primarily on the CDC website to obtain understanding of preparedness planning needs from a national viewpoint.

2. Interviewing the Public Health Preparedness Coordinator to (a) obtain understanding of Durham's programs and (b) obtain reports, opinions, and other information regarding Durham's programs.

3. Reviewing Public Health's four primary programs/plans that make up the readiness posture. (These plans are for (a) Communications, (b) Strategic National Stockpile, (c) Continuity of Operations, and (d) Emergency Operations for all hazards…All Hazards Plan).

4. Comparing requirements in the above plans to departmental documents to determine whether the requirements were met.

5. Reviewing and summarizing the department's responses to functions determined by the State to be critical factors in the readiness posture.

6. Discussing some readiness requirements with Emergency Management and EMS officials.

7. Discussing the program with the State's Preparedness Program Operations Manager.

8. Discussing communication capabilities with the Assistant County Manager in charge of Communications.

Background

Durham County's Emergency Management program operates under Chapter 166A of the North Carolina Emergency Management Act of 1977, Article1A. One purpose of the article is to "…provide for cooperation and coordination of activities relating to emergency and disaster mitigation, preparedness, response and recovery among agencies and officials of this State and with similar agencies and officials of other states, with local and Federal governments, with interstate organizations and with other private and quasi-official organizations."[1]

The above plans include requirements for continuous training including drill exercises, engaging with other stakeholders and entities, and reporting. Our review of the documentation supporting required activities related to the plans showed that they were complete and in compliance with State requirements with one exception, the communications plan.

We noted that the communications plan was in draft form when we began the audit and was completed in January 2013, approximately six weeks after we began the audit. Although the plan was not signed, we believe the department was in compliance because there weren't any specific date established for a signature and the NC Office of Public Health Preparedness & Response review team did not question the department's communication planning during an April 26, 2011 onsite visit. Additionally, we found that the department was effective in communicating to the public based upon its relationship with the County's Public Information Officer who has worked with the department on other occasions to provide information to the public.

The Department is responding to revised directives established by CDC in March 2011. These directives, an effort by the CDC to standardize the preparedness and readiness process across all states, identified 15 capabilities it wanted States and municipalities to have in order to be prepared for an emergency event. The State included compliance with the capabilities in the September 2011 revision to the fiscal year 2012 Agreement Addendum. Appendix 3 is a synopsis of the 15 capabilities.

Readiness and preparedness is primarily about planning and logistics. Equipment and materials are not emphasized although one plan, the Strategic National Stockpile, requires purchase and storage of some supplies such as bandages and syringes and the ability to mobilize them for use if required. However, the plan is more about logistics such as how to mobilize for distribution than about the actual material on hand. Without an effective mobilization and delivery system the supplies would not be useful.

Preparedness and Readiness planning is a joint effort between the State and the County. The State takes the lead in determining planning priorities although it allows the department to pursue capability in addition to those the state mandates. The goal is for the State and the County to achieve its planning goals within five-years, the cycle by which the CDC operates. The State prioritized three capabilities and the County has exceeded that number by five for a total of eight capabilities it has addressed.

Although the planning is going as scheduled, some requirements are difficult to implement. The following example demonstrates one of those difficult areas. In this example the department reported it did not have a good method for identifying at-risk populations.

Background (Continued)

The Federal government, via The Centers for Disease Control (CDC) Office of Public Health Preparedness and Response, plays a pivotal role in ensuring that state and local public health systems are prepared for public health emergencies because of its unique abilities to respond to infectious, occupational, or environmental incidents that affect the public's health. CDC's Office of Public Health Preparedness and Response, Division of State and Local Readiness, administers funds for preparedness activities to State and local public health systems through the Public Health Emergency Preparedness (PHEP) Cooperative Agreement. That agreement with States is the conduit to providing funds to the County through the State of North Carolina's Public Health Emergency Planning (PHEP) unit. In fiscal year 2012, Durham County Health Department received approximately $112,437. The CDC provided approximately $107,437 while the National Association of County and City Health Officials provided $5,000.

The CDC's preparedness vision for the nation is the mantra "people's health protected—public health secured." To achieve this goal, partners and stakeholders across public health, healthcare, bio-defense, emergency management, and the private sector, work together. All of these come to play in Durham County to achieve a disaster readiness posture.

The CDC provides annual guidance and technical assistance to assist State, territorial, and local health departments with their strategic planning to strengthen their public health preparedness capabilities. Technical assistance includes CDC public health expertise, standards for developing priority preparedness capabilities, and expertise for conducting exercises and meeting performance goals. CDC's concept is one of community-based planning. That concept, which is embraced by Durham County, is that planning must not only be representative of the actual population within the community, but also must involve the whole community in the planning process.

Instructions and County requirements come via the Consolidated Agreement, a contract between the State and the County's Public Health Department. That agreement incorporates CDC ideals for preparedness. Specific details or requirements are included in addenda to the Consolidated Agreement.

What is a Performance Audit?

A performance audit is an engagement that provides assurance or conclusions based on an evaluation of sufficient, appropriate evidence against stated criteria, such as specific requirements, measures, or defined business practices. Performance audits provide objective analysis so that management and those charged with governance and oversight can use the information to improve program performance and operations, reduce costs, facilitate decision making by parties with responsibility to oversee or initiate corrective action, and contribute to public accountability.[2]

In its assessment report the department wrote:

> "We do not have a good method in place as to how to identify and track special needs patients within our community. This has traditionally been handled by Emergency Management in Durham County, but recently has been tasked to the department to handle, and we have not yet come up with a good plan to address this."

Identifying at-risk or special needs populations continues to be a long-term concern for the County; however, the County continues to consider options for identifying such populations that will require services if an emergency situation occurs. For example, several documented meetings to discuss identifying at-risk populations have been held with other departments such as Emergency Management and the department's spokesperson says it will continue exploring the matter.

Additionally, the Emergency Management Director is aware of the need for identifying at-risk or special needs persons and maintains a current list of persons with special medical needs that have registered with them. This list is not exhaustive of at-risk populations but as stated earlier, the department continues to identify methods to satisfactorily meet the requirement of identifying all at-risk populations.

Another example of a difficult requirement is that the department does not have all the capabilities required for mass fatalities. The difficulty is that the department does not own refrigeration systems for that purpose. However, Emergency Management has refrigerators for that purpose; thereby, providing the County with Mass Fatality capability. Although that capability is not managed by the Health Department the State's representative is satisfied that the County has the capability for mass fatalities. In its correspondence, the State makes it apparent that a capability within the Health Department or within other County departments is satisfactory to meet the readiness requirement regardless of which agency owns the equipment or expertise. However, that information must be considered in the plan and communicated to the State.

Considering that much of the preparedness planning effort by the department is conducted in conjunction with the State under State guidance and direction, and the fact that the State is working under a five-year planning cycle with the CDC, the State Representative views the County's efforts as satisfactory. The State representative said she is pleased with the County's efforts so far and believes the right team is working to improve the readiness posture in Durham.

Conclusion

We did not identify areas in which the County was not complying with State and Federal rules and guidelines under the old or new guidelines. Guidelines vary in some aspects from year to year and presents somewhat of a "moving target." We concluded that the Department has had various successes in implementing requirements under the old planning process and is on target with the revised program that features Capabilities. Although the department has not completed all the tasks within CDC's Capabilities structure, the coordinated efforts by all organizations result in a satisfactory level of compliance. Therefore, we believe the County complies with State and Federal readiness and preparedness planning requirements.

Bibliography

1 North Carolina General Statutes Chapter 166A Article 1A.

2 Comptroller General of the United States, Government Auditing Standards, Washington D.C: U.S. Governmental Accountability Office, 2007, p. 17

Appendix 1: CDC Capability Requirements

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

- Support the development of public health, medical and mental/behavioral health systems that support recovery,
- Participate in awareness training with community and faith-based partners on how to prevent, respond to, and recover from public health incidents,
- Promote awareness of and access to medical and mental/behavioral health resources that help protect the community's health and address the functional needs (i.e., communication, medical care, independence, supervision, transportation) of at-risk individuals,
- Engage public and private organizations in preparedness activities that represent the functional needs of at-risk individuals as well as the cultural and socio-economic, demographic components of the community,
- Identify those populations that may be at higher risk for adverse health outcomes, and
- Receive and/or integrate the health needs of populations who have been displaced due to incidents that have occurred in their own or distant communities (e.g., improvised nuclear device or hurricane).

Capability 2: Community Recovery
The ability to collaborate with community partners, (e.g., healthcare organizations, business, education, and emergency management) to plan and advocate for the rebuilding of public health, medical, and mental/ behavioral health systems to at least a level of functioning comparable to pre-incident levels, and improved levels where possible.

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

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

Capability 5: Fatality Management
The ability to coordinate with other organizations (e.g., law enforcement, healthcare, emergency management, and medical examiner/coroner) to ensure the proper recovery, handling, identification, transportation, tracking, storage, and disposal of human remains and personal effects; certify cause of death; and facilitate access to mental/ behavioral health services to the family members, responders, and survivors of an incident.

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

Capability 7: Mass Care
The ability to coordinate with partner agencies to address the public health, medical, and mental/ behavioral health needs of those impacted by an incident at a congregate location. This capability includes the coordination of ongoing surveillance and assessment to ensure that health needs continue to be met as the incident evolves.

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

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

Appendix 1: CDC Capability Requirements (Continued)

Capability 10: Medical Surge
The ability to provide adequate medical evaluation and care during events that exceed the normal limits of the medical infrastructure of an affected community. It encompasses the ability of the healthcare system to survive a hazard impact and maintain or rapidly recover operations that were compromised.

Capability 11: Non-Pharmaceutical Interventions
The ability to recommend to the applicable lead agency (if not public health) and implement, if applicable, strategies for disease, injury, and exposure control.

Capability 12: Public Health Laboratory Testing
The ability to conduct rapid and conventional detection, characterization, confirmatory testing, data reporting, investigative support, and laboratory networking to address actual or potential exposure to all-hazards. Hazards include chemical, radiological, and biological agents in multiple matrices that may include clinical samples, food, and environmental samples (e.g., water, air, and soil). This capability supports routine surveillance, including pre-event or pre-incident and post-exposure activities.

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

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

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

Appendix 2: CDC vision, mission, and values objectives

Objective 1:	Prevent and/or mitigate threats to the public's health,
Objective 2:	Integrate public health, the healthcare system, and emergency management,
Objective 3:	Promote resilient individuals and communities,
Objective 4:	Advance surveillance, epidemiology, and laboratory science and service practice,
Objective 5:	Increase the application of science to preparedness and response practice,
Objective 6:	Strengthen public preparedness and response infrastructure,
Objective 7:	Enhance stewardship of public health preparedness funds, and
Objective 8:	Improve the ability of the public health workforce to respond to health threats.

Public Health
*100 Years of Service * 1913-2013*

March 4, 2013

Richard C. Edwards, Internal Audit Director
Durham County Government
200 East Main Street
Durham, North Carolina 27701

Dear Mr. Edwards,

We concur with the assessment that the County's Local Public Health Preparedness (LPHP) Program is in compliance with State and Federal readiness and preparedness planning requirements.

In addition to exceeding the State requirements of addressing three of the fifteen CDC Capabilities, it is also important to note the LPHP program attained a 100 percent score on the 2012 Strategic National Stockpile Plan review which was the highest score awarded in this region. The program has also made strides in the development of a local Medical Reserve Corp which will work collaboratively to provide support to our department and public health agencies through cross-jurisdictional sharing during public health emergency events.

Thank you for taking the time to understand a very complex program and for acknowledging how the program is viewed from a State perspective – "The State's representative believes Durham has a model program and is a leader in the area of preparedness and readiness."

Sincerely,

Gayle B. Harris, MPH
Public Health Director

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