DEPARTMENT OF HEALTH

# RESPONSE SUSTAINABILITY ANNUAL REPORT

## PUBLIC HEALTH EMERGENCY PREPAREDNESS AND RESPONSE

12/20/2024

# Response Sustainability Annual Report

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# Executive Summary

For FY24 and FY25, the state invested in public health emergency preparedness (Sec. 145A.135 MN Statutes), Statutory language: Line 239.27-240.12, Appropriation language: Line 810.26) to support emergency response capabilities at the state, local, and tribal levels. They also invested in the sustainment of a health care strategic stockpile, the transition and demobilization of COVID-19 response activities to existing programs within MDH, archiving of COVID-19 response documents, and integration of lessons learned into response and recovery plans and annexes. Significant progress has been made across the state to develop and maintain a response ready workforce, revise and improve plans, engage communities in preparedness planning, and strengthen partnerships across agencies. The COVID-19 response has been demobilized and COVID-19 documents have been archived. Warehouse operations have been scaled back with attention now focused on sustaining a strategic critical care supply resource for health care operations during emergency responses.

MDH revised and modernized their response structure using a cadre approach to building a stronger response workforce with more depth that will include an improved training and exercise program. The Emergency Preparedness and Response (EPR) Division has established a Data Work Group, which will create a Data Management Plan and standardized processes and procedures to use as a foundation for data needed during emergency responses. MDH EPR continues to support Community Health Boards (CHBs) and Tribal Health Departments (THDs) through guidance, material development, training, and technical assistance.

MDH EPR partnered with the Local Public Health Association (LPHA), providing funding for additional support to CHBs in becoming response ready. They held a statewide conference in collaboration with MDH, offered three leadership-specific trainings, fostered information and resource sharing across CHBs, and provided learning opportunities to develop skills. This included presentations at LPHA meetings on communications and message framing. They are developing a toolkit to fill resource gaps in CHBs preparedness work. This toolkit will contain factsheets, communications resources, tools to onboard new staff, and regional best practices.

Grants ($8,400,00 annually) were distributed to CHBs and THDs and this report shows that this funding has contributed significantly to the governmental public health's system readiness to respond. Progress was made across all activities including staffing, reaching out to communities and across agencies, and building internal readiness through plan and agreements updates. CHBs and THDs have been building their workforce through a number of approaches such as hiring, increasing current staff time spent on emergency preparedness, response, and recovery, and contracting. Recognizing the critical roles of internal and external partners, CHBs have intensified efforts to strengthen and build new relationships. All CHBs are working on updating key plans and examining the status of disaster response agreements.

These dedicated funds for public health emergency preparedness are making a difference in supporting wider engagement with communities and partners. CHBs were able to train more staff on critical response and recovery topics and skills, increasing workforce capacity. Plans addressing multiple components of public health emergency response and recovery have been updated. Several foundational aspects of response and recovery have also been addressed, including maintenance of contact lists, and methods to improve communications. These actions have resulted in significant progress toward a response ready public health system in Minnesota.

# Introduction

## Purpose and Overview

The Public Health Emergency Preparedness and Response Grant (Sec. 145A.135 MN Statutes), provided state, local, and tribal public health with funding intended to build capacity and infrastructure to support a response ready workforce, critical care resources, and updated and improved plans. Strengthening and developing new relationships is another key component of being response ready. Incorporating lessons learned from the COVID-19 response addressed identified gaps and more efficient actions to better protect and maintain the health of all Minnesotans. This funding aided MDH in moving to a post-COVID-19 sustainable model for future responses.

MDH focused on basic but critically important actions. These funds supported the demobilization of the COVID-19 response. Response work was archived, ready to serve as a reference in future responses. Lessons learned and corrective actions were identified and incorporated into plans, training, and response structures to improve response activities. The MDH Strategic Stockpile continues, to maintain a cache of supplies identified as most critical for health care operations during emergencies.

The MDH Emergency Preparedness and Response (EPR) Division has initiated several new projects. The first, a new approach to a response structure, has been developed and implementation is underway. This consists of creating teams of the primary Incident Command Structure (ICS) positions, with more depth built into each position and additional training and practice opportunities. A Data Lead has convened an EPR Work Group to assess current data, identify future data needs, create an EPR Data Management Plan that includes standardization policies and procedures and training recommendations. This will help build a stronger base for data surge needs and increase staff capacity to manage and analyze data that inform decision making and response actions.

Finally, MDH continued to collaborate with the Local Public Health Association (LPHA). Begun under the CDC COVID-19 Crisis Workforce Cooperative Agreement, MDH and LPHA have worked together to provide learning opportunities and leadership development support to local public health and Tribal Health Departments. Several initiatives have been continued and expanded with these state funds, including a joint conference, Minnesota Partners in Public Health: Transforming systems together for a healthy Minnesota. Another hallmark of this partnership has been leadership cohorts intended to support the large number of new public health directors. This has proven particularly popular, resulting in LPHA offering three cohorts of twenty public health directors. LPHA and MDH are coordinating development of public health emergency preparedness training materials, which will allow for creation of a larger number of resources.

## Funding Distribution

MDH Emergency Preparedness and Response (EPR) Division worked with the Public Health Emergency Preparedness (PHEP) Oversight Work Group to adopt principles specific to the response sustainability funding, which included agreement on a funding formula. The PHEP Oversight Work Group is a standing committee of the State Community Health Services Advisory Committee (SCHSAC) and serves in an advisory capacity, making recommendations to SCHSAC who in turn, provide recommendations to the Commissioner of Health. The principles MDH and the Work Group agreed upon included:

- Each CHB needed to have a minimum of .5 FTE dedicated to public health emergency preparedness and response (EPR) in order to strengthen capacity.
- Grant duties were to be aligned with national standards and public health EPR.
- Multi-county CHBs should ensure that all counties have access to staff dedicated to EPR.
    - The formula includes a multi-county component to assure each local public health (LPH) director has a relationship with their local Emergency Manager.

Health equity was an integral part of the funding discussion. While the CDC Public Health Emergency Preparedness (PHEP) Grant funding to CHBs has long included a Social Vulnerability Index (SVI) component, its application varied across MDH programs. MDH EPR and Public Health Practice (PHP) agreed to both adopt SVI as a metric and ensured consistency in the way SVI is calculated and applied, particularly as it relates to city and multi-county CHBs. SCHSAC approved the PHEP Oversight Work Group's recommended funding formula and forwarded it to the Commissioner of Health (see Table 1):

- $75,000 base + population + multi-county + Social Vulnerability Index (SVI)

### Table 1: Response Sustainability Funding CHB Distribution Formula

| Funding Component | Amount | Total |
|---|---|---|
| Base for 51 CHBs | $75,000 | $3,825,000 |

+

| Funding Component | Amount (after base) | Total |
|---|---|---|
| Population | 77% | $2,887,500 |
| Multi-County Addition | 13% | $487,500 |
| SVI (highest per CHB) | 10% | $375,000 |

## Tribal Nation Funding

A collaborative approach was used to determine the funding distribution for the Tribal Nations. The MDH EPR division and MDH Office of American Indian Health discussed different options that would provide the Tribal Health Departments with sufficient funding to make investments in public health emergency preparedness. A review of the historic tribal grant spending amounts was also completed. Based on these conversations and the spending review, the Tribal Nations were allocated $75,000 each, as shown in Table 2.

### Table 2: Tribal Nation Funding

| Funding Component | Amount | Total |
|---|---|---|
| Base for 11 Tribal Nations | $75,000 | $825,000 |

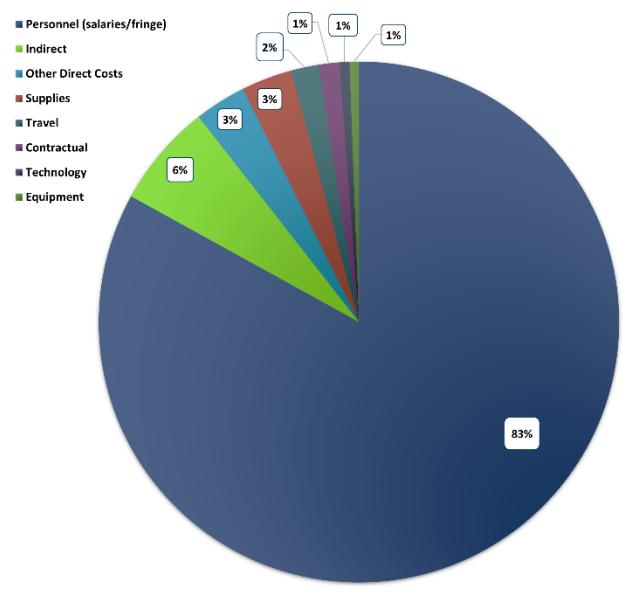
## Grantee Expenditures

Grantees utilized grant funds in a variety of ways at the local level, with majority of the funds being allocated to personnel expenses (Table 3). As shown in Figure 1, 83% of the expended funds were allocated to personnel costs, covering salaries and fringe benefits. This substantial investment in staffing is crucial for ensuring the sustainability of response efforts. The remaining funds were expended in supplies, equipment, technology, travel, contractual, indirect, and other direct costs that support the overall grant initiatives.

### Table 3: Total CHB/THD expenditures by budget category

| Budget Category | Expenditures |
|---|---|
| Personnel (salaries/fringe) | $2,449,469.02 |
| Supplies | $92,953.85 |
| Equipment | $17,133.13 |
| Technology | $18,470.78 |
| Travel | $50,684.25 |
| Contractual | $37,919.52 |
| Other Direct Costs | $94,461.05 |
| Indirect | $189,532.35 |
| **Total** | **$2,950,623.95** |

### Figure 1: Percent of CHB/THD expenditures by budget category




# Accomplishments and Impacts

CHBs and THDs made significant progress in several areas to increase their readiness to respond. Their accomplishments are captured in the remainder of this report. A final section shares the impacts these funds have made to the work CHBs are doing, in the CHBs own words.

## Tribal Health Departments' Accomplishments

Tribal Health Departments are working on tribal specific strategies to increase their capacity for emergency preparedness, response, and recovery. They are participating in regular meetings with MDH EPR staff that allows for information exchange between MDH and the THDs and provides a platform for the THDs to share ideas, resources, and troubleshoot challenges together. In addition, MDH EPR has reconfigured a position to provide dedicated support to the THDs. This position will be 50% tribal-focused.

Strategies of tribal health departments for strengthening their ability to prepare, respond and recover from public health incidents include:

- Increased workforce capacity by hiring a health educator, a nurse, and a planner. In addition, one tribal nation worked with their emergency manager to assign time to public health preparedness.
- Working across internal programs such as communicable diseases, tribal health services, elder focused services and programs, maternal, child, and family health, Statewide Health Improvement Program, chronic disease and injury prevention, and communication. The types of activities performed with these programs promoted emergency preparedness through providing training, establishing regular communication, giving presentations, and distributing flyers.
- Training staff on topics such as the Incident Command System, Psychological First Aid, emPOWER, Shelters/Family Assistance Centers, and Crisis & Emergency Risk Communication.
- Collaborating with other Tribal Nations to share ideas, resources, promising practices, and planning strategies during monthly Tribal meetings, trainings, and conferences.
- Creating or updating contact list policies or procedures.
- Revising, updating, or developing plans.
- Addressing technology gaps.
- Developing and expanding partnerships with tribal governments, public safety and emergency management, social services, community leaders, education and childcare settings, health care, and mental health providers. Activities with partners included providing training, giving presentations on preparedness, clarifying roles and responsibilities, and helping partners understand tribal sovereignty and tribal public health authorities.
- Engaging with their communities through Tribal health fairs, celebrations, increased communications, Powwows, community healing event, enrollee days, listening sessions, individual meetings, and workshops.
- Assessing plans, processes, and procedures for health equity.
- Strengthening risk communication by developing plans and fostering trusted messenger development.

The Tribal Health Departments shared how the Response Sustainability funding has helped them become response ready. These stories can be found under the Impact Stories section.

# CHBs' Accomplishments

## Workforce Capacity

All 51 Community Health Boards (CHBs) built their workforce capacity, using the funding to expand and maintain positions, add key positions to better engage communities, improve communication, and increase efforts to create more equitable response and recovery plans. Table 4 provides an overview of how LPH is building a strong foundation to respond and recover more rapidly. Although the majority of CHBs have successfully added staff or increased FTEs, a few CHBs experienced difficulties increasing their staffing. These difficulties included low salaries, no qualified applicants, local elected officials not allowing hiring, and human resource management delays.

Universally, CHBs expressed their gratitude for these funds that allowed them to dedicate additional staff and time to public health emergency preparedness work.

> *The Response Sustainability Grant has taken [the CHB] from having 0.25 FTE in emergency preparedness work to 0.745 FTE in emergency preparedness work. With this drastic increase, we have been able to integrate departmental preparedness programming. We have had the opportunity to make preparedness a priority for this department, which was not possible before receiving RSG funding.*

*Health Promotions Coordinator went from being funded only .3 FTE (under PHEP and REP) to fully funded and dedicated to preparedness activities - RSG was able to fund remaining .7 FTE; resulting in the creation of a job description for an official "Public Health Emergency Preparedness Coordinator".*

### Table 4: Public Health Emergency Preparedness FTEs

| Position | FTE Baseline 01/01/2024 | FTE As of 09/30/24 |
|---|---|---|
| Emergency Preparedness Coordinator | 28.8 | 33.4 |
| Agency leadership | 10.3 | 15.8 |
| Planners | 13.5 | 14.8 |
| Nurses | 5.3 | 13.1 |
| Health educator/Health promotion | 2.7 | 7.9 |
| Community health worker | 0.5 | 3.7 |
| Communication specialists | 0.7 | 3.0 |
| Administrative office support | 1.9 | 2.5 |
| Case Aid | 0.4 | 1.4 |
| Information technology and data system staff | 0.1 | 1.1 |
| Epidemiologist | 0.8 | 1.0 |
| Behavioral health staff | 0.5 | 0.5 |
| Environmental Health | 0.5 | 0.3 |
| Finance | 0.2 | 0.2 |
| **Total** | **66.2** | **98.7** |

## Disaster response agreements

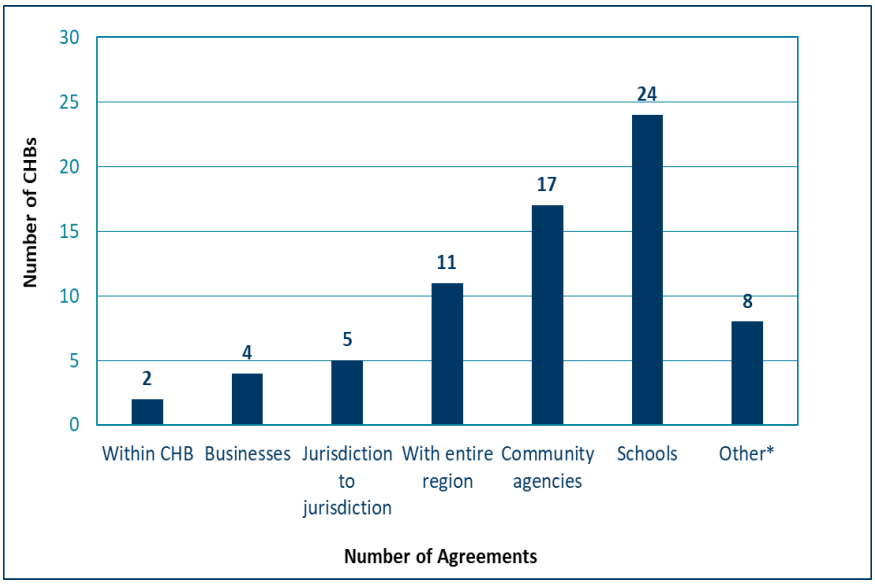
*MOUs, MOAs, and/or Mutual Aid Agreements*

During disaster response, it is critical to know where assistance and resources can be rapidly accessed. One way to ensure this happens is to develop agreements with other agencies or governmental jurisdictions. These agreements can be memoranda of understanding (MOUs), memoranda of agreement (MOAs), or mutual aid agreements. During the past nine months, CHBs have focused on updating current agreements and developing new ones based on the lessons learned from recent responses. See Table 5 and Figure 2.

### Table 5: Number of agreements

| Status | N 09/30/2024 |
|---|---|
| Developed | 20 |
| Revised | 37 |
| Reviewed | 70 |
| Total | 127 |

### Figure 2: Entities CHBs worked with on agreements




CHBs described how the RSG funding has made a difference in their abilities to ensure they have agreements in place for future responses.

> *The CHB successfully created a Memorandum of Agreement with the County Public Information Officer and the County Emergency Management. The purpose of this agreement is to align our work which has improved efficiency in grant duties and in preparing our communities in the County for potential disasters, emergencies, and public health events.*

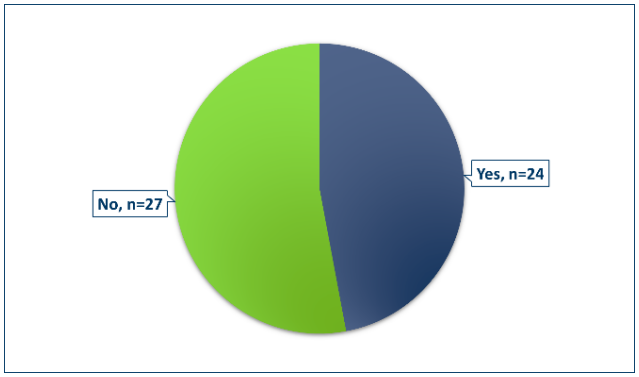
> *RSG funds have facilitated the development of stronger relationships with community partners. The CHB has increased engagement with stakeholders leading to MOU updates and development.*

## Contact lists

Communication during a disaster is a key to effective, coordinated response. Yet the most common gap identified in after-action reports is an outdated contact list resulting in communication gaps and lack of situational awareness. To address this issue, CHBs have developed or updated processes they can use to ensure their lists are maintained and ready for the next disaster response. See Figures 3 and 4.

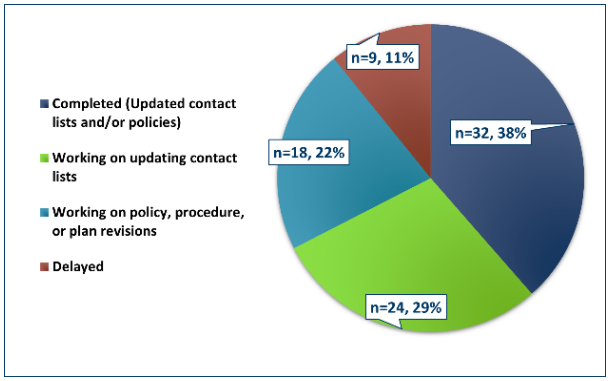
### Figures 3: Do you have a process?

Baseline: January 1, 2024




### Figure 4: Process development status

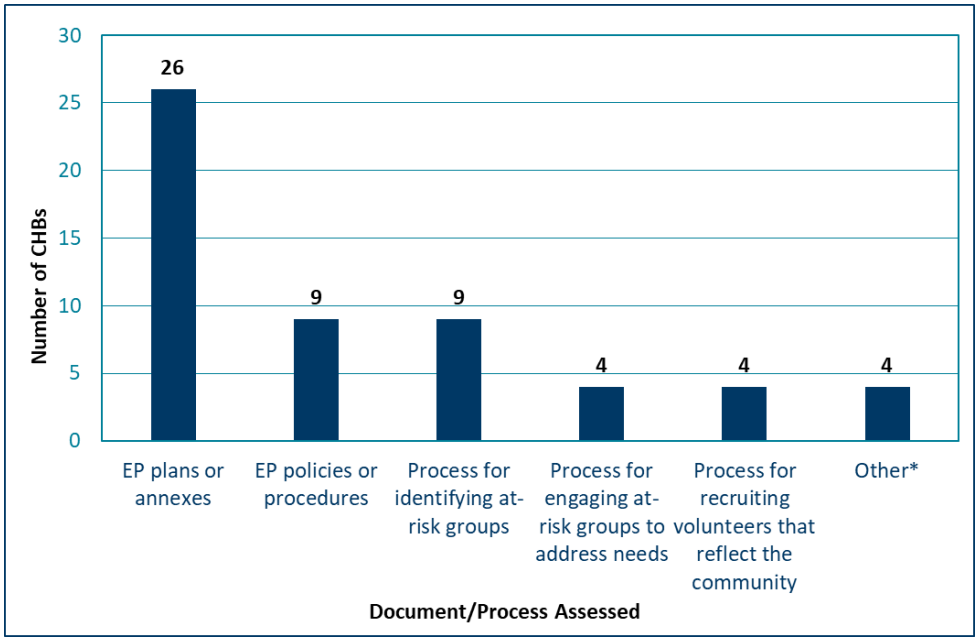
Progress: September 30, 2024




## Health equity in disaster response

Factors that impact daily living and create inequities are exacerbated during disasters. To better protect the health of all Minnesotans, public health needs to plan response actions that recognize these factors and the populations who are disproportionately affected. A first step in improving public health responses is to review plans, policies, and procedures using a health equity perspective. A second important step is to engage communities in conversations about their strengths, challenges, and needs and jointly create equity-centered response plans. CHBs have taken these first two steps and have made considerable progress in identifying gaps and strengths, as can be seen in Figure 5.

### Figure 5: Documents and Processes assessed for health equity



CHBs have implemented strategies that improve relationships and readiness with many different groups within their jurisdictions that include adding community health workers, bilingual/multi-lingual staff, and culturally specific message development, among many other activities. A CHB shared some of the innovative work they have been able to do because of the RSG funds.

> *To recruit diverse volunteers from our community to join our MRC unit, we launched the medical interpreter program, offering potential bilingual volunteers the opportunity to become certified medical interpreters in exchange for volunteering 40 hours over two years with our MRC unit. We partnered with trusted messengers from Spanish, Hmong, and Somali communities, promoted the program through Facebook, Facebook groups, WhatsApp, and existing public health-community partnerships, to ensure that our recruitment efforts reached a diverse range of individuals. As a result of these efforts, we received 22 applications, conducted 16 interviews, and ultimately selected 10 candidates who were bilingual in Spanish and Somali with strong backgrounds in health care, education, nursing, volunteering, and public health. These candidates have strong ties to their cultural communities. The candidates are in the process of enrolling in our MRC unit and the medical interpreter program led by the Academy of Interpretation.*

## Focused Activities

While all 51 CHBs addressed preparedness and response actions described above, those with greater capacity and funding were able to take on additional work, focused on specific areas of public health emergency preparedness, response, and recovery work. These areas help build CHBs capacity to respond more effectively and efficiently. The next few pages describe the work they accomplished.

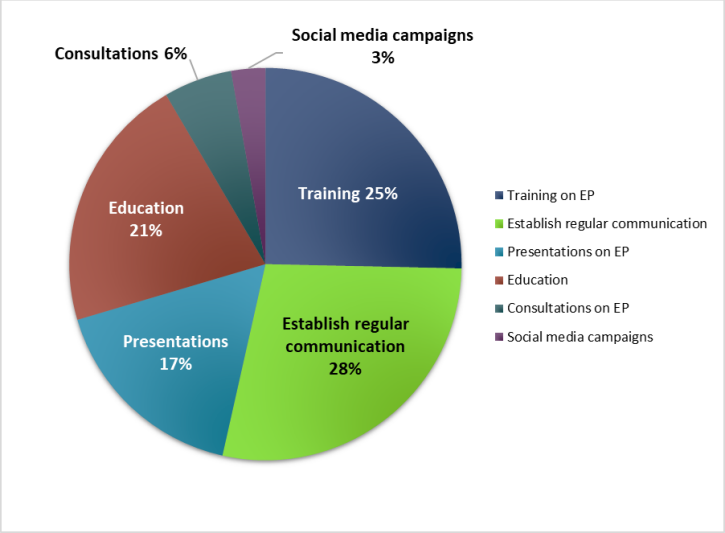
### Working across public health agencies

Thirty-four CHBs focused on working across their agency's public health programs to increase overall agency capacity. Table 6 provides a snapshot of the major public health program areas that participated in presentations, trainings, or exercises about public health emergency preparedness, response, and recovery. Building internal capacity and understanding of public health's role in emergency response and recovery provides a larger base of workforce to draw upon as well as increasing staff capabilities. Communicable disease control and communications programs were the most frequently identified by the CHBs. Figure 6 describes the types of activities employed to help increase staff awareness and capacity. The CHBs almost evenly split their efforts between establishing regular communication, and providing training, education, and presentations.

### Table 6: Public Health programs engaged

| Program | Sept. 30, 2024 |
|---|---|
| Communicable disease control | 26 |
| Communications | 21 |
| Maternal, Child, and Family Health | 13 |
| SHIP | 9 |
| Family Home Visiting | 13 |
| Community Partnership Development | 14 |
| Chronic disease and injury prevention | 8 |
| Equity | 9 |
| Environmental Public Health | 8 |
| School Health | 7 |
| **Total** | **132** |

### Figure 6: Activities increasing staff engagement




The 34 CHBs working on this activity recognized the benefits of being able to broaden their public health emergency preparedness work within their agency.

> *RSG funds have allowed us to expand our preparedness efforts by including more staff, integrating the work across units, and creating more of a department function rather than a PHEP silo. We invited Public Health employees to join an internal EP workgroup and were thrilled to onboard 17 staff who are now actively participating in annex reviews, safety improvements and departmental trainings. This workgroup has allowed for more collaboration opportunities for preparedness and increased bench depth and strength for future responses. This new funding is opening the doors to flexibility, creativity, and collaboration - and it's undoubtedly making an impact.*

## Emergency Preparedness training

Thirty-four CHBs focused on providing emergency preparedness training in order to achieve a response ready workforce. Staff turnover and lessons learned during recent responses highlighted the need for incident command system (ICS) training, topic specific courses, sharing of best practices, and basic public health practice knowledge. The Response Sustainability funds supported the professional development of CHB's public health professionals, with the vast majority of training focused on Incident Command System (ICS) training, followed by Communications, Mental and Behavioral Health, and Equity training. These were the most commonly identified gaps from recent responses. The RSG funds provided the funding for the CHBs to beginning addressing these gaps. Table 7 provides an overview of the 221 trainings attended.

### Table 7: Emergency Preparedness trainings CHBs completed

| Training | N 09/30/2024 |
|---|---|
| Incident Command System (ICS) Trainings | 103 |
| Communications | 34 |
| Mental and Behavioral Health | 25 |
| Equity | 22 |
| Shelter trainings/FAC | 11 |
| Community Engagement and Emergency Preparedness, Response, and Recovery | 8 |
| Emergency Preparedness Conferences | 6 |
| Point of Dispensing (POD) training | 4 |
| Other | 8* |
| **Total** | **221** |

*Other: HAZMAT trainings (2), Emergency plan development (2), Engaging Policy Makers to Improve Health, University of Minnesota: Crafting a compelling data story, Enhancing response and recovery in rural communities, Outbreak at Water's Edge (Epidemiological Investigation)

The 34 CHBs selecting this activity shared how they have been able to improve their readiness to respond by training staff, and in some cases, key partners on plans, incident command system, and other critical emergency preparedness topics.

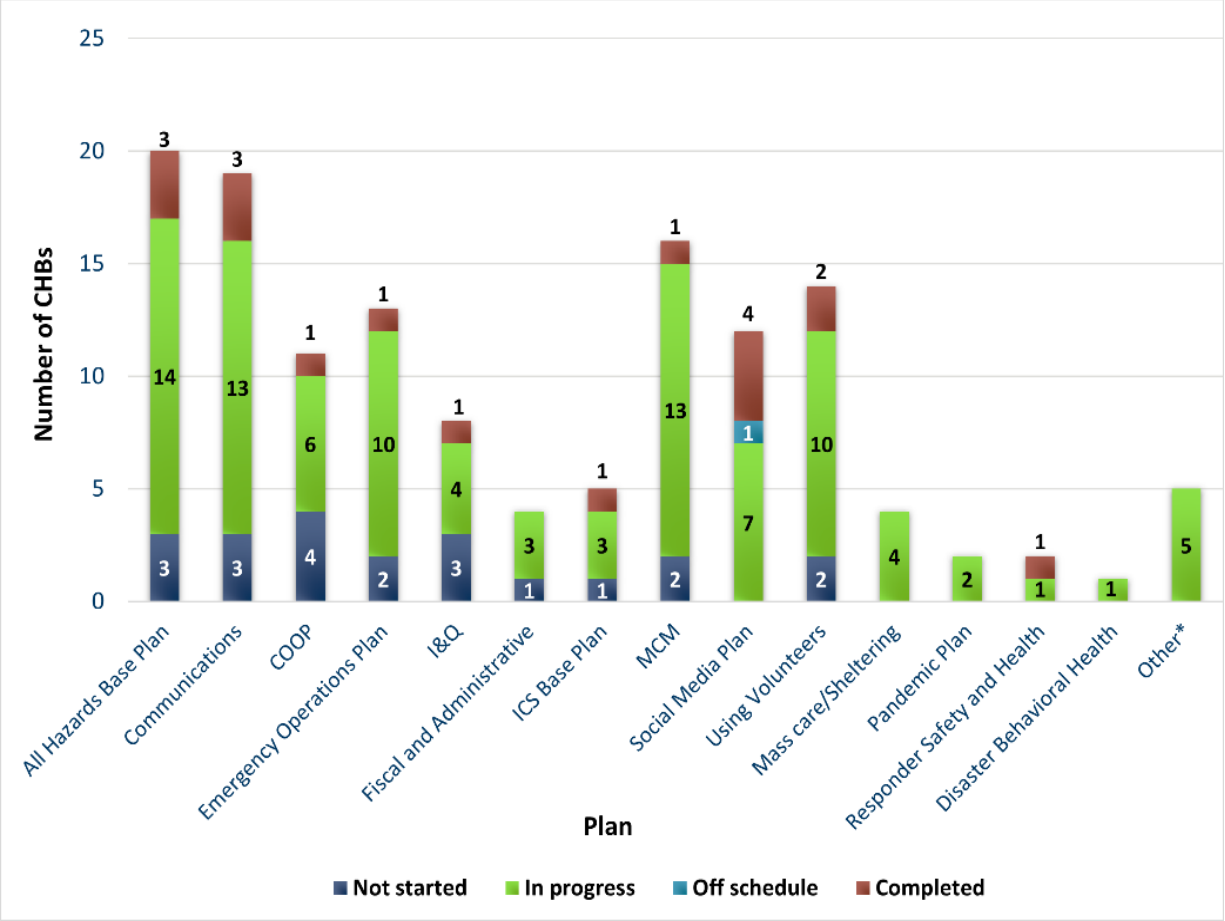
> *[The CHB] been able to train staff on a more regular basis pertaining to emergency preparedness plans. Staff have been trained on the recently completed All Hazards Response Plan and the Notification and Activation Annex. Without RSG funding, we would have a hard time being able to justify training needed staff utilizing non-preparedness funds.*

> *All staff job descriptions require specific training on incident command from FEMA and localized training. Thanks to RSG funding. All existing and new staff have completed FEMA 100, 200, 700, and 800. [The CHB] is waiting to send an additional lead staff to IS-300 and IS-400 pending course availability. Six staff also completed Behavioral Health training using the Question, Persuade, Refer Model.*

## Public Health Emergency Preparedness plans and annexes

CHBs made considerable progress in updating their public health emergency preparedness policies, plans, and procedures. The 25 CHBs working on this activity incorporated results from after action reports to address identified gaps, reduce inefficiencies, and enhance actions that worked well. Using the results of their health equity assessments, many were able to strengthen their efforts aimed at ensuring equitable response activities. Figure 7 provides a snapshot of the ongoing work to improve CHB response plans, policies, and procedures.

## Figure 7: Developing, reviewing, and updating policies, plans, and procedures




*Other: Family Assistance Center Plan, Immigrant Influx Response, Access and Functional Needs, Extreme Heat Event Plan, Human Services Strike Teams

The 25 CHBs who worked on their plans described the progress they made on developing and revising their response plans.

> *Worked with our county EM to review and update the PHEP Annex in our County EOP [emergency operations plan]. Reviewed outdated documents and plan to update them or incorporate them into existing documents such as our regional ones or the EOP.*

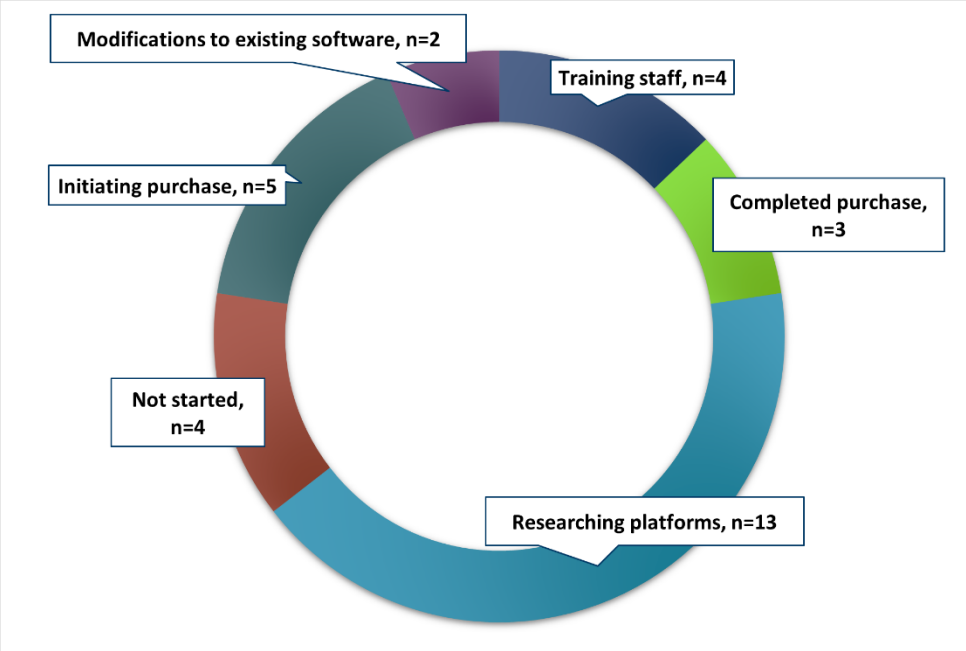
> *We hired an additional full-time Public Health Emergency Preparedness Coordinator. This additional position has enabled [the CHB] to update emergency preparedness plans and connect with community partners to help support those updated plans.*

> *[The CHB] has been able to revise and streamline emergency plans, making them more accessible and user-friendly. These changes include clearer protocols, simplified checklists, and more practical guidance.*

## Technology for Public Health Emergency Preparedness

Software and platforms can aid response work and can also hinder it. Twenty-two CHBs recognized a need to examine their current software and platforms due to challenges they encountered during responses that prevented them from efficiently doing work, quickly obtaining information, or rapidly being able to share information. Using the Response Sustainability Grant, several CHBs have begun identifying options that can address these technology gaps, including assuring staff know how to use software and platforms. Figure 8 provides a status overview on the progress CHBs have made.

### Figure 8: Addressing technology gaps



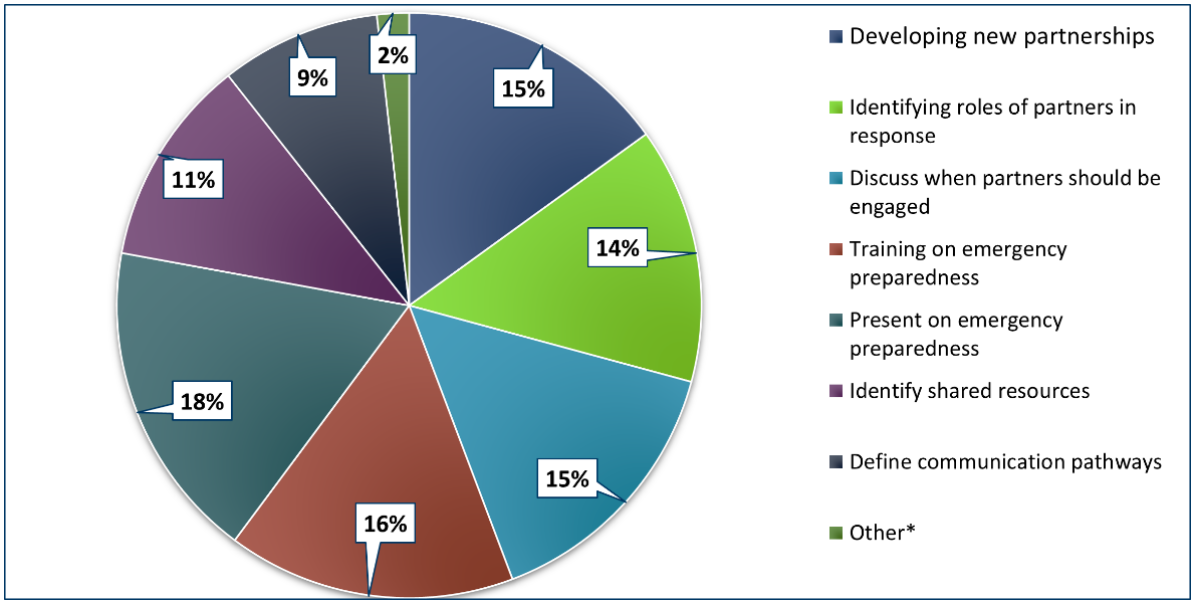

One multi-county, multi-agency CHB described the importance of having the RSG funding to implement advanced technology to improve their ability to work across their counties efficiently.

> *The implementation of Microsoft Teams is still a work in progress. Teams has the potential to streamline internal communication and document collaboration by allowing real-time editing and easier information sharing across the organization. However, not all counties within our CHB currently use Teams, which has posed a challenge in achieving full-scale implementation. Securing a Microsoft license for all counties is ongoing, and this will be critical to ensuring consistent use of the platform across the board. In the meantime, we are continuing to explore alternative solutions to maintain collaboration until Teams can be fully adopted. In the Region, SharePoint has been adopted as a centralized platform for collaboration and document management. This tool has enhanced coordination by allowing all participating counties to access, update, and share preparedness plans, training materials, and response protocols in one location.*

## Partnership development

It is a well-known fact that disaster response requires collaboration across many organizations and community groups. It is also well known that this requires well-established relationships and that these require dedicated time to develop. Twenty-seven CHBs elected to use Response Sustainability funding to concentrate efforts on developing or expanding an astonishing 110 relationships with community partners. On average, each CHB averaged over four new or expanded partnerships. Health care, public safety and emergency management, and cultural/faith-based groups were the most frequently identified sectors for engagement activities, as can be seen in Table 8. A few CHBs also engaged libraries (2), public utilities (1), and correctional facilities (1). The type of activities used to engage partners can be seen in Figure 9 and included developing new partnerships, presentations about emergency preparedness, providing training, identifying roles, and when partners should be engaged.

### Figure 9: Activities conducted to engage community partner sectors




*Other: Created a preparedness survey for community members, Re-organized and coordinated the PHEP Advisory committee meeting

### Table 8: CHB relationships with community partners / organizations

| Sectors | Sept. 30, 2024 |
|---|---|
| Health care (Hospitals/clinics) | 23 |
| Public Safety and Emergency Management | 20 |
| Cultural and Faith-based groups | 19 |
| Education and childcare settings | 16 |
| Local government | 16 |
| Social services | 13 |
| Community leadership | 11 |
| LTC, Assisted Living, other senior services | 10 |
| Voluntary Organizations Active in Disasters and Non-profits | 8 |
| Housing and sheltering | 6 |
| Mental/Behavioral health | 5 |
| Media | 5 |
| Business/Worksites/Agri-business | 4 |
| Coroner, Medical Examiner, and Funeral Homes | 4 |

The 27 CHBs working on this activity described the benefits they experienced in partnering with others in their communities to prepare and respond to incidents.

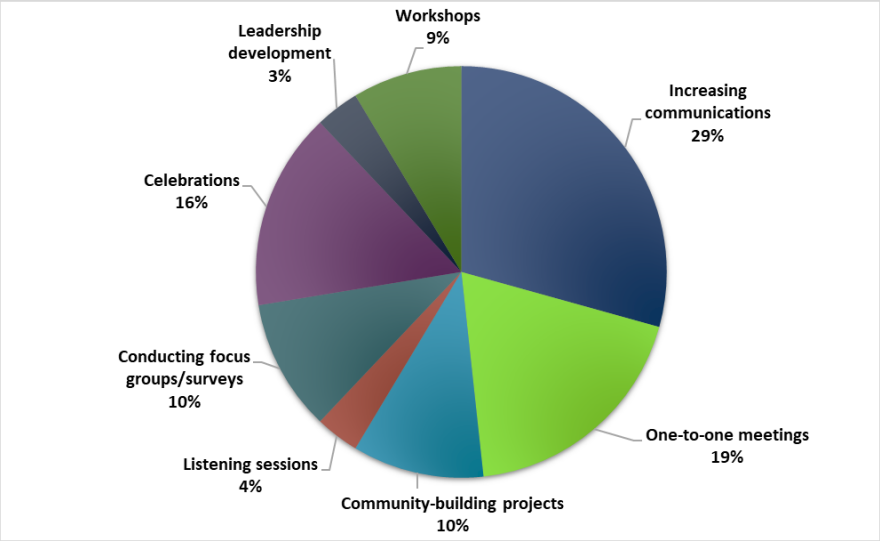
> *We were able to coordinate and provide trainings to external partners to increase capacity and be better prepared for a response to infectious disease, such as measles. We developed new or expanded partnerships with MDH, area schools, area clinics/hospitals, Emergency Management/Sheriff's Departments. Additionally, we were excited to establish a relationship with external community partners in the agriculture communities during this reporting period.*

> *Was able to engage 7 County Senior Federation, and Central MN Council on Aging; both organizations were identified as partners of interest in years previous and because of an increase in staff capacity were finally able to engage with them and get those organizations involved at the Emergency Preparedness Advisory Committee. Their involvement and perspective are critical to support the AFN [access and functional needs] population and promote a health equity lens to response planning efforts.*

## Community Engagement

To work authentically with community groups and organizations, it is important to develop and sustain relationships. This work is just as important as developing partners. The 20 CHBs working on this activity had varied approaches, based on the types of communities in their jurisdictions. Many emphasized the critical component of communications and one-on-one meetings, knowing these underpin all other activities in building relationships. Figure 10 illustrates the strategies used by CHBs ranging from listening sessions and focus groups to training, leadership development, and individual meetings.

### Figure 10: Community engagement activities




The 20 CHBs working on this activity felt strongly that building relationships is a critical component to their response readiness. They shared how they were able to strengthen this component of their preparedness work.

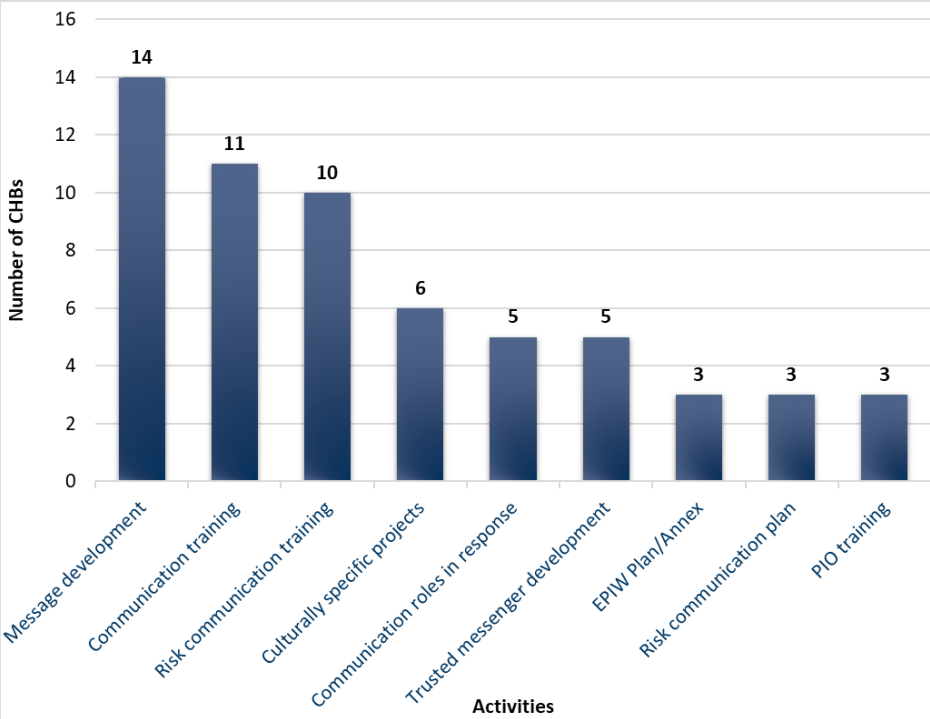
> *Due to increased funding, the EP coordinator spends 100% of their time doing Emergency Preparedness and has been able to do more outreach and engagement with different populations including youth.*

> *We [Public Health, PIO, EM] have attended community events together, we have collaborated on communication, education, meetings, and trainings. We have participated and networked with Leech Lake, Red Lake, and White Earth tribes.*

## Communication

Communication can be challenging at any time and is often identified as a major stumbling block during emergencies. During disasters, effective and timely communication can be the key to a well-coordinated, efficiently run response. Nineteen CHBs recognized these challenges, with several electing to work on plans, message development, training, and several aspects related to health equity communication. Many of these CHBs noted they were able to send several staff to the Crisis & Emergency Risk Communication (CERC) training offered by MDH throughout the state. Figure 11 provides a summary of the CHBs communication progress.

## Figure 11: Improving disaster communications




The 19 CHBs selecting Communications as an additional area of activity recognized the progress they were able to make in improving readiness, pre-incident message development, and emphasizing health equity in messaging.

> *The formation of the new Communications and Emergency Preparedness team has been instrumental in enhancing the department's communication capabilities. By bringing together dedicated communications specialists and implementing streamlined workflows, we have been able to significantly improve the efficiency and effectiveness of our communication efforts, particularly in how we collaborate with trusted messengers.*

> *[The CHB] sent staff to the Crisis and Emergency Risk Communication (CERC) training hosted by MDH. Utilizing lessons learned from this training, [the CHB] was able to create messaging templates that have already been used to communicate with both the public and the media. Creating these materials has always been a priority for our department, but with limited FTE in preparedness work, it was difficult to complete when other work takes precedence.*

# Additional Impact Stories

The Response Sustainability Grant funding importance to the CHBs and THDs cannot be underscored. The work they have been able to undertake and accomplish in less than a year of funding is remarkable. With continued funding, Minnesota's public health system will be ready to respond to disasters affecting our citizens anywhere in the state.

## Tribal Nations' Tribal Health Department Impact Stories

*This [funding] has allowed us to travel to Upper Sioux to observe their shelter training to see if it was a good fit to offer at Bois Forte.*

*This funding has allowed our agency to have staff dedicate more time to reviewing and updating our emergency plans as well as collaborate with internal and external partners on a regular basis.*

*RSG Funding has allowed Leech Lake Band Tribal Health to add a 1.0 FTE Position that will be responsible for emergency preparedness planning and response for the tribe. If not for this funding, they would not have the funding to add any positions to work on ep [emergency preparedness].*

*Traveling to the MMIR [Missing and Murdered Indigenous Relatives] Training was possible due to the [RSG] funding. The training was fantastic and taught me some of the reasons the native community is suffering. I have a better understanding of why generations did not teach the next language.*

*RSG funds have provided an opportunity to collaborate with external partners during a recent school vaccination clinic. USIC worked with county public health and a local charter school to provide a service to children who are part of an at-risk population in our service area.*

*White Earth Tribal Health is able to partner with White Earth Tribal EM and emergency management planner to align tribal health and tribal emergency management plans and activities. This would not have been possible without RSG Funding.*

## Community Health Boards' Impact Stories

### Workforce capacity

*Another grant was expiring, and we are going to be losing our community health worker. Fortunately, the timing of this grant was perfect, and we were able to support her work and transition her to this extremely important work where she can be in our communities, providing education to families pertaining to being ready for emergencies similar to the one we recently experienced, in order to prevent this situation from occurring again. An added bonus is that the Community Health Worker is bilingual and therefore she has the ability to educate not only in English, but in Spanish as well.*

*[The CHB] collaborated with The National Weather Service…on an Amish/Plain Community Integrated Warning Team event…this multidisciplinary event involved a series of presenters from MN*

*and WI providing information about the Plain Community. [The CHB] provided information for Minnesota. Discussion also took place about best practices and next steps to address weather emergencies with the Amish community.*

*Our Emergency Preparedness Coordinator…heard feedback that written Somali wasn't as accessible as an audio option. For National Preparedness Month, they drafted a version of a preparedness handout with Somali translation as a QR code option on both English and Spanish handouts. A Somali county staff then read the content in Somali in a voice over. They were then able to go to the council with feedback.*

*We have been able to use RSG funds to do outreach to our Karen community. We have provided educational materials such as a picture list of items to include in a kit along with the information in the Karen language.*

*The hiring of a 1.0 FTE [staff person] and expanding the time for PHEP for [another staff person] EP in [another county] has allowed [the CHB] to work on PHEP items that in the past were not completed or done hastily. This hire would not have been possible without [the RSG] funding.*

### Disaster response agreements

*Our LPH continues to build upon existing relationships with the new capacity that we have because of RSG. We have identified beneficial MOU partners and will have the capacity to work on updating existing agreements and drafting new agreements.*

*Working on MOUs. County Attorney reviewed in 2023-2024 and contract person is now renewing older MOUs. Added new POD locations and updated those to Plans and Updated Contact lists for all MOUs and partner collaboration and Advisory Committee. Working with Emergency Manager on Updating the County Emergency Operations Plan (EOP) update and Jurisdictional Risk Assessment (JRA).*

### Health equity

*[The CHB] has been able to expand our use of PHDoc to chart access and functional needs that clients may have during an emergency. We have utilized the CMIST model to capture which categories of CMIST the client falls into. During an emergency, we can pull reports to identify which of our clients would need assistance if the emergency would or has impacted folk with those needs. We have also implemented the ability to chart whether folk have supports or not. Clients with little to no supports would be the ones we want to reach out to first in the event of an emergency to check on and see if they need assistance.*

*Working on health equity incorporation in policies, procedures, and resources. For example, included an access, functional need, and cultural resource section to the [CHB] community resource guide which is available for the public and staff to use non-emergency and emergency purposes. This document also references disease prevention and control, emergency services, sheltering, and resources that can be used in case of isolation and quarantine.*

*[CHB is] strengthening resources and understanding of risks, vulnerabilities and needs across our community and increasing health equity in PHEP plans.*

*MDH health equity team [attending] monthly meetings to better prepare LPH for increased understanding and abilities to incorporate equity into preparedness planning.*

*[CHB is] conducting monthly plan review meetings and following the MDH health equity spreadsheet to make updates [to] the plans.*

### Working across Public Health agency programs

*At each of our All-staff meetings, which occurs every other month, there is time dedicated for EP education. We have started with basic EP 101, PHEP Capabilities review, and the role of LPH in emergencies. We then build off of that to review ICS/NIMS and how it would be used within our agency. We are in the process of planning for COOP education at our next all-staff meeting. After this education, each program will review their program priorities at upcoming work plan meetings to then allow us to update our overall agency COOP plan. The intent of this process is to continue to build on EP related trainings for all staff so they have a general idea of EP in the event a response was required of all our staff.*

### Emergency Preparedness training

*The ability to increase the staff time, trainings, and opportunities from the state's funding has been instrumental in increasing our capacity for emergency preparedness work. We have been able to attend more trainings related to communication, risk assessments, health equity, and so much more to better serve our communities and ensure that all individuals have their needs met accordingly. Each of the PHEP Coordinators within our CHB as well are the LPH Directors and other public health staff have been able to increase our focus on Emergency Preparedness. This would not have been possible without the state funding. Thank you.*

*Able to use funding to contract with trainer on providing COOP training and exercise for county-wide supervisors and department heads. All public health staff also participating in COOP training.*

*[The CHB] completed a training needs assessment in the spring for human services and public health staff. The results are being used to create a workforce development program. In addition, over 500 staff indicated an interest in participating in further training and exercises.*

### Public Health Emergency Preparedness plans and annexes

*[THE CHB] was able to meet with the Safety Coordinator and the EM to go over emergency plans for county buildings that were very outdated.*

*Previously we did not have the FTE to support a deep dive into our plans to update them post-COVID. We have been able to begin this work with the additional funding.*

### Partnership development

*[CHB] recognized National Preparedness Month in a much different way this year. Because we have more preparedness funding thanks to the Response Sustainability Grant, we were about to spend more time preparing better tailored communications about the month's goal of bringing awareness to the importance of preparedness. We created new partnerships with grocery and hardware stores to tag preparedness items around the stores. This brought awareness to the items that should be included in an emergency supply kit. These new partners were excited about the preparedness campaign as it was little effort on their part but had potential to really capture the interest of the folk in their stores.*

*In response to the increasing risk of a measles outbreak due to declining MMR vaccination rates, [the CHB] partnered with [another CHB] to host a lunch and learn event for local health care providers in April. The session featured a subject matter expert who shared valuable insights on health care preparedness in the event of a measles outbreak. The discussion centered around key considerations, including the roles and responsibilities of health care professionals in preventing and managing potential cases. Our goal was to equip providers with the knowledge and strategies necessary to ensure their facilities are prepared to respond effectively to this growing public health threat. Previously, PHEP funds only covered a small amount of staff time. RSG funds afforded us the time to pull together these stakeholders for an important conversation.*

*This additional position has enabled [the CHB] to update emergency preparedness plans and connect with community partners to help support those updated plans.*

*[The CHB] has historically reported having difficulty coordinating with the EM. We have made progress towards LPH and EM partnering for a staffed emergency shelter plan.*

*…reconnecting with partners from COVID-19 response and creating new partnerships that will help in future responses. For example, we built on an existing relationship with our local library system to set up a heating/cooling shelter at their [city] location. We were able to leverage an existing relationship to share responsibilities and plan for future community needs.*

*[The CHB] has been able to partner with [the city] Emergency Management Director and host a learning series on various emergency management series of focus with a public health lens. The first meeting was a presentation on Family Assistance Centers and the Incident Command System.*

### Community engagement

*[The CHB's] biggest highlight was adding an additional EP Specialist to our team! This position will focus on Emergency Preparedness Community Engagement, review/updating Closed POD Plan and partnerships. Overall, this position will allow our EP team to increase external/internal partnerships.*

*One highlight was our team was able to provide emergency preparedness education and emergency kit development education to families in the counties we serve as part of their WIC appointments. Specifically, we held this education at our off-site locations where many of our non-English speaking, culturally diverse community members attend. This outreach provided education to a population who may not have received this type of education otherwise.*

*With the additional funds, our team has achieved significant success in optimizing our operations and expanding our impact. [The CHB] was able to create a brand-new position, hiring a dedicated individual to focus on emergency preparedness, response, and health education. This marks a major milestone for the county, as it's the first time they've been able to strengthen their presence in the community, fostering lasting relationships with local residents.*

*We have been able to increase our involvement in school activities and with all of our educational partners to focus on emergency preparedness at a child's level. We have been able to join events such as "Back to School Night", "Be the Voice" events, and increase our involvement with local groups focusing on mental health and disaster recovery.*

### Communication

*Community Health Educators have been able to integrate emergency preparedness into their communications and outreach efforts.*

*We have increased our social media presence and are working on website updates.*

*…developing a monthly newsletter that will tie together various public health grants and programs with an ongoing focus on emergency preparedness. The newsletter will be distributed to both staff and community members, ensuring that preparedness remains a consistent topic of conversation. The goal is to keep both internal staff and the broader public informed about updates in emergency preparedness, share success stories, and provide actionable steps for improving individual and community preparedness. This will not only foster greater awareness but also align public health efforts across multiple programs under a unified communication strategy.*

*National Preparedness Month provided a successful venue to pilot some new ideas around communication and translation. We increased social media presence, tried audio recording for Somali translation, and were able to advertise the events to community partners as a way to increase engagement.*

*Our communications specialist transitioned from a grant funded position to a full-time agency position. She attends many of our program specific meetings, including emergency preparedness team meetings as needed. She's also included in work plan meetings and assists with our EP social media, newspaper, radio spot and newsletter/yearly report development.*

*…our agency has committed and supported funding for a full-time Communications Specialist for our agency. It is a huge advancement to have someone skilled in communication to have time committed in our EP [emergency preparedness] program to truly help highlight and share our EP work and available resources to everyone across our multi-county CHB.*

*…had an intern over the summer months assist us in gathering social media material and organize it in a way that we can easily pull it in the event of a response. This will help cut down on the amount of time it takes staff to find the materials and will allow us to be more efficient in getting important messaging out to our communities.*

*The new Communications and Emergency Preparedness team has made significant strides in enhancing the department's capacity for emergency preparedness. As demonstrated by our recent measles awareness campaign, the team is effectively leveraging various communication channels to raise awareness, encourage vaccination, and promote public health. These efforts are laying the groundwork for improved emergency response and recovery efforts.*