LEWIS AND CLARK CITY-COUNTY
BOARD OF HEALTH MEETING
LEWIS AND CLARK PUBLIC HEALTH
ZOOM
March 23, 2023
(Note: Meeting time 1:00-3:00pm)

REGULAR BOARD MEETING AGENDA

1:00 **CALL TO ORDER**

1:00 **REVIEW OF AGENDA**
1. Review and revision of agenda ……..…..……...Pg. 1

1:05 **MINUTES**
2. February 23, 2023 ……..Pg. 2

1:10 **ACTION ITEMS**
3. PHAB Reaccreditation letter of support .....……..…….Pg. 6
4. Communicable Disease Update and Response Plan Promulgations .……Pg. 8

1:50 **BOARD DISCUSSION**
5. - Work Force Development Plan
- Call for Board of Health Finance Committee
- Transition to hybrid meetings / location ……...……..……Pg. 15

2:30 **HEALTH OFFICER REPORT**
6. - Strategic Plan update
- Legislative Update
- Local Governing Body By-Laws Update ...……..……....……Pg. 113

2:45 **PUBLIC COMMENT**
7. Public comments on matters not mentioned above ...…….……..…Pg. 114

Adjourn

Our mission is to improve and protect the health of all Lewis and Clark County Residents

ADA NOTICE
Lewis and Clark County is committed to providing access to persons with disabilities for its meetings, in compliance with Title II of the Americans with Disabilities Act and the Montana Human Rights Act. The County will not exclude persons with disabilities from participation at its meetings or otherwise deny them County's services, programs, or activities. Persons with disabilities requiring accommodations to participate in the County's meetings, services, programs, or activities should contact Kari DesRosier, as soon as possible to allow sufficient time to arrange for the requested accommodation, at any of the following: (406) 447- 8316 TTY Relay Service 1-800-253-4091 or 711 kgrose@lccountymt.gov 316 N Park, Room 303

Lewis & Clark Public Health

LEWIS & CLARK CITY/COUNTY BOARD OF HEALTH
Helena, Montana

BOARD AGENDA ITEM

Meeting Date	**Agenda Item No.**
March 23, 2023	**1**

___Minutes __X_Board Member Discussion ____Staff & Other Reports ___Action ___Hearing of Delegation

AGENDA ITEMS: Review of Agenda

PERSONNEL INVOLVED: Board Members

BACKGROUND: Time is allowed for board members to review the agenda and to add any new agenda items.

HEALTH DIRECTOR'S RECOMMENDATION: Approval

___ADDITIONAL INFORMATION ATTACHED

BOARD ACTION: **NOTES:**

	MOTION	SECOND	AYE	NAY	ABSTAIN	OTHER
Bedell						
Collins						
Harris						
Kaufman						
MacLaurin						
Murgel						
Rolfe						
Weber						
Weltz						

Lewis & Clark Public Health

LEWIS & CLARK CITY/COUNTY BOARD OF HEALTH
Helena, Montana

BOARD AGENDA ITEM

Meeting Date	Agenda Item No.
March 23, 2023	**2**

_X_ Minutes ___ Board Member Discussion ____ Staff & Other Reports _X_ Action ___ Hearing of Delegation

AGENDA ITEMS February 23, 2022 Minutes

PERSONNEL INVOLVED: Board Members

BACKGROUND: Upon approval, the minutes represent official actions of the Board of Health. Every effort is made to have these recommended minutes accurately portray the proceedings and procedures of the board.

HEALTH DIRECTOR'S RECOMMENDATION: Approval

_X_ ADDITIONAL INFORMATION ATTACHED

BOARD ACTION: **NOTES:**

	MOTION	SECOND	AYE	NAY	ABSTAIN	OTHER
Bedell						
Collins						
Harris						
Kaufman						
MacLaurin						
Murgel						
Rolfe						
Weber						
Weltz						

Lewis & Clark Public Health

LEWIS AND CLARK CITY-COUNTY
BOARD OF HEALTH – MINUTES
1930 9th AVE, HELENA, MONTANA 59601
Zoom Meeting, 1:00 p.m.
February 23, 2023

Members Present
Justin Murgel, chair
Dr. Mikael Bedell, vice chair
Commissioner Tom Rolfe
Mayor Wilmot Collins
Mayor Kelly Harris
Brie MacLaurin
Lisa Kaufman
Katherine Weber
Rex Weltz

Members Absent

Staff Present
Drenda Niemann
Jolene Helgerson
Beth Norberg
Jay Plant
Heather Parmer
Sarah Sandau
Carin McClain
Tabreez Kara
Valerie Stacey

Guests Present

Justin Murgel, chair, called the meeting to order at 1:00 p.m. A quorum was established.

REVIEW OF AGENDA
No changes were made. No public comment was given.

MINUTES
Mr. Murgel asked if there were any corrections or additions to the December 1, 2022, and January 26, 2023 minutes. There being none, the Board approved the minutes as written. No public comment was given.

INTRODUCTIONS
New Staff Introduction & Employee Recognition: Introduction of new employees Carin McClain, Tobacco Prevention Specialist, Tabreez Kara, Suicide Prevention CDC Associate, Angelique Frier, Big Sky Watershed Corps member. Drenda Niemann, Health Officer announced that Valerie Stacey, Sanitarian with the Environmental Services Division, received the Quarterly Employee Recognition award. No public comment was given.

ACTION ITEMS
Variance Request, Aaron and Windy Knutson, 5697 Birdseye Road, Helena, MT: Lisa Kaufman, Hearing Officer, read the hearing officer recommendation (on page 11 of the board packet) from the Knutson Variance held on February 1, 2023. She said the request met all of the Montana Department of Environmental Quality criteria for granting a variance. In answer to a question from Commissioner Tom Rolfe, Ms. Kaufman and Beth Norberg, Sanitarian, both replied that the number of animals processed for the year in condition #5 (on page 14 of the board packet) was set by the applicant when asked to determine

the amount of waste that would be going into the holding tank. Commissioner Rolfe noted that there should not be a limit on the number of animals to help with future business opportunities and to avoid having to submit another variance application for review by the Board. In answer to a question from Mayor Kelly Harris, Ms. Norberg, stated that if the City of Helena started to restrict dumping of septic waste into the City of Helena's Municipality, there is an approve land application site available to use. At this time the City of Helena has not restricted any septic waste unloading. Commissioner Rolfe moved to ratify the hearing officer recommendation. Mayor Wilmot Collins seconded the motion. No public comment was given. The motion carried 9-0 with Katherine Weber's response sent via email to Drenda Niemann, Health Officer (see Attachment "A").

BOARD MEMBER DISCUSSION

Finance Report for 2st Quarter FY23: Heather Parmer, Finance Coordinator, referenced the FY23 comparison to budget and cash flow for July through December 2022 (on pages 34-35 of the board packet). Ms. Parmer noted that the department is 50% through the fiscal year. Total revenue to date is $1,570,481 or 54% of the amount budgeted; actual expenditures are $1,570,643 or 55% of the amount budgeted. Revenues are under expenditures by $162; total ending cash is $599,206. Ms. Parmer said the current cash reserve is at 72 days. The recommended reserve is 90 days. Revenue has increased with the payment of November taxes. No public comment was given.

Air Quality Update: Jay Plant, Sanitarian, gave an update on the 2022-23 Air Quality Monitoring season (on pages 36-38 of the board packet). Mr. Plant noted this year's air quality during the monitoring season which runs from November 1 to March 1 was good overall. No public comment was given.

Customer Satisfaction Survey results: Ms. Niemann presented the Customer Satisfaction Survey Summary Report (on pages 39-49 of the board packet) in which she highlighted the purpose of the survey, methods, results and recommendations.

HEALTH OFFICERS REPORT

Ms. Niemann offered a short update on activities of the Montana Legislature related to public health:

HB 2: General Appropriations Act- In First House Committee

HB 364: Allow for independent subdivision reviews for past due applications- In First House—Third Reading

HB 715: Revise school immunization laws- In First House—Third Reading

SB423: General revise liability related to firearm hold agreements- Currently in Senate Hearing.

SB450: Personal Freedom /Right of Conscience Act related to immunizations and drugs- In First House—Third Reading

SB465: Require implementation of Medicaid community engagement requirements-Probably Dead

SB 475: Generally revise indoor vaping laws- In First House Committee--Tabled

CDC Infrastructure Grant: The CDC grant that provided funding for COVID-19 response is set to expire. This grant allowed Public Health to employee personnel to assist with COVID responses. 2 of the 3 FTE

positions will be terminated at the end of the grant, June 30, 2023. Ms. Niemann has submitted a new grant award to continue the employment of the Epidemiologist position.

Local Governing Body: The five member board met to review and discuss the Local Governing Body By-Laws. Recommended changes were discussed and the County Attorney is currently amending the draft by-laws.

PUBLIC COMMENT
No public comment was given.

The meeting adjourned at 2:17 p.m.

Justin Murgel, Chair

Drenda Niemann, Secretary

LEWIS & CLARK CITY/COUNTY BOARD OF HEALTH
Helena, Montana

BOARD AGENDA ITEM

Meeting Date	**Agenda Item No.**
March 23, 2023	**3**

___Minutes __X__Board Member Discussion ___Staff & Other Reports __X__Action __Hearing of Delegation

AGENDA ITEMS PHAB Reaccreditation Letter of Support

PERSONNEL INVOLVED: Drenda Niemann, Health Officer

BACKGROUND Ms. Niemann will present the PHAB Reaccreditation letter of support for board review and approval.

HEALTH DIRECTOR'S RECOMMENDATION: N/A

__X__ADDITIONAL INFORMATION

BOARD ACTION: **NOTES:**

	MOTION	SECOND	AYE	NAY	ABSTAIN	OTHER
Bedell						
Collins						
Harris						
Kaufman						
MacLaurin						
Murgel						
Rolfe						
Weber						
Weltz						

Lewis & Clark Public Health

LEWIS AND CLARK
CITY-COUNTY BOARD OF HEALTH

1930 Ninth Avenue
Helena, Montana 59601
Telephone 4-HEALTH or dial 443-2584
Fax 406-457-8990

March 23, 2023

Public Health Accreditation Board
Reaccreditation Review Committee

To Whom it May Concern,

As the operational oversite governing body of Lewis and Clark Public Health, the Lewis and Clark City-County Board of Health submits this letter of support for PHAB Reaccreditation. The Board of Health understands the significance and responsibility of accreditation and commits to supporting the department through the reaccreditation process and the ongoing work associated with maintaining accreditation.

Sincerely,

Justin Murgel, Chair
Lewis and Clark City-County Board of Health

March 23, 2023

As the Local Governing Body responsible for approving the Lewis and Clark City-County Board of Health recommendation to hire the department director/health officer for Lewis and Clark Public Health per Interlocal agreement, the Local Governing Body submits this letter of support for PHAB Reaccreditation.

Sincerely,

Wilmot Collins, Mayor of Helena
Local Governing Body Chair

LEWIS & CLARK CITY/COUNTY BOARD OF HEALTH
Helena, Montana

BOARD AGENDA ITEM

Meeting Date	**Agenda Item No.**
March 23, 2023	**4**

___Minutes _X_Board Member Discussion ___Staff & Other Reports _X_Action __Hearing of Delegation

AGENDA ITEMS Communicable Disease Update and Response Plan

PERSONNEL INVOLVED: Laurel Riek, Disease Control and Prevention Division Administrator

BACKGROUND Ms. Riek will provide a brief Communicable Disease update along with the review and approval of the Response Plan Promulgations

HEALTH DIRECTOR'S RECOMMENDATION: N/A

_X_ADDITIONAL INFORMATION

BOARD ACTION: **NOTES:**

	MOTION	SECOND	AYE	NAY	ABSTAIN	OTHER
Bedell						
Collins						
Harris						
Kaufman						
MacLaurin						
Murgel						
Rolfe						
Weber						
Weltz						

Lewis & Clark Public Health

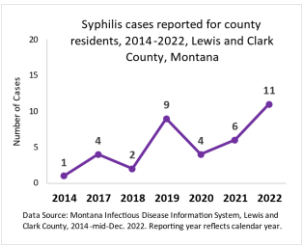
2022 Year End Communicable Disease Report
Date: March 3, 2023

Lewis & Clark Public Health

Reportable Diseases in Lewis & Clark County	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	2022 YTD	2021 YTD	2020 YTD
Campylobacter jejuni			2	2	5	3	8	0	4	2	2	0	**28**	**14**	**19**
Chlamydia	12	2	12	15	15	19	24	15	20	9	9	14	**166**	**180**	**230**
Cryptosporidium					2	2	1	1	1				**7**	**4**	**3**
E. coli 0157													**0**	**0**	**0**
E. coli Non-0157			1			4	3	6		2			**16**	**6**	**5**
Giardia	1	1				1			1	1			**5**	**6**	**2**
Gonorrhea	3		2	3	7	3	2	1	1		3		**25**	**33**	**64**
Haemophilus Influenza										1			**1**	**0**	**0**
Hepatitis A													**0**	**1**	**1**
Hepatitis B	1			2									**3**	**4**	**1**
Hepatitis C	5	5	9	7	4	3	5	8	9	7	5	7	**74**	**49**	**27**
HIV			2	1									**3**	**1**	**3**
Influenza A (Seasonal)	87	43	90	65	66	12	17		3	3	92	136	**614**	**58**	**532**
Influenza B	11	3	4	3	4	1		1					**27**	**0**	**455**
Legionella													**0**	**2**	**1**
Lyme Disease					1							1	**2**	**2**	**0**
Norovirus	1	3	4	4	8	1	1	1	1	1	3	6	**34**	**2**	**4**
Norovirus Outbreak													**0**	**0**	**0**
Pertussis													**0**	**0**	**2**
Q Fever													**0**	**0**	**0**
Rocky Mtn Spotted Fever													**0**	**1**	**0**
Salmonella			1	3	1	3	1	2	1	2			**14**	**8**	**10**
SARS -CoV-2	4028	1077	120	141	505	883	880	540	473	306	300	445	**9698**	**6669**	**4891**
SARS-CoV-2 MIS													**0**	**3**	**0**
Shigella sonnei				2									**2**	**1**	**1**
Strep Pneumoniae Invasive					1	4	1			3			**9**	**2**	**3**
Syphilis	1			2	1	3		1	2	1			**11**	**5**	**4**
Tuberculosis													**0**	**0**	**0**
Varicella								1		1			**2**	**6**	**0**
Viral GI Outbreaks													**0**	**0**	**0**
	4150	**1134**	**247**	**250**	**620**	**942**	**943**	**577**	**516**	**339**	**414**	**609**	**10741**	**7057**	**6258**

Other less common diseases reported in 2022 include: Vibriosis (1), Hemolytic Uremic Syndrome (1), Coccidioidomycosis (1). In addition, we reported 7 rabies post-exposure prophylaxis recommendations for Lewis and Clark County residents. There is a steep increase in Syphilis cases noted in Montana and Lewis and Clark County:

- 2022 had 285 syphilis cases statewide, of which 11 are Lewis and Clark County residents.
- 36 years is the median age of the residents at the time of diagnosis.
- 81% of the county syphilis cases were male.



As always, if you suspect or diagnose any disease listed on the reportable disease sheet, please notify Public Health. This will facilitate an early investigation in order to reduce and prevent the spread of disease. Thank you for your diligence, prevention pays.

Lewis & Clark Public Health

Communicable Disease Response Plan

Effective Date: March 23, 2023

Version: 2.0

Document Number:	DCP-
Document Title:	Communicable Disease Response Plan
Document Owner	Disease Control & Prevention
Approval Date:	March 23, 2023
Approved By:	
Effective Dates:	March 23, 2023 until *March 23, 2026*

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Promulgation Document

Promulgation of Authorization

This document serves as the formal declaration authorizing the use of this emergency response plan to protect the public's health and safety in Lewis & Clark County against communicable diseases. Lewis & Clark City-County Board of Health acknowledges that Lewis & Clark Public Health has the responsibility and duty to execute this plan in defense of public health.

This plan complies with existing federal, state, and local statutes and agreements made with the various agencies identified within. Lewis & Clark Public Health, in defense against disease outbreaks in our communities, prepares and maintains emergency preparedness documents and is committed to the training and exercises required to support this plan.

All partners with roles identified in this plan have participated in its development and concur with the processes and strategies found within, which comply with the *Public Health Emergency Preparedness and Response Capabilities National Standards* (CDC, 2019), and adhere to the science-based, industry, and academic standards of disease control.

All partners and stakeholders are responsible for advising Lewis & Clark Public Health of any changes in their own procedures or operations that could affect any emergency responses undertaken.

This plan is hereby approved for implementation. It supersedes all previous editions.

Board of Health Chair – Justin Murgell	*(Date)*
Health Officer – Drenda Niemann	*(Date)*

Record of Changes

Changes Made	Changed By	Date of Change
Transferred CD Protocol document into Plan Template and updated info for 2019	Brett Lloyd	May 9, 2019
Transferring in CD	Jacqui Snyder	February 6, 2020
Transferring in Definitions and Acronyms from NPI	Jacqui Snyder	March 5, 2020
Transferred foodborne protocol	Jacqui Snyder	March 12, 2020
Complete review and revision by DCP leadership team	Laurel Riek	March 15, 2023

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Table of Contents

1.0 Introduction

1.1 Purpose

The purpose of this plan is to define procedures for LCPH response to communicable disease incidence in Lewis and Clark County with increasing response when outbreaks are recognized. This will also provide a coordinating document for supporting procedure and protocol documents. This is directly in support of our mission statement, "*To improve and protect the health of Lewis and Clark County residents*."

1.2 Scope

This plan and its supporting documents applies to all divisions of LCPH and all communicable disease incidents within Lewis and Clark County.

1.3 Authorities

- Montana Code Annotated
  - 50-2-116 Powers and Duties of Local Boards of Health
  - 50-2-118 Powers and Duties of Health Officers
  - 50-50 Retail Food Establishments
  - 49-2-312 Discrimination Based on Vaccination Status Prohibited
- Administrative Rules of Montana
  - Title 37, Chapter 114 Communicable Disease Control
  - Title 37, Chapter 95, Section 139 Daycare Facilities Health Care Requirements
  - 2013 Food Code, Chapter 2, Subpart 2-2 Retail Food Employee Health
- HIPAA: Federal Health Insurance Portability and Accountability Act of 1996
- Interlocal Agreement
- Lewis and Clark County Rabies Control Regulation (BOH-19-01)
- Memorandum of Understanding between Lewis and Clark Public Health and Lewis and Clark County Sheriff's Office, Helena Police Department and East Helena Police Department for Rabies Prevention

1.3 References

1. **CCDM (Control of Communicable Diseases Manual)**. A current copy is available in the Communicable Disease Nurse office, the Licensed Establishment offices and the Environmental Health Division office.
2. **Red Book (American Academy of Pediatrics).** A current copy is available in the Communicable Disease Nurse office and the Licensed Establishment office.
3. **Epidemiology and Prevention of Vaccine Preventable Diseases (Pink Book).** A current copy is available in the Communicable Disease Nurse office.

4. Assistance from other staff (Environmental Health Specialists, public health nurses, medical advisor).
5. Assistance from DPHHS, Public Health and Safety Division, **Communicable Disease Epidemiology Section**:
6. 24/7 Contact Number – **444-0273** CD/Epi Section Resources - https://dphhs.mt.gov/publichealth/cdepi/CDCPBResources/CDEpi -
7. Centers for Disease Control and Prevention (CDC) www.cdc.gov
8. FDA 2013 Food Code
9. "Blue Book" – Lewis and Clark Public Health Emergency Plans

1.4 Definitions and Acronyms

AAR: After Action Report.

Active Surveillance – Health Department solicits reports of selected, reportable diseases, inquires about observed disease activity and unusual presentations, and provides information on disease activity/trends in the community.

Antiviral Cache: An asset owned by the State of Montana containing antivirals, placed in the care and custody of a host hospital. At the present time, the purpose of the antiviral cache is to treat ill individuals following protocols and procedures that will be developed and distributed at the time of an event.

ARM: Administrative Rules of Montana.

Case Definition: Set of symptoms, clinical or diagnostic findings that constitute a case of a communicable disease. Case classifications include suspect, probable and confirmed. Case definitions can be created by Health Officer, DPHHS, CDC (Centers for Disease Control and Prevention), www.cdc.gov, or the World Health Organization, www.who.int (WHO).

Case: An individual who has been diagnosed with a communicable disease or who has symptoms that fit the case definition of a communicable disease.

CDC: Centers for Disease Control and Prevention.

CDEpi: DPHHS, Public Health and Safety Division, Communicable Disease Epidemiology Section

Cluster - closely grouped series of cases of disease or other health related phenomena with well-defined distribution patterns in relation to time or place or both. An enteric cluster occurs when two or more similar illnesses are suspected to be associated with a common exposure, but investigators are unable to identify a shared food, animal, venue, or experience among ill persons. (NORS)

Communicable Disease Emergency –Any of the following:

1. Single case of unusual disease
    a. Any condition on the list of reportable diseases that requires immediate reporting.
    b. Any condition listed as a threat for biological attack (Table 2)
2. An unusual number of usual diseases

3. Number of cases exceeds the ability of staff to respond in a timely manner
4. Unusual incident of unexplained death in humans or animals
5. Unusual pharmaceutical sales
    a. Report from the state that pharmaceutical sales indicate unusual number of over-the-counter pharmaceuticals for home treatment.

Communicable Disease: an illness due or suspected to be due to a specific infectious agent or its toxic products which results from transmission of that agent or its products to a susceptible host, directly or indirectly.

Condition of Public Health Importance: means a disease, syndrome, symptom, injury, or other threat to health that is identifiable on an individual or community level and that can reasonably be expected to lead to adverse health effects in the community.

Contact: an individual who has been identified as having been exposed, or potentially been exposed, to a communicable or potentially communicable disease through another individual or nonhuman source of the communicable or potential communicable disease.

DES: Disaster and Emergency Services

Disaster - occurrence or imminent threat of widespread or severe damage, injury, or loss of life or property from any natural or artificial cause.

DPHHS: (Montana) Department of Public Health and Human Services.

Emergency - imminent threat of a disaster causing peril to life or property that timely action can prevent.

EMT: Emergency Medical Technician

EOC: Emergency Operations Center

ESF: Emergency Support Function

Exclude: (2013 Food Code 1-201.10) means to prevent a person from working as an employee in a food establishment or entering a food establishment as an employee.

Highly Active Surveillance: increased contact with identified providers for soliciting information on disease activity and disseminating pertinent information.

Isolation: separation during the period of communicability of an infected or probably infected person from other persons, in places and under conditions approved by the Health Officer and preventing the direct or indirect conveyance of the infectious agent to persons who are susceptible to the infectious agent in question or who may convey the infection to others.

LCPH: Lewis and Clark Public Health.

MCA: Montana Code Annotated

MIDIS: DPHHS Montana Infectious Disease Information System

MPHL: Montana Public Health Laboratory

NORS: National Outbreak Reporting System for enteric disease outbreaks

Outbreak – The occurrence of more cases of a disease than would normally be expected in a specific place or group of people over a given period of time. The MPHL and CDC can identify enteric clusters through whole genome sequencing.

The National Outbreak Reporting System (NORS), which covers ***enteric disease outbreaks***, defines an outbreak as two or more cases of similar illness associated with a common exposure.

Passive Surveillance –cases of reportable disease are reported to the health department from the health care community for investigation. Complaints are received from the community regarding clusters or disease incidence.

POD – Point of Distribution

Public Health Emergency – any situation that requires rapid response to prevent or reduce the incidence of disease during natural or man-made disasters, or communicable disease event.

PHEP – Public Health Emergency Preparedness

Quarantine: those measures required by a local Health Officer or the department to prevent transmission of disease to or by those individuals who have been or are otherwise likely to be in contact with an individual with a communicable disease.

Restrict: (2013 Food Code 1-201.10) means to limit the activities of a food employee so that there is no risk of transmitting a disease that is transmissible through food and the food employee does not work with exposed food, clean equipment, utensils, linens, or unwrapped single-service or single-use articles.

SNS: Strategic National Stockpile

STI: Sexually Transmitted Infection

WHO: World Health Organization

2.0 Situation and Assumptions

2.1 Situation

- Administrative Rules of Montana 37.114.204 require timely reporting and investigation of certain reportable diseases.
- The purpose of investigation is to identify and implement control measures that are necessary to prevent transmission.
- The Lewis and Clark Public Health (LCPH) Disease Control and Prevention Division conducts active and passive disease surveillance with state and local partners on a regular basis to identify cases and community disease trends.
- LCPH Environmental Health Specialists regulate food, lodging, and childcare businesses including non-public water systems for public facilities and wastewater systems in Lewis and Clark County.
- Public Health Nurses and Environmental Health Specialists divide responsibility for communicable disease prevention and response according to the mode of transmission. Environmental Health Specialists are responsible for food, water and vector-borne diseases. Public health nurses are responsible for diseases with person-to-person transmission.
- The Communicable Disease Response Guide for Reportable Conditions specifies public health nurse and Environmental Health Specialist responsibility as well as the expected level of response for different diseases.
- Investigation of communicable disease cases can lead to the recognition of clusters and outbreaks. Response may need to be expanded to meet the demands of investigation and prevention of additional cases. (See outbreak response below.)

3.0 Concept of Operations

3.1 Active Surveillance (Routine)

LCPH solicits reports from area health care providers and/or laboratories requesting information on reportable and non-reportable disease activity within Lewis and Clark County. This information is then disseminated back to the providers.

1. Site visits are conducted annually:
    a. Public health nurse/environmental health specialist will schedule site visits to laboratories, physician offices, emergency room, urgent care clinics and other sites (as appropriate). The purpose of the visits is to:
        (1) Review reporting procedures.
        (2) Provide reporting packets.
        (3) Identify a key person at each site to maintain regular contact regarding disease activity and disease reporting.
2. A public health nurse initiates routine contact with designated sites to:
    a. Solicit reports of selected reportable diseases (see list):
        (1) On receipt of a case report through active surveillance, the steps outlined in passive surveillance procedure are to be followed.
        (2) A suspected cluster will trigger highly active surveillance
    b. Inquire about disease activity and unusual presentations
    c. Provide information on disease activity/trends occurring in the community.
3. Prepare and distribute weekly summary of disease activity to:
    a. Health Officer
    b. Medical Director
    c. Division Administrators
    d. CD Team (PHN, EHS)
    e. Staff epidemiologist
4. The communicable disease team will prepare and distribute monthly a Lewis and Clark County Communicable Disease Summary which includes key DPHHS Communicable Disease updates.

3.2 Passive Surveillance

Cases of reportable disease are reported to the health department from the health care community for investigation. Complaints are received from the community regarding clusters or disease incidence.

1. LCPH receives lab reports through MIDIS or other secure reporting system including; JotForm, telephone, or fax.
2. LCPH receives calls reporting individual disease complaints and clusters.

3. Specified diseases in ARM 37.114.204 must be reported immediately by phone. The Communicable Disease Response Guide for Reportable Conditions identifies these diseases
4. LCPH is capable of receiving and reviewing reports 24 hours a day, 7 days a week via an answering service **(406) 523-5564**. Responsibility for receiving and evaluating reports after hours and on weekends is shared among health department management.
5. Case reconciliation is completed as requested by DPHHS CDEpi staff. A line listing of cases and required data elements is sent to lead public health nurse and lead sanitarian through a secure system. This is compared with our records to assure that all cases are reported to the local and state health authority, and that all reports contain the required data elements.
6. The timeliness of reporting diseases is evaluated by comparing the date of diagnosis with the date the health care provider reported the case to LCPH. The timeliness of LCPH reporting to DPHHS is also reviewed.

3.3 Disease Investigation

See Investigation Algorithms Attachment 2

Investigate all communicable diseases promptly in accordance with ARM 37.114.314 and Communicable Disease Response Guide (Attachment 1).

1. Food traceback procedures for identifying sources are located in Attachment 9.
2. Food recall procedures for removing food from commerce are located in Attachment 10.
3. Potential **Rabies exposure** investigation procedures are located in Attachment 14.
4. **Disease clusters and outbreak** investigations are described under Outbreaks below.

3.3.1 Disease Investigation Procedures for Unconfirmed Illness

Complaints and reports involving illnesses that have not been lab confirmed must also be investigated. (e.g. foodborne illness, rashes)

1. Use the *Suspect Food and Waterborne Disease Investigation Form* located in Attachment 3.
2. Obtain all demographic information
    a. Name, age, date of birth, race, ethnicity
    b. Contact information, address
    c. Identify symptoms and onset date
3. Establish potential sources of disease
    a. Others with similar symptoms
    b. Recent travel history/activities/events
    c. Food/water history for as many days as people can remember
        i) Include recreational water exposures
    d. Potential Animal exposures
4. If suspect food is from a retail food facility, then conduct an investigation of that facility as described under outbreak investigation 3.4.3.1.b.

5. If this is a manufactured food, then complete the consumer complaint form that is sent on to FDA. The form is located in the Teams Folder (give link).
6. Request laboratory confirmation of potential communicable disease reported.

3.3.2 Case Investigation Procedures (Lab Confirmed)

1. A lab report is received through MIDIS, by phone, fax or mail from:
    a. Health Care Provider
    b. Laboratory
    c. Hospital
    d. Epidemiologist/DPHHS
2. Case is assigned to a public health nurse or environmental health specialist as specified in Communicable Disease Response Guide, (Attachment 1).
3. Conduct interview with reporting facility
    a. Verify that the case is a resident of Lewis and Clark County. If not a resident, transfer case from MIDIS to DPHHS or the county of residence. Provide an email that gives patient ID and county to DPHHS to ensure timely response. Do not include protected health information in an email.
        i) DPHHS MIDIS guide is located at: https://dphhs.mt.gov/assets/publichealth/CDEpi/CDCPBResources/midisuserguide2019.pdf
    b. Determine if the health care provider has received the laboratory report and if he/she has contacted the patient. It is best practice for the patient to receive diagnosis information from the provider first. Determine that appropriate treatment has been initiated. If unable to contact the provider within 24 hours, contact the case directly.
    c. ***Obtain all available case information***.
        (1) If case is a minor (with exception of STI investigations), obtain the name and relationship of responsible party (parent, legal guardian).
        (2) Age, date of birth, race, ethnicity
        (3) Contact information, address
4. Interview case or guardian
    a. Find disease specific interview forms located here: https://dphhs.mt.gov/publichealth/cdepi/CDCPBResources/CDEpi
    b. Identify symptoms and onset date
    c. Establish potential sources of disease
        i) Others with similar symptoms
        ii) Recent travel history
        iii) For enteric diseases:

(1) Food/water history if infectious agent is food or water-borne

(2) Potential Animal exposures

d. Occupation- for assessment of secondary transmission risk

3.3.3 Implement Control Measures to Prevent Secondary Transmission

1. Provide education to the case regarding disease process, spread and treatment
2. Implement necessary but least restrictive disease control measures as described in the Administrative Rules of Montana 37.114: Communicable Disease Control.

   a. Isolation (separation during the period of communicability of an infected or probably infected person from other persons) as required by communicable disease rules.

   b. Sensitive Occupations - See 2013 Food Code Annex 3, 2-201.11/1-201.12 Decision Trees for restriction or exclusion for food handlers. See ARM 37.114.301 for daycare providers, medical providers and food handlers.

      i) Exclusion will occur when

         (1) Case is symptomatic

         (2) Alternative job duties are not available in accordance with the 2013 Food Code.

      ii) Restriction will occur when

         (1) Alternative job duties are available that will eliminate risk of transmission

         (2) Effective personal hygiene practices can be determined

      iii) Notification of exclusion

         (1) Case will be notified of exclusion order verbally and in writing. Templates can be found in Attachment 7 and in H:\Share\Communicable Disease TEAM- RS & RN\Exclusion letters

         (2) Employer will only be notified of exclusion when

            (a) Employee gives verbal permission or requests call to employer

            (b) Case does not follow exclusion order

            (c) Disease control requires work schedule information (e.g. Hepatitis A)

      iv) Exclusion will remain in effect until:

         (1) Case is asymptomatic; and

         (2) Case meets requirements for restriction; OR

         (3) Samples from case are tested and found to be negative for pathogen.

            (a) Samples can be submitted to the LCPH for transport to Montana Public Health Lab. See Exclusion and Collecting Samples procedure document in Attachment 8.

(b) Costs of lab tests for Public Health control measures may be paid from the Emergency Preparedness grant fund with prior approval from the division administrator.

(i) In the case of an insured individual, the MPHL may charge insurance.

c. Daycares

i) Children must be excluded while symptomatic in accordance with daycare rules. (ARM 37.95.139)

ii) When the risk of transmission exists for other children in the daycare, give prevention and symptom information fact sheets to the daycare provider and parents. Do not release identifying information of the ill child.

d. Schools

i) Provide appropriate information to school nurses and administrators on effective control measures.

ii) Health Alert Network (HAN) system has contact information for school admin and health.

3. Complete case report to DPHHS through MIDIS or submit by confidential fax line at 800-616-7460 or E-Pass if MIDIS is down.

3.3.4 Contact Investigation

1. Obtain information from case about ***contacts during the contagious period*** as applicable.
   a. Name
   b. Address
   c. Phone number
   d. Parent/guardian name if contact is a minor (except in STI investigations).
   e. Last date of exposure
2. Evaluate the risk of exposure based on the extent and timing of the contact
3. If contact is not a resident of Lewis and Clark County, contact DPHHS for referral to the appropriate jurisdiction.
4. Notify contact of exposure
   a. Provide education regarding disease process, spread and treatment.
   b. Refer for treatment if indicated.
   c. Notify the contact's health care provider of the situation and LCPH's recommendations as needed.
   d. Quarantine instructions will be provided if needed in accordance with the Communicable Disease rules (ARM) and CDC. Protocols are located in Attachment 11 Non-Pharmaceutical Interventions.

3.4 Recognizing a Cluster or an Outbreak

A cluster or outbreak can be identified from the following reports.

1. Multiple disease reports with the same agent are found within a short time frame
2. MPHL and CDEpi identify clusters by whole genome sequencing, this can include identification of national/international outbreaks through CDC and/or WHO
3. Two (2) or more people experience a similar illness after ingestion of a common food or meal
4. Multiple complaints are received identifying a common source
5. Single case of unusual communicable disease is identified (i.e., Measles, Ebola, botulism)

3.4.1 Outbreak Response

After a cluster or outbreak has been identified, staff member will notify supervisor and division administrator.

3.4.2 Confirm the Outbreak

1. Conduct initial interviews to determine potential number of cases and sources
2. Identify common exposures (food, water, event, location)
3. Initiate lab testing to identify agent of concern
4. Designate an outbreak control team (EPI-Team) depending on the scope of the outbreak
    a. Disease Control and Prevention Administrator
    b. Program Supervisor and staff
    c. Health Officer
    d. Staff Epidemiologist
    e. Can be expanded as needed to include
        i. All DCP staff
        ii. Medical Director
        iii. PHEP coordinator
        iv. Communications Specialist
        v. EHS – Environmental Health Services team
        vi. Regional Partners
        vii. Temporary staff
6. Convene meetings as appropriate to the outbreak
    a. Situation update – agent of concern, number of cases, what we know
    b. Response planning to define next steps
        i. Generate case definition
        ii. Identify additional cases –
            1. Highly active surveillance

2. Through case interviews
3. Lab reports

iii. Generating a questionnaire to develop hypothesis on source

iv. Process and forms for conducting case interviews

c. Identify any information sharing that could include

i. HAN to providers to identify agent of concern if known and scope of outbreak

ii. Prevention messaging to the public, when applicable,

a. Define disease outbreak

b. Identify PH response

c. Identify actions that individuals can take to protect themselves and their families.

d. Schedule next meeting

3.4.3 Conduct outbreak investigation

1. Conduct case/facility interviews

a. Follow the steps outlined in Disease Investigation Procedures and outbreak specific questions developed for the incident.

b. If the potential source is a food facility, then conduct an on-site evaluation of food safety for that food as soon as possible.

i. Talk with the person in charge/manager about the potential source as identified by initial review.

ii. If related to a banquet or party, identify all the food items provided for that party. This will be used for specific questionnaires for each participant. If it is a menu item, then identify how many orders of that item were served on that day.

iii. Evaluate procedures for food in question from receiving to serving. Identify any gaps in safe food handling.

iv. If food is available for sampling, then take sterile sample and submit to the MPHL for testing. Ask facility to hold any leftover product until testing is complete.

v. Identify any other menu items which contain the foods of concern.

vi. Identify any employees reported being sick in the week prior or the day of concern. Identify when they were working last, what their responsibilities were and what the illness was.

vii. Provide guidance to the facility to prevent food borne illness.

2. Implement Highly Active surveillance to identify additional cases

a. On receipt of a case report through active surveillance, follow the steps outlined in Disease Investigation Procedures (page 9).

3. Analyze data collected from interviews and lab reports
    a. Generate hypothesis regarding source
    b. Identify possible sources and means of transmission
    c. Define the population at risk
    d. Identify information that can be shared with providers and the public to prevent further disease and identify additional cases.

4. Implement Control Measures to Prevent Secondary Transmission
    a. Conduct contact investigations as described on page 9.
    b. Provide education
    c. Refer for treatment
    d. Initiate movement restrictions with Health Officer and Board of Health authorities as needed to prevent spread of disease in accordance with ARM 37.114 subchapter 5. Depending on the level of public health risk the Health Officer will also notify the County Attorney, Coroner, Medical community, Disaster and Emergency Services Coordinator, elected officials and law enforcement.

2. Closure orders for public events and buildings – when imminent threat of widespread disease or loss of life could be slowed or stopped by restricting assembly according to MCA 50-2-118.

3.5 Outbreak Response and Escalation to Public Health Emergency

The Health Officer and the Division Administrators have authority to escalate response with command post activation and implement the Public Health All Hazards Annex. Circumstances that may trigger the use of the All-Hazards Annex include:

1. When a response requires reassignment of staff for an extended period of time
2. When a response includes extended staff call out after business hours
3. Routine services are suspended
4. Frontline staff can't keep up with the calls for information on a specific topic
5. Series of health events or cases of disease closely grouped by time and/or place
    a. Naturally-occurring diseases of highest concern are listed in section 1 on the Communicable Disease Response Guide. (*Attachment 1*).
    b. Agents of highest concern for biological attack (Table 2).

Actions that can be taken can include….

1. Activate an incident management team.

2. Request an Emergency or Disaster Declaration

   A County Declaration of an Emergency may be requested when

   - Resources are required outside our agency
   - Time required for response will be excessive
   - Response requires activation of the strategic national stockpile when available supplies do not meet the need
   - Compulsory closure of public events is anticipated to prevent further spread of disease
   - Large-scale quarantine is needed.

3. Request resource support from County DES and/or DPHHS.

3.5.1 Non-Pharmaceutical Interventions

1. Provide strategies for preventing, limiting and/or eliminating the spread of communicable disease

   a. Isolation of those that are identified as a case with a communicable disease easily transmitted to others. This can be by education or by health officer order as needed for the severity of the illness.

   b. Quarantine

   c. Restriction of movement and gatherings

   d. Guidance to community for best practices to protect their families and the community.

   e. For more specific guidance see the *Non-Pharmaceutical Intervention Plan* (Attachment 11).

3.5.2 Mass Prophylaxis

1. Provide for prophylaxis to prevent further disease when appropriate.

   a. Mass distribution (including vaccine, antibiotics, antivirals using approved methods and doses to provide large scale distribution)

      i. Convene a planning team with local partners (Health care providers, schools, congregate settings, pharmacists, communications specialists and others as needed)

      ii. Identify eligible population and obtain signed standing orders for distribution

      iii. Identify locations and mode of distribution (drive-through, walk-up clinics, mobile clinics, and pharmacies)

      iv. Obtain standing orders for prophylaxis distribution.

v. Staffing support team including vaccinators, traffic controllers, clinic manager, medical supplies, clinic supplies (See POD inventory spreadsheet in Attachment 13)

vi. Obtain supply for distribution

vii. Communicate to the public regarding who is eligible, when and where distribution will occur. (e.g. web, call center, social media, advertising, press releases)

b. Monitor the effectiveness of distribution activities to achieve the desired outcome

i. Document distribution progress

2. If the emergency requires a distribution from the *Strategic National Stockpile*, additional procedures will be required. Refer to the Emergency Medical Countermeasures Plan (Attachment 12) for specific guidance.

3.5.3 Mass Fatality Management

1. When a communicable disease has been identified as the cause of fatalities, consult with DPHHS Communicable Disease Section on special precautions for handling of the deceased.

2. Provide disease management information for coroner, health care providers, emergency responders, morticians, and the general public.

a. The Health Alert Network system has contacts to quickly disseminate critical information.

3. Funerals for individuals who have died of a reportable disease must be conducted with instruction from the Health Officer in accordance with ARM 37.114.303. All available information to protect those that gather will be provided. This will include:

a. HAN messaging

b. Public information

3.5.4 When outbreak is over ….

1. Emergency outbreak procedures will remain in effect until incidence of disease has been eliminated or has been reclassified as endemic. A communicable disease outbreak will be "under control" when three (3) successive incubation periods have passed with no new cases.

2. Create an outbreak report for CDEpi, and department epi-team.

a. Include case definition, total case numbers, analysis of investigation with probable source information, methods to prevent further incidents, and identifying resource demands in the report.

3. When appropriate, conduct an AAR to determine successes and challenges and any changes needed to response plan.

4.0 Plan Development & Maintenance

- The LCPH PHEP Coordinator will maintain this plan. This plan will be reviewed, tested and updated annually. Recommended changes to this annex should be forwarded to the LCPH PHEP Coordinator as needs become apparent.
- In the event that there have been no food-related outbreak investigations conducted during the year, we will plan and conduct a mock foodborne illness investigation to test program readiness. The mock investigation should simulate response to an actual confirmed foodborne disease outbreak and include on-site inspection, sample collection and analysis...
- Trainings and exercises should include external partners.
- After Action Reports will be done after all exercises and for all incidents that meet our *Significant Incident AAR Protocol*.

5.0 Attachments

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Attachment 1: Communicable Disease Response Guide

DPHHS Sept 2022

Montana Communicable Disease Reporting Reference for Local Public Health Jurisdictions

The list of reportable diseases, reporting timeframes, control measures and other requirements below apply to local public health jurisdictions (LHJ) and are based on the Administrative Rules of Montana. Please contact the DPHHS Communicable Disease Program at 444-0273 for more information.

FOR LOCAL HEALTH DEPARTMENT USE ONLY

CONDITION[1]	LHJ REPORT TO DPHHS	INVESTIGATION FORM[2]	FAX/ ePASS FORM	STAFF LEAD	CONTROL MEASURE REFERENCE[3]
Acquired Immune Deficiency Syndrome (AIDS)	7 days	CDC HIV/AIDS form	YES	Helen	ARM 37.114.503
Anaplasmosis	7 days	CDC Tick-Borne Rickettsial Disease form	YES	Devon	CCDM
Anthrax* ☎	**Immediately**	DPHHS General Reporting form/DPHHS consult	YES	Jessica	CCDM
Arboviral diseases*	7 days	DPHHS Arboviral form	NO	Devon	CCDM
Arsenic poisoning	7 days	DPHHS Arsenic Exposure Questionnaire	YES	Abbie	ARM 37.114.546
Babesiosis	7 days	CDC Babesiosis form	YES	Devon	CCDM
Botulism* ☎	**Immediately**	DPHHS Botulism form/DPHHS consult	YES	Rachel	CCDM
Brucellosis*	**24 hours**	DPHHS Brucellosis form	NO	Sam	CCDM
Cadmium poisoning	7 days	DPHHS Cadmium Exposure Questionnaire	YES	Abbie	ARM 37.114.546
Campylobacter	7 days	DPHHS Campylobacteriosis form	NO	Rachel	CCDM
Candida auris*	7 days	DPHHS *C. auris* form	YES	Erika	CDC MDRO guidance
Chancroid	7 days	DPHHS STD form	YES	Cara	ARM 37.114.512
***Chlamydia trachomatis* infection**	7 days	DPHHS STD form	NO	Cara	ARM 37.114.515
Coccidioidomycosis	7 days	DPHHS General Reporting form	NO	Danny	CCDM
Colorado tick fever	7 days	CDC Tick-Borne Rickettsial Disease form	NO	Devon	CCDM
Coronavirus Disease 2019 (COVID-19)	7 days	CDC COVID form	NO	Sam	CCDM
Cryptosporidiosis	7 days	DPHHS Cryptosporidiosis form	NO	Rachel	CCDM
Cyclosporiasis	7 days	CDC Cyclosporiasis form	NO	Rachel	CCDM
Dengue virus	7 days	CDC Dengue Fever form	NO	Devon	CCDM
Diphtheria*	**24 hours**	CDC Diphtheria form	YES	Jessica	CCDM
Ehrlichiosis	7 days	CDC Tick-Borne Rickettsial Disease form	YES	Devon	CCDM
Escherichia coli*, shiga-toxin producing (STEC)	7 days	DPHHS STEC form	NO	Rachel	CCDM
GI outbreak/outbreak in congregate setting	**24 hours**	DPHHS Cluster/Outbreak form	YES	Rachel	CCDM
Giardiasis	7 days	DPHHS Giardiasis form	NO	Rachel	CCDM
Gonorrheal infection	7 days	DPHHS STD form	NO	Cara	ARM 37.114.530
Granuloma inguinale	7 days	DPHHS STD form	YES	Cara	ARM 37.114.540
Haemophilus influenzae*, invasive disease	7 days	CDC ABC form	NO	Jessica	CCDM
Hansen's disease	7 days	DPHHS General Reporting form	NO	Jessica	CCDM
Hantavirus Pulmonary Syndrome/infection*	7 days	CDC Hantavirus form	YES	Sam	CCDM
Hemolytic uremic syndrome, post-diarrheal	7 days	DPHHS HUS form	NO	Rachel	CCDM
Hepatitis A, acute	7 days	DPHHS Viral Hepatitis form	YES	Rachel	CCDM
Hepatitis B, acute, chronic, perinatal	7 days	DPHHS Viral Hepatitis form (acute) DPHHS General reporting form (chronic) DPHHS Hepatitis B perinatal forms (perinatal)	NO	Jennifer Floch	ARM 37.114.540
Hepatitis C, acute, chronic	7 days	DPHHS Viral Hepatitis form (acute) DPHHS General reporting form (chronic)	NO NO	Helen	ARM 37.114.542
Human Immunodeficiency Virus (HIV)	7 days	CDC HIV/AIDS form	YES	Helen	ARM 37.114.503
Influenza (cases, hospitalizations/deaths*)	**24 hours (deaths);** 7 days (cases/hosp)	DPHHS Influenza death/hospitalization form	NO	Devon	CCDM
Lead Poisoning (blood levels ≥ 3.5 micrograms per dL)	7 days	DPHHS Lead Poisoning Questionnaire	YES	Abbie	ARM 37.114.546
Legionellosis	7 days	CDC Legionellosis form	YES	Rachel	CCDM
Leptospirosis	7 days	CDC Leptospirosis form	YES	Rachel	CCDM
Listeriosis*	7 days	CDC *Listeria* Initiative (LI) form	YES	Rachel	CCDM
Lyme disease	7 days	DPHHS Lyme Disease form	YES	Devon	CCDM
Lymphogranuloma venereum	7 days	DPHHS STD form	YES	Cara	ARM 37.114.552
Malaria	7 days	CDC Malaria form	YES	Devon	CCDM
Measles (rubeola)*	**24 hours**	CDC Measles form	YES	Jessica	CCDM
Melioidosis*	**24 hours**	DPHHS General Reporting form	YES	Sam	CCDM
Meningococcal disease *(Neisseria meningitidis)**	7 days	CDC Meningococcal Disease form	NO	Jessica	CCDM
Mercury poisoning	7 days	DPHHS Mercury Exposure Questionnaire	YES	Abbie	ARM 37.114.546
Monkeypox	24 hours	CDC Monkeypox Form	YES	Beth	CCDM
Mumps	7 days	CDC Mumps form	NO	Jessica	CCDM
Novel Influenza A virus	**24 hours**	CDC Novel Influenza form/DPHHS consult	YES	Devon	CCDM
Outbreak of a reportable disease or condition, or any disease in the CCDM	**24 hours**	DPHHS Outbreak Report Form	YES	Rachel/all	CCDM
Pertussis	7 days	CDC Pertussis form	NO	Jessica	ARM 37.114.563
Plague (*Yersinia pestis*)* ☎	**Immediately**	CDC Plague form/DPHHS consult	YES	Devon	CCDM
Poliomyelitis* ☎	**Immediately**	CDC Polio form/DPHHS consult	YES	Jessica	CCDM
Psittacosis	7 days	DPHHS Psittacosis form	NO	Sam	ARM 37.114.561
Q Fever (*Coxiella burnetii)*	7 days	CDC Q Fever form	YES	Sam	CCDM
Rabies in a human* or animal	**24 hours**	CDC Rabies form for suspect human cases; case entry into MIDIS for positive animals	YES	Devon/Jessica	ARM 37.114.571
Rabies post-exposure prophylaxis (PEP) recommendation or administration	7 days	MIDIS PEP Case Investigation	NO	Devon/Jessica	
Rubella, including congenital*	**24 hours**	CDC Rubella form	YES	Jessica	CCDM
Salmonellosis*	7 days	DPHHS Salmonellosis form	NO	Rachel	CCDM
Severe Acute Respiratory Syndrome-associated Coronavirus (SARS-CoV) disease* ☎	**Immediately**	CDC SARS form/DPHHS consult	YES	Sam	CCDM
Shigellosis*	7 days	DPHHS Shigellosis form	NO	Rachel	CCDM
Smallpox* ☎	**Immediately**	CDC Smallpox form/DPHHS consult	YES	Jessica	CCDM
Spotted Fever Rickettsiosis	7 days	CDC Tick-Borne Rickettsial Disease form	YES	Devon	CCDM
***Streptococcus pneumoniae* invasive disease**	7 days	CDC *Streptococcus pneumoniae* form	NO	Jessica	CCDM
Streptococcal toxic shock syndrome (STSS)	7 days	CDC ABC form	NO	Jessica	CCDM
Syphilis	**24 hours**	DPHHS STD form	NO	Cara	ARM 37.114.583
Tetanus	7 days	CDC Tetanus form	NO	Jessica	CCDM
Tickborne relapsing fever	7 days	DPHHS Tickborne Relapsing Fever Form	YES	Devon	CCDM
Toxic shock syndrome, non-streptococcal (TSS)	7 days	CDC ABC form	NO	Jessica	CCDM
Transmissible spongiform encephalopathies (TSE)	7 days	DPHHS CJD form	YES	Jessica	CCDM
Trichinellosis (Trichinosis)*	7 days	DPHHS General Reporting form	NO	Rachel	CCDM
Tuberculosis* (including latent TB infection [LTBI])	7 days	DPHHS Tuberculosis form(s)	YES	Ryan	ARM 37.114 subch. 10
Tularemia* ☎	**Immediately**	DPHHS Tularemia form/DPHHS consult	YES	Devon	CCDM
Typhoid Fever/Paratyphoid Fever*	7 days	CDC Typhoid form	YES	Rachel	CCDM
Varicella (chickenpox)	7 days	CDC Varicella form	NO	Jessica	CCDM
Vibrio cholerae* infection (Cholera)	7 days	CDC Cholera form	YES	Rachel	CCDM
Vibriosis*	7 days	DPHHS Vibriosis form	YES	Rachel	CCDM
Viral hemorrhagic fevers ☎	**Immediately**	DPHHS General Reporting form/DPHHS consult	YES	Jessica	CCDM
Yellow fever	7 days	DPHHS General Reporting form	NO	Devon	CCDM

DPHHS Sept 2022

Montana Communicable Disease Confirmation of Disease for Local Public Health Jurisdictions

If a local health officer receives information about a case of any of the following diseases, the officer must work with the department to ensure that a specimen from the case is submitted for testing, when possible, to confirm the existence or absence of the disease in question, or for further examination associated with surveillance or investigation of disease transmission, per ARM 37.114.313. Please contact the DPHHS Communicable Disease Program at 444-0273 for more information.

DISEASE	STAFF LEAD	CONTROL MEASURE REFERENCE[2]
Carbapenem-resistant organisms (CRO)*	Erika	ARM 37.114.313
Vancomycin-intermediate staphylococcus aureus (VISA)*	Erika	ARM 37.114.313
Vancomycin-resistant staphylococcus aureus (VRSA)*	Erika	ARM 37.114.313

[1] Also reportable is any unusual incident of unexplained illness or death in a human or animal with potential human health implications, per ARM 37.114.203

[2] All forms can be found on the CDEPI Resources site accessible to public health professionals [https://dphhs.mt.gov/publichealth/cdepi/CDCPBResources/CDEpi]. Additional forms may be required. These forms should be used for the disease case investigation, but only the ones marked 'YES' need to be sent to CDEpi for additional reporting.

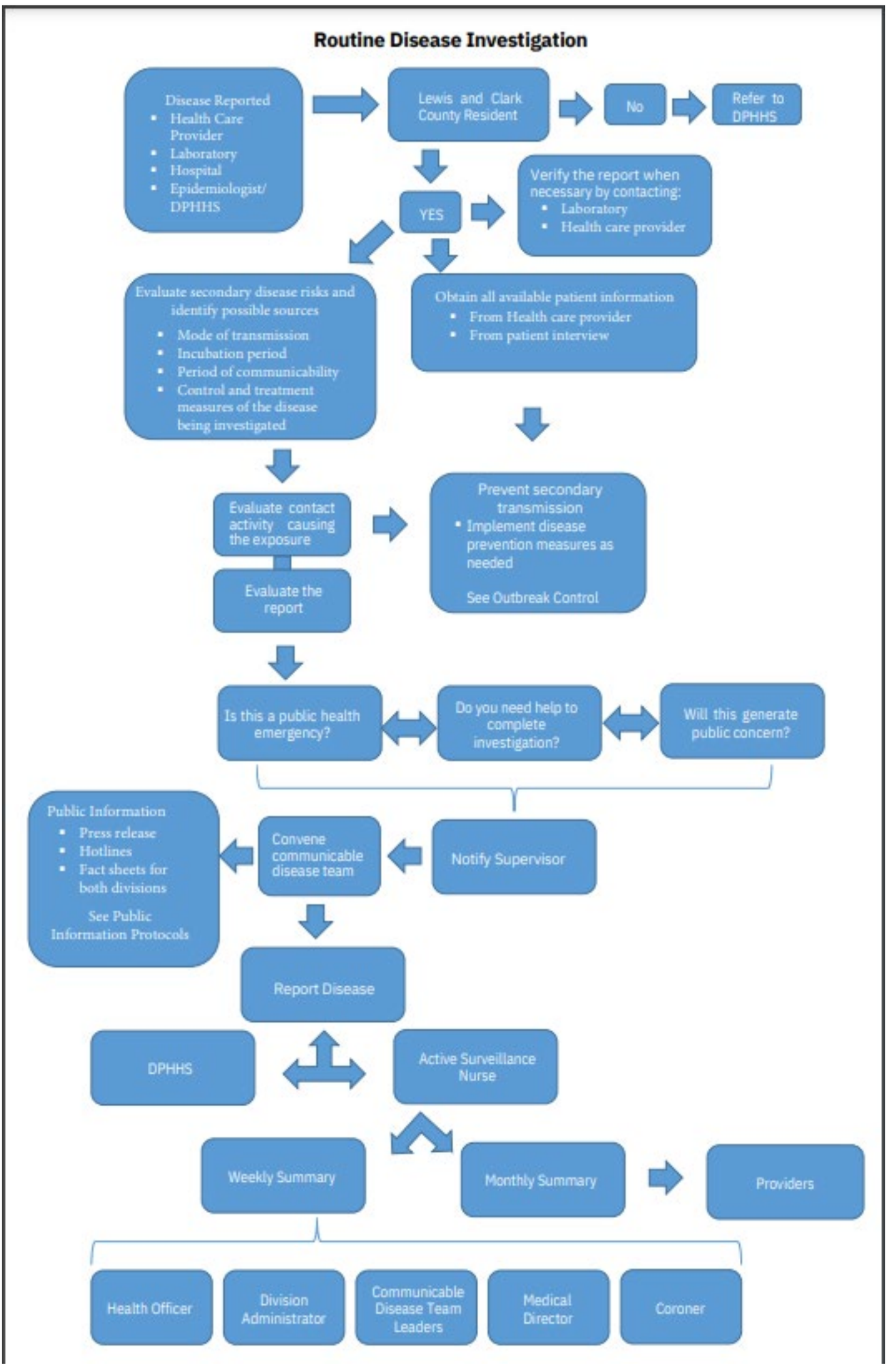
[3] CCDM= Control of Communicable Diseases Control Manual, 21st edition; ARM= Administrative Rules of Montana

*Confirmatory specimen required to be sent to MTPHL

QR code for the CDEpi Resources

Attachment 2: Algorithms for Disease Response

Routine Disease Investigation



Outbreak Control Trigger Points to Prevent Secondary Transmission

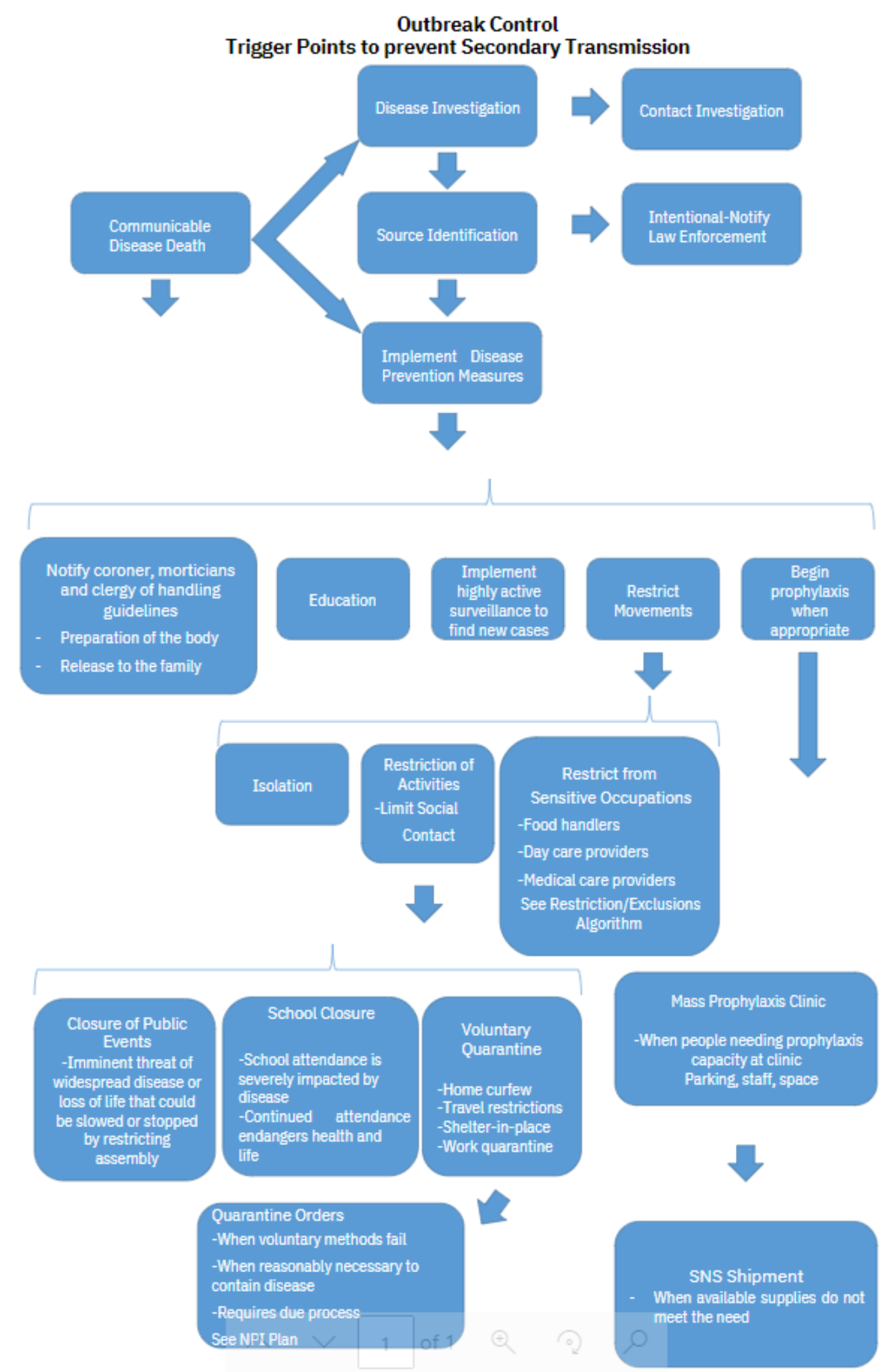


Table 2: Biological Agents of Highest Concern for a Bioterrorism Attack

Attachment 3: Suspect Food and Waterborne Illness Investigation Form

Suspect Food and Waterborne Illness Investigation Form

Suspected:
Confirmed:
Date of Lab Results:

Reported by: Date: Time:
Date: Time:
Investigator:

Case Demographics

Name: Parent
Address:
Home phone: Work Cell phone
Date of Birth
Age: Sex: **Occupation:**
Race: White Native HI/other PI **Ethnicity:** Hispanic or Latino
Asian Am Indian/AK Native Not Hispanic or Latino
Black/Afr Amer Other
Contacts: Household Day Care

Clinical Information

Onset date: Time: Incubation Period:
Duration: Case Outcome: Date:
Days of work missed:
Symptoms:
Nausea Vomiting:
Diarrhea: Bloody: Max # of stools per 24 hours:
Abdominal cramps or pain:
Fever: Headache: Other:

Physician: Phone:
Date Contacted: Diagnosis:
Hospital: Date:
Date Samples taken:

Prior Medical Problems
Current Medications:

Investigation

Anyone else ill:
Water Source:
Do you have **pets** in your household:
Are there any **farm animals** at your residenc
Have you had recent contact with any **wildlife**
uring the 2 weeks before your illness, did you go **swimming**? Where?

Recent Travel History:
Common Sources of lab reported illness (from Control of Communicable Diseases in Man, CDC):
Do you smoke, chew fingernails, chew, chew on pens or pencils?

Comments:

Food Consumed During Previous Meals: Note: Identify as best remembered or typical meals

Date: ______
Time: ____
Time: ____
Time: ____

Date: ______
Time: ____
Time: ____
Time: ____

Date: ______
Time: ____
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Date: ______
Time: ____
Time: ____
Time: ____

Attachment 4: Foodborne Illness Food Facility Investigation Form

Environmental Assessment Field Guide

Suspect Agent or Pathogen of Concern and Corresponding Field Focus	
VIRUSES → **FIELD FOCUS**	
☐ Norovirus ☐ Hepatitis A	BHC, HW, Ill FW
☐ *Clostridium botulinum* ☐ *Clostridium perfringens* ☐ *Bacillus cereus* ☐ *Staphylococcus aureus*	Cooling, HH, RH, RTS, ROP
BACTERIAL INFECTIONS → **FIELD FOCUS**	
☐ *Escherichia coli* Enterohemorrhagic or Shiga toxin-producing ☐ *Shigella spp* dysenteriae, flexneri, boydii, sonnei ☐ *Campylobacter jejuni* ☐ *Salmonella spp* typhi, paratyphi, typhimurium, enteritidis ☐ *Listeria monocytogenes* ☐ *Yersinia* enterocolitica	Cook, CH, HW, Ill FW, Source, XC, CA, Produce Washing
PARASITES → **FIELD FOCUS**	
☐ *Cryptosporidium parvum* ☐ *Giardia lamblia* ☐ *Trichinella spiralis* ☐ *Cyclospora cayetanensis* ☐ *Toxoplasma gondii*	BHC, HW, Ill FW, Produce Washing, Source, Water
[redacted] → [redacted]	
☐ Scombroid fish poisoning ☐ Shellfish poisoning PSP, DSP, NSP, ASP ☐ *Vibrio spp* *vulnificus, parahaemolyticus, cholera*	Shellfish Tags, Source, Receiving, CH, Cook, XC, CA

Risk Factors & Interventions

Ill Food Workers (Ill FW)
- ☐ Exclude Ill FW
- ☐ Check work schedules
- ☐ Determine employee health status
- ☐ Determine roles of food workers for suspected meals or ingredients

Bare Hand Contact (BHC)
- ☐ Gloves/utensils available and signs of usage
- ☐ History of BHC prevention in establishment
- ☐ Discussion of food preparation steps

Handwashing (HW)
- ☐ Handwash sinks available and have soap and towels
- ☐ Observe proper HW

Cold Holding (CH), Hot Holding (HH), Cooling, Reheating (RH), Room Temperature Storage (RTS), Reduced Oxygen Packaging (ROP)
- ☐ Proper CH and HH
- ☐ Proper Cooling and RH practices
- ☐ History of Cooling or RH practices in establishment
- ☐ History of proper temperature control practices
- ☐ Presence of RTS or advanced preparation
- ☐ ROP products used in suspect menu

Cross Contamination (XC), Cook, Consumer Advisory (CA)
- ☐ Proper storage of raw meats
- ☐ Separation of utensils used for raw product
- ☐ Cleaning and sanitizing of equipment and utensils
- ☐ Menu with proper CA
- ☐ Calibrated digital thermometer readily available
- ☐ Cooking methods validated and logs checked

Receiving/Source
- ☐ Copy of receipts
- ☐ Shellfish Tags

Produce Washing
- ☐ Clean, sanitized sink available
- ☐ Proper process observed or discussed
- ☐ Suspect products sources identified

Remediation & Control Measures

Consider each item listed below and check each used.

Control Measures
- ☐ Behavior Change
- ☐ Procedure Change
- ☐ Exclude Ill FW
- ☐ Food Destruction
- ☐ Hold Order
- ☐ Cleaning & Sanitizing
- ☐ Closure

Investigation Methods
- ☐ Food Samples
- ☐ Environmental Samples
- ☐ Stool Samples
- ☐ Photographs
- ☐ Receipts, Inventory, Trace-back
- ☐ Multiple FE's Investigated
- ☐ Additional Case Finding

Moving Forward
- ☐ Follow-Up Visit Scheduled
- ☐ Follow-Up Visit with Interpreter
- ☐ Increased Inspections
- ☐ Menu Reduction
- ☐ Required Ed/Training
- ☐ Risk Control Plan
- ☐ Office Conference

Communication
- ☐ Local Health CD-Epi
- ☐ State Food Safety
- ☐ State CD-Epi

Environmental Assessment Field Guide for Molluscan Shellfish Illness

Suspect Agent or Pathogen of Concern and Corresponding Field Focus		Risk Factors & Interventions	Remediation & Control Measures
VIRUSES ⟹ FIELD FOCUS			
☐ Norovirus	Ill FW, BHC, HW, Source, CA		
BACTERIAL INFECTIONS ➡ FIELD FOCUS			
☐ *Vibrio* species	CH, XC, Source, CA		
SHELLFISH TOXINS ➡ FIELD FOCUS			
☐ Shellfish Poisoning PSP, DSP, ASP	Source		

Ill Food Workers (Ill FW)
- ☐ Exclusion policy
- ☐ Check work schedules
- ☐ Determine employee health status
- ☐ Determine roles of food workers for implicated meals or ingredients

Bare Hand Contact (BHC)
- ☐ Gloves/utensils available and signs of usage
- ☐ History of BHC prevention in establishment
- ☐ Observations of BHC during the investigation
- ☐ Discussion of BHC prevention for implicated meal
- ☐ Discussion of food preparation steps

Handwashing (HW)
- ☐ Handwash sinks available and have soap and towels
- ☐ Observe proper HW

Cold Holding (CH)
- ☐ Proper CH at Receiving, Storage, Prep, Service
- ☐ History of proper temperature control practices
- ☐ Advanced preparation

Cross Contamination (XC)
- ☐ Proper storage of other foods
- ☐ Separation of utensils used for raw product
- ☐ Cleaning and sanitizing of equipment and utensils
- ☐ Discuss XC prevention during implicated meal

Source
- ☐ Copies of relevant tags/receipts/invoices

Consumer Advisory (CA)
- ☐ Disclosure
- ☐ Reminder

Consider each item listed below and check each used.

Control Measures
- ☐ Behavior Change
- ☐ Procedure Change
- ☐ Exclude Ill FW
- ☐ Food Destruction
- ☐ Hold Order
- ☐ Cleaning & Sanitizing
- ☐ Closure

Investigation Methods
- ☐ Food Samples
- ☐ Environmental Samples
- ☐ Stool Samples
- ☐ Photographs
- ☐ Receipts, Inventory, Trace-back
- ☐ Multiple FEs Investigated
- ☐ Additional Case Finding

Moving Forward
- ☐ Follow-Up Visit Scheduled
- ☐ Follow-Up Visit with Interpreter
- ☐ Increased Inspections
- ☐ Menu Reduction
- ☐ Required Ed/Training
- ☐ Risk Control Plan
- ☐ Office Conference

Communication
- ☐ State Shellfish Program
- ☐ Local Health CD-Epi
- ☐ State Food Safety
- ☐ State CD-Epi

Attachment 5: Food Sampling Procedures

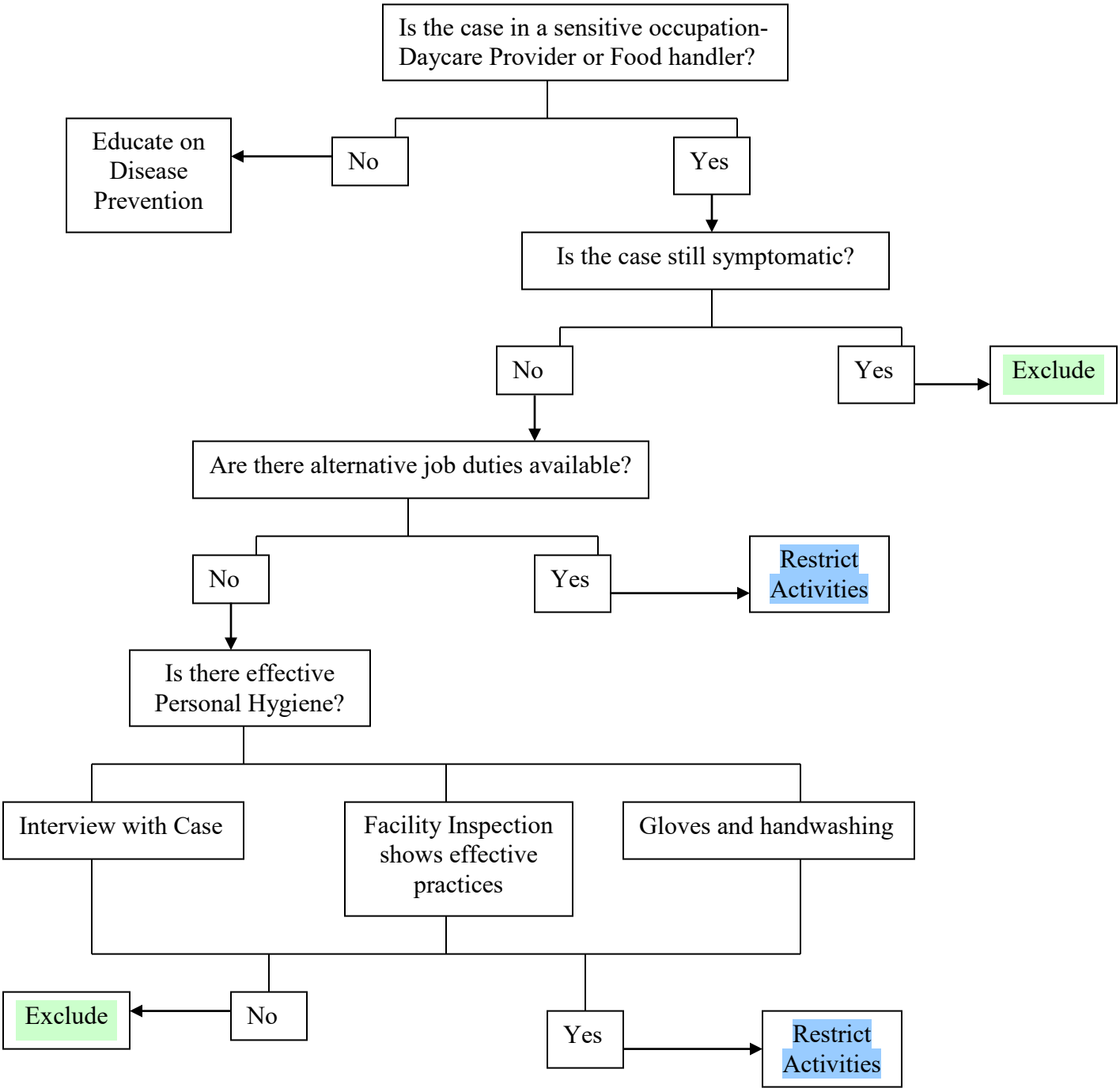
Food Sampling Procedures

Food samples may be collected if warranted by the investigation and suspected food remains onsite.

1. The Licensed Establishment team will decide which collected food samples will be forwarded to the Montana Public Health Laboratory for testing as advised by the laboratory. (All samples must be submitted to the Montana Public Health Laboratory. The laboratory will then determine if other laboratory support is required).
2. If food samples are to be collected, the procedures from the Montana Public Health Laboratory must be followed depending on the food sample.
3. If food samples are in the original packaging, the entire package should be collected and stored as instructed by the Montana Public Health Laboratory.
4. If unpackaged food is collected, it must be done aseptically to avoid contamination of the product using procedures provided by the laboratory.
5. Use the correct kit for specimen collection and delivery.
6. Follow procedures for food collection and handling, and human sample collection handling as directed by the Laboratory. The procedures are in the foodborne illness outbreak kit.
7. Contact the Montana Public Health Laboratory (DPHHS) for proper procedures regarding transportation of specimens to the lab (phone number 406-444-3444).
8. Reporting of results: telephone, fax, mail – provide contact name and number for results.

Attachment 6: Decision Tree for Exclusion and Restriction

Prevention of Secondary Disease Transmission
By Restriction or Exclusion from Sensitive Occupations



Attachment 7: Exclusion and Restriction Order Templates

Lewis & Clark Public Health

Division of Disease Control and Prevention
1930 Ninth Avenue, Helena MT 59601
Phone: 406-457-8900
Fax: 406-457-8997

Health Officer Exclusion Order

Name
Address

Date

Dear Name:

Your child, Child's Name, was diagnosed with Salmonellosis on diagnosis date. This disease may be spread through fecal contamination of the child's and/or caregiver's hands. Children who attend day care are especially at risk for spreading salmonellosis to others. Therefore, by order of the Lewis and Clark County Health Officer, your child must not return to day care until released to do so.

The authority to exclude your child as a day care attendee is located in the Administrative Rules of Montana (ARM). Relevant sections of the ARM are provided on the back of this letter.

In order for your child to return to day care, you must complete the following:

1. Your child must be free of all symptoms
2. If prescribed, your child must finish the entire course of antibiotics
3. Wait 48 hours
4. Collect stool sample using the kit and instructions provided to you
5. Contact a public health nurse at 457-8900 and make an appointment to drop off the sample and collect additional kit
6. Wait 24 hours
7. Collect stool sample using the kit and instructions provided to you
8. Contact the public health nurse at 457-8900 and make an appointment to drop off the sample

When two (2) consecutive stool samples are culture negative for salmonella, we will provide you with a letter allowing your child to return to day care.

Due to the public health risk associated with salmonellosis, it is imperative that you follow the directions provided in this order. Please understand that if you do not follow these instructions, we will need to take additional action.

_____ Date: _____

Drenda Niemann, MPA, CPH
Health Officer

I have discussed and reviewed this order with Franchesca Talbot, RS. I understand and agree to the provisions of this Exclusion Order.

_____ Date: _____

Parent Name

Ec: Drenda Neiman, Health Officer
Laurel Riek, Licensed Establishment Program Supervisor

For your information, sections of the Administrative Rules of Montana that regulate control of communicable diseases are included in this letter.

Administrative Rules of Montana (ARM) 37.95.139 CHILD CARE FACILITIES: HEALTH CARE REQUIREMENTS (7) The parent or guardian may also provide the day care facility with a signed certification of health from a licensed physician, except that the following restrictions must be followed:

(a) If a child is excluded for shigellosis or salmonella, the child may not be readmitted until the child has no diarrhea or fever, the child's parent or guardian produces documentation that two stools, taken at least 24 hours apart, are negative for shigellosis or salmonella, and the local health authority has given written approval for the child to be readmitted to the day care facility;

Lewis & Clark Public Health

Division of Disease Control and Prevention
1930 Ninth Avenue, Helena MT 59601
Phone: 406-457-8900
Fax: 406-457-8997
http://www.lccountymt.gov/health.html

Date: DATE, 2019

Facility: ADDRESS
Helena, MT 59601
License #

To NAME, General Manager:

You are hereby notified that the FACILITY employee NAME is excluded from work as a food handler until further notice by order of Lewis and Clark Public Health. This employee may work in a restricted capacity in a food service facility if the employer and employee so choose and if both the employee and Person in Charge (PIC) at the food service facility ensure proper compliance with this status. A restricted capacity means that the employee will have no contact with food, surfaces in a food preparation or food storage area, or with clean dishes, utensils, or single service articles.

Please see the following definition from the Montana Food Code:
"Restrict" means to limit the activities of a FOOD EMPLOYEE so that there is no RISK of transmitting a disease that is transmissible through FOOD and the FOOD EMPLOYEE does not work with exposed FOOD, clean EQUIPMENT, UTENSILS, LINENS, or unwrapped SINGLE-SERVICE or SINGLE-USE ARTICLES.

You may also wish to see Section 2-2 in the Montana Food Code for information on employee health exclusions and restrictions. This can be found at https://www.fda.gov/media/87140/download.

You will be notified when this exclusion/restriction is lifted.

Signed by Drenda?

Lewis & Clark Public Health

Division of Disease Control and Prevention
1930 Ninth Avenue, Helena MT 59601
Phone: 406-457-8900
Fax: 406-457-8997

Health Officer Exclusion/Restriction Order

Date

To: Name
Address
Email

Lewis and Clark Public Health was notified on **Date** that you have been diagnosed with **(Salmonellosis, Shigellosis.)** This disease may be spread through fecal contamination from unclean hands to food and food contact surfaces. Therefore, by order of the Lewis and Clark County Health Officer, you must not work as a food handler or in a kitchen until released to do so. The authority to exclude you as an employee in a sensitive occupation is located in the Administrative Rules of Montana (ARM). Relevant sections of the ARM are provided on the back of this letter.

In order to return to work as a food handler, you must complete the following:

1. You must be free of all symptoms
2. If prescribed, finish your antibiotics then
3. Wait 48 hours
4. Collect stool sample using the kit and instructions provided to you
5. Contact a public health nurse at 457-8900 and make an appointment to drop off the sample and collect additional kit
6. Wait 24 hours
7. Collect stool sample using the kit and instructions provided to you
8. Contact the public health nurse at 457-8900 and make an appointment to drop off the sample

When two (2) consecutive stool samples are culture negative for (**Disease)**, we will provide you with a letter allowing you to return to work, without restriction.

Once you are symptom-free for at least 24 hours, you may work in a food service facility **in a restricted capacity only, and only if the employer agrees.** This would mean that you may not work in the kitchen or with any food, clean surfaces, or clean dishes/utensils or single service articles. From the Food code, please see the following definition: “Restrict" means to limit the activities of a FOOD EMPLOYEE so that there is no RISK of transmitting a disease that is transmissible through FOOD and the FOOD EMPLOYEE does not work with exposed FOOD, clean EQUIPMENT, UTENSILS, LINENS, or unwrapped SINGLE-SERVICE or SINGLE-USE ARTICLES.

Please contact us if you feel there is work in a restricted capacity available with your employer.

Due to the public health risk of foodborne illness, it is imperative that you follow the directions provided in this order. Please understand that if you do not follow these instructions, we will need to take additional action.

_____ Date: _____

Drenda Niemann, MPA, CPH, Health Officer

I have discussed and reviewed this order with **(Sanitarian of the Day)**, RS. I understand and agree to the provisions of this Exclusion Order.

_____ Date: _____

NAME

Ec: Drenda Neiman, Health Officer
Laurel Riek, Administrator, Disease Control and Prevention Division
Nina Heinzinger, Licensed Establishment Program Supervisor

For your information, sections of the Administrative Rules of Montana that regulate control of communicable diseases are included in this letter.

Administrative Rules of Montana (ARM) **37.114.301** SENSITIVE OCCUPATIONS

(1) A local health officer or the department may restrict a person employed or engaged in direct care of children, the elderly, or individuals who are otherwise at a high risk for disease from practicing an occupation or activity while infected by a reportable disease if, given the means of transmission of the disease in question, the nature of the person's work would tend to transmit the disease.

(2) No infectious person may engage in any occupation or activity involving the preparation, serving, or handling of food, including milk, to be consumed by others than his/her immediate family, until a local health officer determines him/her to be free of the infectious agent or unlikely to transmit the infectious agent due to the nature of his/her particular work.

(3) Persons involved in food preparation, serving, or handling of food may be subject to additional restrictions as specified in: "Food Code, 2013, Recommendations of the United States Public Health Service, Food and Drug Administration" published by National Technical Information Service, Publication PB2013-110462, ISBN 978-1-935239-02-4, November 3, 2013.

Food Code, 2013, Chapter 2, Section **2-201.11**

(A) The PERMIT HOLDER shall require FOOD EMPLOYEES and CONDITIONAL EMPLOYEES to report to the PERSON IN CHARGE information about their health and activities as they relate to diseases that are transmissible through FOOD. A FOOD EMPLOYEE or CONDITIONAL EMPLOYEE shall report the information in a manner that allows the PERSON IN CHARGE to reduce the RISK of foodborne disease transmission, including providing necessary additional information, such as the date of onset of symptoms and an illness, or of a diagnosis without symptoms, if the FOOD EMPLOYEE or CONDITIONAL EMPLOYEE:

(2) Has an illness diagnosed by a HEALTH PRACTITIONER due to:
- (a) Norovirus,
- (b) Hepatitis A virus,
- (c) Shigella spp.,
- (d) SHIGA TOXIN-PRODUCING ESCHERICHIA COLI,
- (e) Salmonella Typhi;
- (f) nontyphoidal Salmonella

2013 Food Code Section with Disease specific information:

2-201.12 The PERSON IN CHARGE shall EXCLUDE or RESTRICT a FOOD EMPLOYEE from a FOOD ESTABLISHMENT in accordance with the following:

(A) *Except when the symptom is from a noninfectious condition,* EXCLUDE a FOOD EMPLOYEE if the FOOD EMPLOYEE is: (1) Symptomatic with vomiting or diarrhea; or

(2) Symptomatic with vomiting or diarrhea and diagnosed with an infection from Norovirus, *Shigella* spp., nontyphoidal *Salmonella,* or SHIGA TOXIN-PRODUCING *E. COL* P

(3) If a FOOD EMPLOYEE was diagnosed with an infection from *Shigella* spp. and EXCLUDED as specified under Subparagraph 2-201.12(A)(2):

(a) RESTRICT the FOOD EMPLOYEE, who is ASYMPTOMATIC for at least 24 hours and works in a FOOD ESTABLISHMENT not serving a HIGHLY SUSCEPTIBLE POPULATION, until the conditions for reinstatement as specified under Subparagraphs (E)(1) or (2) of this section are met; or

(b) Retain the EXCLUSION for the FOOD EMPLOYEE, who is ASYMPTOMATIC for at least 24 hours and works in a FOOD ESTABLISHMENT that serves a HIGHLY SUSCEPTIBLE POPULATION, until the conditions for reinstatement as specified under Subparagraphs (E)(1) or (2), or (E)(1) and (3)(a) of this section are met.

(E) Reinstate a FOOD EMPLOYEE who was EXCLUDED as specified under Subparagraphs 2-201.12(A)(2) or (E)(1) or who was RESTRICTED under Subparagraph 2-201.12(E)(2) if the PERSON IN CHARGE obtains APPROVAL from the REGULATORY AUTHORITY and one of the following conditions is met:

(1) The EXCLUDED or RESTRICTED FOOD EMPLOYEE provides to the PERSON IN CHARGE written medical documentation from a HEALTH PRACTITIONER stating that the FOOD EMPLOYEE is free of a *Shigella* spp. infection based on test results showing 2 consecutive negative stool specimen cultures that are taken:

(a) Not earlier than 48 hours after discontinuance of antibiotics, and

(b) At least 24 hours apart;

(2) The FOOD EMPLOYEE was EXCLUDED or RESTRICTED after symptoms of vomiting or diarrhea resolved, and more than 7 calendar days have passed since the FOOD EMPLOYEE became ASYMPTOMATIC; or

(3) The FOOD EMPLOYEE was EXCLUDED or RESTRICTED and did not develop symptoms and more than 7 calendar days have passed since the FOOD EMPLOYEE was diagnosed.

1-201.10 Statement of Application and Listing of Terms Defined Terms. (A) The following definitions shall apply in the interpretation and application of this Code. (B) Terms Defined. As used in this Code, each of the terms listed in ¶ 1- 201.10(B) shall have the meaning stated below.

“Restrict" means to limit the activities of a FOOD EMPLOYEE so that there is no RISK of transmitting a disease that is transmissible through FOOD and the FOOD EMPLOYEE does not work with exposed FOOD, clean EQUIPMENT, UTENSILS, LINENS, or unwrapped SINGLE-SERVICE or SINGLE-USE ARTICLES.

Lewis & Clark Public Health

Division of Disease Control and Prevention
1930 Ninth Avenue, Helena MT 59601
Phone: 406-457-8900
Fax: 406-457-8997

Health Officer Restriction Order

Date:

Name
Address
Email

Thank you for your cooperation with the Exclusion Order. You must continue with the stool sample process until you have 2 culture negative results. At this time, one sample has tested culture negative for (**disease.)** As you are currently asymptomatic and in the process of obtaining the additional culture negative sample, you may work in a food service facility **in a restricted capacity only, and only if the employer agrees.**

This would mean that you may not work in the kitchen or with any food, clean surfaces, or clean dishes/utensils or single service articles. From the 2013 Food Code, please see the following definition: “Restrict" means to limit the activities of a food employee so that there is no risk of transmitting a disease that is transmissible through food and the food employee does not work with exposed food, clean equipment, utensils, linens, or unwrapped single-service or single-use articles.

You have requested to work in a restricted capacity by **(Describe here).** We can authorize your return to work in this restricted capacity until such time as we are able to give you a release notice.

Due to the public health risk of foodborne illness, it is imperative that you follow the directions provided in this order. Please understand that if you do not follow these instructions, we will need to take additional action.

_____ Date:

Drenda Niemann, MPA, CPH
Health Officer

Lewis & Clark Public Health

Division of Disease Control and Prevention
1930 Ninth Avenue, Helena MT 59601
Phone: 406-457-8900
Fax: 406-457-8997

DATE

Name
Address
City

RE: Release from Exclusion Order

Dear NAME:

On DATE, we were notified by the Montana Public Health Laboratory that your child has provided two negative stool cultures and is free of (Disease). At this time, your child is released from exclusion and may return to day care unrestricted. Thank you for your attention to this matter.

If you have questions about this release you may call **(Sanitarian), 406-xxx-xxxx** or Nina Heinzinger at 406-447-8361.
Sincerely,

Drenda Niemann, MPA, CPH
Health Officer

Ec: Laurel Riek, Disease Control & Prevention Division Administrator

Attachment 8: Exclusion and Collecting Samples Procedures

Lewis & Clark Public Health

Division of Disease Control and Prevention
1930 Ninth Avenue, Helena MT 59601
Phone: 406-457-8900
Fax: 406-457-8997

Exclusion and Collecting Samples

1. RS provide case with test kit (Cary-Blair Transport media, hat)
    a. Instruct on how to collect sample
        i. Use Swab immediately
        ii. Place swab in Cary-Blair Transport Media
        iii. Refrigerate until delivered to laboratory
2. RS Instruct on how to return the sample
    a. Call PHN and make appointment to deliver the sample (457-8900)
3. RS Complete lab form and deliver to PHN with another Carey-Blair kit.
    a. Write in comment box "Test of Cure: SALM-SCR"
    b. No tests need to be marked. Comment will suffice.
4. When case arrives,
    a. PHN meets with case in private room
    b. Obtains sample
    c. Confirms date and time of collection
    d. Obtains lab sheet from folder in lab
    e. Gives additional kit with instructions to collect after 24 hours
5. PHN will initiate new lab sheet
6. PHN will Deliver to the Montana Public Health Lab

Lab results will be sent to the Sanitarians

* RS will call case and give them the results. If they have 2 negative stool samples 24 hours apart they will be released from exclusion.
* RS will notify PHN so that unused lab sheet will be destroyed.

Reviewed 12/7/2022

Attachment 9: Traceback for Food Source Identification

Traceback Protocol

PURPOSE

This procedure is intended to guide Environmental Health Specialists on how to address the trace-back of foods implicated in an illness, outbreak, or intentional food contamination. Additionally, the procedure outlines how the roles of involved agencies will be coordinated.

INTRODUCTION

A trace-back investigation is the method used to determine and document the distribution and production chain, and the source(s) of a *product* that has been implicated in a foodborne illness investigation. A food may be implicated or associated with foodborne illness outbreak through epidemiological or statistical analysis, laboratory analysis, food preparation review or a combination of these methods. A trace-back investigation involves good interviewing techniques, a complete record review, and timely reporting to meet its intended purpose. A subsequent source investigation may be conducted to determine possible routes or points of contamination by inspecting common distribution sites, and/or processors identified in the trace-back investigation.

A trace-back investigation may be conducted for several reasons:

- to identify the source and distribution of the implicated food and remove the contaminated product from the marketplace,
- to distinguish between two or more implicated food products, and
- to determine potential routes and/or sources of contamination to prevent future illnesses.

CDC or state/local health or regulatory agencies may conduct limited trace-backs and/or trace-forward investigations to strengthen an epidemiological association by comparing the distribution of illnesses and the distribution of the product. This is often referred to as an “epi” trace-back.

TRACE-BACK PROCEDURES

INITIATING A TRACEBACK INVESTIGATION

Initiation of a trace-back investigation usually begins when 1) epidemiological evidence implicates a food product ***and*** 2) hazard analysis shows that other contributing factors were not to blame (e.g., cross-contamination, ill food workers, other on-site sources of infectious agent). Other factors that will be considered prior to initiating a trace-back investigation include disease severity, the risk of ongoing exposure, the availability of shipping records, reliable exposure data, the size and scope of the outbreak(s), and the availability of resources to conduct the investigations.

When the licensed establishment team determines that a foodborne illness outbreak has occurred, Lewis and Clark Public Health will follow the Communicable Disease Response Plan, Outbreak Response. During a foodborne illness outbreak Lewis and Clark Public Health will consult with the Montana Department of Public Health (DPHHS) when necessary to determine if a trace-back investigation is needed. When an implicated product involves interstate commerce, DPHHS will notify the Food and Drug Association (FDA) or the United States Department of Agriculture (USDA) depending on the type of product involved.

Information needed for the trace-back investigation will include a written epidemiologic summary, a hazard analysis and inspection reports (including a food preparation review), laboratory results, and copies of any invoices and distribution information.

All information from the trace-back investigation will be forwarded as requested to the DPHHS, FDA and CDC.

TRACE-BACK COORDINATION

Lewis and Clark Public Health will coordinate with the DPHHS and the FDA on all trace-back investigations. Most trace-back investigations are in response to a multi-state foodborne illness outbreaks and therefore trace-backs are usually occurring simultaneously in multiple jurisdictions. When it is a multi-state outbreak the FDA will ask for assistance from the state/local agencies.

PRODUCT SAMPLING

If leftover food from the implicated meal(s) or product from an implicated shipment is available, it may be collected for laboratory analysis. Necessary materials and instructions may be obtained from DPHHS Public Health Laboratory.

TRACE-BACK REPORTS

The investigating sanitarian(s) along with the program supervisor will be responsible for generating a report. The trace-back report should include the following forms and include relevant invoices, inventory records, shipping/receiving records, as well as a cover letter summarizing the timeline and information gathered from observations and interviews. The report will be submitted to DPHHS, who is responsible for sharing the report with federal agencies as needed.

Forms for these reports are available through DPHHS, FCSS.

- Form A: Food Investigation Traceback Report – identifies food item under investigation and distribution.
- Form B: Food Investigation Traceback Report – identifies food item under investigation, place of service and preparation and/or purchase.
- Form C: Flow Diagram of Product Source and Distribution

TRACE-BACK RESPONSIBILITIES

The investigating sanitarian is responsible for completing the following tasks:

1. Review background information on the outbreak and establishment prior to visiting the establishment.
2. Conduct an investigation and record collection at the implicated establishment(s). The investigation must include the following information.
    a. Epidemiologic data
        i. Exposure dates
        ii. Exposure places
    b. Environmental inspection
        i. Food service employee health

   ii. Cross-contamination issues
   iii. Collection of food samples, if directed
c. Preliminary trace-back and distribution information
d. Implicated product name and any available packaging, labeling

3. Analyze the data. Discuss analysis and next steps with the supervisor
4. Write trace-back report and submit it for review by supervisor and division administrator

The Licensed Establishment Supervisor is responsible for completing the following tasks.

1. Coordinate with DPHHS and FDA on trace-back investigation.
2. Update the Health Officer on the trace-back investigation.
3. Maintain regular contact with the investigating sanitarian(s).
4. Review trace-back records and data analysis.
5. Review the final trace-back report.
6. Submit final trace-back report to all agencies involved in the investigation.

Coordinating Agencies may provide direction and technical expertise, depending on the food product involved. Contact information is listed below:

Montana Department of Public Health and Human Services (DPHHS)
406-444-2837 OR hhsfcs@mt.gov
Food and Drug Administration (FDA)
888-723-3366
United States Department of Agriculture (USDA)
Meat and Poultry 888-674-6854 OR MPHotline.fsis@usda.gov

Links to DPHHS Forms

DPHHS Forms are found on the Sanitarian Resource page under Emergency Preparedness
https://dphhs.mt.gov/publichealth/FCSS/sanitarianresource/FCSdeliverables

Form A: Food Investigation Traceback Report
Form B: Food Investigation Traceback Report
Form C: Flow Diagram of Product Source and Distribution

Attachment 10: Recall Procedures for Removing Food from Commerce

Lewis and Clark Public Health

Recall Procedures of Food

PURPOSE

This procedure will address the responsibilities of Lewis and Clark Public Health (LCPH) in assisting the Montana Department of Public Health and Human Services (DPHHS) and FDA in mandatory and voluntary recalls from industry.

INTRODUCTION

Recall of food is in the common interest of the industry, the government and in particular, the consumer. A recall is defined as an action to remove from sale, distribution and consumption foods which may pose a safety hazard to the consumer.

A food recall notice may be initiated when there is suspected or confirmed presence of physical, bacterial, or chemical contaminant in a distributed food product that could cause illness or injury. Examples of contaminants include bacterial pathogens, metal filings or a major food allergen that is not disclosed on the label. A recall may also be initiated when a food product has been deemed to be misbranded, adulterated, or determined in some other way to pose harm to the health and safety of the consumer.

RECALL PROCEDURES

1. The FDA and other Federal food safety agencies will issue food product recall notices to the FDA liaison in the DPHHS Food and Consumer Safety Section (FCSS). Food product recalls regarding products that have been produced or distributed within Montana will be routed to interested parties such as local health department sanitarians via email.

2. The recall notices from FCSS are broken down into three categories:

Recall Level	Category
1	Action Needed
2	Discretionary
3	Advisory

Level 1: Action needed recall means the food product is in Montana, or the action is warranted

Level 2: Discretionary recall means the food product may be or is in Montana, but exact information is not known

Level 3: Advisory recall means no actionable information is known

3. FCSS will send the recall notice to all LCPH sanitarians.

4. The Licensed Establishment Supervisor will assure the sanitarians take the appropriate action stated in the recall notice. Each sanitarian will be responsible for contacting the establishments they inspect unless otherwise directed by the LE supervisor. With wide distribution of recalled products, a single email to multiple facilities may be advised.

Description of recommended action to be taken by sanitarian staff:

Alert level 1 – Action Recommended

- Identify distributors and retailers in assigned area.
- Supervisor will create message for sending to the affected facilities.
- This will be forwarded to staff sanitarians for distribution to affected facility contacts. HANMasterList has contact information for each facility.
- When requested by FCSS or FDA, sanitarian will contact distributors or retailers
    - Verify that distributor or retailer is aware of recall.
    - Confirm if product is currently or has been in stock.
    - Advise retailer to remove product and follow recall instructions.
    - Notify DPHHS where product was located and its disposition.

Alert level 2 - Discretionary

- Recall notice will be evaluated for risk to the public. Bacterial or physical contamination concerns will always be distributed to affected facilities.
- Identify distributors and retailers in assigned area.
- Supervisor will create message for sending to the affected facilities.
- This will be forwarded to staff sanitarians for distribution to affected facility contacts. HANMasterList has contact information for each facility.
- When requested by FCSS or FDA, sanitarian will contact distributors or retailers
    - Verify that distributor or retailer is aware of recall.
    - Confirm if product is currently or has been in stock.
    - Advise retailer to remove product and follow recall instructions.
    - Notify DPHHS where product was located and its disposition.

Alert level 3 – Advisory

- No action needs to be taken
- Be alert for additional updates.

Attachment 11: Non-Pharmaceutical Intervention Plan

Lewis & Clark Public Health

Non-Pharmaceutical Interventions (NPI) Plan

Effective Date: October 8, 2019

Version: 1.0

Document Number:	**DCP-010**
Document Title:	**Non-Pharmaceutical Intervention (NPI) Plan**
Document Owner	**Disease Control & Prevention**
Approval Date:	**October 8, 2019**
Approved By:	**Drenda Niemann, Health Officer**
Effective Dates:	**October 8, 2019 until *October 8, 2022***

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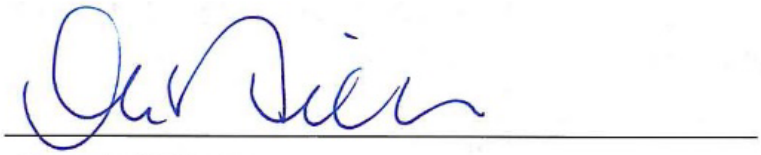
Signature Page:



Oct 8, 19

Drenda Niemann — **Date**

LCPH Health Officer

Record of Changes

Changes Made	Changed By	Date of Change
Isolation & Quarantine Protocol added to plan as an attachment	Brett Lloyd	10/7/2019
Document approved by Health Officer	BL	10/8/2019
Blending in I&Q plan	Jacqui Snyder	3/3/2020

Table of Contents

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1.0 Introduction

1.1 Purpose

The Lewis & Clark County Emergency Operations Plan (EOP) indicates that Lewis & Clark Public Health (LCPH) will respond to emergencies and events that involve public health. As a focused approach to operations intended to support the EOP, this plan defines the functions of LCPH with regard to non-pharmaceutical interventions (NPI).

This plan will be referenced during routine situations where exclusion, compliance orders or other NPI's might be considered ranging from single cases of infectious disease to large-scale infectious disease outbreaks, epidemics, and pandemics. It is designed to assist decision makers in implementing containment measures, which may include the implementation of NPIs at different levels. This document will include decision matrices, reference legal authority that enables or limits the ability to implement actions, template legal orders, and guidelines for implementing NPIs.

This plan is based on the CDC's Public Health Preparedness Capability 11 outlining guidance related to non-pharmaceutical interventions. This capability consists of the ability to perform the following functions:

- Engage partners and identify factors that impact NPIs
- Determine non-pharmaceutical interventions
- Implement non-pharmaceutical interventions
- Monitor non-pharmaceutical interventions

This plan is intended to support measures outlined in the LCPH All-Hazards Emergency Operations Plan and is considered a supplemental document to the LCPH Communicable Disease Response Plan.

1.2 Scope

This plan encompasses specific operations of LCPH and its response partners. Implementation is not contingent on activating the County EOP, but also may function as a core part of activation of the EOP.

This plan does not replace the day to day duties of LCPH staff or programs. It supports those activities and supplements them by defining procedures necessary when situations expand beyond the scope of day to day operations.

1.3 Policies

Montana statutes related to the prevention and control of communicable disease outline state and local responsibilities that may be implemented by DPHHS and/or local public health officials are found in 50-1-204, 50-2-116, 50-2-118, and 20-5-45 of the Montana Code Annotated (MCA). They allow potential use of NPIs in response to naturally occurring or artificially introduced biological agents in connection with significant public health events such as terror-related events. In addition, the Administrative Rules of Montana (ARM) 37.114.307, 37.114.308 and 37.115.314 allows for the implementation of NPIs, including isolation and quarantine. These statutes and rules encompass all levels of potential use ranging from individual cases to larger scale events such as outbreaks, epidemics or pandemics.

2.0 Situation & Assumptions

2.1 Situation

Controlling the spread of disease is a multi-faceted and complex endeavor requiring flexibility and multiple strategies. Non-pharmaceutical interventions (NPI), as defined by the US Centers for Disease Control and Prevention's (CDC) Public Health Capabilities, are steps taken to implement strategies for disease, injury, and exposure control. One benefit of NPI is that they are able to be implemented quickly and widely through crisis communications strategies, public education campaigns and using "off-the-shelf", cost-effective resources. The need to utilize NPI to control the spread of communicable diseases, and the success of such efforts, varies considerably in relation to the disease for which the approaches are being considered.

Examples of NPI strategies may include the following:

- Separation of individuals with a contagious disease from individuals who are not sick (isolation)
- Separation or restricted movement of healthy, but exposed individuals to determine if they are ill (quarantine)
- Restrictions on movement and travel advisories and warnings, such as screening at port of entry, limiting public transportation, and issuing travel precautions
- Social distancing
- School and childcare closures
- Postponement or cancellation of mass gatherings
- Closures and modifications of workplace or community events
- External decontamination
- Hygiene and sanitation
- Precautionary protective behaviors, such as personal decontamination, shelter in place, and face mask in special situations during significant public health events, such as severe pandemics

2.2 Assumptions

1. Day to day operations often involve the use of NPIs, including quarantine and isolation per the guidance provided in ARM's and the American Public Health Association Control of Communicable Diseases Manual (CCDM) adopted by the ARM. Various diseases can escalate to cluster/outbreak levels or beyond, including progressing to a significant public health event.
2. Operations involving these standard methods of action are inclusive, based on established relationships and partnerships with the public, stakeholders and partners, and contributing agencies.
3. Depending on the infectious disease and the situation surrounding the event, decisions on control measures for cases and outbreaks may be a shared decision with MT DPHHS per ARM.
4. Adjacent counties and other jurisdictions shall be included in response efforts, if necessary, and will be responses will be coordinated by MT DPHHS
5. Large-scale NPI events will require the participation of many public health resources, including workforce, as well as coordination with state authorities, multiple community entities, health care entities, and first responder agencies

6. LCPH will start with the implementation of the least restrictive means possible to reduce the spread of infection
7. LCPH will coordinate closely with healthcare providers and healthcare facilities to assist with achieving voluntary compliance of ill or exposed persons
8. An effective public communication program is essential to achieving voluntary compliance with all disease control strategies in large-scale events
9. NPI measures may require the involuntary quarantine or isolation of individuals who may pose a threat to the public's health and do not cooperate with orders from the Health Officer
10. Individuals confined under these measures will be supported by partners to the extent possible through means such as provision of food, shelter, and other necessities
11. An event triggering activation of the NPI plan is also likely to involve other emergency response capabilities.

3.0 Concept of Operations

3.1 General

LCPH has the authority to recommend or require NPI measures during cases of communicable disease. However, the health department must and does consult with MT DPHHS during significant public health events. Together, MT DPHHS and the local health jurisdiction will assess the severity of exposure or transmission at the jurisdictional level and determine the need for NPIs. Local health authorities identify NPI recommendations based on science, risks, resource availability, and legal authorities.

When instituting NPI measures, LCPH will try to start with the least restrictive means first. Additional measures will be taken if the least restrictive measures are ineffectual due to lack of compliance or recognition of other factors influencing the spread of disease in a population.

3.2 Notification

If the situation dictates that action must be taken, LCPH staff will reach out to appropriate partners and organizations to discuss and plan for implementing NPI measures as needed. Local partners may include, but are not limited to:

- MTDPHHS
  - **CDEpi 24/7 Notification Number: 406-444-0273**
- St. Peter's Healthcare, local clinics, and healthcare organizations (assisted living, nursing home, etc.)
- Local emergency medical services (EMS)
- School Districts
- Local fire departments
- City/County Administration
- City/County Attorney
- Local law enforcement
- Disaster and Emergency Services (DES)
- County Extension Agents
- Local Veterinary Offices
- Local Animal Shelter Contacts
- Mental and behavioral health agencies
- Surrounding county health departments
- Businesses
- Community and faith-based organizations
- Environmental health agency(s)
- Local public works or utilities providers

3.3 Activation

If LCPH and local leaders decide to implement various NPI strategies, they will be activated and coordinated in accordance with existing plans, policies and protocols and under the authority of the Health Officer and relevant statues, policies, and ordinances.

3.4 Direction & Control

NPI strategies may be multi-agency and even multi-jurisdictional and will likely be coordinated by either the LCPH Disease Control & Prevention and/or Environmental Health Services Divisions depending on the situation, types of hazards present and cooperating partners. Regardless of which LCPH division(s) and local partners are involved, all public health actions will likely fall under the authority of the involved County Health Officer(s) unless State or Federal agencies are involved (e.g. terrorism incident under FBI authority).

Large scale events that require multiagency or multijurisdictional cooperation may be managed using the Incident Command System (ICS) as outlined in the LCPH All Hazards Annex and County EOP and response plans.

3.5 NPI Strategies

LCPH may consider utilization of multiple strategies for preventing the spread of disease, including NPI. Examples of NPI measures may include, but are not limited to:

- Public Information & Education on prevention measures and self-care.
- Voluntary/Involuntary isolation and/or quarantine orders
- Restrictions on activities or movement, high-risk occupations, and public events
- School and/or public venue closures

Relevant LCPH plans and protocols for disease control strategies fall under the *LCPH CD Response Plan* and include:

- LCPH Communicable Disease Response Plan
    - LCPH Pandemic Flu Plan
    - LCPH Pertussis Investigation Protocol
    - LCPH Truck & Train Wreck Protocol

The above documents outline specific strategies and procedures for determining and implementing disease control measures within the County.

3.6 Monitoring NPIs

The incident management team will be responsible for monitoring the implementation and effectiveness of interventions, adjusting intervention methods and scope as the incident evolves, and determining the level or point at which interventions are no longer needed.

Current LCPH response plans and protocols (see 3.5 above) outline the processes, formal or informal, for monitoring.

3.7 NPI Locations & Housing Resources

It is assumed that in most instances those who need to be isolated or quarantined will be accommodated within their own homes. However, LCPH recognizes that some instances of disease outbreak or suspected infection will affect individuals or groups who do not have access to housing. This may include members of the homeless community as well as visitors to the area who are no longer able to stay in their hotels or with the friends and family who were accommodating their visit.

If one or two individuals needs to be isolated or quarantined but do not have adequate housing, LCPH may utilize hotel resources to accommodate them. If hotel resources are not available, LCPH may coordinate with local healthcare partners and MT-DPHHS to develop appropriate housing options.

If hotel resources and medical center resources are scarce or a larger number of individuals require isolation and/or quarantine, LCPH will work with its partner organizations such as Red Cross designated shelters, schools (depending on time of year), and fairgrounds to assist with accommodations if possible.

If a large group of people (e.g. tourists) require isolation and/or quarantine, LCPH will work with MT-DPHHS to determine where such a group could be accommodated for an extended period of time.

Zoonotic Infections

If domestic animals/pets are requiring isolation and quarantine for zoonotic infections, it would be assumed that they would be accommodated within their own homes or property. However, LCPH recognizes that in some instances this may not be possible.

If needed, LCPH may coordinate with local veterinary, shelter, and/or boarding facilities for isolation and quarantine of small scale outbreaks.

When a large group of animals requires isolation and/or quarantine, LCPH will work with local land owners, extension agents and/or county fairgrounds along with the Montana Department of Livestock to determine where and how such a group could be accommodated.

3.8 Isolation and Quarantine

1. **Determination of need for Quarantine or Isolation**
    a. Upon receipt of a report of a communicable disease, the Health Officer shall confirm the diagnosis. If the case is suspect or probable, the Health Officer may handle the case as communicable until medical or laboratory information rules out the diagnosis of communicable disease.
    b. Upon confirmation of the diagnosis or determination that the disease meets the case definition of a communicable disease, the health officer will consult the communicable disease rules (ARM 37.114.101 to 1016), the Control of Communicable Disease Manual, the Guidelines for Isolation Precautions in Hospitals and CDC's recommendations and current guidelines released to public health officials through the Health Alert Network (HAN) or other source.
    c. The Health Officer will determine the least restrictive control measures available, including isolation of cases and quarantine of contacts for any condition of public health importance.
2. **Reports:** Upon receiving a report of an infectious disease that requires isolation or quarantine, the Health officer will notify the DPHHS Communicable Disease Control and Prevention Bureau, Epidemiology Section. Depending on the level of public health risk the Health Officer will also notify: Board of Health (BOH), County Attorney, Coroner, medical community, Disaster and Emergency Services (DES) coordinator, elected officials, and law enforcement.
3. **Implement the Public Health All Hazards Annex**
    a. The Health Officer and the Division Administrators have authority to implement the Public Health All Hazards Annex.
    b. Circumstances that trigger the use of the All Hazards Annex
        (i) When a response includes staff call out after business hours.
        (ii) When a response requires reassignment of staff for an extended period of time
        (iii) Routine services are suspended
        (iv) Frontline staff can't keep up with the calls for information on a specific topic
4. **Practices and Conditions:** LCPH shall adhere to the following practices and conditions when isolating or quarantining individuals or groups

a. Isolation and quarantine will use the least restrictive means necessary to prevent the spread of a communicable or potentially communicable disease to others and may include, but are not limited to, confinement to private homes or other private and public premises.

b. Public education and voluntary compliance will be used whenever appropriate. These requests will use strategies such as:

   (i) Voluntary home curfew

   (ii) Suspension or restrictions on group assembly

   (iii) Cancellation of public events

   (iv) Closure of mass transit

   (v) Restriction of travel

   (vi) Snow days, shelter-in-place, work quarantine

c. Exposure to a communicable disease at a *public event* with unidentified contacts will be handled by issuing public service announcements and/or emergency broadcasts to provide:

   (i) Information for disease prevention

   (ii) Information about disease and incidence of disease

   (iii) Information for individuals to evaluate their risk of exposure

d. Quarantine orders that limit personal liberties will be used only when clear and convincing evidence is shown that such an order is reasonably necessary to prevent or limit the transmission of a communicable or potentially communicable disease to others.

e. When issuing quarantine orders, due process rights must be recognized and satisfied. This includes:

   (i) Adequate notice

   (ii) Right to be heard

   (iii) Access to legal counsel

   (iv) Final decision a court can review

f. Isolated individuals must be housed separately from quarantined individuals.

g. The health status of isolated and quarantined individuals must be monitored regularly to determine if they continue to require isolation or quarantine.

h. If a quarantined individual subsequently becomes infected or is reasonably believed to have become infected with a communicable or potentially communicable disease he or she must promptly be removed to isolation.

i. Isolation and quarantine must be immediately terminated when an individual poses no substantial risk of transmitting a communicable or potentially communicable disease to others.

j. Requests for provisions for those quarantined will be made to the Emergency Operations Center (EOC) as needed.

   (i) The needs of individuals who are isolated or quarantined shall be addressed in a systematic fashion, including, but not limited to, providing adequate food, clothing, shelter, means of communication, and medical care.

(ii) Cultural and religious beliefs shall be respected when addressing the needs of individuals and establishing and maintaining premises for isolation and quarantine.

k. Premises used for isolation and quarantine shall be maintained in a safe and hygienic manner and be designed to minimize the likelihood of further transmission of infection to isolated or quarantined individuals.

5. **Quarantine and Isolation Orders.** The Health Officer, to prevent or limit the transmission of a communicable or potentially communicable disease, may order isolation or quarantine of individuals or groups. The Board of Health will be notified within 24 hours of action taken under this section. Isolation requirements shall be guided by the Centers for Disease Control: *2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings*.

a. **Content of Order**:

(i) Identify the isolated or quarantined individuals or groups of individuals by name or shared or similar characteristics or circumstances;

(ii) Statement of authority;

(iii) A description of the circumstances upon which the order is based;

(iv) A description of the process for obtaining a hearing, and access to legal counsel;

(v) The premises subject to isolation or quarantine;

(vi) A statement of compliance with the public health practices and conditions for isolation and quarantine of § 6 of this protocol;

(vii) The date and time at which isolation or quarantine commences; and

(viii) The necessary requirements for lifting the isolation and quarantine order.

b. **Notice.** A copy of the written order shall be given to the individual to be isolated or quarantined. If the written order applies to a group of individuals and it is impractical to provide individual copies, it may be posted in a conspicuous place in the isolation or quarantine premises.

c. **Relief from Isolation and Quarantine.** An isolated or quarantined individual or group of individuals may appeal to district court for an order to show cause why isolation or quarantine should not be terminated.

d. **Continuances.** Prior to the expiration of an order issued pursuant to § 7 of this protocol, the Health Officer may extend the isolation or quarantine order.

6. **Monitoring of Individuals in Isolation and Quarantine**.

a. The Health Officer or the Department of Public Health and Human Services may inspect the place of isolation at any time to determine compliance with the order. ARM 37.114.308

b. Quarantined individuals will be **monitored** by:

(i) Telephone calls from LCPH staff

1. The planning section of the LCPH Command Post will request additional resources if necessary.

(ii) Directions to the individual to call LCPH and health care provider if symptoms develop

(iii) Home visits as needed

7. **Release from Isolation and Quarantine Orders**. The Health Officer may authorize release of individuals or groups from isolation and quarantine when:
   a. The incubation period has passed and no symptoms of communicable disease are present.
   b. When the period of contagion has passed, which may be longer than the symptomatic period.
8. **Enforcement.** Health Officer may request a sheriff or other peace officer to assist in carrying out the provisions of quarantine or isolation. (50-2-120 MCA).
9. **Foreign Travelers**. Ill travelers from a foreign country must be isolated and quarantined until the etiologic agent of the disease is determined. Then appropriate control measures for that etiologic agent must be implemented. (ARM 37.114.595 (1))
10. **Building Closures.** The Health Officer shall take steps to limit contact between people in order to protect the public health from imminent threats, including but not limited to ordering the closure of buildings or facilities where people congregate and canceling events. (MCA 50-2-118 (2)).
    a. Prior to taking such action, the appropriate elected officials, the County Attorney's office and law enforcement will be notified.
    b. Declaration of an emergency and activation of the emergency operations center (Page 14, Section VII (F) Health Department All-Hazard Annex) will be requested when the response requires cancelation of public events or closure of public buildings**.**
11. **Decontamination.** The local Health Officer is authorized to make inspections for conditions of public health importance and issue written orders for compliance or for correction, destruction, or removal of the condition. (MCA 50-2-118 (1)). This can include ordering decontamination of places that are infected with communicable diseases. (MCA 50-2-116 (1)(g)) Decontamination of the environment will be in accordance with the Control of Communicable Disease Manual or by guidance documents from CDC that are released through the HAN or other source.

3.9 Recovery

Recovery activities will vary with the situation, but essentially focus on returning to "pre-incident" conditions and identifying areas for improvement. The LCPH All Hazards Annex and County EOP both outline strategies for the recovery phase of an incident as well as the need to conduct an "after action review" and report as appropriate.

4.0 Organization & Responsibilities

4.1 Organization

Organization of incident response and management personnel will be in accordance with established plans and procedures. For the most part, larger incidents will be managed using the ICS in a "Unified Command" structure. The LCPH All Hazard Annex, CD Response Plan, and County EOP all outline organizational strategies for incident management. NPI response will fall under these existing documents.

4.2 Roles & Responsibilities

Lewis & Clark Public Health

LCPH staff roles and responsibilities with regard to NPI measures are defined clearly in the following documents as appropriate:

- LCPH Communicable Disease Response Plan
  - LCPH Pandemic Flu Plan
  - LCPH Pertussis Investigation Protocol
  - LCPH Isolation & Quarantine Protocol
  - LCPH Truck & Train Wreck Protocol

For the most part, LCPH DCP and EHS staff will decide the most appropriate NPI measures given the situation and will act under the authority of the Health Officer and relevant policies, statutes and ordinances. Activities include:

- Assess the public health threat, evaluate potential consequences based on established criteria, and determine whether isolation and/or quarantine are necessary in any given outbreak situation.
- Initiate the isolation and/or quarantine of individuals as a protective action to limit the spread of infectious agents or contaminants to others.
- Under specific circumstances, may immediately order or seek a court order to detain infected or exposed individuals and place them in isolation or quarantine.
- Identify an appropriate placement for individuals who are isolated or quarantined, if they cannot stay at their homes or do not have a suitable home environment, and arrange transportation to the designated facility.
- Establish Epi Team to coordinate response.
- Address public concerns and disseminate information containing common message in coordination with DPHHS, CDC, Department, City and County Public Information Officers, and adjacent jurisdictional health departments.

Law Enforcement

Lewis & Clark County Sherriff's Office (LCSO) and Helena & East Helena Police Departments (HPD/EHPD) have responsibility for the following activities within their jurisdictions:

- Assist with service of notice related to involuntary isolation and/or quarantine, if needed.
- Execute arrest warrants related to isolation and/or quarantine cases, if needed.

City & County Attorney's Offices

- Petition the court ex parte to authorize involuntary detention, once need is determined by LCPH.
- Represent LCPH in any petition or appeal hearings required to carry out involuntary isolation or quarantine.
- Coordinate with LCPH, LCSO/HPD/EHPD to serve notice related to involuntary isolation or quarantine.

5.0 Plan Development & Maintenance

LCPH staff will review this plan annually to ensure currency and accuracy. The goals of this review are to

- Ensure overall plan accuracy and readiness
- Address and resolve policy, methodology, and technological issues
- Ensure this guide coordinates with related plans, procedures, and protocols
- Make necessary corrections, edits, updates, or procedural adjustments

The LCPH PHEP Coordinator is assigned as the primary person assigned responsibility for conducting this review and maintaining these procedures to ensure they remain appropriate to the goals and capabilities of the agency.

Changes are tracked in a versioning method and in the Record of Change log found at the front of this document.

6.0 Authorities & References

Montana Code Annotated (MCA)

General Provisions, Local Boards of Health, Part 1

- MCA 20-5-405, Medical or Religious Exemption [Selected portion, see MCA Link for full citation]
  - (3) Whenever there is good cause to believe that a person for whom an exemption has been filed under this section has a disease or has been exposed to a disease listed in 20-5-403 or will as the result of school attendance be exposed to the disease, the person may be excluded from the school by the local health officer or the department until the excluding authority is satisfied that the person no longer risks contracting or transmitting that disease.
- MCA 50-2-115, **Legal Adviser to Local Boards**
  - Legal adviser to local boards. The county attorney shall serve as legal adviser to local boards as established by 50-2-104 and 50-2-106. The county attorney shall represent the local board in those matters relating to the functions, powers, and duties of local boards.
- MCA 50-2-116, **Powers and Duties of Local Boards of Health** [Selected portion, see MCA Link for full citation]
  - (1) In order to carry out the purposes of the public health system, in collaboration with federal, state, and local partners, each local board of health shall:

    …(f) identify, assess, prevent, and ameliorate conditions of public health importance through:

    (i) epidemiological tracking and investigation;

    (ii) screening and testing;

    (iii) isolation and quarantine measures;

    (iv) diagnosis, treatment, and case management;

    (v) abatement of public health nuisances;

    (vi) inspections;

    (vii) collecting and maintaining health information;

    (viii) education and training of health professionals; or

    (ix) other public health measures as allowed by law;….
- MCA 50-2-118, **Powers and Duties of Local Health Officers**
  - In order to carry out the purpose of the public health system, in collaboration with federal, state, and local partners, local health officers or their authorized representatives shall:

    (1) make inspections for conditions of public health importance and issue written orders for compliance or for correction, destruction, or removal of the condition;

(2) take steps to limit contact between people in order to protect the public health from imminent threats, including but not limited to ordering the closure of buildings or facilities where people congregate and canceling events;

(3) report communicable diseases to the department as required by rule;

(4) establish and maintain quarantine and isolation measures as adopted by the local board of health; and

(5) pursue action with the appropriate court if this chapter or rules adopted by the local board or department under this chapter are violated.

- MCA 50-2-120, **Assistance from Law Enforcement Officials**
  - A state or local health officer may request a sheriff, constable, or other peace officer to assist the health officer in carrying out the provisions of this chapter. If the officer does not render the service, the officer is guilty of a misdemeanor and may be removed from office.

Administrative Rules of Montana (ARM), 37.114.101 to 1016

Publications Incorporated by Reference in ARM 37.114.105:

- The "Control of Communicable Diseases Manual, An Official Report of the American Public Health Association", 20th edition, 2015, which lists and specifies control measures for communicable diseases.
- The "2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings" published by the U.S. Centers for Disease Control and Prevention, which specifies precautions that should be taken to prevent transmission of communicable diseases for cases admitted to a hospital or other health care facility.
- The "Sexually Transmitted Diseases Treatment Guidelines, 2015" are published by the U.S. Centers for Disease Control and Prevention in the June 5, 2015, Morbidity and Mortality Weekly Report, volume 64, hereafter referred to as "Sexually Transmitted Diseases Treatment Guidelines, 2015," and specify the most currently accepted effective treatments for sexually transmitted diseases.
- The "Food Code, 2013, Recommendations of the United States Public Health Service, Food and Drug Administration" published by the National Technical Information Service.
- The Official American Thoracic Society/Centers for Disease Control and Prevention/Infectious Diseases Society of America Clinical Practice Guidelines: Treatment of Drug-Susceptible Tuberculosis, published in Clinical Infectious Diseases, October 1, 2016.
- The "Guidelines for the Investigation of Contacts of Persons with Infectious Tuberculosis," which provide recommendations from the National Tuberculosis Controllers Association and the U.S. Centers for Disease Control and Prevention, published December 16, 2005.

7.0 Attachments

Attachment 1: Acronyms & Definitions

AAR: After Action Report.

ARM: Administrative Rules of Montana.

Case: An individual who has been diagnosed with a communicable disease or who has symptoms that fit the case definition of a communicable disease.

Case Definition: Set of symptoms, clinical or diagnostic findings that constitute a case of a communicable disease. Case classifications include suspect, probable and confirmed. The Health Officer, DPHHS, CDC is the Centers for Disease Control and Prevention, www.cdc.gov (CDC), or the World Health Organization, www.who.int (WHO) may create case definition.

CDC: Centers for Disease Control (and Prevention).

Communicable Disease: an illness due or suspected to be due to a specific infectious agent or its toxic products which results from transmission of that agent or its products to a susceptible host, directly or indirectly. ARM 37.114.101(5).

Condition of Public Health Importance: means a disease, syndrome, symptom, injury, or other threat to health that is identifiable on an individual or community level and that can reasonably be expected to lead to adverse health effects in the community.

Contact: an individual who has been identified as having been exposed, or potentially been exposed, to a communicable or potentially communicable disease through another individual or nonhuman source of the communicable or potential communicable disease.

DPHHS: (Montana) Department of Public Health & Human Services.

Isolation: separation during the period of communicability of an infected or probably infected person from other persons, in places and under conditions approved by the department or local Health Officer and preventing the direct or indirect conveyance of the infectious agent to persons who are susceptible to the infectious agent in question or who may convey the infection to others. ARM 37.114.101 (22)

LCPH: Lewis & Clark Public Health.

Quarantine: those measures required by a local Health Officer or the department to prevent transmission of disease to or by those individuals who have been or are otherwise likely to be in contact with an individual with a communicable disease. ARM 37.114.101 (27)

WHO: World Health Organization.

Lewis & Clark
Public Health

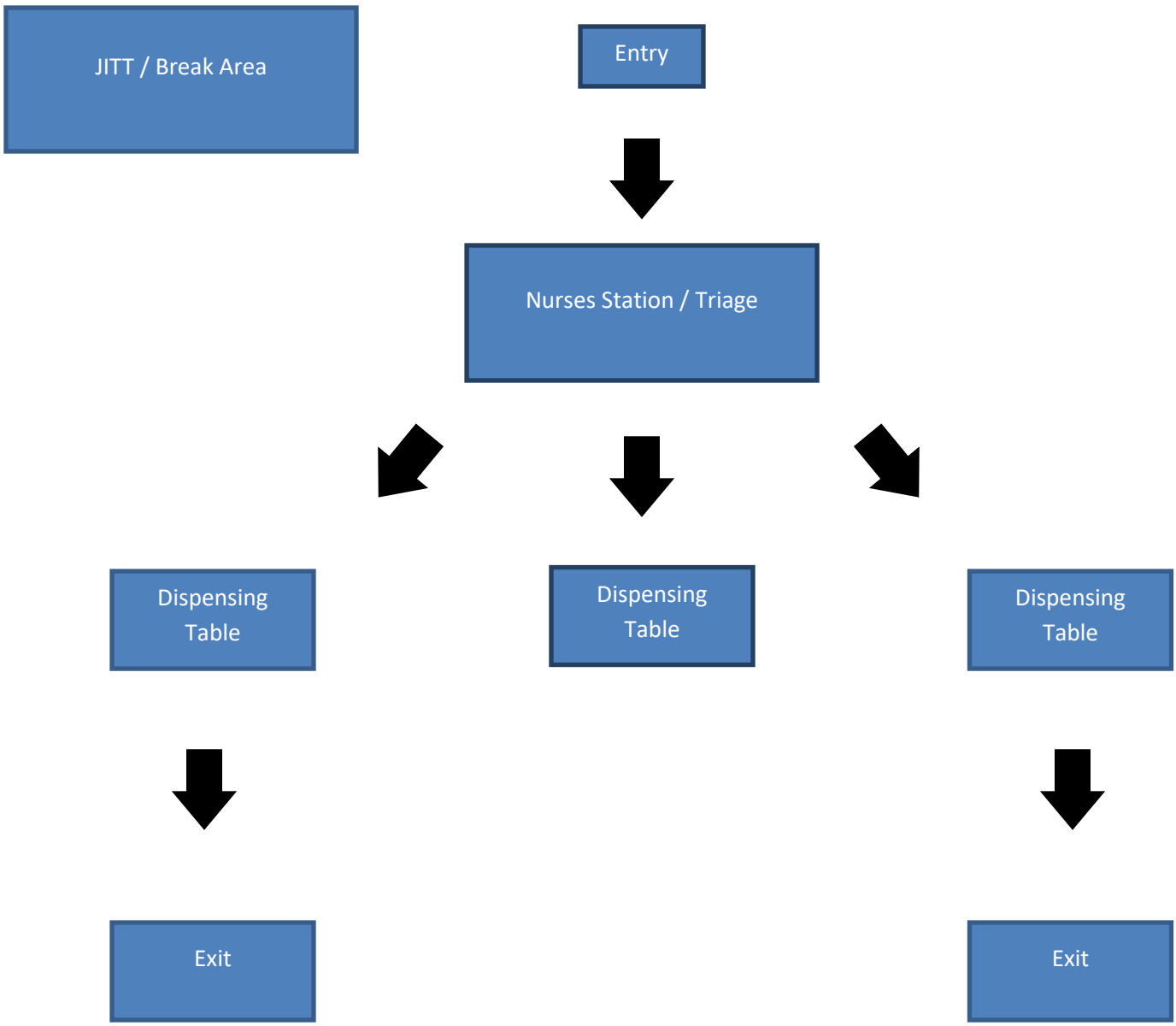
Helena, Montana

Attachment 12: Emergency Medical Countermeasures Plan

Lewis & Clark Public Health

Division of Disease Control and Prevention
1930 Ninth Avenue, Helena MT 59601
Phone: 406-457-8900
Fax: 406-457-8997

Standard POD Setup Diagram



Lewis & Clark Public Health

Disease Control and Prevention
1930 Ninth Avenue, Helena MT 59601
Phone: 406-457-8900
Fax: 406-457-8997

Position:	**POD Manager**
Role:	Responsible for administrative oversight of the POD. Directs activities of Liaison, Public Information Officer, Medical Director and Health & Safety officer; Provides direct supervision to Section Chiefs.
You report to:	**Operations Section Chief**

Before your shift:

- ☐ Register at Staff Check-in
- ☐ Clearly display ID badge
- ☐ Familiarize self with location of all clinic areas
- ☐ Review your Job Action Sheet
- ☐ Attend clinic orientation
- ☐ Check in with your Supervisor
- ☐ Review job responsibilities with your Supervisor
- ☐ Receive vaccine/medication if not already treated
- ☐ Coordinate initial delivery of clinical and non-clinical supplies and equipment with Logistics Section Chief
- ☐ Provide orientation and convene walk through for all staff with Clinical Manager
- ☐ Ensure site is physically set-up and ready for operations
- ☐ Conduct clinic walk through with Clinical Manager

During your shift:

- ☐ Wear appropriate PPE, as needed
- ☐ Supervise all administrative aspects of the clinic
- ☐ Make appropriate staff assignments using the NDPHCS POD operations organizational chart
- ☐ Ensure staffing requirements are met, both clinical and non-clinical
- ☐ Ensure clinic operation through Section Chiefs
- ☐ Orient and supervise non-clinical staff through Section Chiefs
- ☐ Ensure security of clinic site and medication through security liaison
- ☐ Communicate with NDPHCS, Clinical Manager and other staff, as needed
- ☐ Assign/reassign staff to meet needs throughout shift
- ☐ Communicate need for additional supplies and equipment with Logistics Section Chief
- ☐ Coordinate external communications with Public Information Officer
- ☐ Coordinate communications/issues to EOC with Liaison
- ☐ Serve as troubleshooter and resource person during clinic operation, or clearly identify designee

After your shift:

- ☐ Assist with teardown or cleanup of clinic
- ☐ Attend staff debriefing at shift change and/or at close of clinic
- ☐ Prepare clinic for next day operations, as needed
- ☐ Brief incoming POD Manager
- ☐ Sign out with Finance/Administration
- ☐ Return ID, PPE and any other supplies and documentation

Lewis & Clark Public Health

Disease Control and Prevention
1930 Ninth Avenue, Helena MT 59601
Phone: 406-457-8900
Fax: 406-457-8997

Position:	**Clinical Manager**
Role:	Responsible for the clinical operations and staff supervision at the POD. Must be a licensed nurse or physician with experience in planning and operating clinics. Needs supervisory/management skills.
You report to:	**POD Manager**

Before your shift:

- ☐ Register at Staff Check-in
- ☐ Clearly display ID badge
- ☐ Familiarize self with location of all clinic areas
- ☐ Review your Job Action Sheet
- ☐ Attend clinic orientation
- ☐ Check in with your Supervisor
- ☐ Review job responsibilities with your Supervisor
- ☐ Receive vaccine/medication if not already treated Register at Staff Check-in
- ☐ Review standing orders and emergency protocols
- ☐ Meet with Logistics Coordinator
- ☐ Review POD layout with Logistics Coordinator
- ☐ Designate Staging area for dispensing of meds
- ☐ Designate area of clinic for Triage
- ☐ Designate area of clinic for transporting of clients
- ☐ Designate space for medical consultation
- ☐ Meet with Triage, Screeners, Dispenser and Medical Evaluators after check-in
- ☐ Ensure Maintenance receives “Just in Time” training for medical waste
- ☐ Design optimal clinic flow structure to minimize bottlenecking

During your shift:

- ☐ Wear appropriate PPE, as needed
- ☐ Assure breaks for staff of the clinic/dispensing area
- ☐ Assure Behavioral Health is stationed nearby
- ☐ Assure dispensing tables are well supplied and equipped
- ☐ Assure supplies are accessible to staff
- ☐ Report issues to POD Manager

After your shift:

- ☐ Assist with teardown or cleanup of clinic
- ☐ Attend staff debriefing at shift change and/or at close of clinic
- ☐ Prepare clinic for next day operations, as needed
- ☐ Brief incoming Clinical Manager
- ☐ Sign out with Finance/Administration
- ☐ Return ID, PPE and any other supplies and documentation

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Position:	**Greeter Team Leader**
Role:	Greet participants and expedite the flow into the POD. Should be volunteers with excellent communication, decision-making and assessment skills; trained administrative professionals, as needed.
You report to:	**POD Manager**

Before your shift:

- ☐ Register at Staff Check-in
- ☐ Clearly display ID badge
- ☐ Familiarize self with location of all clinic areas
- ☐ Review your Job Action Sheet
- ☐ Attend clinic orientation
- ☐ Check in with your Supervisor
- ☐ Review job responsibilities with your Supervisor
- ☐ Receive vaccine/medication if not already treated
- ☐ Review job responsibilities with Greeter Team

During your shift:

- ☐ Wear appropriate PPE, as needed
- ☐ Coordinate distribution of registration forms, clipboards and pens
- ☐ Coordinate directing individuals to clinic line
- ☐ Coordinate directing individuals who appear ill to Triage
- ☐ Coordinate referrals of individuals to Behavioral Health, as needed
- ☐ Coordinate referrals of individuals with language barriers to Interpreters
- ☐ Coordinate Notification of Security to handle disruptive individuals, as needed
- ☐ Resolve issues or problems to presented by Greeters
- ☐ Report issues or problems to Clinical Manager

After your shift:

- ☐ Assist with teardown or cleanup of clinic
- ☐ Attend staff debriefing at shift change and/or at close of clinic
- ☐ Prepare clinic for next day operations, as needed
- ☐ Brief incoming Greeter Team Leader
- ☐ Sign out with Finance/Administration
- ☐ Return ID, PPE and any other supplies and documentation

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Position:	**Greeter**
Role:	Greet participants and expedite the flow into the POD. Should have excellent communication, decision-making and assessment skills.
You report to:	**Greeter Team Leader**

Before your shift:

- ☐ Register at Staff Check-in
- ☐ Clearly display ID badge
- ☐ Familiarize self with location of all clinic areas
- ☐ Review your Job Action Sheet
- ☐ Attend clinic orientation
- ☐ Check in with your Supervisor
- ☐ Review job responsibilities with your Supervisor
- ☐ Receive vaccine/medication if not already treated

During your shift:

- ☐ Wear appropriate PPE, as needed
- ☐ Pass out registration forms, clipboards and pens
- ☐ Direct individuals to clinic line
- ☐ Direct individuals who appear ill to Triage
- ☐ Refer individuals to behavioral health, as needed
- ☐ Refer individuals with language barriers to translator
- ☐ Notify security to handle disruptive individuals, as needed
- ☐ Report issues or problems to Greeter Team Leader

After your shift:

- ☐ Assist with teardown or cleanup of clinic
- ☐ Attend staff debriefing at shift change and/or at close of clinic
- ☐ Prepare clinic for next day operations, as needed
- ☐ Brief incoming Greeter
- ☐ Sign out with Finance/Administration
- ☐ Return ID, PPE and any other supplies and documentation

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Position:	**Medical Screener**
Role:	Clears or defers for prophylactic treatment. Must be an MD, ARNP.
You report to:	**Clinical manager**

Before your shift:

- ☐ Register at Staff Check-in
- ☐ Clearly display ID badge
- ☐ Familiarize self with location of all clinic areas
- ☐ Review your Job Action Sheet
- ☐ Attend clinic orientation
- ☐ Check in with your Supervisor
- ☐ Review job responsibilities with your Supervisor
- ☐ Receive vaccine/medication if not already treated
- ☐ Review standing orders and emergency protocols
- ☐ Address any language or special needs concerns

During your shift:

- ☐ Wear appropriate PPE, as needed
- ☐ Review registration form to assess for contraindications
- ☐ Following clinic protocols, clear or defer for prophylaxis
- ☐ Following clinic protocols, determine proper medication regimen
- ☐ Indicate appropriate medication regimen on registration form
- ☐ Direct individuals to medication dispensing workstation
- ☐ Refer individuals to medical consultation, as needed
- ☐ Refer individuals to behavioral health, as needed
- ☐ Report issues or problems to clinic area leader
- ☐ Notify security to handle disruptive individuals as needed.

After your shift:

- ☐ Assist with teardown or cleanup of clinic
- ☐ Attend staff debriefing at shift change and/or at close of clinic
- ☐ Prepare clinic for next day operations, as needed
- ☐ Brief incoming Medical Screener
- ☐ Sign out with Finance/Administration
- ☐ Return ID, PPE and any other supplies and documentation

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Position:	**Triage**
Role:	Responsible for sorting clients in groups and direct client to appropriate area of the clinic. Preferably a public health nurse, other clinician or physician with experience in clinical triage. Works closely with Clinical Manager, Screeners and Medical Evaluators. Reporting to this role are Clinic/Dispensing Runners. Located in the clinic/dispensing area.
You report to:	**Triage Team Leader/Medical Screener**

Before your shift:

- ☐ Register at Staff Check-in
- ☐ Clearly display ID badge
- ☐ Familiarize self with location of all clinic areas
- ☐ Review your Job Action Sheet
- ☐ Attend clinic orientation
- ☐ Check in with your Supervisor
- ☐ Review job responsibilities with your Supervisor
- ☐ Receive vaccine/medication if not already treated

During your shift:

- ☐ Wear appropriate PPE, as needed
- ☐ Assess and sort ill persons, those not eligible and those eligible for vaccine/antibiotic treatment to minimize bottlenecking
- ☐ Consult with Medical Evaluators as needed

After your shift:

- ☐ Assist with teardown or cleanup of clinic
- ☐ Attend staff debriefing at shift change and/or at close of clinic
- ☐ Prepare clinic for next day operations, as needed
- ☐ Brief incoming Triage staff
- ☐ Sign out with Finance/Administration
- ☐ Return ID, PPE and any other supplies and documentation

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Position:	**Registration Clerk Team Leader**
Role:	Ensure form completion and process the participant to the appropriate next station. Reporting to you are trained administrative and clerical personnel.
You report to:	**POD Manager**

Before your shift:

- ☐ Register at Staff Check-in
- ☐ Clearly display ID badge
- ☐ Familiarize self with location of all clinic areas
- ☐ Review your Job Action Sheet
- ☐ Attend clinic orientation
- ☐ Check in with your Supervisor
- ☐ Review job responsibilities with your Supervisor
- ☐ Receive vaccine/medication if not already treated
- ☐ Review job responsibilities with Registration Team

During your shift:

- ☐ Wear appropriate PPE, as needed
- ☐ Continually monitor forms, request new copies of forms from administration so there is no disruption in traffic flow
- ☐ Collect forms for Registrations Clerks and regularly send to Data Collectors
- ☐ Coordinate directing individuals who have education questions to education workstation, as needed
- ☐ Coordinate direct individuals who have medical questions to medical screening workstation, as needed
- ☐ Coordinate referrals of individuals to behavioral health, as needed
- ☐ Coordinate referrals of individuals with language barriers to Interpreters, as needed
- ☐ Coordinate referrals of individuals with properly completed forms and no questions or barriers to dispensing
- ☐ Resolve issues or problems presented by Greeters
- ☐ Report issues or problems to Clinical Manager

After your shift:

- ☐ Assist with teardown or cleanup of clinic
- ☐ Attend staff debriefing at shift change and/or at close of clinic
- ☐ Prepare clinic for next day operations, as needed
- ☐ Brief incoming Registration Clerk Team Leader
- ☐ Sign out with Finance/Administration
- ☐ Return ID, PPE and any other supplies and documentation

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Position:	**Registration Clerk**
Role:	Ensure form completion and process the participant to the appropriate next station. Should be trained administrative and clerical personnel.
You report to:	**Registration Team Leader**

Before your shift:

- ☐ Register at Staff Check-in
- ☐ Clearly display ID badge
- ☐ Familiarize self with location of all clinic areas
- ☐ Review your Job Action Sheet
- ☐ Attend clinic orientation
- ☐ Check in with your Supervisor
- ☐ Review job responsibilities with your Supervisor
- ☐ Receive vaccine/medication if not already treated

During your shift:

- ☐ Wear appropriate PPE, as needed
- ☐ Confirm registration form is completed
- ☐ Direct individuals who have education questions to education workstation
- ☐ Direct individuals who have medical questions to medical screening workstation
- ☐ Refer individuals to behavioral health, as needed
- ☐ Refer individuals with language barriers to translator
- ☐ Refer individuals with properly completed forms and no questions or barriers to dispensing
- ☐ Report issues or problems to clinic area leader

After your shift:

- ☐ Assist with teardown or cleanup of clinic
- ☐ Attend staff debriefing at shift change and/or at close of clinic
- ☐ Prepare clinic for next day operations, as needed
- ☐ Brief incoming Registration Clerk
- ☐ Sign out with Finance/Administration
- ☐ Return ID, PPE and any other supplies and documentation

Lewis & Clark Public Health

Disease Control and Prevention
1930 Ninth Avenue, Helena MT 59601
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Position:	**Dispensing Team Leader**
Role:	Provide nursing supervision and management to dispensing personnel. Must be qualified to administer vaccine or dispense medication under state law and have supervisory experience. Reporting to you are Dispensing Personnel.
You report to:	**Clinical Manager**

Before your shift:

- ☐ Register at Staff Check-in
- ☐ Clearly display ID badge
- ☐ Familiarize self with location of all clinic areas
- ☐ Review your Job Action Sheet
- ☐ Attend clinic orientation
- ☐ Check in with your Supervisor
- ☐ Review job responsibilities with your Supervisor
- ☐ Receive vaccine/medication if not already treated
- ☐ Review standing orders and emergency protocols

During your shift:

- ☐ Wear appropriate PPE, as needed
- ☐ Designate space for patient confidentiality
- ☐ Familiarize self with the personnel working under your supervision
- ☐ Monitor colleagues and clients for signs of stress or fatigue and notify your supervisor as needed
- ☐ Ensure adequate supply levels-use a runner to get supplies as needed
- ☐ Train incoming vaccinators if directed to do so by Medical Services Director
- ☐ Provide routine progress reports to Clinical Nurse Manager and Planning Team Leader on a regular basis
- ☐ Provide supervisory guidance to personnel under you
- ☐ Troubleshoot any problems that may occur with personnel under you (ex. if an allergic reaction occurs-direct and/or assist personnel as needed)
- ☐ When necessary, be prepared to step in and take over a staff member's vaccinator/ dispensing position short term until another qualified staff member can take over
- ☐ Schedule and ensure that vaccinator/dispenser staff take regular breaks
- ☐ Ensure that all documentation has been filled in and is complete

After your shift:

- ☐ Assist with teardown or cleanup of clinic
- ☐ Attend staff debriefing at shift change and/or at close of clinic
- ☐ Prepare clinic for next day operations, as needed
- ☐ Brief incoming Dispensing Team Leader
- ☐ Sign out with Finance/Administration
- ☐ Return ID, PPE and any other supplies and documentation
- ☐ When relieved, hand in all documentation and paperwork to the Planning Team Leader

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Position:	**Dispensing**
Role:	Responsible for administering vaccine/antibiotics. Works closely with Clinical Manager, Screeners, Triage and Medical Evaluators. Reporting to this role are Clinic/Dispenser Runners, Vaccine/Antibiotic Dispensing Runners. Located in the clinic/dispensing area.
You report to:	**Dispensing Team Leader**

Before your shift:

- ☐ Register at Staff Check-in
- ☐ Clearly display ID badge
- ☐ Familiarize self with location of all clinic areas
- ☐ Review your Job Action Sheet
- ☐ Attend clinic orientation
- ☐ Check in with your Supervisor
- ☐ Review job responsibilities with your Supervisor
- ☐ Receive vaccine/medication if not already treated
- ☐ Review standing orders and emergency protocols
- ☐ Get vaccine/medication
- ☐ Meet with Triage, Screeners, Dispenser and Medical Evaluators after check-in
- ☐ Review triage layout with Clinical Manager

During your shift:

- ☐ Wear appropriate PPE, as needed
- ☐ Quickly review medical hx of side effects and causes. Dispense meds as ordered by the POD Manager
- ☐ Consult with Medical Evaluators as needed

After your shift:

- ☐ Assist with teardown or cleanup of clinic
- ☐ Attend staff debriefing at shift change and/or at close of clinic
- ☐ Prepare clinic for next day operations, as needed
- ☐ Brief incoming Dispensing staff
- ☐ Sign out with Finance/Administration
- ☐ Return ID, PPE and any other supplies and documentation

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Position:	**Educator**
Role:	Provide information and answer questions. Must be clinical health professionals and/or health educators. At least one clinic person must be available to address clinical questions from participants
You report to:	**Clinical Manager**

Before your shift:

- ☐ Register at Staff Check-in
- ☐ Clearly display ID badge
- ☐ Familiarize self with location of all clinic areas
- ☐ Review your Job Action Sheet
- ☐ Attend clinic orientation
- ☐ Check in with your Supervisor
- ☐ Review job responsibilities with your Supervisor
- ☐ Receive vaccine/medication if not already treated

During your shift:

- ☐ Wear appropriate PPE, as needed
- ☐ Disseminate education materials regarding the disease and prophylaxis
- ☐ Answer general questions regarding the disease and prophylaxis
- ☐ Refer individuals to behavioral health, as needed
- ☐ Refer individuals with language barriers to translator
- ☐ Report issues or problems to Clinic Area Leader

After your shift:

- ☐ Assist with teardown or cleanup of clinic
- ☐ Attend staff debriefing at shift change and/or at close of clinic
- ☐ Prepare clinic for next day operations, as needed
- ☐ Brief incoming Educator
- ☐ Sign out with Finance/Administration
- ☐ Return ID, PPE and any other supplies and documentation

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Position:	**Behavioral Health Support**
Role:	To assist victims, families, first responders, staff and the general community with the emotional and behavioral aspects of a public health emergency at a POD.
You report to:	**POD Manager**

Before your shift:

- ☐ Register at Staff Check-in
- ☐ Clearly display ID badge
- ☐ Familiarize self with location of all clinic areas
- ☐ Review your Job Action Sheet
- ☐ Attend clinic orientation
- ☐ Check in with your Supervisor
- ☐ Review job responsibilities with your Supervisor
- ☐ Receive vaccine/medication if not already treated

During your shift:

- ☐ Wear appropriate PPE, as needed
- ☐ Provide Psychological First Aid, Behavioral Health Needs Assessments, Brief Counseling Interventions, and Crisis Intervention, Problem Solving and Public Education and Information Counseling services, as needed.
- ☐ Monitor staff and first responders for symptoms of stress or physical/psychological overload and communicate any concerns to POD Manager.
- ☐ Provide psycho-educational, resource and referral information to health care and human service providers and other community agencies.
- ☐ Complete evaluation at the conclusion of the clinic

After your shift:

- ☐ Assist with teardown or cleanup of clinic
- ☐ Attend staff debriefing at shift change and/or at close of clinic
- ☐ Prepare clinic for next day operations, as needed
- ☐ Brief incoming DBHRT staff
- ☐ Sign out with Finance/Administration
- ☐ Return ID, PPE and any other supplies and documentation
- ☐ Complete a Behavioral Health Support report within 72 hours of the clinic

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Position:	**Data Collector**
Role:	Collect all data from clinical areas throughout the POD and turn into the Finance &Administration Chief. Should be trained administrative professionals, as needed.
You report to:	**Finance & Administration Chief**

Before your shift:

- ☐ Register at Staff Check-in
- ☐ Clearly display ID badge
- ☐ Familiarize self with location of all clinic areas
- ☐ Review your Job Action Sheet
- ☐ Attend clinic orientation
- ☐ Check in with your Supervisor
- ☐ Review job responsibilities with your Supervisor
- ☐ Receive vaccine/medication if not already treated

During your shift:

- ☐ Wear appropriate PPE, as needed
- ☐ Continuously collect completed medical registration forms and return to the Administration Station for drop-off.
- ☐ Continuously ensure there are new registration forms available at all key stations.
- ☐ Collect clipboards and pens for recycling throughout the medical stations.
- ☐ Assist in the area of Staff Check Area on an as needed basis.
- ☐ Give directions as need (e.g., restrooms, public phones)
- ☐ Report any issues or problems to appropriate area leader

After your shift:

- ☐ Assist with teardown or cleanup of clinic
- ☐ Attend staff debriefing at shift change and/or at close of clinic
- ☐ Prepare clinic for next day operations, as needed
- ☐ Brief incoming Data Collector
- ☐ Sign out with Finance/Administration
- ☐ Return ID, PPE and any other supplies and documentation

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Position:	**Hospitality Staff**
Role:	Responsible for break area for workers. Provide food and beverage service to POD staff. Staffed by volunteer organizations (i.e. American Red Cross)
You report to:	**POD manager**

Before your shift:

- ☐ Register at Staff Check-in
- ☐ Clearly display ID badge
- ☐ Familiarize self with location of all clinic areas
- ☐ Review your Job Action Sheet
- ☐ Attend clinic orientation
- ☐ Check in with your Supervisor
- ☐ Review job responsibilities with your Supervisor
- ☐ Receive vaccine/medication if not already treated

During your shift:

- ☐ Wear appropriate PPE, as needed
- ☐ Maintain a clean and comfortable break area
- ☐ Refer workers to debriefing staff as needed
- ☐ Maintain adequate supplies of food and drink
- ☐ Ensure food and beverage supplies have been obtained from a licensed source
- ☐ Report issues or problems to appropriate personnel

After your shift:

- ☐ Assist with teardown or cleanup of clinic
- ☐ Attend staff debriefing at shift change and/or at close of clinic
- ☐ Prepare clinic for next day operations, as needed
- ☐ Brief incoming Hospitality staff
- ☐ Sign out with Finance/Administration
- ☐ Return ID, PPE and any other supplies and documentation

Appendix C POD staffing requirements
EMC plan

Assumptions

- Craig and Wolf Creek will use MT DOT POD
- Marysville and Helena valley NW will use Fairgrounds POD
- Divide population by 3.2 for HOH (Head of Householed) pickup
- Distribution complete w/in 24 hr
- Drug dispensing table takes 3 minutes to throughput 1 customer
- Entire POD throughput takes 10 minutes
- Lincoln and Augusta will be staffed to serve population in 12 hours instead of 24.
- POD workers will work 12 hour shifts

MT DOT POD Population Estimate				
City	Population	Throughput required/hour	Workers/ 12 hour	Workers/ 24 hours
East Helena	1984			
Helena Valley North East	1719			
Helena ValleySouth East	8227			
Helena Valley North East	1276			
Craig	43			
Wolf Creek	2513			
Totals	**15762**	**172**	**25**	**50**

Fairgrounds - POD Population Estimate				
City	Population	Throughput required/hour	Workers/ 12 hour	Workers/ 24 hours
Helena City	28190			
Helena West Side	1637			
Helena Valley - West Central	7883			
Helena Valley - North West	3482			
Helena Undesignated	2827			
Mayrsville	80			
Totals	**44099**	**574**	**55**	**110**

Augusta (CDD +CDP) 365 HOH pick up	1167	**15**	**6**	**12**
Lincoln (CDP + Lincoln town cdd) 740 HOH pick up	2367	**31**	**8**	**16**

Census Designated Places (CDPs) are the statistical counterparts of incorporated places, and are delineated to provide data for settled concentrations of population that are identifiable by name but are not legally incorporated under the laws of the state in which they are located. The boundaries usually are defined in cooperation with local or tribal officials and generally updated prior to each decennial census. These boundaries, which usually coincide with visible features or the boundary of an adjacent incorporated place or another legal entity boundary, have no legal status, nor do these places have officials elected to serve traditional municipal functions. CDP boundaries may change from one decennial census to the next with changes in the settlement pattern; a CDP with the same name as in an earlier census does not necessarily have the same boundary. CDPs must be contained within a single state and may not extend into an incorporated place. There are no population size requirements for CDPs.

Attachments:

POD Security Template Summary

Section I	Public Security
A	Crowd Control
B	Law Enforcement
C	Fire Control
D	Information
E	Special Needs

Section II	Access Controls / Pharmaceuticals
A	Badging
B	Staff Entrance/Exit
C	Supplies/Equipment Loading Docks

Section III	Traffic
A	Parking
B	Vehicle Entrance/Exit Control

Section IV	Perimeter Protection
A	Barriers

Section V	Designation of Responsibility
A	Chain of Command
B	Understanding of Roles

Section VI	Recommendations
A	POD Security Adequacy

Attachments:

POD Security Template

Facility Name: Lewis & Clark County Fairgrounds
Estimated Throughput Per Hour: 150-200
Inspection Date: Dec 20, 2020

Section I - Public Security	
A	Crowd Control
1	Determine where and how the queue/line into the dispensing area will be organized. Consider the need for signs and/or barriers. Describe how the queue/line will be organized and what resources will be required to help direct the public.
	__X_Satisfactory ___Needs Improvement ___Not Applicable ___Not Reviewed
	NOTES:
	This has all been done and tested via the PureView Testing site since August 2020. Signage and a traffic plan are in place and being implemented daily.

2	Determine the minimum number of law enforcement and/or security personnel working in eight or twelve-hour shifts (depending on local protocol) required for crowd control. Consider their mobility as well as their visibility to the public. Number of required law enforcement and/or security personnel: __O__
	__X Satisfactory ___Needs Improvement ___Not Applicable ___Not Reviewed
	NOTES:
	At this time no law enforcement is needed. Traffic control and access control can be handled by volunteers and county public health or PureView staff. Traffic and Access control can be managed by 15-20 people per shift.

Attachments:

B	Law Enforcement
1	Determine the minimum number of law enforcement personnel working in eight or twelve-hour shifts (depending on local protocol) required for general law enforcement issues including personnel required for roaming patrols. Consider their mobility as well as their visibility to the public. Number of required law enforcement personnel: __0__ __X Satisfactory ___Needs Improvement ___Not Applicable ___Not Reviewed NOTES: Current daily law enforcement staffing is expected to be adequate to respond should help be needed. Response times to the fairgrounds are measured in minutes for both law enforcement and fire as well as EMS should there be any emergencies. We do not expect to need law enforcement presence on site to manage the POD.
2	Address issues such as where law enforcement personnel will hold detainees or unruly citizens, the transfer of detainees to jails if necessary, the number of flexi-cuffs required and how/when detainees will receive their prophylaxis or vaccination. ___Satisfactory ___Needs Improvement X Not Applicable ___Not Reviewed NOTES: Once detainees are booked into jail, LCPH will coordinate with Jail medical staff to vaccinate detainees as needed.
3	Can signs be posted prohibiting firearms and weapons in the facility? __X Satisfactory ___Needs Improvement ___Not Applicable ___Not Reviewed NOTES: Yes, however, recent changes to Montana Concealed Carry laws may make doing so no longer allowed.

Attachments:

4	Determine if the facility has a working security camera system available for use. Security camera system available: Yes____ No__X__
	___Satisfactory ___Needs Improvement __X_Not Applicable ___Not Reviewed
	NOTES:
	Cameras are not needed for POD operations at this site. If the facility were to be used for storage or supplies etc., the fairgrounds is staffed 24/7 by maintenance personnel.

C	**Fire Control**
1	Determine if the facility is in compliance with fire ordinances and that the local fire marshal has approved the site for POD operations
	_X Satisfactory ___Needs Improvement ___Not Applicable ___Not Reviewed
	NOTES:
	As a County facility, the location is regularly inspected by the Fire Marshall and meets all fire and safety codes.

2	Review and familiarize law enforcement with the facility's evacuation plan. Confirm that the plan is in compliance with local fire ordinances and that evacuation routes are posted. Determine which areas and/or doors may pose a fire hazard if locked.
	_X Satisfactory ___Needs Improvement ___Not Applicable ___Not Reviewed NOTES:

Attachments:

D	Information
1	Address the issue of information dissemination to the public. Determine what resources (bullhorns, PA systems, loudspeakers, signs or pamphlets) are needed and are available to keep the public aware of the information they will require in order to alleviate the possibility of public frustration that may cause security issues to arise.
	_X Satisfactory ___Needs Improvement ___Not Applicable ___Not Reviewed
	NOTES:
	Signage and access/traffic control points (TCP) will be utilized to provide information as needed. Handouts and pamphlets will be utilized both in the building and on the 15/30 minute observation lines.

2	Determine what resources are required to facilitate clear lines of communication between the POD staff, the Emergency Operations Center, the Public Information Officer and the media to allow information to flow to those who have not yet received POD services and may be on the way to the facility.
	_X Satisfactory ___Needs Improvement ___Not Applicable ___Not Reviewed
	NOTES:
	Email and phone are adequate for normal operations. If these platforms are compromised, public safety, HAM, or GMRS radios may be utilized as needed.

E	Special Needs
1	Determine what personnel may be required to assist individuals with special needs. Determine what measures must be taken in order to assist those with special needs. (i.e., is an alternate entrance needed)
	_X Satisfactory ___Needs Improvement ___Not Applicable ___Not Reviewed
	NOTES:
	While we plan to use this location for a drive thru POD, contingency plans have been discussed for assisting people who are unable to drive themselves or wait in a long line of cars. Plans include partnering with assisted living facilities for use of their vans to transport disabled patients and to allow those vans/vehicles to bypass the regular line and go to the west side of the building for service.

Attachments:

Section II - Access Control / Pharmaceuticals	
A	**Badging**
1	Determine what measures must be taken to ensure that law enforcement and/or security personnel are familiar with badging standards for staff and people dispensing.
	_X__Satisfactory ___Needs Improvement ___Not Applicable ___Not Reviewed
	NOTES:
	All traffic volunteers wear yellow or orange hi-viz vests. All medical staff wears name tags and full PPE. Most also wear scrubs. All are easily identifiable as POD staff.

B	**Staff Entrance/Exit**
1	Designate an entrance/exit location that may be used only by POD staff and law enforcement and/or security personnel. Determine what resources are available and what will be required to secure this location (locks, guards, ID entry only, etc). Determine if locking these areas may pose a fire hazard.
	__X_Satisfactory ___Needs Improvement ___Not Applicable ___Not Reviewed
	NOTES:
	The west side of the main building has been designated and marked off with signage already.

Attachments:

C	Supplies/ Equipment Loading Docks
1	Determine what resources are available and what will be required to secure the loading docks for supplies, equipment and pharmaceuticals (locks, guards, ID entry only, etc). Determine if locking these areas may pose a fire hazard.
	X Satisfactory ___Needs Improvement ___Not Applicable ___Not Reviewed
	NOTES:
	The location has forklift and unloading capability. fairgrounds staff are available to operate forklifts as needed.

2	Determine the minimum number of "No Parking" signs, traffic cones and parking barriers required to ensure loading areas remain free from obstruction Number of required "No Parking" signs: __12__ Number of required traffic cones/candles: _100___ Number of required barriers: __2__
	_X Satisfactory ___Needs Improvement ___Not Applicable ___Not Reviewed
	NOTES:

3	Determine if products not actively being dispensed can be kept out of site of the general public.
	_X_Satisfactory ___Needs Improvement ___Not Applicable ___Not Reviewed
	NOTES:
	Coolers, freezers and storage space is available.

Attachments:

Section III - Traffic	
A	**Parking**
1	Locate existing handicap-designated parking spaces and determine the number of additional handicap spaces that may be required. Number of available handicap parking spaces: _15-20___ Number of additional handicap spaces needed: __0__
	_X__Satisfactory ___Needs Improvement ___Not Applicable ___Not Reviewed
	NOTES:
	Portable handicap parking signs are available on site and can be used to designate spaces as needed for convenience.

B	Vehicle Entrance/Exit Control
1	Determine the number of available vehicle entrance/exits to the facility. Determine the minimum number of law enforcement and/or security personnel working in twelve-hour shifts required at each entrance/exit to control the flow of traffic in and out of the facility. Number of available vehicle entrance/exits: __3__ ____ Number of required law enforcement and/or security personnel:__3 __X_Satisfactory ___Needs Improvement ___Not Applicable ___Not Reviewed NOTES: Both the east and west gates have been closed and locked forcing all traffic to enter the grounds via the main gate. 2-3 personnel, along with signage, are adequate to screen and manage incoming traffic at the first traffic control point.

2	Coordinate with law enforcement/security personnel to ensure traffic congestion issues can be alleviated and that emergency and supply vehicles can access the facility with ease.
	Number of required signs: _12____
	Number of required barriers: __2___
	Number of required traffic cones: _50-100___
	Is any road closing required: Yes ___ No _X__
	__X_Satisfactory ___Needs Improvement ___Not Applicable ___Not Reviewed
	NOTES:
	A comprehensive traffic plan has been developed that allows for managing up to 500 vehicles without impacting traffic off site on Custer Ave. This plan is attached.

Attachments:

Section IV - Perimeter Protection	
A	**Barriers**
1	Determine what types of perimeter barriers already exist at the facility. Determine what types of barriers or resources may still be required to secure the facility's perimeter.
	_X__Satisfactory ___Needs Improvement ___Not Applicable ___Not Reviewed
	NOTES:
	physical barriers are not really needed. signage is adequate to manage traffic. volunteers can be used to augment or control traffic movement further.

Section V - Designation of Responsibility	
A	**Chain of Command**
1	Outline an efficient chain of command system for security and POD personnel. Please attach copy. (Unnecessary for law enforcement personnel.)
	__X_Satisfactory ___Needs Improvement ___Not Applicable ___Not Reviewed
	NOTES:
	Chain of Command is, in order: POD Manager, Vaccine Coordinator, Volunteer Coordinator, “traffic control shift manager”. POD staff fall under the larger Unified Health Command Ops Section for the county (attached.)

B	Understanding of Roles
1	Develop a system to designate responsibility to law enforcement and/or security personnel to promote efficiency and the understanding of security roles and responsibilities. (For Example, Just-In-Time Training Materials)
	_X__Satisfactory ___Needs Improvement ___Not Applicable ___Not Reviewed
	NOTES:
	If law enforcement is actually needed to manage a situation, the POD Manager will coordinate with Fairgrounds Staff and the arriving officers as appropriate to respond. Fairgrounds Staff is always the primary responsible party for activities and incidents happening on the Grounds. The POD Manager is the lead POC for anything happening relative to the POD operations. If a crime has been committed, LEO lead will take charge until the situation is resolved.

Attachments:

Section VI - Recommendation				
A	**POD Site Security Adequacy**			
1	After reviewing the information in this assessment, determine the overall adequacy of the POD site for effective implementation of security operations. Determine if security issues exist that may disqualify the site for use as a POD.			
	Total Number of: 20 Satisfactory	**Total Number of:** 0 Needs Improvement	**Total Number of:** 2 Not Applicable	**Total Number of:** 0 Not Reviewed
	POD Site Adequate: Yes **X** No			
	NOTES:			
	No law enforcement presence is needed to manage normal POD operations. All access control and traffic management can be handled by volunteers (COAD).			

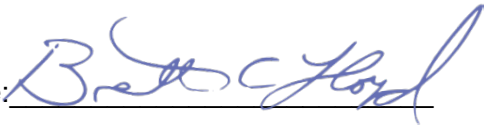
Signature(s) of POD site security inspector(s):

Name: Brett Lloyd

Department or Agency: Lewis & Clark Public Health

Work Phone: 406-457-8897

E-Mail Address: blloyd@lccountymt.gov

Signature: 

Date: Dec 20, 2020

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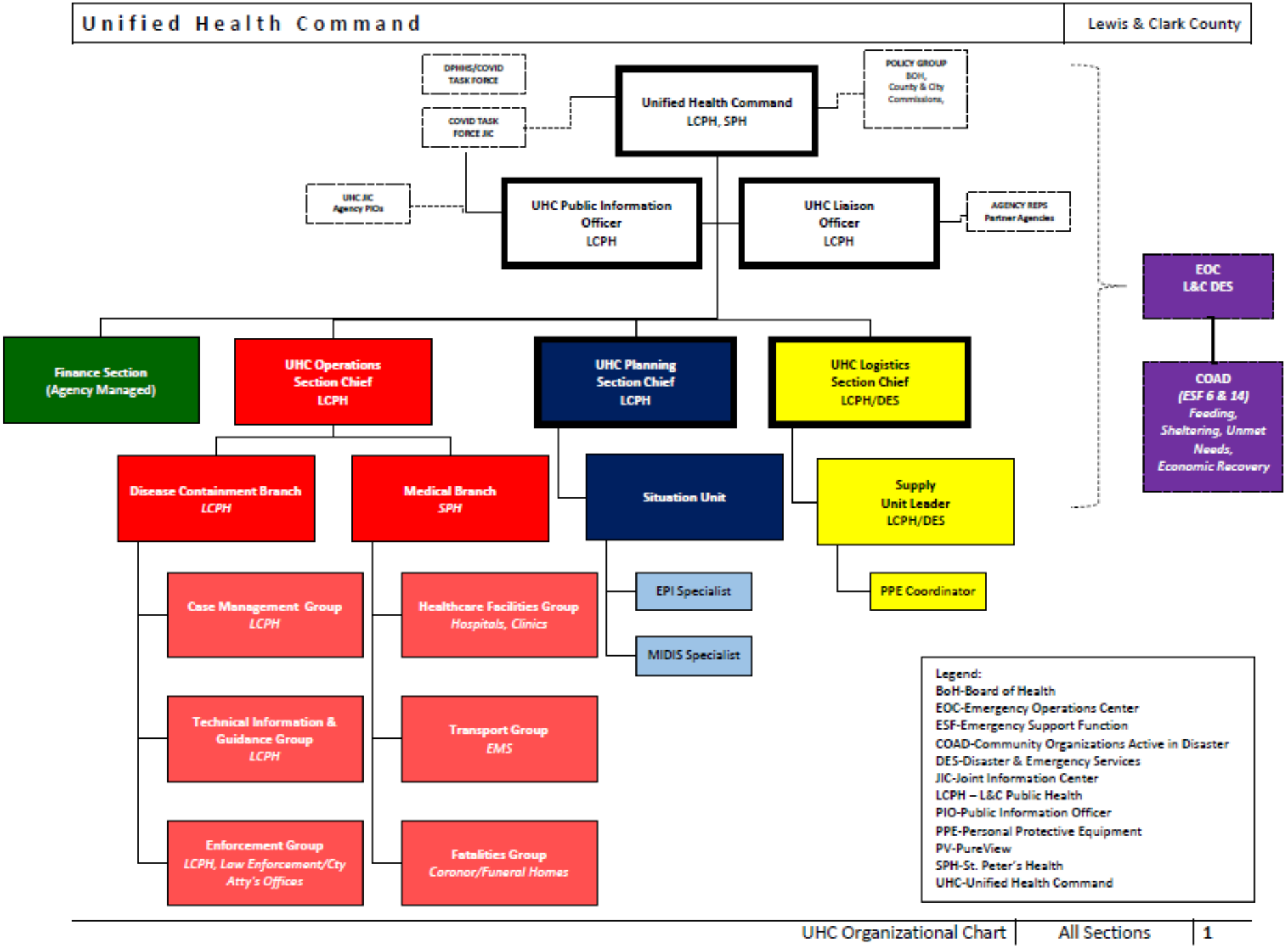

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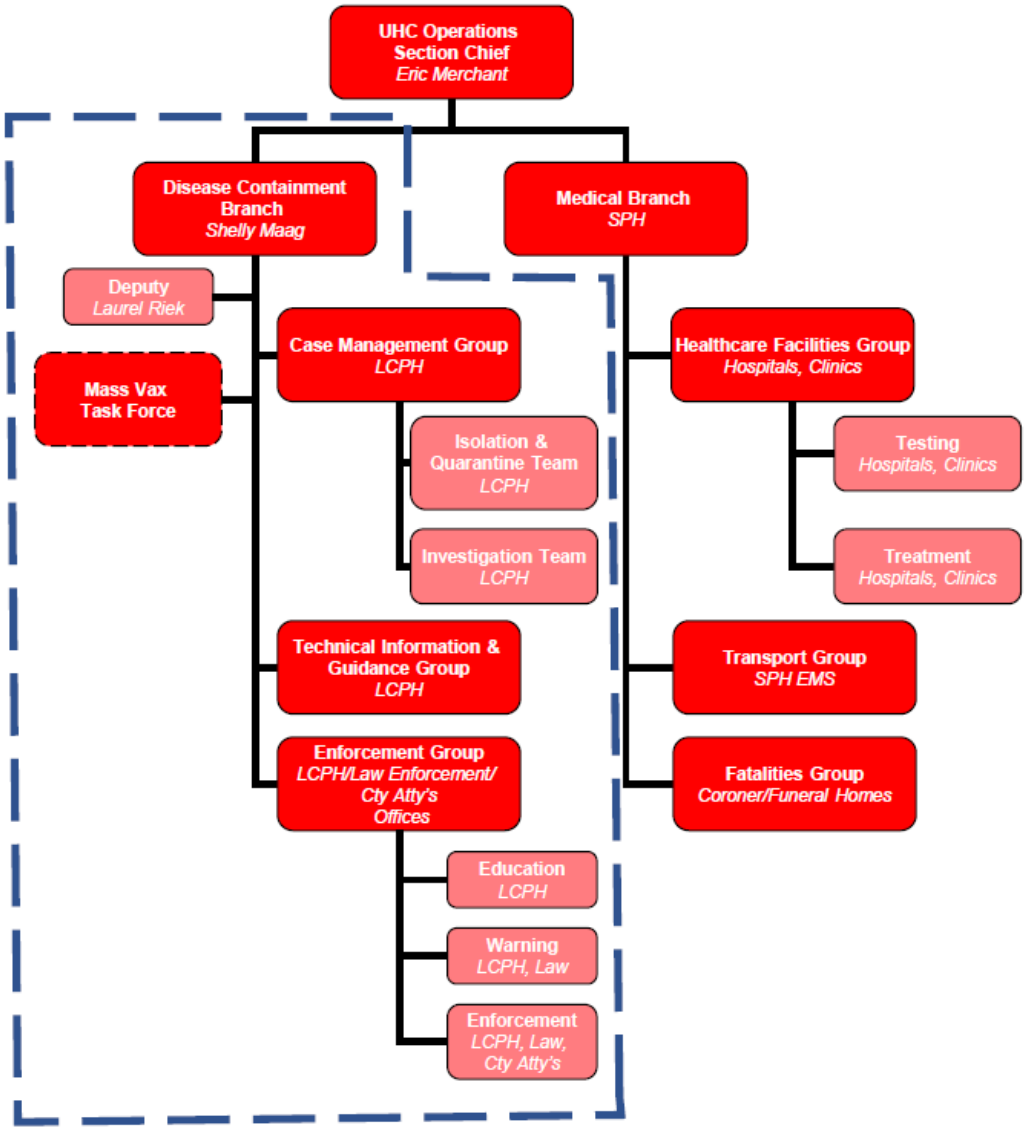

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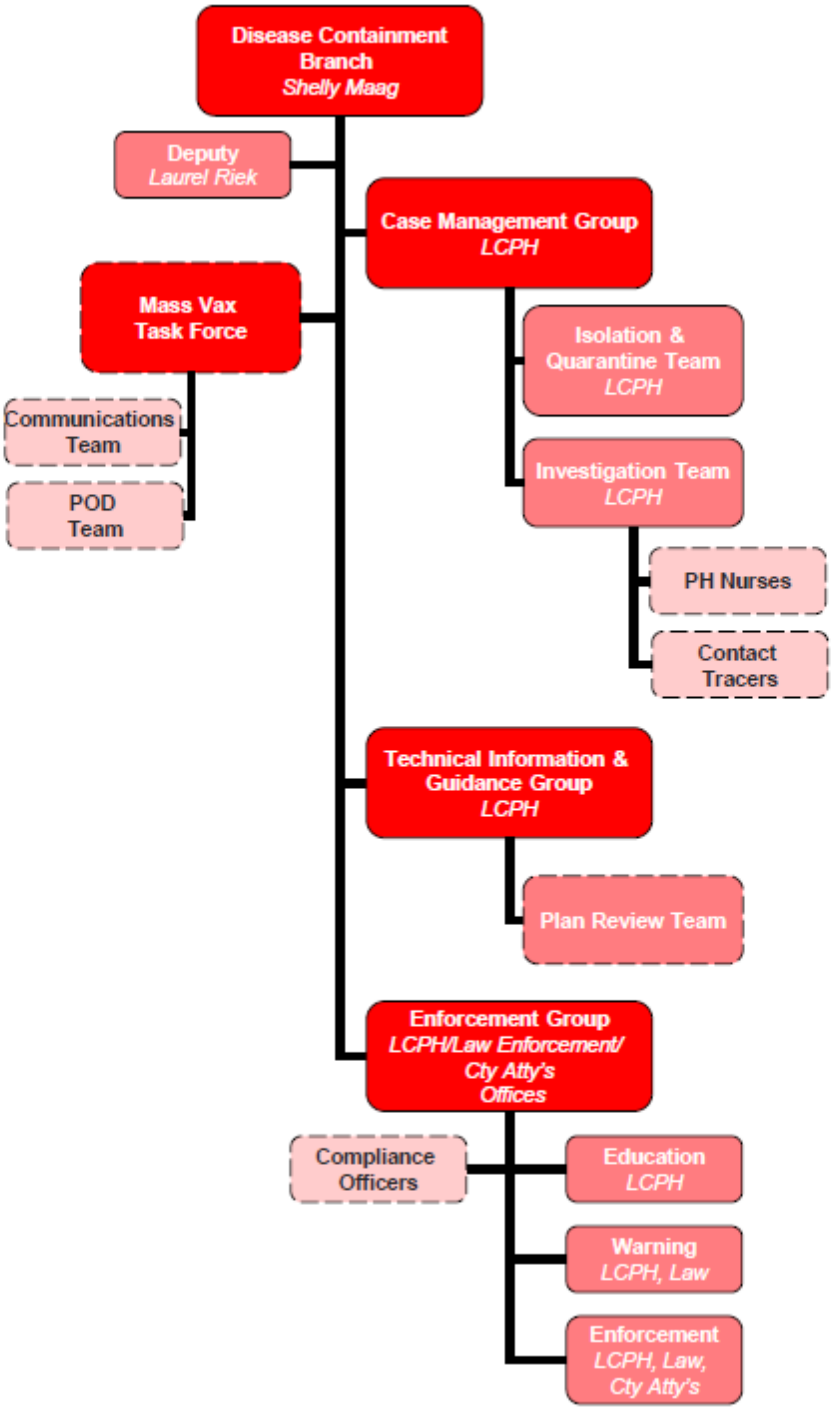

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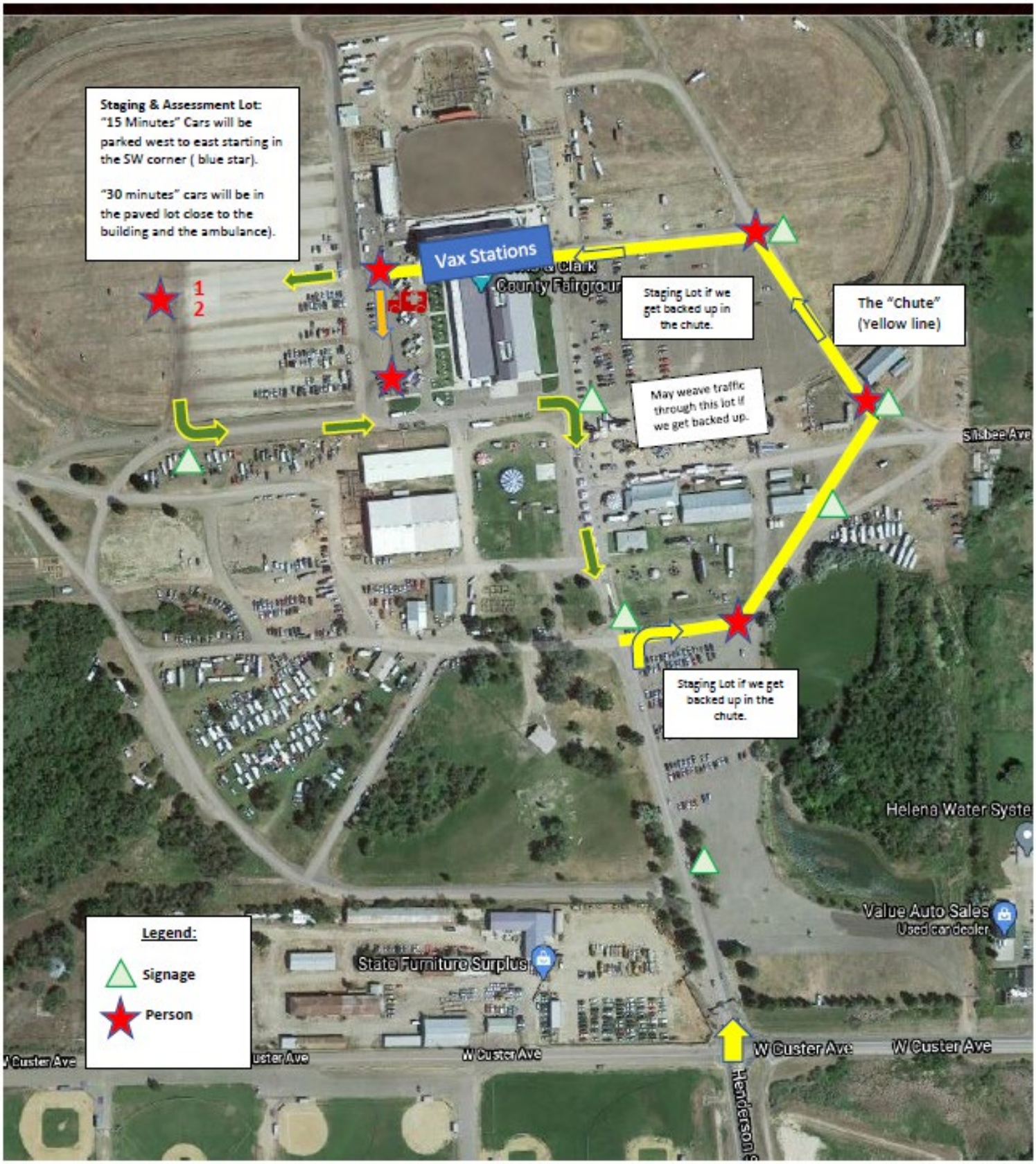

Lewis & Clark Public Health

Division of Disease Control and Prevention
1930 Ninth Avenue, Helena MT 59601
Phone: 406-457-8900
Fax: 406-457-8997

Emergency Medical Countermeasures (EMC) Plan

Contents

Purpose:

The emergency medical countermeasures (EMC) plan provides procedures for set up and operation of distribution points for emergency medication and other medical countermeasures.

Mission:

a) Receive EMC assets during an emergency

b) Deliver and distribute EMC to drop points and/or PODs

c) Dispense EMC to the population in Lewis and Clark County

Scope:

a) This plan delineates procedures for publicizing and distributing emergency medication to the population of Lewis and Clark County within 48 hours of when such medication is available. Included are procedures for communication, security, supplies, distribution point (POD) layout, management, and dispensing operations.

b) Response strategies and required resources will vary depending on the size and characteristics of the population impacted; the availability of medications, staffing, and supplies; the epidemiology of the illness; and the level of public concern.

Situation Overview:

a) **Medical countermeasures, or MCMs**: FDA-regulated products (biologics, drugs, devices) that may be used in the event of a potential public health emergency stemming from a terrorist attack with a biological, chemical, or radiological/nuclear material, or a naturally occurring emerging disease.

   i) MCMs can be used to diagnose, prevent, protect from, or treat conditions associated with chemical, biological, radiological, or nuclear (CBRN) threats, or emerging infectious diseases.

   ii) MCMs can include:

      (1) Biologic products, such as vaccines, blood products and antibodies

      (2) Drugs, such as antimicrobial or antiviral drugs

      (3) Devices, including diagnostic tests to identify threat agents, and personal protective equipment (PPE), such as gloves, respirators (face masks), and ventilators

b) **Lewis & Clark County Demographics and Vulnerable Populations:** Lewis & Clark County has several challenges that may have an impact on distribution of ECM. Public Health is prepared to meet the needs of the population it serves, especially its most vulnerable residents.

   i) The U.S. Census Bureau estimated the population of Lewis and Clark County in 2017 to be 67,773. Almost half of county residents (46%) live within the city limits of Helena, which is the county seat and the state capital. Smaller rural communities include Augusta, East Helena, Lincoln, Canyon Creek, Craig, Marysville, and Wolf Creek. All but East Helena are unincorporated. Coordination of ECM will account for rural communities and provide opportunities for residents to receive ECM.

ii) The location of the VA Medical Center and the Montana National Guard at Fort Harrison in Helena, Lewis and Clark County has a higher percentage of veterans than the U.S. in general. Coordination of ECM must account for the military and veteran population in the community. Lewis & Clark County will partner with the Department of Veterans Affairs and the National Guard to ensure that those populations have access to ECM.

iii) Poverty is not evenly distributed throughout Helena and East Helena. Each community has neighborhoods where the average income is lower than that of surrounding areas. The percentage of Lewis & Clark County residents living below the poverty line is 8.1% as of 2016. Lewis & Clark County will make accommodations to reach residents who may not have the means to reach POD sites and/ or other distribution points.

iv) The exact number of Lewis & Clark County residents who are homeless is unknown at this time. The United Way of Lewis & Clark County reports worLewis & Clark with 278 adults, 23 youth aged 18-24, and 62 families from September 2017 through November 2018. This number may be low due to lack of participation in the survey. Lewis & Clark County will make accommodations to reach the homeless population through coordination with the Community Organization Active in Disaster (COAD), local non-profit organizations, Pure View Health Center, Saint Peter's Health, and other service providers as able and appropriate.

Assumptions:

a) The Department of Public Health & Human Services (DPHHS) will provide details of the event and response guidance.

b) The state will receive the shipment of emergency countermeasures (EMC) from Centers for Disease Control (CDC) or other sources.

c) The state will coordinate shipment of EMC to Lewis and Clark County.

d) EMC operations will be supported by personnel from Volunteer Fire Departments, Police Auxiliary, the Center for Mental Health, Tri-County COAD, and St. Peters Health, PureView and other partners as needed and able.

Roles and Responsibilities:

a) Lewis and Clark Public Health (LCPH) will specifically manage receipt and distribution of emergency medical counter measures and coordinate incident management with other responding agencies through Unified Command or as appropriate.

i) Receives and stores EMC

ii) Sets up POD

iii) Provides JITT (Just in time training)

iv) Conducts POD operations

v) Demobilizes PODs

b) Lewis and Clark County Disaster and Emergency Service (DES) will coordinate support for incident management through the County Emergency Operations Center (EOC) as needed.

c) The Lewis and Clark Public Health Medical Advisor:

i) Writes standing orders for medication administration,

ii) Serves as a consultant for nursing staff

iii) Signs receipt of shipments of medical countermeasures

d) Lewis and Clark County Sheriff

i) Provides security at POD sites

e) Lewis and Clark County Public Works

i) Assist with transport of EMC to POD sites

Concept of Operations

f) The Lewis and Clark County Health Officer will:

i) Activate the Incident Command Post (ICP) or Unified Health Command (UHC) and request activation of the County Emergency Operations Center (EOC) when the following situations occur and as appropriate:

(1) A large number of persons with similar symptoms, disease, syndrome, or deaths

(2) An unusual illness in a population – single case of disease from uncommon agent, and/or a disease with unusual geographic or seasonal distribution, and/or an endemic disease or unexplained increase in incidence

(3) A higher than normal morbidity and mortality from a common disease or syndrome

(4) A failure of a common disease to respond to usual therapy

(5) Multiple unusual or unexplained disease entities in the same patient

(6) Multiple atypical presentations of disease agents

(7) Similar genetic type in agents isolated from temporally or spatially distinct sources

(8) Unusual, genetically engineered, or an antiquated strain of a disease agent

(9) Simultaneous clusters of similar illness in non-contiguous areas

(10) Atypical aerosol-, food-, or water-borne transmission of a disease

(11) Unexplained increases in emergency medical service requests

(12) A chemical, biological, radiological, nuclear, or explosive (CBRNE) incident

(13) A medical emergency brought on by a natural disaster

(14) Claim of a biological or chemical release reported by intelligence or law enforcement

(15) An indication from intelligence sources or law enforcement of an increased potential for a terrorist attack

(16) Local cases of a novel influenza virus

ii) Demobilize the Incident Command Post (ICP/UHC) and County Emergency Operations Center (EOC) when the following situations occur and as appropriate:

(1) The elimination of a threat and/or incident that required a ECM response operation

(2) The eradication of an illness or disease outbreak

(3) The achievement of ECM dispensing targets and objectives

(4) Private medication centers, pharmacies, and local clinics have adequate capacity and resources to distribute ECM without the use of PODs

g) The ICP will maintain communication with the EOC to coordinate the staff and operation of the Drop Point site(s).

h) The ICP will coordinate security for dispensing sites and transportation of EMC materiel from the drop point to dispensing sites and hospitals.

i) The ICP will provide reports to the EOC when there is a major operation status change, when a problem arises, or at times requested by the EOC.

j) **Command and Control:** Public Health Incident Command Post

i) **Incident Commander:** Health Officer or Designated Backup

ii) **Public Information Officer:**

(1) Provides public notification

(a) POD site opening dates, hours of operation

(b) Geographic areas served by each POD

(c) What the public needs to know before they go:

(i) Head of household may pick up,

(ii) Bring allergy and DOB for all household members,

(iii) No medical services for symptomatic persons are available at POD.

iii) **Liaison Officer:** Coordinates resource and information management with cooperating and supporting agencies

(1) Transportation, volunteers, facilities, equipment

(2) Keeps agency heads and elected officials apprised of the situation

(3) Communicates with neighboring jurisdictions to facilitate mutual aid assistance.

iv) **Safety Officer:**

(1) Ensures safety of all clinic workers and clients.

(2) Assesses the operation for safety issues, instructs staff on safety procedures, and implements safety measures as needed.

v) **Logistics Section Chief:** Coordinates staffing and resources for the POD

(1) Ensures facility is in worLewis & Clark order for clinic operations.

(2) Works with the EOC regarding procurement of supplies.

(3) Notifies POD sites immediately of the need to distribute EMC.

(a) Locations:

(i) Lewis and Clark County Fairgrounds

(ii) Montana Department of Transportation Headquarters

(iii) Community Center in Lincoln

(iv) Senior Center in Augusta.

(4) Calls County EOC for volunteers. Includes the following information:

(a) Job type and number needed: e.g. forms checker(5) greeter, (5)

(b) Training that will be provided

(c) Where to go, when to be there

(5) Requests

(a) Law enforcement for POD security

(b) County Public Works department to schedule EMC transport to POD sites

vi) **Operations Section Chief:** Coordinates POD operations

(1) All sites will use chairs and tables located on site.

(2) Layout, equipment and staff are described in APPENDIX A

(a) POD set up is complete when

(i) Tables, chairs and signage are in place

(ii) Forms and supplies are delivered and distributed to work stations

(iii) Staff staging area has supplies for volunteer identification and job action sheets

(iv) EMC delivery is scheduled

(v) Security has been notified of scheduled opening

vii) **Planning Section Chief:**

(1) Determines data elements needed for operational period planning

(2) Identifies sources of such data and establish access to such sources

(3) Communicates technical support and supply projections to Logistics and other section chiefs as appropriate

(4) Collects and interprets data and reports to Incident Commander

(5) Develops an Incident Action Plan and continuously evaluates the progress of the event and intervention(s)

viii) **Finance Section Chief:** Supervises the documentation of expenditures relevant to the incident.

Objective 1: Receive and store EMC assets

a) Controlled Substances must be received by:

i) The Medical Advisor to the Health Department, OR

ii) Pharmacist from St Peter's Hospital

b) Uncontrolled Substances may be accepted by Health Department Division Administrator or Public Health Nurse.

c) EMC material will be received at Lewis and Clark County Public Works Department, and stored there; 3402 Cooney Drive, Helena MT.

d) Upon receipt, the EMC assets will be inventoried and the person in charge of receipt will document the following information:

   i) Product Description

   ii) Product Size

   iii) Unit of Use

   iv) National Drug Code

   v) Lot Number

   vi) Expiration Dates

e) If excess EMC must be returned for any reason:

   i) Sites with small unused quantities of medications and/or vaccines will be asked to transport ECM back to a storage site where the ECM will be re-inventoried.

   ii) Lewis & Clark Public Health will arrange a pickup of ECM for sites that have large unused quantities of medications and/or vaccines.

   iii) Once collected and inventoried by Public Health, ECM will either be reallocated for use at a different POD or be transported and returned to DPHHS following the agency's instructions.

Objective 2: Set up PODs and begin dispensing within 24 hours.

a) Public Health Medical Advisor will issue standing orders for dispensing medications prior to distribution.

b) Some pharmaceuticals may require dispensing by a pharmacist only, and therefore special authorization may be necessary.

   i) The St Peter's Health Pharmacy may act as the dispensing agency if dispensing authorization is required.

c) Coordination may be through the County Emergency Operations Center, if activated. If not, Public Health will request support directly from community partners.

Objective 3: Deliver EMC to drop points and PODs for distribution.

a) Logistics is responsible for coordination of transport through the Emergency Operations Center, if activated. If not, Public Health will request assistance directly from Public Works department.

Objective 4: Operate 4 PODs 24 hours/day until EMC is distributed to population of Lewis and Clark County

a) Each dispensing site will have stations for

   i) **Greeting:** Greet participants and expedite the flow into the POD.

ii) **Registration**: Ensure form completion and process the participant to the appropriate next station.

iii) **Triage**: Assess and sort ill persons, those not eligible and those eligible for vaccine/antibiotic treatment to minimize bottlenecLewis & Clark.

iv) **Drug dispensing**: Disseminate medical countermeasure treatment.

b) Additional staff positions

i) **Medical Screening**: Clears or defers for medical countermeasure treatment. Must be a MD or mid-level practitioner.

ii) **Behavioral Health Support**: Assists staff and the general community with the emotional and behavioral aspects of a public health emergency at a POD

iii) **Data Collector:** Collects all data from clinical areas throughout the POD

iv) **Educator:** Provides information and answer questions. Must be clinical health professionals and/or health educators

v) **Hospitality worker:** Responsible for maintaining the break area for workers. Provides food and beverage service to POD staff.

vi) **POD manager**: Responsible for administrative oversight of the POD. Supervises all administrative aspects of the clinic. Reports to Operations Section Chief

(1) Makes appropriate staff assignments

(2) Ensures staffing requirements are met, both clinical and non-clinical

(3) Ensures clinic operation

(4) Orients and supervises non-clinical staff

(5) Ensures security of clinic site and medication

(6) Provides Just-In-time training

vii) **Clinical Manager**: Responsible for the clinical operations and staff supervision at the POD. Reports to Operations Section Chief

c) Just in Time Training (JITT) will be provided by POD or Clinical Manager for all volunteers.

d) Lewis and Clark Public Health (LCPH) will coordinate dispensing sites

i) St Peter's Health will institute an emergency call-out of staff and detail as many as can be spared to the dispensing site.

ii) LCPH will activate a mutual aid agreement with Gallatin, Silver Bow, Jefferson, Broadwater, and Madison counties.

iii) A volunteer call out will be requested from Lewis and Clark County EOC.

Closed PODS for Special Populations:

e) EMC will be disbursed to sheltered-in-populations such as nursing homes, assisted living facilities, and detention centers.

f) These facilities will be dispensing sites for their patient populations.

g) ICP Operations will

i) Notify all sites and medical partners when the prophylactic or vaccination regimen is known

ii) Coordinate delivery of EMC to drop points

h) Push sites include:

i) St. Peters Health

ii) Blue Cross Blue Shield

iii) State Employees

iv) Helena and East Helena School Districts (for staff)

v) Pediatric Clinics

vi) Carroll College

Demobilization procedures

The decision to end EMC response operations, discontinue receipt of SNS (when applicable), and demobilize incident command will be made by the Health Officer/IC/UHC or their designee(s) in consultation with SMEs. These individuals include, but are not limited to:

- Disease Prevention & Control Supervisor
- Public Health Nurse Supervisor
- Public Health Medical Director
- Public Health Emergency Coordinator
- Public Health Communications Specialist
- Public Health Epidemiologist

SMEs from other local, state, and federal agencies may also be consulted before demobilization occurs. These individuals/agencies include, but are not limited to:

- Lewis & Clark County DES
- Lewis & Clark County Sheriff
- Montana DPHHS
- Neighboring jurisdictional health officers
- Montana State Epidemiologist, and State Lab Director
- Centers for Disease Control and Prevention (CDC)

Factors that may trigger demobilization include, but are not limited to:

- The elimination of a threat and/or incident that required an EMC response operation
- The eradication of an illness or disease outbreak
- The achievement of EMC dispensing targets and objectives

Once the decision to demobilize has been made, incident command will notify all parties involved in the EMC response operation. Incident Command will develop a demobilization plan and distribute that plan to all supporting agencies. Discussion on how to reconstitute normal services may also be held with the appropriate parties.

The LHO or his/her designee will notify DPHHS that SNS/EMC are no longer needed if previously requested and pushed to Public Health. HMAC may facilitate this notification process. DPHHS will specify a date and time that supply shipments should terminate.

Incident Command will communicate with all local distribution centers to coordinate the breakdown of dispensing sites. Breakdown will include, but is not limited to:

- Returning any unused medications and/or vaccines to LCPH (DPHHS)
- Returning equipment and other resources to where they came from
- Appropriate cleanup and disposal of all biomedical waste, including syringes.

Legal Issues

i) In order to establish statewide consistency, the following guidance is for clarification of the legal issues that may arise during an emergency.

   i) **Standing Orders.** The local Medical Officer is authorized to issue standing orders and protocols for dispensing sites. However, if a local order is not in place the State Medical Officer has developed a standing order to prescribe medications for individuals at a Point of Dispensing (POD) site during a mass prophylaxis event.

   ii) **Authority to Dispense.** If the State Medical Officer has determined there is a need to use the Strategic National Stockpile medical assets for prophylaxis purposes, the following authority will go into effect. Criteria were shared with the MT Board of Pharmacy and will be reviewed annually.

      (1) *As per MCA 37-2-104 a medical practitioner may furnish a patient any drug during an emergency*. Additionally, the furnishing of drugs by a medical practitioner will only be conducted in special incidents requiring the Strategic National Stockpile and is not a usual course of doing business. Therefore, all licensed medical practitioners who have a relationship with dispensing medications are potential candidates to dispense at a POD.

      (2) A “medical practitioner” is defined in MCA 37-2-101 and means any person licensed by the state of Montana to engage in the practice of medicine, dentistry, osteopathy, podiatry, optometry, or a nursing specialty and is in the licensed practice to administer or prescribe drugs.

      (3) Lewis and Clark Public Health will ultimately decide eligibility to dispense as long as it does not supersede the above guidance.

Attachment 13: Pandemic Flu Plan

Promulgation Document
Pandemic Flu Plan

Promulgation of Authorization

This document serves as the formal declaration authorizing the use of this emergency response plan to protect the public's health and safety in Lewis & Clark County against communicable diseases. Lewis & Clark City-County Board of Health acknowledges that Lewis & Clark Public Health has the responsibility and duty to execute this plan in defense of public health.

This plan complies with existing federal, state, and local statutes and agreements made with the various agencies identified within. Lewis & Clark Public Health, in defense against disease outbreaks in our communities, prepares and maintains emergency preparedness documents and is committed to the training and exercises required to support this plan.

All partners with roles identified in this plan have participated in its development and concur with the processes and strategies found within, which comply with the *Public Health Emergency Preparedness and Response Capabilities National Standards* (CDC, 2019), and adhere to the science-based, industry, and academic standards of disease control.

All partners and stakeholders are responsible for advising Lewis & Clark Public Health of any changes in their own procedures or operations that could affect any emergency responses undertaken.

This plan is hereby approved for implementation. It supersedes all previous editions.

Board of Health Chair – Justin Murgell *(Print Name)*	*(Date)*
Health Officer – Drenda Niemann *(Sign)*	*(Date)*

Last Update: March 14, 2023

Pandemic Influenza Plan

Purpose:
The purpose of this plan is to provide a framework and context within the larger *Communicable Disease Response Plan* for response to an Influenza Pandemic.

Scope:
This plan falls under the umbrella CD Response Plan as well as the LCPH All-Hazards Annex and the Lewis & Clark County Emergency Operations Plan. Response to a pandemic flu will be conducted within the scope and authority of those higher level plans.

Situation:
Pandemic Influenza will stress, even overwhelm, all aspects of the public health and larger healthcare system response, but it will be managed using existing plans and procedures as well as lessons learned from the recent Covid Pandemic. It is possible that a highly impacting and/or long duration pandemic will degrade the ability of LCPH to maintain staffing and services. In those instances, we will do the best we can with what we have still available.

Access & Functional Needs Accommodations:
LCPH recognizes that certain segments of the population may be at higher risk during a flu pandemic and will adjust our response strategies based on the best data and risk assessment outcomes we have at our disposal given the situation. We routinely work very closely with a variety of populations and service providers to help identify those likely to be most at risk during a pandemic and to mitigate those risks as much as possible.

Planning Assumptions:
This plan assumes that LCPH will be able to maintain at least a basic level of service in spite of the impacts of the pandemic and that we will have adequate staff, space and resources to do so.

Concept of Operations:
(*see the CD Response Plan, Section 3.0*)

Risk Communications:
(*see the LCPH Emergency Risk Communications Plan)*

Information Communications:
Information sharing regarding incident operations will utilize all available platforms including, but not limited to phone, internet-based programs, GIS platforms, email and others. The County's primary productivity software is Microsoft 365, which includes Outlook (email) Teams (video meetings) as well as the usual office suite of Word, Excel, and PowerPoint. We will use these and others available (e.g state platforms like the Montana Infectious Disease Information System (MIDIS), Health Alert Network (HAN), and the Montana Immunization Information System (imMTrax) as appropriate.

Roles & Responsibilities:
(see the LCPH All-Hazards Annex, Section 4.0)

Plan Review & Maintenance:
This plan will be reviewed annually and after incidents or exercises as needed. Appropriate training and exercises will be conducted annually as needed and in accordance with the PHEP deliverables, LCPH and Lewis & Clark County Training & Exercise Plans.

Last Update: March 14, 2023

Attachment 14: Potential Rabies Exposure Rules and Procedures

Lewis & Clark Public Health

Office of the Sheriff
Integrity Dedication Courage Loyalty Compassion Professionalism Accountability

City of Helena

CITY OF EAST HELENA

Lewis & Clark County
Rabies Control & Prevention Kit

Lewis and Clark Public Health
Lewis and Clark County Sheriff's Office
City of Helena Police Department
City of East Helena Police Department

Lewis & Clark Public Health

Office of the Sheriff
Integrity Dedication Courage Loyalty Compassion Professionalism Accountability

City of Helena

CITY OF EAST HELENA

Table of Contents

Lewis & Clark Public Health

Office of the Sheriff
Integrity Dedication Courage Loyalty Compassion Professionalism Accountability

City of Helena

CITY OF EAST HELENA

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Lewis & Clark Public Health

Office of the Sheriff

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CITY OF EAST HELENA

SECTION 1

Process Schematic for Addressing Potential Rabies Exposure

Animal Bites in Lewis and Clark County

Lewis & Clark Public Health

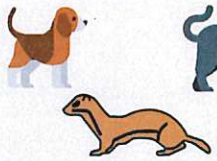
These are the steps public health performs when a potential rabies exposure occurs. Contact Lewis and Clark Public Health to report potential exposures.

Was the person bitten, or was there saliva contact from the animal to an open cut or mucous membrane of the individual? [1]

What type of mammal was involved in the exposure?

Rabbit, guinea pig, hamster, mouse, squirrel, chipmunk

Bites from small rodents almost never require PEP. Consult if animal exhibits extremely unusual behavior.



Dog, cat or ferret

Can the animal be located and observed for 10 days after the exposure?

NO

YES

Is the animal alive and healthy after the 10 day observation period?

YES

NO

Evaluate animal health by a veterinarian!

Rabies Ruled Out

Rabies Highly Suspected

Test animal for rabies. What is the result?

PEP is not recommended

Negative −

Positive +

Recommend PEP [2]

Unsuitable ?

Consider all factors: Nature of contact, rabies epidemiology, animal species and animal behavior. May need to recommend PEP.

Bat

Bats pose a particular risk of rabies in Montana, especially because bites may not be obvious. PEP should be considered when contact between a human and a bat has occurred or is suspected. Consider, was the bat found indoors?
Did the bat have access to a room where a person was: sleeping, intoxicated, mentally disabled, a child?

Can the animal safely be captured for rabies testing?

YES

NO

Wildlife, farm animals, other?

Requires additional consultation with veterinarian and/or MT DPHHS

Contact Lewis and Clark Public Health Department immediately for any exposure to a human by an animal susceptible of rabies infection (ARM 37.114.203).

Division of Disease Control and Prevention
1930 Ninth Avenue, Helena MT 59601
Phone: 406-457-8900
Fax: 406-457-8997
24/7 Number: 406-523-5564

[1] All bites and wounds should receive proper wound care. Assess the need for a tetanus booster.
[2] Refer to the Advisory Committee on Immunization Practices for guidance on post-exposure prophylaxis (PEP) recommended to prevent rabies infection.

Prepared by the Communicable Disease Epidemiology Program, MT DPHHS cdepi.mt.gov Rev. 12/27/2018

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CITY OF EAST HELENA

SECTION 2

Memorandum of Agreement Between Lewis and Clark Public Health, Lewis and Clark County Sherriff, City of Helena Police Department, and City of East Helena Police Department

MEMORANDUM OF AGREEMENT

Between
Lewis and Clark Public Health;
Lewis and Clark County Sheriff's Office;
City of Helena Police Department; And
City of East Helena Police Department

This Memorandum of Agreement (MOA) sets forth the terms of agreement between Lewis and Clark Public Health (LCPH), the Lewis and Clark County Sheriff's Office (LCSO), the City of Helena Police Department (HPD) and the City of East Helena Police Department (EHPD) for protecting public health, safety and welfare of the people and animals of Lewis and Clark County.

BACKGROUND

The responsibilities for investigating a potential rabies exposure has been divided between law enforcement personnel, including city and county designated Animal Control Officers, and LCPH. LCPH, LCSO, HPD, and EHPD (Parties) recognize that strong communication and collaboration is needed to appropriately respond to a potential rabies exposure and protect human health.

As human rabies exposure investigations become more complicated and resources are stretched, the opportunity for identifying risks for potential rabies exposure and intervening appropriately with animal confinement for observation (quarantine), testing and/or post exposure prophylaxis (PEP) in a timely manner may be missed. This can result in a human case of rabies which ultimately results in death.

PURPOSE

The purpose of this agreement is to establish procedures for cooperation and collaboration between Parties for the investigation and mitigation of potential rabies exposures, including the location of the animal involved, determining vaccine status, ordering a health assessment, requiring confinement for observation (quarantine), or euthanasia and testing to rule out the risk of rabies and/or to identify the need for PEP.

AGREEMENT

In order to rule out an actual rabies exposure or follow up with PEP, as deemed necessary, all potential rabies exposures involving a human will be investigated using the process and responsibilities identified below. All investigations and actions taken to mitigate human rabies will be implemented according to the requirements of the Lewis and Clark County Rabies Control Regulation or the City of Helena Animal Control Ordinance, as applicable.

Lewis & Clark Public Health

Office of the Sheriff

City of Helena

Domestic dogs, cats and ferrets

LCSO, HPD, and EHPD agrees to:

- Investigate and manage all potential rabies exposures
- Work with victim to identify and locate the animal involved
- Place animal in confinement for observation (quarantine), as needed
- If animal is euthanized, collect sample and ship to the Montana State Veterinary Diagnostic Laboratory (State Veterinary Lab)
- Notify LCPH
  - If animal cannot be located
  - If animal shows signs or symptoms consistent with rabies
  - If animal dies

LCPH Agrees to:

- Contact victim to provide counseling on PEP
- Report exposure and decisions regarding PEP to the Montana Department of Public Health and Human Services (DPHHS)

Bats:

LCSO, HPD, and EHPD agrees to:

- Collect bat(s) for euthanasia
- Submit bat(s) for testing to the State Veterinary Lab

LCPH Agrees to:

- Evaluate exposure risks
- Contact LCSO, HPD, EHPD for collection of bat(s), if available
- Contact victim to provide counseling on PEP
- Report exposure and decisions regarding PEP to DPHHS

Other Wild Animals, Livestock:

LCSO, HPD, and EHPD agrees to:

- If possible, keep animal in a secure area to prevent escape until further instructions are provided
- Investigate circumstances of potential rabies exposure
- Contact LCPH for guidance on actions to take with animal
- If animal is euthanized, collect sample and ship to the State Veterinary Lab

Lewis & Clark Public Health

Office of the Sheriff

City of Helena

CITY OF EAST HELENA

LCPH Agrees to:

- Provide Parties with animal management guidance
- Contact victim and provide counseling on PEP
- Report exposure and decisions regarding PEP to DPHHS

ASSIGNMENT

Parties may not assign or delegate any obligation or duty contained herein without prior consent of the other parties, for which consent may not be unreasonably withheld.

TERM

The MOA will commence on March 28, 2019, and shall remain in effect indefinitely or until Parties agree to change or eliminate the agreement. Parties may terminate this agreement without cause upon 30-day written notice to Parties.

East Helena Police Department
William Harrington, Chief of Police
By: W. [signature]
Date: 04-16-19

Helena Police Department
Steve Hagen, Chief of Police
By: [signature]
Date: 4/11/19

Lewis and Clark Public Health
Drenda Neimann, Health Officer
By: [signature]
Date: 4/11/19

Lewis and Clark County Sheriff
Leo C. Dutton, Sheriff/Coroner
By: Leo P. Dutton
Date: 04-15-19

Cc: Drenda Niemann, Health Officer, Lewis and Clark Public Health
Leo Dutton, Lewis and Clark County Sheriff
Steve Hagen, Chief of Police, City Of Helena Police Department
William Harrington, Deputy Chief, East Helena Police Department
Leo Gallagher, Lewis and Clark County Attorney

Lewis & Clark Public Health

Office of the Sheriff

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City of Helena

CITY OF EAST HELENA

SECTION 3

Lewis and Clark County Rabies Control Regulation (BOH-19-01)

LEWIS AND CLARK COUNTY RABIES CONTROL REGULATION

(BOH-19-01)

Contents

LEWIS AND CLARK COUNTY RABIES CONTROL REGULATION

1 PURPOSE

The Lewis and Clark City-County Board of Health (Board) sets forth this regulation to protect the public health, safety, and welfare of the people and animals of Lewis and Clark County and to control and prevent the spread of rabies.

2 EFFECTIVE DATE AND REVIEW PROCEDURES

2.1. All provisions established under this regulation shall become effective upon adoption by the Board.

2.2. At any time, the Board may propose additions or revisions to these regulations. Changes proposed to the regulation by the Board shall be processed for adoption as prescribed by existing County Administrative Regulations.

3 AUTHORITY AND SCOPE OF REGULATION

3.1. Mont. Code Ann. Sections 50-2-116(1)(f) and (g) require local boards of health to identify, assess, prevent, and ameliorate conditions of public health importance and to protect the public from the introduction of and spread of communicable disease. Mont. Code Ann. § 50-2-116(2) authorizes local boards of health to adopt regulations that do not conflict with regulations adopted by the Montana Department of Public Health and Human Services (DPHHS) for the control of communicable disease. Rabies or potential rabies exposure is identified as a reportable communicable disease.

3.2. This Regulation shall apply in all parts of Lewis and Clark County where a comparable Regulation does not exist. The requirement to vaccinate dogs, cats and ferrets is applied throughout Lewis and Clark County. Where rabies vaccination of dogs, cats and ferrets is required by municipal code (ordinance) and is consistent with the regulations prescribed herein, municipalities shall continue to administer the municipal code including enforcement.

4 DEFINITIONS

4.1. "Animal" means any member of the order Mammalia, all of which are capable of being infected with and transmitting rabies.

4.2. "Animal Control Officer" means a person designated by the Lewis and Clark County Sheriff or Chief of Police of any incorporated city in Lewis and Clark County to assist with the enforcement of the provisions of this Regulation.

4.3. "Animal Shelter" means the Lewis and Clark County Animal Shelter that is operated by Lewis and Clark Humane Society for the purpose of impounding or harboring animals.

4.4. "Bite" means the wound made by a biting animal where the skin has been penetrated by the teeth of an animal.

4.5. "Cat" means any domestic feline animal (Felis catus).

4.6. "Confinement for Observation" and/or "Confined for Observation" means isolation of an animal that has caused a potential human rabies exposure to prevent further potential exposure and watch for signs and symptoms of rabies.

4.7. "Department" means Lewis and Clark Public Health.

4.8. "Dog" means any domestic canine animal (Canis familiaris).

4.9. "Ferret" means any domestic animal that is descended from the European polecat (Mustela putorius furo).

4.10. "Lewis and Clark County Enforcement Officer" means any Animal Control Officer or any Lewis and Clark County Law Enforcement Officer.

4.11. "Health Officer" means the Health Officer appointed by the Lewis and Clark City-County Board of Health in accordance with Mont. Code Ann. § 50-2-116(1)(a), or his or her designee.

4.12. "Owner" means a person having the right of property or custody of an animal or who keeps or harbors an animal or knowingly permits an animal to remain on or about any premises occupied by that person. This term shall not apply to veterinarians or kennel operators who have temporary custody, for a period of less than 60 days, of animals owned by others.

4.13. "Potential Rabies Exposure" means a bite or by contamination from an animal or wild animal of a mucous membrane, scratch, abrasion or open wound of a human by the saliva or other infectious material and direct, or suspected, contact between a bat and a human.

4.14. "Rabies Vaccination" (used interchangeably with "Rabies immunization" and "Rabies Vaccine Administration") means the inoculation of an animal with an anti-rabies vaccine administered by a licensed veterinarian or under the direct supervision of a licensed veterinarian as defined in Mont. Code Ann. § 37-18-305.

4.15. "Rabies Vaccine" means an anti-rabies vaccine approved for use in the United States.

4.16. "Wild Animal" means any non-domesticated member of the order Mammalia, all of which are capable of being infected with and transmitting rabies, excluding domestic dogs, cats and ferrets; domestic livestock; hybrids of domestic and wild animals; legally captive wild animals, rodents and rabbits.

5 HEALTH OFFICER, LAW ENFORCEMENT OFFICERS

5.1. The Health Officer or his or her designees are responsible for and are hereby vested with the power and authority to enforce this regulation.

5.2. As provided in Mont. Code Ann. § 50-2-120 the Health Officer may request a sheriff or other peace officer to assist the Health Officer in carrying out the provisions of this regulation.

5.3. As provided in Mont. Code Ann. § 50-2-122, MCA, it is unlawful to hinder a Health Officer in the performance of his or her duties, remove or deface any placard or notice posted by the local health officer, or violate a confinement for observation regulation.

6 RABIES VACCINATION REQUIREMENTS – DOGS, CATS AND FERRETS

6.1. Initial Vaccination:

(a) Every dog, cat or ferret that is at least 3 months old shall be vaccinated and any subsequent vaccinations shall be administered in accordance with the vaccine manufacturer's recommendation.

(b) Regardless of age, any dog, cat or ferret with no record of rabies vaccination shall be required to be vaccinated and the initial vaccination will confer immunity as stated in part (c) of this Subsection.

(c) Any dog, cat or ferret receiving an initial vaccination is not considered effectively vaccinated for 28 days.

6.2. Revaccination:

(a) Regardless of the age of a dog, cat or ferret at initial vaccination, subsequent doses shall be administered according to the vaccine manufacturer's recommendation.

(b) Thereafter, the interval between revaccinations shall conform to the recommendations of the vaccine manufacturer.

6.3. Vaccination Exemption: If, after an animal receives one initial and one booster rabies vaccination, a licensed veterinarian determines that an additional vaccination would endanger the animal's life due to disease or other medical considerations, the animal

may be exempted from the requirement for revaccination while the condition exists. The licensed veterinarian must complete and submit to the Department an "Exemption from Rabies Vaccination Certificate" on a form approved by the Department. A copy of the Certificate shall be provided to the Department. If an exempted animal bites another animal or person, then the animal must be confined for observation as specified in 9.4

6.4. Proof of Rabies Vaccination:

All dogs, cats, and ferrets shall be vaccinated by a licensed veterinarian against rabies in accordance with procedures recommended in the latest version of the U.S. Public Health Compendium for rabies vaccine, and are to be identified on the health certificate by the date of rabies vaccination and the serial number of the rabies vaccination and tag. ARM 32.3.213. A proof of rabies vaccination certificate using the National Association of State Public Health Veterinarians (NASPHV) Form 51 (revised 2007) or equivalent will be issued by the Veterinarian. A copy of the form will be provided to the Owner and the original filed with the veterinarian, Animal Shelter, or other Animal Welfare Organization incorporated and operated under section 501(c)(3) of the Internal Revenue Code (IRS). Along with a copy of the Certificate, the veterinarian will issue a durable tag. The tag will include the year of vaccination, name of the clinic/veterinarian, an address of the clinic/veterinarian and a unique number. The tag number will be placed on the Certificate.

6.5. The Owner is responsible for assuring that the rabies tag is securely attached to a collar or harness or show proof of current rabies status as indicated in Section 6.3 upon request.

6.6. Any unvaccinated dog, cat or ferret of more than 3 months of age that is acquired or moved into Lewis and Clark County must be vaccinated within 30 days of purchase or arrival unless there is documented evidence of current vaccination.

6.7. The safety and efficacy of rabies vaccination for wild animals and hybrids of wild animals have not been established and no rabies vaccinations are licensed for these animals. Wild animals and hybrids of wild animals will be treated as unvaccinated animals.

7 VACCINATION FOR RABIES PRIOR TO TRANSFER OF ANIMAL OWNERSHIP

7.1. It is unlawful for any person to sell, offer for adoption, or give away any dog, cat or ferret over 3 months of age unless such animal has been vaccinated against rabies as prescribed by this regulation.

7.2. Licensed veterinary clinics, animal shelters, and animal welfare organizations incorporated and operated under section 501(c)(3) of the Internal Revenue Code are not required to vaccinate an animal in their care, but may not sell, adopt or give away an unvaccinated animal.

8 REPORTING POTENTIAL RABIES EXPOSURE AND SUSPECTED RABIES

8.1. It shall be the duty of every Lewis and Clark County Enforcement Officer and all healthcare providers of Lewis and Clark County to ensure that the Health Officer is notified when animal bite victims are treated or when potential rabies exposure incidents are reported.

8.2. Any person having knowledge of an animal known to have rabies or symptoms suggestive or consistent with rabies, as determined by a veterinarian, shall report the facts immediately to the Health Officer and the State Veterinarian.

8.3. Any person having knowledge of any animal or person having been bitten by an animal susceptible to rabies shall report the facts immediately to the Health Officer.

9 INVESTIGATIONS AND MANAGEMENT OF POTENTIAL RABIES EXPOSURE

9.1. The Health Officer must apply generally accepted control measures, as identified in the most recent version of the National Association of State Public Health Veterinarians Compendium of Animal Rabies Prevention and Control, for confirmed or potential rabies exposures to a human by a species susceptible to rabies infection.

9.2. The Health Officer must investigate each report of potential rabies exposure and gather, at a minimum, information about the circumstances of the potential rabies exposure; nature of the exposure; name, age, and address of the exposed individual; vaccination status of the animal in question; treatment of the exposed person; and eventual outcome for both animal and person involved.

9.3. As soon as possible after investigating a report of potential rabies exposure, the Health Officer must inform the exposed person or the individual responsible for the exposed person, if that person is a minor, whether or not post-exposure treatment is recommended to prevent rabies.

9.4. Whenever the circumstances involve a dog, cat, or ferret the Health officer must:

(a) Order the animal confined for observation for signs and/symptoms of illness during a ten-day period at the Animal Shelter, veterinary facility, or other facility approved by the Health Officer. Any illness in the animal during the confinement for observation or before release is evaluated by a veterinarian for signs and

symptoms suggestive of rabies. If the symptoms observed are consistent with rabies, the Health Officer shall order the animal euthanized and the head or appropriate tissue sent to the Montana Department of Livestock's diagnostic laboratory for rabies analysis. The Health Officer may also order an animal euthanized subsequent to confinement for observation and the brain analyzed.

(b) Require the animal be vaccinated against rabies prior to release from confinement for observation. Vaccination should not occur during the 10 day confinement for observation period in order to avoid the potential for development of a response to vaccination, which could result in the affected animal being unnecessarily euthanized.

(c) If an animal dies during the confinement for observation period, the animal's head shall be sent to the Montana Department of Livestock's diagnostic laboratory for rabies testing.

(d) If a biting animal has a current rabies vaccination the Health Officer may permit the owner to confine the animal at home under strict confinement for observation for a minimum of 10 days. Home confinement is subject to a determination by the Health Officer or Lewis and Clark County Enforcement Officer that the owner is cooperative, responsible, has the facilities to confine the animal and will allow observation of the confined animal by the Health Officer and/or Lewis and Clark County Enforcement Officer upon request. Permission for home confinement for observation may be revoked by the Health Officer at any time during the confinement period.

9.5. If a potential rabies exposure involves other animals such as domestic livestock; captive wild animals; hybrids of wild animals; rodents; or rabbits, the animal must be kept in a secure area, if possible, to prevent escape until decisions can be made regarding human health risks.

10 IMPOUNDMENT

10.1. Animals that are subject to impoundment under this regulation include but are not limited to:

(a) Any animal kept or maintained contrary to the provisions of this Regulation;

(b) An animal subject to a potential rabies exposure investigation; or

(c) An animal to be held for confinement for observation or isolation.

10.2. The cost of impoundment shall be the responsibility of the Owner. It is unlawful for any person to refuse or neglect to surrender any animal subject to impoundment. At the direction of the Health Officer, any Lewis and Clark County Enforcement Officer shall seize and impound such animal at the Owner's expense.

10.3. Animals impounded under this regulation shall be released to the Owner at the end of the confinement for observation period, as determined by the Health Officer. The

Owner shall be required to pay any impoundment costs, including veterinarian evaluation or treatment and vaccination, prior to release of the animal. If an impounded animal is not claimed by its Owner and fees and costs paid within 72 hours of the end of the confinement for observation or investigation period, the Owner forfeits all rights, title and interest thereto to Lewis and Clark Humane Society and the animal is subject to adoption in accordance with the Lewis and Clark Humane Society policies and procedures.

11 WILD ANIMALS

This section shall be administered in conjunction with the Montana Department of Public Health and Human Services and the Montana Department of Livestock. Where this Section of the regulation conflicts with the application of the Montana Code Annotated or the Administrative Rules of Montana, the Montana Code Annotated and/or the Administrative Rules of Montana shall prevail.

11.1. If a wild animal has bitten or otherwise exposed a person to the possibility of contracting rabies, the animal may be destroyed and the animal's head sent to the Montana Department of Livestock's diagnostic laboratory for rabies testing.

12 PENALTIES FOR VIOLATIONS

12.1. A person who does not comply with these rules adopted by the Board is guilty of a misdemeanor. Upon conviction, the person shall be fined not less than $10 or more than $200. Mont. Code Ann. §50-2-124.

12.2. Each day of violation constitutes a separate offense. Mont. Code Ann. §50-2-124 (3).

12.3. Fines, except justice's court fines, must be paid to the county treasurer. Mont. Code Ann. § 50-2-124 (4).

LEWIS AND CLARK CITY-COUNTY BOARD OF HEALTH

Jim Benish, Chair — Date: 03/28/2019

Drenda Niemann, Health Officer
Lewis & Clark Public Health — Date: 3/28/19

Lewis & Clark Public Health

Office of the Sheriff

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City of Helena

CITY OF EAST HELENA

SECTION 4

City of Helena Code, Title 5, Police Regulations, Chapter 2, Animal Control

City of Helena

City of Helena Code
Title 5, Police Regulations
Chapter 2, Animal Control

5-2-1: DEFINITIONS:

The following words and terms as used in this chapter shall have the meanings respectively ascribed to them:

ANIMAL CONTROL OFFICER: All duly appointed and qualified deputies, as well as the duly appointed and qualified city animal control officer.

ANIMAL SHELTER: Any premises provided by the city and maintained for impounding and caring for dogs and other animals.

BEE: Any stage Apis mellifera and all European subspecies.

ENCLOSURE: A vehicle, pen, cage, kennel or other similar object surrounded on all sides sufficient to prevent an animal from escaping.

EXPOSED TO RABIES: A dog has been exposed to rabies if it has been bitten by or been exposed to any animal known to be or suspected of being infected with rabies.

HIVE: A frame hive, box hive, observation hive, receptacle or container or part of a container, natural or artificial, used as a domicile for bees that is clearly recognized for that use.

HOBBYIST APIARY SITE: An apiary site registered by a hobbyist beekeeper.

HOBBYIST BEEKEEPER: A person who owns a total of no more than two (2) hives.

KENNEL: A building, enclosure or portion of any premises in or at which dogs or cats are boarded or kept for hire or for sale; in or at which dogs or cats are kept or maintained by any person other than the owner thereof; or in or at which three (3) or more cats and/or dogs over the age of six (6) months are kept or maintained.

OWNER: Any person owning, keeping or harboring a dog or other animal who is presumed to be the adult head of the household owning, keeping or harboring such an animal.

PERSON: Any individual.

SPAYED FEMALE: Any bitch which has undergone surgery to prevent conception, whose owner can provide suitable proof of such surgery.

STRAY ANIMALS: Any animal, the owner of which cannot be ascertained.

VACCINATION: The inoculation of a dog or cat with antirabies vaccine, having an effective immunity of at least two (2) years, and administered under the direction of the public health officer by a licensed veterinarian or with any other vaccine approved by the public health officer and the state veterinarian.

WILD ANIMAL: Any animal which is not a domesticated animal. (Ord. 2193, 8-10-1981; amd. Ord. 2488, 1-23-1989; Ord. 3123, 7-12-2010; Ord. 3178, 6-24-2013)

5-2-2: VACCINATION REQUIRED:

It is unlawful for any person to keep, maintain or harbor any dog or cat over six (6) months of age unless it has a currently valid "vaccination", as defined in section 5-2-1 of this chapter. Proof of valid vaccination will be required at the time of licensing or upon demand by the animal control officer or a police officer of the city. (Ord. 2488, 1-23-1989)

5-2-3: LICENSING AND REGISTRATION:

A. No person shall own, keep or harbor any dog within the city limits, unless such dog is licensed as herein provided. Application for such license shall be made to the administrative services director, or such agent as shall be designated by the administrative services director. Such application shall state the name and address of the owner and the name, breed, color and sex of the dog. The license fee shall be paid at the time of making application, a numbered receipt given to the applicant, and a numbered metallic or plastic tag shall be issued to the owner. Every person engaged in operating a dog or cat "kennel", as defined in this chapter, shall pay an annual kennel license fee. All dog licenses and kennel licenses shall be issued for one year, beginning January 1. Any license issued for any dog for the year immediately preceding shall be valid to, but not including, March 1 of the current year. No application for a dog license shall be accepted until the applicant has produced satisfactory evidence that the dog for which the license is to be issued has a currently valid "avianized flury" strain rabies vaccine as of the date of the application. Any person licensing a dog on or after March 1 of any year shall pay an additional fee with the ordinary license fee unless such person can present evidence satisfactory to the administrative services director that the animal being licensed has not been kept, held or owned within the city for a period in excess of one week immediately prior to the date on which application is made.

B. In the event that a license tag issued for a dog shall be lost, the owner may obtain a duplicate tag upon the payment of a duplicate tag fee. (Ord. 3177, 6-10-2013, eff. 7-15-2013)

C. If there is a change of ownership of a dog or kennel during the license year, the new owner may have the current license transferred to his name upon application to the treasurer.

D. No person shall use for any dog a license, receipt of license tag or evidence of vaccination for rabies, issued for any other dog. (Ord. 2193, 8-10-1981)

E. Any person keeping any unlicensed dog shall be deemed guilty of a misdemeanor and shall, upon conviction therefor, be punished by a fine of not less than thirty five dollars ($35.00), nor more than one hundred dollars ($100.00). (Ord. 2565, 9-10-1990)

5-2-4: TAG AND COLLAR:

The license tag provided for by section 5-2-3 of this chapter shall be stamped with the number and year for which issued. The shape, design or color of such tag shall be changed from year to year. Every licensed dog shall, at all times, wear a choke chain, collar or harness to which is attached its license tag. (Ord. 2193, 8-10-1981)

5-2-5: NUMBER OF DOGS:

It is unlawful for any person, persons or family to keep, harbor or maintain in or on the same premises, three (3) or more dogs over six (6) months of age, without first obtaining a kennel license, as provided in section 5-2-6 of this chapter. (Ord. 2193, 8-10-1981)

5-2-6: KENNEL LICENSE:

A. A kennel license is required by any person or family owning or harboring three (3) or more dogs or cats over six (6) months of age. The following conditions must be met before such a license will be issued: (Ord. 3177, 6-10-2013, eff. 7-15-2013)

1. The intended facilities must be inspected by the animal control officer, such inspection to include the physical facilities, as well as the effect on the neighborhood.

2. Following the inspection, the animal control officer will recommend to the licensing authority either approval or disapproval of the application. (Ord. 2193, 8-10-1981)

3. The applicant must pay the required kennel fee. (Ord. 3177, 6-10-2013, eff. 7-15-2013)

4. Kennels will be permitted only in areas of the city zoned for such usage, as defined in the city zoning ordinance. (Ord. 2193, 8-10-1981)

B. All kennel licenses will expire on December 31 of each year, unless sooner revoked. The animal control officer will investigate all complaints concerning licensed or improperly operated kennels and may recommend revocation of the license if it is deemed necessary. The licensee will be given at least five (5) days' written notice of such recommendation, during which time he may appeal the animal control officer's recommendation. The licensing authority will then take action as required. (Ord. 2312, 8-8-1983)

C. Any person keeping or maintaining any unlicensed kennel shall be deemed guilty of a misdemeanor and shall, upon conviction therefor, be punished by a fine of not less than thirty five dollars ($35.00) or more than one hundred dollars ($100.00). (Ord. 2565, 9-10-1990)

5-2-7: DOG CENSUS:

At least once every five (5) years, a complete census may be taken of all dogs in the city and anyone found to be harboring an unlicensed dog required to be licensed by the provisions of this chapter shall be required immediately to obtain a license for such dog or shall be cited into court to answer to charges of violation of this chapter. (Ord. 2193, 8-10-1981)

5-2-8: REMOVAL OF EXCREMENT:

A. It is unlawful for any person in control of an animal to cause or permit such animal to be on any property, public or private, not owned or possessed by such person, to fail to remove excrement left by such animal.

B. The provisions of this section shall not apply to the ownership or use of seeing eye dogs by blind persons, dogs when used in police activities by the city, or tracking dogs when used by or with the permission of the city. (Ord. 2193, 8-10-1981)

5-2-9: RABIES CONTROL:

A. Every animal which bites a person shall be promptly reported to the animal control officer and shall thereupon be securely quarantined at the direction of the animal control officer for a period of not less than ten (10) days, and shall not be released from such quarantine except by written permission of the animal control officer. At the direction of the animal control officer, such quarantine may be on the premises of the owner, in a veterinary hospital or veterinarian's office of the owner's choice, all at the expense of the owner. In the case of stray animals or in the cases of animals whose ownership is not known, such quarantine shall be at a veterinary hospital, a veterinarian's office, or at such place designated and deemed appropriate by the animal control officer. (Ord. 2478, 8-8-1988)

B. The owner, upon demand by the animal control officer, shall forthwith surrender any animal which has bitten a human or which is suspected as having been exposed to rabies, for supervised quarantine which expense shall be borne by the owner and may be reclaimed by the owner if adjudged free of rabies, upon payment of fees as set forth in section 5-2-20 of this chapter, and upon compliance of licensing provisions set forth in section 5-2-3 of this chapter. (Ord. 2193, 8-10-1981)

C. When an animal under quarantine has been diagnosed as being rabid or suspected by a licensed veterinarian as being rabid, and dies while under such observation, the animal control officer shall immediately send the head of such animal to a competent laboratory for pathological examination, and shall notify the proper public health office of reports of human contacts and the diagnosis made of the suspected animal. (Ord. 2478, 8-8-1988)

D. When one or both reports gives a positive diagnosis of rabies, the animal control officer shall recommend a city wide quarantine for a period of thirty (30) days, and upon the invocation of such quarantine, no animal shall be taken into the streets or permitted to be in the streets during such period of quarantine.

E. Every unvaccinated animal bitten by an animal showing positive symptoms of rabies shall be forthwith destroyed, or shall, at the owner's option and expense, be held under not less than fifteen (15) days quarantine, and thereafter, in the discretion of the veterinarian, said animal may be quarantined for a period of not less than ninety (90) days.

F. In the event there are additional positive cases of rabies occurring during the period of the quarantine, such period of quarantine may be extended, in the interest of the public safety, for additional periods of thirty (30) days, at the discretion of the animal control officer.

G. No person shall kill, or cause to be killed, any rabid animal, any animal suspected of having been exposed to rabies, or any animal biting a human, except as herein provided, nor remove the same from the city limits without written permission from the animal control officer. The animal control officer shall direct the disposition of any animal found to be infected with rabies. No person shall fail or refuse to surrender any animal for quarantine or destruction as required herein, when demand is made therefor by the animal control officer. (Ord. 2193, 8-10-1981)

5-2-10: REPORTS OF BITE CASES:

It shall be the duty of every physician or other practitioner to report to the animal control officer the names and addresses of persons treated for bites inflicted by animals, together with such other information as will be helpful in rabies control. (Ord. 2193, 8-10-1981)

5-2-11: RESPONSIBILITIES OF VETERINARIANS:

It shall be the duty of every licensed veterinarian to report to the animal control officer his diagnosis of any animal observed by him as a rabies suspect. (Ord. 2193, 8-10-1981)

5-2-12: EXEMPTIONS TO LICENSING AND VACCINATION:

Hospitals, clinics and other premises operated by licensed veterinarians for the care and treatment of animals are exempt from the provisions of this chapter, except where such duties are expressly stated. The licensing and vaccination requirements of this chapter shall not apply to any animal belonging to a nonresident of the city and kept within the city limits for not longer than thirty (30) days, provided all such dogs shall, at all times while in the city, be kept within a building, enclosure or vehicle, or be under restraint by the owner. (Ord. 2193, 8-10-1981)

5-2-13: INVESTIGATION:

For the purpose of discharging the duties imposed by this chapter and to enforce its provisions, the animal control officer, or any police officer, is empowered to enter upon any premises upon which a dog is kept or harbored and to demand the exhibition by the owner of such dog, or the license for such dog. It is further provided that the officer may enter the premises where any animal is kept in a reportedly cruel or inhumane manner and demand to examine such animal and to take possession of such animal when, in his opinion, it requires humane treatment. No person shall interfere with, hinder or molest the animal control officer in the performance of any duty of his office, or seek to release any animal in the custody of the animal control officer, except as herein provided.

It shall be the duty of the animal control officer to keep, or cause to be kept, accurate and detailed records of the licensing, impoundment and disposition of all animals coming into his custody. It shall be the duty of the animal control officer to keep, or cause to be kept, accurate and detailed records of all bite cases reported to him and his investigation of the same. It shall be the duty of the animal control officer to keep, or cause to be kept, accurate and detailed records of all monies belonging to the city, which records shall be open to inspection at reasonable times by such persons responsible for similar records of the city, and shall be audited by the city annually in the same manner as other city records are audited. (Ord. 2193, 8-10-1981)

5-2-14: ANIMALS RUNNING AT LARGE:

Any person who owns, harbors or keeps an animal, or the parent or guardian of any such person under the age of eighteen (18) years, is strictly liable for any violation of this section. All animals not confined within an enclosure or on the owner's property must be kept on a leash not more than ten feet (10') long that is physically held by a responsible person, or must be securely held by a responsible person so as to prevent the animal from running at large, with the following exceptions: All dogs must be kept under control, either on a leash or within sight and under voice control of their owners or other responsible persons when they are within any "natural park" as defined in section 7-12-1 of this code and as designated by the city commission or within a fenced area of a dog park as designated by the city commission. Dogs must be kept on a leash as described above within one hundred (100) yards of any trailhead to any natural park. (Ord. 3178, 6-24-2013)

5-2-15: ANIMALS DEEMED A NUISANCE:

It is unlawful for any person to own, harbor, keep, or maintain any animal that causes annoyance to any person by prolonged barking, howling, yelping, or other means. All female dogs or other animals in heat (estrus) shall be kept in a confined area or enclosure not accessible to male animals. (Ord. 3178, 6-24-2013)

5-2-16: VICIOUS ANIMALS; PROCEDURE:

A. Whenever an affidavit is made before the animal control officer or the judge that any dog or other animal has bitten a person and that the person bitten was not at the time trespassing upon the property of, or injuring or attempting to injure the person, family or the property of the owner, the animal control officer or judge shall issue an order requiring the owner of such dog or other animal to surrender the same to a licensed veterinarian for quarantine within twenty four (24) hours after service of the order. Such order may be served by the animal control officer or any law enforcement officer, and, if the owner cannot be found at his place of residence, the order may be served by leaving it with a person of suitable age and discretion at, or by placing it in a prominent place at the front door of such residence. It is unlawful for any person to refuse or neglect to surrender any such vicious animal within twenty four (24) hours after the service of such order as provided in this section, and the animal control officer shall forthwith seize and impound such animal at a licensed veterinarian office at the owner's expense. In the event that the owner is unknown, upon the making of such affidavit, the animal control officer or any law enforcement officer shall seize and impound such animal without notice. All dogs or other animals impounded under this section shall be quarantined at a licensed veterinarian hospital in the city for the period and under the same conditions as stated in section 5-2-9 of this chapter. Nothing in this section or any other provision of this chapter shall be deemed to abrogate any of the rights of the city or its citizens as announced in sections 5-2-33 through 5-2-36 of this chapter. (Ord. 3121, 1-11-2010, eff. 3-1-2010)

5-2-17: RESERVED:

(Ord. 3178, 6-24-2013)

5-2-18: IMPOUNDMENT AND DISPOSITION:

All unlicensed dogs found running at large and dogs and other animals at large that are sick, injured or that constitute a public nuisance, shall be taken by the animal control officer and impounded in the animal shelter and there confined in a humane manner for a period of not less than three (3), nor more than five (5) days. Dogs and other animals impounded and not claimed by their owners at the expiration of three (3) days may be disposed of at the discretion of the said animal control officer, except as hereinafter provided in the cases of certain dogs and cats. When dogs are found running

at large, and their ownership is known to the animal control officer, such dogs need not be impounded, but the animal control officer may, at his discretion, cite the owners of such dogs to appear in court to answer charges of violation of this chapter. Immediately upon impounding dogs or other animals, the animal control officer shall make every possible effort to notify the owners of such dogs or other animals so impounded, and inform such owners of the conditions whereby they may regain possession of such animals. (Ord. 2193, 8-10-1981)

5-2-19: REDEMPTION AND DESTRUCTION:

The owners shall be entitled to regain possession of any impounded dog, except as hereinafter provided in the cases of certain dogs, upon compliance with the license provisions contained in section 5-2-3 of this chapter and the payment of the fees and charges provided for in section 5-2-3 of this chapter. Any other animal impounded under the provisions of this chapter may be reclaimed by the owner upon the payment of the fees and charges provided for in section 5-2-20 of this chapter. Any animal impounded under the provisions of this chapter and not reclaimed by its owner within three (3) days may be humanely destroyed by the animal control officer or placed in the custody of some person deemed to be a responsible and suitable person to be the owner of such animal. The animal control officer may destroy any sick or injured animal which has been impounded without holding it for three (3) days, if its condition is such as makes its earlier destruction necessary or desirable. All animals destroyed shall be destroyed by a lethal injection of sodium-pentobarbital, by carbon monoxide or other poisonous gas and not by shooting. (Ord. 2193, 8-10-1981)

5-2-20: IMPOUNDMENT FEES:

Any animal impounded hereunder may be reclaimed as herein provided upon payment of an impoundment fee by the owner to the animal control officer or animal shelter personnel and an additional fee for each day such animal has been kept in the animal shelter. Said daily fee is determined by the board of directors of the Lewis And Clark County Humane Society using reasonable accounting practices to establish a reasonable charge per day for keeping each animal in the animal shelter. The daily fee may be changed no more than once each year by the board. The adoption of any new fee must be preceded by notice to the city, the county, and their animal control officers. The board shall also take reasonable steps to ensure the public dissemination of said new fee. Impoundment fees set forth herein and such additional sums as herein provided for keeping animals shall be collected by the animal control officer or animal shelter personnel for the city. Proof of valid license will be required before the animal will be released. (Ord. 2849, 8-24-1998; amd. Ord. 3177, 6-10-2013, eff. 7-15-2013)

City of Helena

5-2-21: WILD ANIMALS; PERMITS AND EXCEPTIONS:

It shall be unlawful for any person to keep or maintain, or cause to be kept or maintained, any wild animal without first applying for and receiving a permit from the animal control officer except that no permit is required to keep or maintain the following wild animals: canaries, parakeets, chinchillas, chipmunks, gophers, finches, guinea pigs, hamsters, marmoset monkeys, parrot type birds, rabbits, squirrel monkeys, turtles, tropical fish (except caribe), nonpoisonous reptiles (where permitted by state and federal law), white mice and white rats. The provisions of this section shall not prohibit the keeping or maintaining of the following wild animals:

A. Any wild animals which are kept confined in zoos, museums or any other place where they are kept as live specimens for the public to view.

B. Any wild animals which are kept confined and placed on exhibit in a circus, carnival or any other type of exhibit or show.

C. Wild animals in bona fide, licensed veterinary hospitals for treatment. (Ord. 2193, 8-10-1981)

5-2-22: WILD ANIMALS; ISSUANCE:

A. The animal control officer shall issue a permit for the keeping or maintaining of a wild animal if he finds the following:

1. That a nonrefundable fee, as established by resolution of the city commission, has been paid to the department of finance;

2. That the wild animal is at all times kept or maintained in a safe manner and that it is at all times confined securely so that the keeping of such animal will not constitute a danger to human life or the property of others;

3. That adequate safeguards are made to prevent unauthorized access to such animal by members of the public;

4. That the health or well being of the animal is not in any way endangered by the manner of keeping or confinement;

5. That the keeping of such animal does not constitute a nuisance and will not harm the surrounding neighborhood;

6. That the keeping of such animal will not create or cause offensive odors or constitute a danger to public health;

7. That the quarters in which such animal is kept or confined are adequately lighted and ventilated and are so constructed that they may be kept in clean and sanitary condition;

8. That the applicant proves his ability to respond in damages to and including the amount of one hundred thousand dollars ($100,000.00) bodily injury to or death of any person or persons or for damages to property owned by any other person which may result from the ownership, keeping or maintenance of such animal. Proof of liability to respond in damages may be given by filing with the animal control officer, in a form approved by the city attorney, a certificate of insurance, issued by a solvent corporation holding a certificate of authority to do business in the state, or a bond from a responsible and solvent corporation authorized to issue bonds shall provide that no cancellation of the insurance or bond will be made unless thirty (30) days' written notice is first given to the animal control officer;

9. That the applicant has proof of state and/or federal permits for the species or specimen when so required by law.

B. In no event shall a permit be issued for the keeping of more than two (2) wild animals over the age of two (2) months at any single location.

C. Any applicant denied a permit pursuant to these provisions may appeal to the city commission. (Ord. 2193, 8-10-1981)

5-2-23: CONDITIONS:

If, at any time, it appears to the animal control officer that there are grounds for denial or revocation of the wild animal permit, but that such grounds could be eliminated by the imposition of conditions, or of additional conditions, he may notify the applicant or permittee, in writing, that he intends to improve or amend such conditions. (Ord. 2193, 8-10-1981)

5-2-24: REVOCATION:

A wild animal permit may be revoked on any one or more of the following grounds:

A. Any fact exists which would be a reason for denial of the permit.

B. The permittee, or any agent or employee of the permittee, has violated, or has been convicted of violating, any provision of this or any other ordinance, or of any of the state now, or hereafter in force regulating the activity for which the permit was issued.

C. The permittee obtained the permit by false or fraudulent representations.

Prior to any such revocation, the animal control officer shall provide the permittee with written notice by United States mail, of his intent to revoke the permit and advising the permittee of his right to appeal such decision. Any permittee aggrieved by a decision to revoke the permit may appeal to the city commission. (Ord. 2193, 8-10-1981)

5-2-25: CRUELTY TO ANIMALS:

A. It is unlawful for any person to wilfully and cruelly inflict pain upon or injure any animal. It is unlawful for any person to lay out or expose any poison for the purpose of killing any dog or other animal, or to aid or abet any person in so doing. Any animal whose owner has been charged with cruelty to that animal may be retained at the animal shelter until disposition of the charge, if the animal control officer believes that returning the animal to the owner may endanger its life. At the hearing if the owner is convicted, the judge shall determine whether the animal will be returned to the owner or placed for adoption by the animal shelter.

B. A person commits the offense of cruelty to animals if he knowingly or negligently subjects an animal to mistreatment or neglect by:

1. Overworking, beating, tormenting, injuring or killing any animal; carrying any animal in a cruel manner.

2. Failing to provide an animal in his custody with proper food, drink or shelter.

3. Promoting, sponsoring, conducting or participating in a horse race of more than two (2) miles; or promoting, sponsoring, or conducting or participating in any fight between any animals.

4. A person violating the provisions of this section shall be guilty of a misdemeanor. (Ord. 2278, 11-15-1982)

5-2-26: PROVOKING ANIMALS:

It is unlawful for any person to provoke, harangue, tease, torment or in any way disturb a dog or other animal with the intent to cause it to bark or attack any person. (Ord. 2193, 8-10-1981)

5-2-27: ABANDONMENT OF ANIMALS:

It is unlawful for any person to abandon any animal within the city. Any person violating this section shall bear all expenses incurred by the city in caring for said animal and shall reimburse the city for all said costs, as determined by the department of finance. (Ord. 2193, 8-10-1981)

5-2-28: LIABILITY OF NONOWNERS:

Every operator of a self-propelled vehicle upon the streets and ways of the city shall, immediately upon injuring, striking, maiming or running down any animal, give aid to such animal or immediately notify the animal control officer or police officer, furnishing sufficient facts relative to such injury. (Ord. 2193, 8-10-1981)

5-2-29: COPIES OF REGULATIONS:

A copy of this chapter and of all regulations applicable to the control of animals shall be made available to all persons procuring a dog license and to all other persons who demand the same from the animal control officer at the prescribed charge. (Ord. 2193, 8-10-1981)

5-2-30: VIOLATION; PROCEDURE:

Upon observing an animal running at large in the city, the animal control officer or other law enforcement officer will attempt to determine the owner by noting the animal's license number if possible, or by following the animal home. A citation will be issued to the owner for failure to comply with applicable sections of this chapter. If the owner cannot be determined, the animal will be taken to the city animal shelter. Any dangerous or vicious animal may be subdued by the use of reasonable means, including lethal means if necessary, by the animal control officer or other law enforcement officer. The animal control officer will keep a complete register of every dog or other animal impounded, showing time and place of capture, breed, color, sex and distinguishing marks, and, if licensed, the number of the license and the name and address of the owner. Licensed animals will be kept separate from unlicensed, and males will be kept separate from females. (Ord. 3047, 12-5-2005)

5-2-31: VIOLATION; FINE SCHEDULE:

A progressive schedule of fines shall be assessed against any animal owner found to be in violation of the provisions of this chapter within a year, that is not specifically provided for in another section:

First offense	$35.00 to $100.00
Second offense	$100.00 to $250.00
Third and subsequent offenses	$250.00 to $500.00

The court may allow an animal owner found in violation of this chapter to perform community service in satisfaction of all or part of the fine assessed under this section. (Ord. 2906, 2-26-2001)

5-2-32: VIOLATION; LICENSEE'S LIABILITY AND TRANSFER:

In all prosecutions for violations of this chapter, the person who applied for and obtained the license for the dog in question shall be deemed the person responsible for the violation unless there has been a transfer of ownership prior to the violation. Any transfer of ownership must be evidenced by a transfer license issued by the administrative services director. A transfer license may be obtained by furnishing the name and address of the transferee to the administrative services director and paying a fee. (Ord. 3177, 6-10-2013, eff. 7-15-2013)

5-2-33: DEFINITIONS:

Unless the context clearly requires otherwise, the definitions in this section apply throughout this chapter.

DANGEROUS DOG: Any dog that according to the records of the city of Helena: a) has inflicted severe injury on a human being without provocation on public or private property, b) has killed a domestic animal without provocation while off the owner's property, or c) has been previously found to be potentially dangerous, the owner having received notice of such and the dog again aggressively bites, attacks, or endangers the safety of humans or domestic animals.

POTENTIALLY DANGEROUS DOG: Any dog that when unprovoked: a) inflicts bites on a human or a domestic animal either on public or private property, or b) charges or approaches a person upon the streets, sidewalks, or any public grounds in a menacing fashion or apparent attitude of attack, or any dog with a known propensity, tendency, or disposition to attack unprovoked, to cause injury, or otherwise threaten the safety of humans or domestic animals.

PROPER ENCLOSURE OF A DANGEROUS DOG: While on the owner's property, a dangerous dog shall be securely confined indoors or in a securely enclosed and locked pen or structure, suitable to prevent the entry of young children and designed to prevent the animal from escaping. Such pen or structure shall have secure sides and a secure top, and shall also provide protection from the elements for the dog. If it has no bottom secured to the sides the sides must be imbedded in the ground no less than two feet (2').

SEVERE INJURY: Any physical injury consisting of multiple bite wounds, broken bones, muscle tears, deep puncture wounds, or disfiguring lacerations. (Ord. 2452, 9-14-1987; amd. Ord. 3102, 9-22-2008)

5-2-34: REGISTRATION:

A. It is unlawful for an owner to have a dangerous dog in the city without a certificate of registration issued under this section. This section shall not apply to dogs used by law enforcement officials for police work.

B. The city shall issue a certificate of registration to the owner of a dangerous dog if the owner presents to the city sufficient evidence of:

1. A proper enclosure to confine a dangerous dog and the posting of the premises with a clearly visible warning sign that there is a dangerous dog on the property. In addition, the owner shall conspicuously display a sign with a warning symbol that informs children of the presence of a dangerous dog;

2. A surety bond issued by a surety insurer qualified under the laws of the state in a form acceptable to the city in the sum of at least fifty thousand dollars ($50,000.00), payable to any person injured by the vicious dog; or

3. A policy of liability insurance, such as homeowner's insurance, issued by an insurer qualified under the laws of the state in the amount of at least fifty thousand dollars ($50,000.00), insuring the owner for any personal injuries inflicted by the dangerous dog. (Ord. 2452, 9-14-1987)

4. The city will charge an annual fee to register dangerous dogs. Said fee is in addition to regular dog licensing fees. (Ord. 3177, 6-10-2013, eff. 7-15-2013)

5-2-35: RESTRAINT; DECLARATION; DETERMINATION:

A. It is unlawful for an owner of a dangerous dog to permit the dog to be outside the property enclosure unless the dog is muzzled and restrained by a substantial chain or leash and under control of a responsible person. The muzzle shall be made in a manner that will not cause injury to the dog or interfere with its vision or respiration but shall prevent it from biting any person or animal.

B. Dogs may not be declared dangerous if the threat, injury, or damage was sustained by a person who, at the time, was committing a wilful trespass or other tort upon the premises occupied by the owner of the dog, or was tormenting, abusing, or assaulting the dog or has, in the past, been observed or reported to have tormented, abused, or assaulted the dog or was committing or attempting to commit a crime.

C. If a dog is determined to be a dangerous dog or a potentially dangerous dog the animal control officer will notify the owner of the dog of said status. Notification will either be accomplished through the regular United States mail or by personal delivery of the notice to the owner. If the owner disputes the classification of the dog, the owner may, within three (3) business days of receipt of the notification, request a hearing. The request must be filed with the clerk of municipal court and a copy must be served on the animal control officer the same day the request is filed. Service on the animal control officer must be accomplished by either mailing the copy through the regular United States mail or by personal service. Within ten (10) business days of the request, a hearing must be held before the municipal court unless continued as provided in this section. Pending the outcome of the aforementioned appeal process, the dog shall remain securely confined on the premises of the owner as hereinabove set forth. However, if the dog is in the possession of the city or the local humane society, it will remain in impoundment at the expense of the owner. The judge may continue the hearing if the dog is:

1. In the possession of the owner and is confined; or

2. Impounded and the owner pays the expenses of maintaining the dog in impoundment during the continuance period. (Ord. 3121, 1-11-2010, eff. 3-1-2010)

5-2-36: CONFISCATION:

A. Any dangerous dog shall be immediately confiscated by an animal control officer if the:

1. Dog is not validly registered under this chapter;

2. Owner does not secure the liability insurance coverage required under this chapter;

3. Dog is not maintained in the proper enclosure;

4. Dog is outside of the dwelling of the owner, or outside of the proper enclosure and not under physical restraint of the owner.

B. If a dangerous dog of any owner with a prior conviction under this chapter attacks or bites a person or another domestic animal, the dangerous dog shall be confiscated immediately by an animal control officer, placed in quarantine for the proper length of time, or immediately destroyed in an expeditious and humane manner.

C. Any dog that aggressively attacks and causes severe injury or death of any human, whether the dog has previously been declared potentially dangerous or dangerous, shall be confiscated immediately by an animal control officer, placed in quarantine for the proper length of time, or immediately destroyed in an expeditious and humane manner.

D. Any owner of any dog who violates any provision of sections 5-2-33 through 5-2-36 of this chapter shall be guilty of a misdemeanor and shall be fined a minimum fine of five hundred dollars ($500.00). Further, the owner of any dog that aggressively attacks and causes severe injury to or death of any human, whether the dog has previously been declared a potentially dangerous or dangerous dog, shall be guilty of a misdemeanor and shall be fined a minimum of five hundred dollars ($500.00). Further, the owner of a dangerous dog with a prior conviction under this chapter which attacks or bites any person or other domestic animal, shall be guilty of a misdemeanor and fined a minimum of five hundred dollars ($500.00). In addition to any fine imposed hereunder, any violation of this chapter, as announced herein, may result in incarceration in the city jail for a term not to exceed ninety (90) days. (Ord. 2452, 9-14-1987)

5-2-37: APPLICATION:

If any provision of this chapter or its application to any person or circumstance is held invalid, the remainder of this chapter is not affected. (Ord. 2452, 9-14-1987)

Lewis & Clark Public Health

Office of the Sheriff

City of Helena

CITY OF EAST HELENA

SECTION V

City of East Helena Code, Title 6, Police Regulations, Chapter 3, Dogs

City of East Helena Code
Title 6, Police Regulations
Chapter 3, Dogs

6-3-1: DEFINITIONS:

As used in this chapter, the following words and terms shall have the meanings set forth below:

ABANDONED: Any dog that is not fed or sheltered by its owner.

ANIMAL SHELTER: Any place designated by the City to impound and care for dogs violating this chapter.

BARKING DOG: Any dog which annoys or disturbs any person by repeated and frequent barking, yelping, or howling.

CONFINED: Within the premises or property boundary of the owner or under the restraint of the owner or another person authorized to control the dog.

DOG CONTROL OFFICER OR DCO: Any person hired by or contracted with by the City to enforce this chapter. This term includes a Law Enforcement Officer of the City.

OWNER: Any person who owns, keeps, or harbors a dog or allows the same to remain or be fed in or about his premises.

PUBLIC NUISANCE: Any dog that threatens people or property specifically including livestock, other dogs, or pets; that damages or destroys property; that is abandoned or deserted by its owner; that is not restrained as required by this chapter; that is not licensed as required by this chapter; that is not vaccinated as required by this chapter; or, that is a barking dog as defined by this chapter.

RESTRAINT: Being controlled by a leash, at the heel position, in a vehicle, or on the property of the owner of the dog.

VACCINATED: Inoculated with an antirabies vaccine within the previous two (2) years.

VICIOUS DOG: Any dog that, unprovoked, bites, or attempts to bite any person or that, unprovoked, had killed or injured another animal. (Ord. 177, 8-7-1990)

6-3-2: ENFORCEMENT:

This chapter shall be enforced by the DCO or any City Law Enforcement Officer. The Chief of Police shall be the primary Animal Control Officer of the City. (Ord. 177, 8-7-1990)

6-3-3: ANIMAL SHELTER:

All animals shall be kept in a safe and sanitary condition and shall be regularly fed and watered in a humane manner. A shelter may be built and operated by the City or the City may contract with a veterinarian or other suitable person or organization to supply or operate a shelter. (Ord. 177, 8-7-1990)

6-3-4: IMPOUNDMENT AND DISPOSITION:

The following dogs are subject to impoundment:

A. A dog which is a public nuisance in violation of section 6-3-7 of this chapter

B. A vicious dog in violation of section 6-3-8 of this chapter

C. A dog held for quarantine.

D. An injured dog whose owner cannot be located.

E. A dog subject to restraint which is in violation of section 6-3-11 of this chapter.

The DCO may impound such dogs upon personal observation, or as ordered by a court having jurisdiction over the offenses herein, or in response to a written complaint signed by the complainant and which contains the complainant's name and address, the dog's description, and an explanation of the reason for the violation. The DCO will impound dogs at the animal shelter where they will be confined for not less than three (3) nor more than five (5) days. the DCO shall make a reasonable effort to notify the owner of any impounded dog. (Ord. 177, 8-7-1990)

6-3-5: REDEMPTION AND DESTRUCTION:

Should any impounded dog not be reclaimed by its owner within three (3) days, it may be humanely destroyed or placed with a person deemed suitable by the shelter. Notwithstanding the above, the shelter manager may destroy any sick or injured dog before the three (3) day period if the shelter manager determines it is necessary and humane. Destruction will be medically acceptable and by humane means. (Ord. 177, 8-7-1990)

6-3-6: IMPOUNDMENT FEES:

Impounded dogs may be reclaimed by the owner by payment of a twenty five dollar ($25.00) impoundment fee and a boarding fee set by the shelter. Payment of these fees shall be made to the shelter. (Ord. 177, 8-7-1990)

6-3-7: PUBLIC NUISANCE DOGS:

A. It shall be unlawful for any person to keep or maintain a dog which is a public nuisance

B. Any person who keeps or maintains a dog which is a public nuisance in violation of this section shall be guilty of a misdemeanor, punishable by a fine of not less than twenty five dollars ($25.00) for more than one hundred dollars ($100.00) for the first offense, not less than sixty dollars ($60.00) or more than one hundred fifty dollars ($150.00) for the second offense, and not less than one hundred dollars ($100.00) or more than two hundred fifty dollars ($250.00) for the third and any subsequent offense.

C. Second and subsequent offenses as set forth above are chargeable directly to the person violating this chapter and are not dependent upon the involvement of the same dog.

D. Upon the conviction of any person under this section, the court may, in its discretion, order any public nuisance dog or dogs owned or kept by such person to be impounded as set forth in sections 6-3-4, 6-3-5, and 6-3-6 of this chapter. Where the owner is convicted of keeping or maintaining two (2) or more public nuisance dogs, and it cannot be ascertained through the testimony of the owner or otherwise the specific dogs which are the subject matter of the complaint, the court may impound all dogs of the owner. (Ord. 177, 8-7-1990)

6-3-8: VICIOUS DOGS:

Any person who keeps or maintains a "vicious dog" as defined in section 6-3-1 of this chapter, shall be guilty of a misdemeanor, punishable for a first offense by a fine of one hundred dollars ($100.00) or destruction of the dog, or both. If the dog is not ordered destroyed, the dog shall be confined at all times. A second offense involving the same dog is punishable by a fine to the owner of two hundred fifty dollars ($250.00) and upon the second conviction, the dog shall be turned over to the DCO for destruction unless the dog is permanently removed outside the corporate limits of the city within forty eight (48) hours of the owner's conviction. (Ord. 212, 5-27-1997)

6-3-9: DOG BITES:

A. If any dog bites a person within the city, the bite shall be immediately reported to the DCO, who shall promptly investigate the matter. If the DCO determines that the dog does not have current rabies shots as set forth in section 6-3-12 of this chapter, then the DCO or any city law enforcement officer shall order the quarantine of the dog, at the owner's expense, in an escape proof enclosure at a veterinarian's office, at a kennel not operated by the owner, or at an animal shelter. If the dog is quarantined by the DCO, the owner shall pay an impoundment fee.

B. If the owner is not home, the order may be served upon a person at the owner's residence of suitable age, or by placing it in a prominent place at the main entrance of the residence. The dog shall be seized by the DCO if the owner refuses to surrender the dog within a reasonable time after receiving the notice. If the owner is unknown or the dog is at large, the DCO may seize and impound the dog without notice. All dogs impounded under this section shall be quarantined as required by the Montana Department of Health and Environmental Sciences. (Ord. 177, 8-7-1990)

6-3-10: LICENSING:

A. Required: Any person who owns, harbors, or keeps any dog within the City must license the dog with the City Clerk within thirty (30) days after the dog becomes six (6) months old or within thirty (30) days of the date the dog was brought into the City. The licenses shall be renewed by March 1 (the due date) of each year by supplying to the City Clerk the required fee, the owner's name and address, a description of the dog including name, color, age, and sex, and written proof of a current rabies vaccination, in accordance with the manufacturer's recommended time period. Licenses are not transferable between dogs or owners.

B. License Fees:

1. Spayed or neutered dog (written proof required)		$ 3.00
2. Unaltered dog		10.00
3. Duplicate tags		1.00
4. Delinquent tags (tags sold after due date)		Applicable fee plus $1.00

C. Issuance: Licenses will be issued for one (1) year, beginning with January 1 of each year. Licenses shall not be delinquent if after the due date: 1) the dog became six (6) months old; 2) the owners moved into the City; or 3) the dog was acquired after the due date.

D. Chain And Tags Required: Every dog within the City shall wear a choke chain, collar or harness which has attached to it the current license and rabies vaccination tags issued to that dog. (Ord. 177, 8-7-1990)

6-3-11: RESTRAINT OF DOGS:

No person shall permit any dog which he owns, harbors, or keeps to be off of the property of the owner unless such dog is under the restraint of the owner or another person authorized to control the dog. (Ord. 181, 4-2-1991)

6-3-12: VACCINATION:

It is unlawful for any person to keep, maintain, or harbor any dog over six (6) months of age unless it has been vaccinated against rabies and is currently immune. Dogs must be vaccinated every two (2) years. (Ord. 177, 8-7-1990)

6-3-13: WARNINGS:

At the DCO's discretion, one (1) warning may be issued to owners of dogs in violation of this chapter. (Ord. 177, 8-7-1990)

6-3-14: RECORDS:

The City shall assure that accurate records are maintained of requests for services, any capture, impoundment, or disposition of a dog, and all money collected. The records shall show the time, date, and method of notifying owners of the capture and impoundment of their dog. (Ord. 177, 8-7-1990)

6-3-15: RESTITUTION:

Any court having jurisdiction to hear and decide misdemeanor offenses in this chapter shall also be able to order full restitution for such offenses. (Ord. 177, 8-7-1990)

6-3-16: DOGS PROHIBITED IN CITY PARKS[1], EXCEPTION:

Except as otherwise provided herein, no person shall permit any dog which he owns, harbors, or keeps to be within any of the City parks within the City of East Helena. The owner, harborer, or keeper of such dog, including the parent or guardian of any such person under the age of eighteen (18) years, shall be strictly liable for any such violation of this section. This section shall not apply to a service dog actually assisting and accompanying a person with a disability as defined by applicable law.

Exception: A dog may be accompanied by its handler upon the graveled, asphalted, or cemented walkways within Kennedy Park, provided:

A. The dog remains only upon these walkways;

B. The dog and handler are appropriately connected to each other with a dog leash of not more than eight feet (8') in length;

C. The dog is currently licensed by the City or other County or municipality and this license is evidenced by the dog or handler; and

D. Handler will remove all fecal substance from the park and while walking the dog, and the handler is in physical possession of an appropriate bag for such purpose. (Ord. 258, 8-18-2015)

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Lewis & Clark
Public Health

LEWIS & CLARK CITY/COUNTY BOARD OF HEALTH
Helena, Montana

BOARD AGENDA ITEM

Meeting Date	Agenda Item No.
March 23, 2023	**5**

___Minutes _X_Board Member Discussion ___Staff & Other Reports __Action ___Hearing of Delegation

AGENDA ITEMS: Board Member Discussion

PERSONNEL INVOLVED: Board Members/Staff

BACKGROUND Work Force Development Plan; Call for Board of Health Finance Committee; Transition to hybrid meeting/location

HEALTH DIRECTOR'S RECOMMENDATION: N/A

X ADDITIONAL INFORMATION ATTACHED

BOARD ACTION: **NOTES:**

	MOTION	SECOND	AYE	NAY	ABSTAIN	OTHER
Bedell						
Collins						
Harris						
Kaufman						
MacLaurin						
Murgel						
Rolfe						
Weber						
Weltz						

Lewis & Clark Public Health

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2023-2026 Lewis and Clark Public Health Workforce Development Plan

Overview

This document provides a comprehensive workforce development plan for the health department. It also addresses PHAB Accreditation Standard 8.2: a health department workforce development plan that ensures that staff development is addressed, coordinated, and appropriate for the health department's needs. The plan will include professional development opportunities to support individual and organizational growth, as well as a supportive work environment to help public health employees and the organization thrive (PHAB v2022).

Phase 1: Organizing for Success - Project Plan

The planning process started with analysis of the PHAB Re-accreditation requirements for workforce development to determine the timeline and requirements to meet re-accreditation. The next step was determining a Workforce Development (WFD) Lead at LCPH, which in 2022, was the Community Health Promotion Division Administrator. The WFD Lead began a research and information gathering process including participating in national webinars, joining the NACCHO Workforce Development workgroup, and the Montana Workforce Assessment/Plan Advisory Council lead by the University of Montana.

<u>Workforce Development Assessment and Plan Development Timeline</u>

April – August 2022
- Research and Information Gathering
- Draft Project Plan
- Draft Workforce Assessment Survey (WAS)

September 2022
- Launch LCPH WAS

September to December 2022
- Staff complete WAS

January 2023
- Analyze WAS Data
- Draft WAS Data Report
- Update WFD Plan

February 2023
- Draft WAS Summary Report and WFD Plan to Senior Leadership

March 2023
- Finalize WFD Plan and Present to Board of Health

June 2023
- Montana Workforce Development Assessment Results Expected

July 2023
- Determine if any modifications should be made after the state assessment

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Phase 2: Environmental Scan: Assessing Organizational Environment
An environmental scan identifies needs and gaps in the WFD efforts and is described herein.

History
LCPH has assessed the workforce and developed a workforce development plan since 2015.

Governance
The LCPH WFD Plan should align with the LCPH strategic plan and the quality improvement plan. The workforce development plan is maintained on the LCPH Intranet. Senior management staff are responsible for notifying new employees of its existence and location.

Labor Structure
The current collective bargaining agreement, "Agreement between L&C Co and Montana Federation of Public Employees Representing employees of the Public Health Department and County Landfill" dated July 1, 2022 – June 30, 2025, is available on the Intranet and addresses staff training.

Programmatic and Budgeting Considerations
The health department has a strong learning culture. There are multiple objectives outlined in the current strategic plan to enhance workforce competencies. Staff regularly attend trainings, webinars, and conferences each year, including the Summer Institute hosted by the Montana Department of Public Health and Human Services and the annual Confluence Public Health Alliance conference. Supervisors have attended supervisor training offered by the Lewis and Clark County Human Resources Office, called "HR Talks." The training topics included supervision, planning and goal setting, performance management, and succession planning. Professional development is included in program budgets under the "training" category.

This plan helps to formalize our learning culture and ensure that it reaches across all facets of the health department. It provides us with a systematic approach to identifying gaps in knowledge, targeting trainings, and tracking staff learning opportunities. The cost of training opportunities can be supported by a specific grant budget, funding from the MT Department of Public Health and Human Services, by applying for scholarships, and the health department budget. The health department has budgeted over $58,000 for training in fiscal year 2023 an increase of more than $37,500 from last plan.

Employee Performance
Annual performance appraisals in Trakstar in addition to regular staff check-ins with their supervisor, allow for opportunities to set and attain professional development goals on a continual basis.

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CEU and Licensure Requirements

Staff and supervisors will work together to find opportunities to meet Continuing Education Units (CEUs) and licensure requirements for applicable staff and add them to their annual training plan and Trakstar appraisals.

Diversity

The LCPH Inclusiveness and Cultural Competency and Humility policies guide training on diversity, equity, and inclusion (DEI). Further, LCPH has incorporated DEI language in all job descriptions and interview questions.

Challenges

There have been and we expect continued challenges in implementing the WFD Plan. These are included here:

- Challenge in communicating the complexity and breadth of the work that public health does to the public and county leadership.
- History of underinvestment in public health.
- Majority of funding for training and workforce is program focused/limited short-term grant funding.
- The health department is bound by countywide compensation schedules and there is little to no flexibility to attract trained workers with bonuses or elevated starting wages.

Lessons Learned

Through the challenges of the 2020-2023 period including the COVID-19 pandemic response, significant staff burnout due response efforts and backlash to the public health field, and the efforts by LCPH to embark on an anti-racism learning journey, LCPH learned and was reminded of the power of community partnerships as well as the strength and cohesion of the LCPH department. Additionally, we learned that, with the impact of COVID-19 response and its physical and mental impacts on staff, it is ok to put some efforts on hold. We learned that sometimes stepping back, assessing, and pivoting, even during emergency response, can be the best course of action.

Through that pause process, two major successes occurred: 1) LCPH pursued a deeper effort of learning and assessment through the Widerstand Consulting anti-racism process, and 2) LCPH began to implement a Montana-based Secondary Trauma Resiliency Skills Training for human service workers, called STAR-T. This began with senior leadership and then was expanded to all staff, followed by deeper dives with specific teams as determined by need. LCPH staff led by addressing the needs and capacity of our staff at the current time, in a pandemic, and the results have been impactful and sustainable. LCPH continues to conduct division and team specific assessments of staff needs and adjust in real time.

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Phase 3: Selecting Competencies

Competencies are the measurable knowledge, skills, abilities, and behavior critical to doing a job successfully. Competencies were identified by the Council on Linkages Between Academia and Public Health Practice, Building Skills for a More Strategic Public Health Workforce: A Call to Action from the National Consortium for Public Health Workforce Development and deBeaumont Foundation specific public health professional organizations, the 2022 Lewis and Clark Public Health Widerstand Anti-Racism Audit Report, and recommendations from LCPH senior leadership. Modifications have been made for clarity and brevity.

Phase 4: Workforce Training and Capacity Assessment

Training Assessment

The 2022 Workforce Assessment Survey was implemented through a confidential HIPAA compliant online JotForm Survey format. It assessed workforce characteristics and demographics, core competencies, and training needs. The Workforce Development Survey Summary Report and the original survey tool can be found in the attachments. Additionally, this plan is informed by informal workforce needs assessments conducted by supervisors at LCPH during annual appraisals and regular individual and team meetings, to assess and address needs in real time. These informal processes in 2021-2023 led to additional identified needs that will guide how we implement the WFD Plan and Annual Training Plan. These include:

- Updating and utilizing a consistent LCPH Orientation checklist and process.
- Offering and/or facilitating learning opportunities around cultural celebrations, inclusivity, and resilience.
- Providing opportunities for connection and gathering.

The Widerstand Anti-Racism audit is an attachment and also guides this plan.

Capacity Assessment

LCPH utilized the Public Health Workforce Calculator tool from the Public Health National Center for Innovations. The Public Health Workforce Calculator is a tool to help local health departments with workforce planning efforts by utilizing information provided about the local health department to estimate the number of full-time equivalents (FTEs) needed to ensure the provision of the Foundational Public Health Services. The Calculator is intended for use in decentralized public health systems that serve less than 500,000 residents. More information can be found online: https://phnci.org/transformation/workforce-calculator. LCPH chose to use the Basic Streamlined version of tool.

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Based on serving a population 71,000, the results are as follows:

Category	Recommended FTE	Comments
Total FTE	**37.4**	Meet recommendations
Foundational Capabilities Total	16.8	Meet recommendations
Assessment and Surveillance	2.5	Meet recommendations
Emergency Preparedness and Response	1.7	Meet recommendations
All Other	12.7	Meet recommendations for total FTE but do not have dedicated staff for Health Equity
Foundational Area Total FTE	**20.6**	Do not meet all, see below
Chronic Disease and Injury Prevention	5.6	Do not meet recommendations
Communicable Disease Control	3.1	Meet recommendations
Environmental Public Health	6.9	Meet recommendations
Maternal, Child & Family Health	3.8	Meet recommendations
Clinical Care Access/Linkage	1.2	Meet recommendations

The Workforce Calculator Tool results can be found in the attachments.

LCPH does not meet the recommendations for having dedicated staff focused on Health Equity and does not have sufficient staffing working on chronic disease prevention. These are priorities that were identified in the 2021 Community Health Assessment and 2022 Community Health Improvement Report and are focus areas for the 2023-2026 LCPH Strategic Plan. Funding continues to be a barrier for these staffing gaps.

Phase 5: The WFD Plan

The following goals and objectives have been prioritized based on the 2022 WAS. The plan remains flexible to allow for emerging issues in public health and the ability to reassess training needs.

The Health Equity, Cultural Competency/Humility, and Inclusiveness policies have specific training requirements on DEI, cultural, and linguistic competency/humility. Organization and individual assessments and training needs will be integrated into the LCPH WFD annual training plan and individual training plans.

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2023-2026 WFD Goals and Objectives

Goal 1: Be responsive to LCPH staff professional development and training needs in real-time.

> **Objective 1:** Monitor emerging issues and current needs through conducting informal assessments with teams and staff and paying attention to current and emerging issues in the culture (e.g., public health state and national forums), on an ongoing basis throughout the three-year period.

Goal 2: Improve the identified skills in the domains that have the lowest average scores in the 2022 WAS.

> **Objective 2:** In the 8 core competency domains that have low average scores, increase the average overall score by 2% compared to the 2025 WAS average scores.
> **Objective 3:** In the 5 foundational domains that have low average scores, increase the average overall score by 2% compared to the 2025 WAS average scores.
> **Objective 4:** In the Addressing Public Health Issues competencies that have low average scores, increase the average overall score by 2% compared to the 2025 WAS average scores.

Goal 3: Retain current LCPH staff.

> **Objective 5:** Continue to encourage staff to pursue the Certificate in Public Health (CPH) options from the University of Montana and continue to provide tuition reimbursement and allotment of 8 hours per week of work time, such that at least one LCPH staff per year pursues the CPH, during the three-year period.
> **Objective 6:** LCPH supervisors continue to support staff to participate in professional development opportunities through funding (if available), flexibility of work, and time throughout the three-year period.
> **Objective 7:** Encourage staff to participate and/or take a leadership role in organizations outside of LCPH at a community, state, or national levels, to expand leadership and professional development skills throughout the project period.

Communication with Staff

The WFD Plan and annual training plan will be sent out to all staff upon final approval via email and posted online on the LCPH Intranet. Trainings will be either hosted for all staff or hosted during division or team meetings as appropriate.

Annual Training Plan

The three-year WFD Plan will inform the annual training plan. It will be developed each year in January by the senior leadership team to span the March-February period. The March 2023-February 2024 Annual Training Plan is included in the attachments. The LCPH Administration Team will review the annual training plan monthly as part of their regular meetings to track progress, schedule trainings, and plan communication with all staff. The LCPH Administration

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Team includes the following staff (Health Officer, Finance Coordinator, Communications Specialist, Administrative Assistant Lead, three Division Administrators, Environmental Health Administrative Assistant, Epidemiologist, and System Improvement Specialist).

Phase 6: Evaluation

Evaluation of training will provide LCPH the necessary feedback regarding its efforts, content, delivery, and effectiveness. Training offered by the department will be evaluated using course evaluation surveys, if applicable. Pre-and post-test on course content may be used where appropriate. All staff and required new employee orientation trainings will be tracked using Training Manager software by the LCPH Administrative Assistant Lead. Documentation of completion of CEUs and licensure requirements, and other professional development training will be tracked in individual staff Trakstar annual appraisals and through staff filing systems (e.g. certificates).

Developed: February 2023. Presented to the Board of Health March 23, 2023.

Lewis and Clark Public Health

Workforce Development Survey Summary Report

September, 2022

Lewis and Clark County, Montana
2-28-2023

Table of Contents

Background

Since 2015, Lewis and Clark Public Health (LCPH) has periodically assessed training and workforce development needs of LCPH staff in Lewis and Clark jurisdiction. Historically, LCPH partnered with the Montana Department of Public Health and Human Services to survey all state and local health department staff to assess skills and knowledge required to effectively provide public health services. Due to limitation of the survey data specific to Lewis and Clark County jurisdiction, LCPH developed and administered their own Workforce Assessment Survey (WAS) in 2022.

Purpose

To identify gaps in knowledge, skills, and abilities through the assessment of both organizational and individual needs and address those gaps through targeted training and development opportunities.

Findings from WAS are incorporated into the LCPH Workforce Development Plan. The Workforce Development Plan is the primary document governing staff development at LCPH. The health department's management team is responsible for updating this plan at least every five years.

Methods

Survey Concepts

The WAS questions were based on core competencies identified by the Council on Linkages Between Academia and Public Health Practice, Building Skills for a More Strategic Public Health Workforce: A Call to Action from the National Consortium for Public Health Workforce Development and deBeaumont Foundation specific public health professional organizations, the 2022 Lewis and Clark Public Health Widerstand Anti-Racism Audit Report, and recommendations from LCPH senior leadership. Modifications have been made for clarity and brevity.

Survey Development, Response Options, and Distribution

The Workforce Assessment Survey (WAS) was developed in an online format using JotForm software and was distributed via email to all LCPH regular Part/Full-Time employees in September 2022. The WAS had four sections with questions structured into one or multiple-choice answers, scales, matrix tables, or open-ended qualitative questions. The survey had a total of 105 questions with most of them requiring a response. The average time to fill out the survey was approximately 15 minutes.

Analytics Techniques

Quantitative data were analyzed in SAS 9.4 (Statistical Analysis System) and Microsoft Excel was used to group qualitative data. Most questions were tabulated separately by section and some analyses were stratified by demographic category where sample size was sufficient and reliable. Qualitative data from the open-ended questions were coded and grouped thematically during analysis.

Limitations and Assumptions

The response rate was not a 100% which does not provide a comprehensive picture for LCPH. Multi-cross-sectional comparisons stratified by each division were not possible as some of the divisions had an inadequate response sample size (<10). This was due either to the small number of employees working in specific division, or the number of employees to whom the questions were not applicable. In addition, because of the changes in WAS structure and question content, historical data from workforce development surveys are not comparable to results from WAS 2022.

Results

Overview

Lewis and Clark Public Health (LCPH) employees were asked to fill out an electronic Workforce Assessment Survey (WAS) in September 2022. In Total, 37 LCPH employees responded to the survey which resulted in 77.1% overall response rate. Employees from the Community Health Promotion Division had the biggest representation in the survey response (n=15), followed by the Disease Control and Prevention Division (n=10), Environmental Health Division (n=9), and the Administration (n=3). Majority (n=33; 89.2%) of the survey respondents were permanent LCPH employees.

The 105-question survey had four sections: I. Workforce Characteristics and Demographics; II. Training and Needs Assessment; III. The Foundational Public Health Services Framework; and IV. Addressing Public Health Issues. See Appendix A for final survey instrument.

I. Workforce Characteristics and Demographics

Age Group, Gender and Gender Identify, Race and Hispanic Origin, and Health

At the time of the survey administered, the LCPH had 48 Full/Part-Time employees. White/Caucasian and Non-Hispanic White LCPH employees, accounted for majority of the survey respondents (89.2% respectively). Similarly, majority of the respondents were female (n=30; 81.1%) with 13.5% employees identify as being part of LGBTQ+ community. About eight percent (n=3) of the respondents said they had disability or had accessibility needs. 8.1% (n=3) of respondents were aged 29 years or younger, close to a half (n=17; 46.0%) were in the 30-49 years age group, and 35.1% (n=13) were aged 50 years and older, 10.8% (n=4) did not provide an answer.

Experience and Education

Respondents were asked to select a range with number of years they have worked at LCPH. Little over half of the respondents (n=20; 54.1%) stated they have worked at LCPH for 4 years or less, 16.2% (n=6) have been with LCPH between 5-10 years, and 29.7% (n=11) spent over a decade working at LCPH. Among the group of respondents who have worked at LCPH under 5 years, 76.8% (n=10) said they were planning on retiring or seeking employment outside LCPH within the next 5 years.

When asked how many years employees have worked in the field of public health, over half (n=23; 62.2%) of respondents said they have at least 5 years of public health experience and 37.8% (n=14) listed less than 5 years of public health experience. 16.7% of respondents have worked at LCPH less than 5 years but have 5 or more years of public health experience.

The top two reasons listed for what brought employees to public health field were; 1.) the desire and passion to help others (n=15; 48.4%); and 2.) the need for change in employment, seek new opportunities, or their public health education (n=14; 45.2%). Additionally, survey respondents were asked what brought them to LCPH with the top reason listed as need for change in employment, seek new opportunities, or their public health education (83.9%; n=26). The top three reasons why resurvey respondents keep working at LCPH were; 1.) the ability to apply education and expertise, or desire and passion to help others (n=20; 40.8%); 2.) being respected, valued, coworkers, and the environment at LCPH (n=18; 36.7%), and 3.) support from supervisor, upper management, and strong leadership (n=6; 12.2%).

Almost eleven percent (n=4) of survey respondents said their highest education level was an Associate's degree or lower level of educational attainment. Substantial proportion (n=22; 59.5%) of LCPH employees who answered the survey listed Bachelor's degree as their highest level of educational attainment, and about one-third of respondents (n=11; 29.7%) had either Master's or PhD as their highest level of educational attainment. Out of the LCPH employees who answered this survey and who were hired within the last four years, 45.0% (n=9) had either Master's or PhD degree.

When asked about the field of study in which the respondents completed their highest level of education, the top four most frequent responses were Biological Sciences (n=7; 20.0%), followed by Public Health (n=6; 17.1%), Dietetics or

Nursing (n=5; 14.3%), or Business (n=4; 11.4%). Respondents were also asked about other or additional areas of education completed with the top four most frequent answers listed as; 1.) Social Science (n=7; 24.1%); 2.) Public Health (6; 20.7%); 3.) Environmental Sciences (n=4; 13.8%); and 4.) Dietetics or Nursing (n=4; 13.8%). Out of all the respondents, 46.0% (n=17) had additional credentials with most frequently listed as registered sanitarians (n=8; 47.1%).

Over half of the survey respondents (n=21; 56.0%) said they were interested in pursuing additional education and few employees (n=3) said they were currently enrolled in educational program. Among those who were interested in obtaining more education, 55.0% (n=11) expressed the desired to get certified, 40.0% (n=8) wanted to pursue either Master's or PhD level education, and one person was interested in earning a Bachelor's degree. Of those employees who said they were planning on retirement, or leaving LCPH to work elsewhere, or were not sure, within the next 5 years, 60.0% (n=12) said they were interested in pursuing additional education.

II. Training and Needs Assessment

Section II of the survey asked LCPH employees to assess their level of knowledge or skill for each competency statement listed within each of the eight Domains:

1. Data Analytics and Assessment Skills
2. Policy Development and Program Planning Skills
3. Communication Skills
4. Health Equity Skills
5. Community Partnership Skills
6. Public Health Sciences Skills
7. Management and Finance Skills
8. Leadership and Systems Thinking Skills

Table 1 shows the rating scale and proficiency level employees referred to, to help them select the scale that best describes their perceived level of expertise competency statement.

Table 1: Competency Statement Rating Scale

Rating Scale	Proficiency Level
1 = None	I am unaware or have very little knowledge of the skill
2 = Aware	I have heard of, but have limited knowledge or ability to apply the skill
3 = Knowledgeable	I am comfortable with my knowledge or ability to apply the skill
4 = Proficient	I am very comfortable, am an expert, or could teach this skill to others

Domains 1-8: Overview

To obtain sufficient sample size for detailed analysis, survey respondent's rating scale answers were aggregated into two categories None/Aware and Knowledgeable/Proficient. Proportions for those two categories were calculated across all competency statements within each Domain. For example, in Domain 1, respondents scored either None or Aware for all of the eight competency statements. In addition, an overall average score was calculated for each Domain based on employee rating scale, the total score for each Domain, and the number of survey respondents for specific Domain.

Out of the eight Domains, the top two were Domains *6. Public Health Sciences Skills* and *8. Leadership and Systems Thinking Skills* with the highest number of employees who rated themselves across all competency statements within those Domains as being unaware or having very little knowledge of this skill (1=None); or heard of, but had limited knowledge or ability to apply this skill (2=Aware) [Table 2].

Domains *3. Communication Skills* and *7. Management and Finance Skills* were the top two Domains with the highest number of employees across all competency statements within those Domains stating they were either comfortable with their knowledge or ability to apply the skill (3=Knowledgeable); or were very comfortable, an expert, or could teach this skills to others (4=Proficient) [Table 2].

The top three Domains with the two lowest average scores were *1. Data Analytics and Assessment Skills, 6. Public Health Sciences Skills, and 8. Leadership and Systems Thinking Skills* [Table 2].

The top two Domains with the two highest average scores were *3.* Communication Skills and *5. Community Partnership Skills* [Table 2].

Table 2. Domains 1-8. Overall Scores

Domains	None/Aware	Knowledgeable/ Proficient	Domain average score (max score =4)	Employees scored *above* average	Employees scored *below* average
1. Data Analytics and Assessment Skills	3 (8.1%)	34 (91.9%)	2.6	15 (40.5%)	22 (59.5%)
2. Policy Development and Program Planning Skills	1 (2.7%)	36 (97.3%)	2.7	18 (48.6%)	19 (52.8%)
3. Communication Skills	0	37 (100%)	2.9	19 (21.4%)	18 (48.6%)
4. Health Equity Skills	2 (5.4%)	35 (94.6%)	2.7	19 (51.4%)	18 (48.6%)
5. Community Partnership Skills	2 (5.4%)	35 (94.6%)	2.8	21 (56.8%)	16 (43.2%)
6. Public Health Sciences Skills	4 (10.8%)	33 (89.2%)	2.6	19 (51.4%)	18 (48.6%)
7. Management and Finance Skills	0	37 (100%)	2.7	18 (48.6%)	19 (51.4%)
8. Leadership and Systems Thinking Skills	7 (18.9%)	30 (81.1%)	2.5	21 (56.8%)	16 (43.2%)

Domain 1: Data Analytics and Assessment Skills

Based on the eight competency statements in *Domain 1 Data Analytics and Assessment Skills,* four competencies had at least 50% of survey respondents stating they were unaware or had very little knowledge of this skill (1=None); or heard of, but had limited knowledge or ability to apply this skill (2=Aware) [Table 3].

Table 3. Domain 1: Data Analytics and Assessment Skills

To what degree are you able to effectively…		
Competency	**1=None/ 2 = Aware**	**3=Knowledgeable/ 4= Proficient**
1. Describe factors that affect the health of a community (e.g., income, education, laws, environment, climate change, resilience, homelessness, food security, access to healthcare, racial equity, distribution of resources and power, social and community engagement, changing demographics)	8 (21.6%)	29 (78.4%)
2. Access existing quantitative and qualitative data (e.g., community input, big data, vital statistics, electronic health records, transportation patterns, employment statistics, environmental monitoring, health equity impact assessments, revenue and expenditures)	21 (56.8%)	16 (43.2%)
3. Collect quantitative and qualitative data	13 (36.1%)	23 (63.9%)

4. Analyze quantitative and qualitative data	15 (40.5%)	22 (59.5%)
5. Manage quantitative and qualitative data	21 (56.8%)	16 (43.2%)
6. Use quantitative and qualitative data	13 (35.1%)	24 (64.9%)
7. Apply public health informatics in using data, information, and knowledge	25 (67.6%)	12 (32.4%)
8. Assess community health status	25 (67.6%)	12 (32.4%)

Domain 2: Policy Development and Program Planning Skills

Two out of the seven competency statements in *Domain 2. Policy Development and Program Planning Skills* had at least 50% of survey respondents stating they were unaware or had very little knowledge of this skill (1=None); or heard of, but had limited knowledge or ability to apply this skill (2=Aware) [Table 4].

Table 4. Domain 2: Policy Development and Program Planning Skills

To what degree are you able to effectively…		
Competency	**1=None/ 2 = Aware**	**3=Knowledgeable/ 4= Proficient**
1. Develop policies, programs, and services	13 (35.1%)	24 (64.9%)
2. Implement policies, programs, and services (e.g., within the organization, external to the organization, in collaboration with others)	10 (27.8%)	26 (72.3%)
3. Evaluate policies, programs, services, and organizational performance (e.g., outputs, outcomes, processes, procedures, return on investment)	13 (36.1%)	23 (63.9%)
4. Improve policies, programs, services, and organizational performance	10 (27.0%)	27 (73.0%)
5. Influence policies, programs, and services external to the organization (e.g., zoning, transportation, housing, education)	20 (54.0%)	17 (45.9%)
6. Engage in organizational strategic planning	15 (40.5%)	22 (59.4%)
7. Engage in community health improvement planning	19 (51.3%)	18 (48.6%)

Domain 3: Communication Skills

All four of the competency statements in *Domain 3. Communication Skills* had at least 50% of survey respondents stating they were either comfortable with their knowledge or ability to apply the skill (3=Knowledgeable), or were very comfortable, an expert, or could teach this skills to others (4=Proficient) [Table 5].

Table 5. Domain 3: Communication Skills

To what degree are you able to effectively…		
Competency	**1=None/ 2 = Aware**	**3=Knowledgeable/ 4= Proficient**
1. Determine communication strategies	11 29.7%()	26 (70.3%)
2. Communicate with internal and external audiences (e.g., staff, elected officials, students, volunteers, community-based organizations, healthcare professionals, the public)	5 (13.5%)	32 (86.5%)
3. Respond to information, misinformation, and disinformation (e.g., through social media, town hall meetings, commentaries, letters to the editor)	13 (35.1%)	24 (64.9%)
4. Facilitate communication among individuals, groups, and organizations	8 (21.6%)	29 (78.4%)

Domain 4: Health Equity Skills

One out of the seven competency statements in *Domain 4. Health Equity Skills* had at least 50% of survey respondents stating they were unaware or had very little knowledge of this skill (1=None); or heard of, but had limited knowledge or ability to apply this skill (2=Aware) [Table 6].

Table 6. Domain 4: Health Equity Skills

To what degree are you able to effectively…		
Competency	**1=None/ 2 = Aware**	**3=Knowledgeable/ 4= Proficient**
1. Apply principles of ethics, diversity, equity, inclusion, and justice (e.g., Public Health Code of Ethics, Health Insurance Portability and Accountability Act)	13 (35.1%)	24 (64.9%)
2. Engage in continuous self-reflection about one's biases (e.g., perceptions, assumptions, stereotypes)	9 (24.3%)	28 (75.7%)
3. Recognize the diversity of individuals and populations	7 (18.9%)	30 (81.1%)
4. Reduce systemic and structural barriers that perpetuate health inequities (e.g., racism, sexism, bigotry, poverty, gender discrimination)	17 (45.9%)	20 (54.1%)
5. Implement organizational policies, programs, and services to achieve health equity and social and environmental justice	22 (59.5%)	15 (40.5%)
6. Contribute to achieving and sustaining a diverse, inclusive, and competent public health workforce	12 (32.4%)	25 (67.6%)
7. Advocate for health equity and social and environmental justice (e.g., for reforming systems contributing to racism, advancing fair housing practices, changing labor laws and policies, protecting communities from environmental hazards)	14 (38.9%)	22 (61.1%)

Domain 5: Community Partnership Skills

All of the five competency statements in *Domain 5. Community Partnership Skills* had at least 50% of survey respondents stating they were either comfortable with their knowledge or ability to apply the skill (3=Knowledgeable), or were very comfortable, an expert, or could teach this skills to others (4=Proficient) [Table 7].

Table 7. Domain 5: Community Partnership Skills

To what degree are you able to effectively…		
Competency	**1=None/ 2 = Aware**	**3=Knowledgeable/ 4= Proficient**
1. Describe conditions, systems, and policies affecting community health and resilience (e.g., social and institutional inequities, determinants of health, structural racism, historical trauma, gender discrimination, power dynamics, natural disasters, poverty, housing, trust, local politics, competition, redlining)	13 (35.1%)	24 (64.9%)
2. Establish relationships to improve community health and resilience (e.g., partnerships with organizations serving the same population, health departments, healthcare institutions, academic institutions, politicians and other policymakers, environmental agencies and organizations, emergency response organizations, businesses, financial institutions, housing authorities, public transit, customers/clients)	15 (40.5%)	22 (59.4%)
3. Maintain relationships that improve community health and resilience	11 (29.7%)	26 (70.3%)
4. Collaborate with community members and organizations	8 (21.6%)	29 (78.4%)
5. Share power and ownership with community members and others	13 (35.1%)	24 (64.9%)

Domain 6: Public Health Sciences Skills

Two out of the four competency statements in *Domain 6. Health Equity Skills* had at least 50% of survey respondents stating they were unaware or had very little knowledge of this skill (1=None); or heard of, but had limited knowledge or ability to apply this skill (2=Aware) [Table 8].

Table 8. Domain 6: Public Health Sciences Skills

To what degree are you able to effectively…		
Competency	**1=None/ 2 = Aware**	**3=Knowledgeable/ 4= Proficient**
1. Describe systems, policies, and events impacting public health (e.g., slavery, colonialism, John Snow and the London cholera outbreak, smallpox eradication, development of vaccines, Tuskegee Syphilis Study, fluoridation of drinking water, Jim Crow laws, establishment of Medicare and Medicaid, Americans with Disabilities Act, seatbelt legislation, banning tobacco in public buildings, death penalty, gun violence, globalization, deforestation, climate change, COVID-19 pandemic)	20 (54.0%)	17 (45.9%)
2. Apply public health sciences (e.g., biostatistics, epidemiology, environmental health, health services administration, social and behavioral sciences, and public health informatics) in delivering the 10 Essential Public Health Services	19 (51.3%)	18 (48.6%)
3. Use evidence in developing, implementing, evaluating, and improving policies, programs, and services	14 (37.8%)	23 (62.2%)
4. Contribute to the evidence base for improving health	15 (40.5%)	22 (59.5%)

Domain 7: Management and Finance Skills

Almost half (n=6) of the thirteen competency statements in *Domain 7. Management and Finance Skills* had at least 50% of survey respondents stating they were unaware or had very little knowledge of this skill (1=None); or heard of, but had limited knowledge or ability to apply this skill (2=Aware) [Table 9].

Table 9. Domain 7: Management and Finance Skills

To what degree are you able to effectively…		
Competency	**1=None/ 2 = Aware**	**3=Knowledgeable/ 4= Proficient**
1. Describe factors that affect the health of an organization (e.g., equitable and fair treatment of employees, support from the governing body and community, sustainability of funding, training of managers)	20 (54.1%)	17 (45.9%)
2. Secure human resources (e.g., staff, interns, consultants, volunteers)	20 (54.1%)	17 (45.9%)
3. Manage human resources	17 (45.9%)	20 (54.0%)
4. Engage in professional development (e.g., training, mentoring, peer advising, coaching, drills, exercises)	8 (21.6%)	29 (78.4%)
5. Secure financial resources	24 (64.8%)	13 (35.1%)
6. Manage financial resources	21 (56.7%)	6 (43.2%)
7. Implement organizational policies, programs, and services to achieve diversity, equity, inclusion, and justice	19 (51.4%)	18 (48.7%)

8. Manage programs and services	10 (27.0%)	27 (73.0%)
9. Engage in contingency planning (e.g., for emergencies, succession, cross-training staff, continuity of operations, economic downturns)	19 (51.4%)	18 (48.7%)
10. Apply critical thinking in decision making	4 (10.8%)	33 (89.2%)
11. Engage individuals and teams to achieve program and organizational goals	7 (18.9%)	30 (81.1%)
12. Facilitate collaboration among individuals, groups, and organizations	6 (16.2%)	31 (83.8%)
13. Engage in performance management	12 (32.4%)	25 (67.6%)

Domain 8: Leadership and Systems Thinking Skills

Half of the eight competency statements in *Domain 8. Leadership and Systems Thinking Skills* had at least 50% of survey respondents stating they were unaware or had very little knowledge of this skill (1=None); or heard of, but had limited knowledge or ability to apply this skill (2=Aware) [Table 10].

Table 10. Domain 8: Leadership and Systems Thinking Skills

To what degree are you able to effectively…		
Competency	**1=None/ 2 = Aware**	**3=Knowledgeable/ 4= Proficient**
1. Create opportunities to achieve cross-sector alignment (e.g., community coalitions, academic health department partnerships)	17 (45.9%)	20 (54.0%)
2. Implement a vision for a healthy community	22 (59.4%)	15 (40.5%)
3. Address facilitators and barriers impacting delivery of the 10 Essential Public Health Services	22 (59.4%)	15 (40.5%)
4. Create opportunities for creativity and innovation	19 (52.8%)	17 (47.2%)
5. Respond to emerging needs	14 (37.8%)	23 (62.2%)
6. Manage organizational change	16 (43.2%)	21 (56.8%)
7. Engage politicians, policymakers, and the public to support public health infrastructure (e.g., funding, workforce, legal authority, facilities, data systems)	25 (67.6%)	12 (32.4%)
8. Advocate for public health	12 (32.4%)	25 (67.6%)

III. The Foundational Public Health Services Framework

In section III, LCPH employees were asked to rate their level of knowledge or skill for each competency statement listed within each of the 5 Foundational Areas:

1. Communicable Disease Control
2. Chronic Disease and Injury Prevention
3. Environmental Public Health
4. Maternal and Child Health
5. Access to and Linkage with Care

Table 11 reflects the rating scale and proficiency level employees referred to, to help them select the scale that best describes their perceived level of expertise competency statement.

Table 11. Competency Statement Rating Scale

Rating Scale	Proficiency Level
1 = None	I am unaware or have very little knowledge of the skill
2 = Aware	I have heard of, but have limited knowledge or ability to apply the skill
3 = Knowledgeable	I am comfortable with my knowledge or ability to apply the skill
4 = Proficient	I am very comfortable, am an expert, or could teach this skill to others
No rating - leave blank	Not applicable

Foundational Areas 1-5: Overview

To obtain sufficient sample size for detailed analysis, survey respondent's rating scale answers were aggregated into two categories None/Aware and Knowledgeable/Proficient. Proportions for those two categories were calculated across all competency statements within each Foundation Area. For example, in Foundational Area 1, respondents scored either None or Aware for all of the 5 competency statements. In addition, an overall average score was calculated for each Foundational Area based on employee rating scale, the total score for each Foundational Area, and the number of survey respondents for specific Foundational Area.

Top two out of the five Foundational Areas; *3. Environmental Public Health* and *4. Maternal and Child Health* had the highest number of employees who rated themselves across all competency statements within those Foundational Areas as being unaware or had very little knowledge of this skill (1=None); or heard of, but had limited knowledge or ability to apply this skill (2=Aware) [Table 12].

The top two Foundational Areas *1. Communicable Disease Control* and *2. Chronic Disease and Injury Prevention* had the highest number of employees across all competency statements within those Foundational Areas stating they were either comfortable with their knowledge or ability to apply the skill (3=Knowledgeable), or were very comfortable, an expert, or could teach this skills to others (4=Proficient) [Table 12].

The top three Foundational Areas with the two lowest average scores were *3. Environmental Public Health,* 4*. Maternal and Child Health and 5. Access to and Linkage with Care* [Table 12].

Table 12. Foundational Area 1-5. Overall Scores

Foundational Areas	None/Aware	Knowledgeable/ Proficient	Foundational area average score (max score =4)	Employees scored *above* average	Employees scored *below* average
1. Communicable Disease Control	7 (22.6%)	24 (77.4%)	2.3	17 (54.8%)	14 (45.2%)
2. Chronic Disease and Injury Prevention	10 (32.3%)	21 (67.7%)	2.1	16 (51.6%)	15 (48.4%)
3. Environmental Public Health	14 (45.2%)	17 (54.8%)	2.0	19 (61.3%)	12 (38.7%)
4. Maternal and Child Health	15 (51.7%)	14 (48.3%)	2.0	17 (58.6%)	12 (41.4%)
5. Access to and Linkage with Care	11 (36.7%)	19 (63.3%)	1.8	20 (66.7%)	10 (33.3%)

Foundational Area 1: Communicable Disease Control

Five out of the seven competency statements in *Foundation Area 1. Communicable Disease Control* had at least 50% of survey respondents stating they were unaware or had very little knowledge of this skill (1=None); or heard of, but had limited knowledge or ability to apply this skill (2=Aware) [Table 13].

Table 13. Foundational Area 1: Communicable Disease Control

To what degree are you able to effectively…		
Competency	**1=None/ 2 = Aware**	**3=Knowledgeable/ 4= Proficient**
1. Provide timely, statewide, and locally relevant and accurate information to the health care system and community on communicable diseases and their control.	13 (43.3%)	17 (56.7%)
2. Identify statewide and local communicable disease control community partners and their capacities, develop, and implement a prioritized communicable disease control plan, and ability to seek and secure funding for high priority initiatives.	16 (57.1%)	12 (42.9%)
3. Receive laboratory reports and other relevant data; conduct disease investigations, including contact tracing and notification; and recognize, identify, and respond to communicable disease outbreaks for notifiable conditions in accordance with local, national, and state mandates and guidelines.	13 (44.8%)	16 (55.2%)
4. Assure the availability of partner notification services for newly diagnosed cases of communicable diseases according to CDC guidelines.	17 (58.6%)	12 (41.4%)
5. Assure the appropriate treatment of individuals who have reportable communicable diseases, such as TB, STIs, and HIV in accordance with local and state laws and CDC guidelines.	19 (67.9%)	9 (32.1%)
6. Support the recognition of outbreaks and other events of public health significance by assuring capacity for the identification and characterization of the causative agents of disease and their origin, including those that are rare and unusual.	15 (50.0%)	15 (50.0%)
7. Coordinate and integrate categorically-funded communicable disease programs and services.	20 (68.9%)	9 (31.0%)

Foundational Area 2: Chronic Disease and Injury Prevention

All five of the competency statements in *Foundation Area 2. Chronic Disease and Injury Prevention* had at least 50% of survey respondents stating they were unaware or had very little knowledge of this skill (1=None); or heard of, but had limited knowledge or ability to apply this skill (2=Aware) [Table 14].

Table 14. Foundational Area 2: Chronic Disease and Injury Prevention

To what degree are you able to effectively…		
Competency	**1=None/ 2 = Aware**	**3=Knowledgeable/ 4= Proficient**
1. Provide timely, statewide, and locally relevant, complete, and accurate information to the health care system and community on chronic disease and injury prevention and control	17 (54.8%)	14 (45.2%)

2. Identify statewide and local chronic disease and injury prevention community partners and their capacities, develop, and implement a prioritized prevention plan, and ability to seek and secure funding for high priority initiatives. Reduce statewide and community rates of tobacco use through a program that conforms to standards set by state or local laws and CDC's Office on Smoking and Health, including activities to reduce youth initiation, increase cessation, and reduce secondhand exposure to harmful substances.	21 (70.0%)	9 (30.0%)
3. Reduce statewide and community rates of tobacco use through a program that conforms to standards set by state or local laws and CDC's Office on Smoking and Health, including activities to reduce youth initiation, increase cessation, and reduce secondhand exposure to harmful substances.	23 (82.1%)	5 (17.9%)
4. Work actively with statewide and community partners to increase statewide and community rates of healthy eating and active living through a prioritized approach focusing on best and promising practices aligned with national, state, and local guidelines for healthy eating and active living.	19 (63.3%)	11 (36.7%)
5. Coordinate and integrate categorically-funded chronic disease and injury prevention programs and services.	18 (60.0%)	12 (40.0%)

Foundational Area 3: Environmental Public Health

All six of the competency statements in *Foundation Area 3. Environmental Public Health* had at least 50% of survey respondents stating they were unaware or had very little knowledge of this skill (1=None); or heard of, but had limited knowledge or ability to apply this skill (2=Aware) [Table 15].

Table 15. Foundational Area 3: Environmental Public Health

To what degree are you able to effectively…		
Competency	**1=None/ 2 = Aware**	**3=Knowledgeable/ 4= Proficient**
1. Provide timely, statewide, and locally relevant, complete, and accurate information to the state, health care system, and community on environmental public health threats and health impacts from common environmental or toxic exposures.	18 (58.1%)	13 (41.9%)
2. Identify statewide and local community environmental public health partners and their capacities, develop, and implement a prioritized plan, and ability to seek and secure action funding for high priority initiatives.	19 (63.3%)	11 (36.7%)
3. Conduct mandated environmental public health laboratory testing, inspections, and oversight to protect food, recreation sites, and drinking water; manage liquid and solid waste streams safely; and identify other public health hazards related to environmental factors in accordance with federal, state, and local laws and regulations.	16 (57.1%)	12 (42.9%)
4. Protect workers and the public from chemical and radiation hazards in accordance with federal, state, and local laws and regulations.	20 (66.7%)	10 (33.3%)
5. Participate in broad land use planning and sustainable development to encourage decisions that promote positive public health outcomes and resilient communities (e.g., housing and urban development, recreational facilities, transportation systems and climate change).	22 (73.3%)	8 (26.7%)
6. Coordinate and integrate categorically-funded environmental public health programs and services.	18 (62.1%)	11 (38.0%)

Foundational Area 4: Maternal and Child Health

All five of the competency statements in *Foundation Area 4. Maternal and Child Health* had at least 50% of survey respondents stating they were unaware or had very little knowledge of this skill (1=None); or heard of, but had limited knowledge or ability to apply this skill (2=Aware) [Table 16].

Table 16. Foundational Area 4: Maternal and Child Health

To what degree are you able to effectively…		
Competency	**1=None/ 2 = Aware**	**3=Knowledgeable/ 4= Proficient**
1. Provide timely, statewide, and locally relevant, complete, and accurate information to the health care system and community on emerging and on-going maternal child health trends.	17 (60.7%)	11 (39.3%)
2. Identify local maternal and child health community partners and their capacities; using life course expertise and an understanding of health disparities, develop a prioritized prevention plan; and ability to seek and secure funding for high priority initiatives.	18 (64.3%)	10 (35.7%)
3. Identify, disseminate, and promote emerging and evidence-based early interventions in the prenatal and early childhood period that promote lifelong health and positive social emotional development.	18 (66.7%)	9 (33.3%)
4. Assure newborn screening as mandated by a state or local governing body including wraparound services, reporting back, following up, and service engagement activities.	18 (69.2%)	8 (30.8%)
5. Coordinate and integrate categorically funded maternal, child, and family health programs and services.	17 (65.4%)	9 (34.6%)

Foundational Area 5: Access to and Linkage with Care

Two out of the three competency statements in *Foundation Area 5. Access to and Linkage with Care* had at least 50% of survey respondents stating they were unaware or had very little knowledge of this skill (1=None); or heard of, but had limited knowledge or ability to apply this skill (2=Aware) [Table 17].

Table 17. Foundational Area 5: Access to and Linkage with Care

To what degree are you able to effectively…		
Competency	**1=None/ 2 = Aware**	**3=Knowledgeable/ 4= Proficient**
1. Provide timely, statewide, and locally relevant, complete, and accurate information to the health care system and community on access and linkage to clinical care (including behavioral health), healthcare system access, quality, and cost.	14 (46.7%)	16 (53.3%)
2. Inspect and license healthcare facilities, and license, monitor, and discipline healthcare providers, where applicable.	19 (82.6%)	4 (17.4%)
3. In concert with national and statewide groups and local providers of healthcare, identify healthcare partners and competencies, develop prioritized plans for increasing access to health homes and quality health care, and seek funding for high priority policy initiatives.	23 (82.1%)	5 (17.9%)

IV. Addressing Public Health Issues

In section four of the survey, employees were given definitions for each of the five concepts and were asked about the knowledge and confidence in day-to-day work and current skill level for each concept.

Social Determinants of Equity and *Environmental Justice* were the top two concepts with higher proportion of survey respondents saying they have heard either *Not at All* or *Not Much* of these concepts in public health [Table 18].

Structural Racism and *Environmental Justice* were the top two concepts with higher proportion of survey respondents saying they were either *Not at All* or *Not Much* confident when addressing these concepts in their work [Table 18].

Table 18. Addressing Public Health Issues

Concepts	How much, if anything, have you ***heard*** of the following concepts in public health		How ***confident are you in addressing*** the follow public health concepts in your work	
	Not at All/ Not Much	A little/A Lot	Not at All/ Not Much	A little/A Lot
1. Health Equity	1 (2.7%)	36 (97.3%)	7 (18.9%)	30 (81.1%)
2. Social Determinants of Equity	4 (10.8%)	33 (89.2%)	9 (24.3%)	28 (75.6%)
3. Social Determinants of Health	2 (5.4%)	35 (94.6%)	6 (16.2%)	31 (83.8%)
4. Structural Racism	2 (5.4%)	35 (94.6%)	12 (32.4%)	25 (67.6%)
5. Environmental Justice	3 (8.1%)	34 (91.9%)	15 (39.5%)	22 (59.5%)

References

1. Core competencies for Public Health Professionals. The Council on Linkages Between Academia and Public Health Practice. Accessed: http://www.phf.org/resourcestools/pages/core_public_health_competencies.aspx
2. Building Skills for a More Strategic Public Health Workforce: A Call to Action from the National Consortium for Public Health Workforce Development. Accessed: https://debeaumont.org/wp-content/uploads/2019/04/Building-Skills-for-a-More-Strategic-Public-Health-Workforce.pdf
3. The 2022 Lewis and Clark Public Health Widerstand Anti-Racism Audit Report, and recommendations from LCPH senior leadership. Lewis and Clark Public Health, Montana 2022.

Appendix A: Survey Instrument

Workforce Assessment Survey

Lewis and Clark Public Health

Its purpose is to identify the strengths of our staff, as well as areas in which we might benefit from training. You may remember taking a similar survey in 2017. The survey asks about some demographics and skills and knowledge required to effectively provide public health services.

The questions are based on core competencies identified by the Council on Linkages Between Academia and Public Health Practice, Building Skills for a More Strategic Public Health Workforce: A Call to Action from the National Consortium for Public Health Workforce Development and deBeaumont Foundation specific public health professional organizations, the 2022 Lewis and Clark Public Health Widerstand Anti-Racism Audit Report, and recommendations from LCPH senior leadership. Modifications have been made for clarity and brevity.

Some questions in this survey are based on questions from the Public Health Workforce Interests and Needs Survey (PH WINS). PH WINS was developed by the de Beaumont Foundation and the Association of State and Territorial Health Officials to understand the interests and needs of the state and local governmental public health workforce in the United States, and was fielded in 2014, 2017, and 2021. For more information, visit phwins.org

The information from this survey will be used to revise and update the Workforce Development Plan and guide professional development, training, recruitment, retention, and workplace culture improvements, goals, and activities for the 2022-2025 period. Your involvement is crucial to the development of a valid and useful plan.

LCPH will be sending out an employee satisfaction/workplace culture survey in the coming months. **Our goal is 100% participation in the survey. It will take approximately 45 minutes to complete and is due on Friday, October 14, 2022.**

Your responses are confidential and the data will be summarized in report that will inform the workforce development training plan for LCPH.

Section I: Workforce Characteristics and Demographics

This section will ask you to provide some demographic information, which will give us an idea of the diversity of our staff and of future staff. Questions noted with * require an answer.

1. To which gender do you most identify? *

- Female
- Male
- Transgender Female
- Transgender Male
- Gender Variant/Non-Conforming
- Prefer Not to Answer

2. Which of the following race categories best describes you? *

- Asian or Pacific Islander
- Black or African American
- Native American or Alaskan Native
- White or Caucasian
- Multiracial or Biracial
- Prefer Not to Answer

3. Which of the following ethnicity categories best describes you? *

Hispanic or Latino
Not Hispanic or Latino
Prefer Not to Answer

4. Do you identify as a person with a disability or are you a person with accessibility needs? *

Yes
No
Prefer Not to Answer

5. Do you identify as being part of the LGBTQ+ community? *

Yes
No
Prefer Not to Answer

6. What age group are you in? *

Under 20 years
20-29 years
30-39 years
40-49 years
50-59 years
60 years or older
Prefer Not to Answer

7. What is the highest level of education you have completed? *

High School graduate
Associate's degree
Bachelor's degree
Master's degree
Doctoral degree
Not Applicable

8. For your highest level of education completed, what is your field of study? *

Biological Sciences
Communication
Dietetics
Environmental Sciences
Epidemiology
General Studies
Nursing
Public Health
Social Sciences
Not Applicable

9. Please select other/additional areas of education you have completed? *

Biological Sciences
Communication
Dietetics
Environmental Sciences
Epidemiology
General Studies

Nursing
Public Health
Social Sciences
Not Applicable

10. Please identify any additional credentials you have attained? Check all that apply. *

Breastfeeding/Lactation Certification (CLC, CLE, or IBCLC)
Certification in Public Health
Certified Health Education Specialist (CHES or Master CHES)
Emergency Management
Laboratory Certification
Licenses Clinical Social Worker(LCSW)
Registered Dietitian (RD)
Registered Sanitarian
Not Formally Certified
Not Applicable

11. Are you interested in pursuing additional education? *

Yes
No
I am currently enrolled in an educational program

12. If Yes, what level? *

Certification
Associates
Bachelors
Masters
PhD

13. Which division of the Health Department do you work in? *

Administration
Community Health Promotion
Disease Control and Prevention
Environmental Health

14. What is your employment status? *

Permanent
Temporary
Contract

15. How many years have you worked for LCPH? *

Less than 1 year
1-2 years
3-4 years
5-10 years
11-20 years
More than 20 years

16. How many years have you worked in the field of public health? *

Less than 1 year

1-2 years
3-4 years
5-10 years
11-20 years
More than 20 years

17. In how many years do you plan to retire or seek employment outside of the Health Department? *
0-5 years
6-10 years
More than 10 years
Not sure

18. What brought you to field of public health?

19. What brought you to work at LCPH?

20. What keeps you working at LCPH?

Section II. Training and Needs Assessment

This section, will ask about crosscutting knowledge and skills for the broad practice of public health, as defined by the 10 Essential Public Health Services. These questions are organized into 8 skill areas, or domains, that cut across public health disciplines. The purpose of this assessment is to help you explore your level of competence within these 8 domains.

Domain 1: Data Analytics and Assessment Skills

Note: The competency statements listed in each domain should be interpreted as broadly as possible to apply to your position.

Rate yourself to what degree are you able to effectively…

1 = None I am unaware or have very little knowledge of the skill
2 = Aware I have heard of, but have limited knowledge or ability to apply the skill
3 = Knowledgeable I am comfortable with my knowledge or ability to apply the skill
4 = Proficient I am very comfortable, am an expert, or could teach this skill to others

1. Describe factors that affect the health of a community (e.g., income, education, laws, environment, climate change, resilience, homelessness, food security, access to healthcare, racial equity, distribution of resources and power, social and community engagement, changing demographics)

2. Access existing quantitative and qualitative data (e.g., community input, big data, vital statistics, electronic health records, transportation patterns, employment statistics, environmental monitoring, health equity impact assessments, revenue and expenditures)

3. Collect quantitative and qualitative data

4. Analyze quantitative and qualitative data

5. Manage quantitative and qualitative data

6. Use quantitative and qualitative data

7. Apply public health informatics in using data, information, and knowledge

8. Assess community health status

Domain 2: Policy Development and Program Planning Skills

Note: The competency statements listed in each domain should be interpreted as broadly as possible to apply to your position.

Rate yourself to what degree are you able to effectively…

1 = None I am unaware or have very little knowledge of the skill
2 = Aware I have heard of, but have limited knowledge or ability to apply the skill
3 = Knowledgeable I am comfortable with my knowledge or ability to apply the skill
4 = Proficient I am very comfortable, am an expert, or could teach this skill to others

1. Develop policies, programs, and services

2. Implement policies, programs, and services (e.g., within the organization, external to the organization, in collaboration with others)

3. Evaluate policies, programs, services, and organizational performance (e.g., outputs, outcomes, processes, procedures, return on investment)

4. Improve policies, programs, services, and organizational performance

5. Influence policies, programs, and services external to the organization (e.g., zoning, transportation, housing, education)

6. Engage in organizational strategic planning

7. Engage in community health improvement planning

Domain 3: Communication Skills

Note: The competency statements listed in each domain should be interpreted as broadly as possible to apply to your position.

Rate yourself to what degree are you able to effectively…

1 = None I am unaware or have very little knowledge of the skill
2 = Aware I have heard of, but have limited knowledge or ability to apply the skill
3 = Knowledgeable I am comfortable with my knowledge or ability to apply the skill
4 = Proficient I am very comfortable, am an expert, or could teach this skill to others

1. Determine communication strategies

2. Communicate with internal and external audiences (e.g., staff, elected officials, students, volunteers, community-based organizations, healthcare professionals, the public)

3. Respond to information, misinformation, and disinformation (e.g., through social media, town hall meetings, commentaries, letters to the editor)

4. Facilitate communication among individuals, groups, and organizations

Domain 4: Health Equity Skills

Note: The competency statements listed in each domain should be interpreted as broadly as possible to apply to your position.

Rate yourself to what degree are you able to effectively…

1 = None I am unaware or have very little knowledge of the skill
2 = Aware I have heard of, but have limited knowledge or ability to apply the skill

3 = Knowledgeable I am comfortable with my knowledge or ability to apply the skill
4 = Proficient I am very comfortable, am an expert, or could teach this skill to others

1. Apply principles of ethics, diversity, equity, inclusion, and justice (e.g., Public Health Code of Ethics, Health Insurance Portability and Accountability Act)

2. Engage in continuous self-reflection about one's biases (e.g., perceptions, assumptions, stereotypes)

3. Recognize the diversity of individuals and populations

4. Reduce systemic and structural barriers that perpetuate health inequities (e.g., racism, sexism, bigotry, poverty, gender discrimination)

5. Implement organizational policies, programs, and services to achieve health equity and social and environmental justice

6. Contribute to achieving and sustaining a diverse, inclusive, and competent public health workforce

7. Advocate for health equity and social and environmental justice (e.g., for reforming systems contributing to racism, advancing fair housing practices, changing labor laws and policies, protecting communities from environmental hazards)

Domain 5: Community Partnership Skills

Note: The competency statements listed in each domain should be interpreted as broadly as possible to apply to your position.

Rate yourself to what degree are you able to effectively…

1 = None I am unaware or have very little knowledge of the skill
2 = Aware I have heard of, but have limited knowledge or ability to apply the skill
3 = Knowledgeable I am comfortable with my knowledge or ability to apply the skill
4 = Proficient I am very comfortable, am an expert, or could teach this skill to others

1. Describe conditions, systems, and policies affecting community health and resilience (e.g., social and institutional inequities, determinants of health, structural racism, historical trauma, gender discrimination, power dynamics, natural disasters, poverty, housing, trust, local politics, competition, redlining)

2. Establish relationships to improve community health and resilience (e.g., partnerships with organizations serving the same population, health departments, healthcare institutions, academic institutions, politicians and other policymakers, environmental agencies and organizations, emergency response organizations, businesses, financial institutions, housing authorities, public transit, customers/clients)

3. Maintain relationships that improve community health and resilience

4. Collaborate with community members and organizations

5. Share power and ownership with community members and others

Domain 6: Public Health Sciences Skills

Note: The competency statements listed in each domain should be interpreted as broadly as possible to apply to your position.

Rate yourself to what degree are you able to effectively…

1 = None I am unaware or have very little knowledge of the skill
2 = Aware I have heard of, but have limited knowledge or ability to apply the skill
3 = Knowledgeable I am comfortable with my knowledge or ability to apply the skill
4 = Proficient I am very comfortable, am an expert, or could teach this skill to others

1. Describe systems, policies, and events impacting public health (e.g., slavery, colonialism, John Snow and the London cholera outbreak, smallpox eradication, development of vaccines, Tuskegee Syphilis Study, fluoridation of drinking water, Jim Crow laws, establishment of Medicare and Medicaid, Americans with Disabilities Act, seatbelt legislation, banning tobacco in public buildings, death penalty, gun violence, globalization, deforestation, climate change, COVID-19 pandemic)

2. Apply public health sciences (e.g., biostatistics, epidemiology, environmental health, health services administration, social and behavioral sciences, and public health informatics) in delivering the 10 Essential Public Health Services

3. Use evidence in developing, implementing, evaluating, and improving policies, programs, and services

4. Contribute to the evidence base for improving health

Domain 7: Management and Finance Skills

Note: The competency statements listed in each domain should be interpreted as broadly as possible to apply to your position.

Rate yourself to what degree are you able to effectively…

1 = None I am unaware or have very little knowledge of the skill
2 = Aware I have heard of, but have limited knowledge or ability to apply the skill
3 = Knowledgeable I am comfortable with my knowledge or ability to apply the skill
4 = Proficient I am very comfortable, am an expert, or could teach this skill to others

1. Describe factors that affect the health of an organization (e.g., equitable and fair treatment of employees, support from the governing body and community, sustainability of funding, training of managers)

2. Secure human resources (e.g., staff, interns, consultants, volunteers)

3. Manage human resources

4. Engage in professional development (e.g., training, mentoring, peer advising, coaching, drills, exercises)

5. Secure financial resources

6. Manage financial resources

7. Implement organizational policies, programs, and services to achieve diversity, equity, inclusion, and justice

8. Manage programs and services

9. Engage in contingency planning (e.g., for emergencies, succession, cross-training staff, continuity of operations, economic downturns)

10. Apply critical thinking in decision making

11. Engage individuals and teams to achieve program and organizational goals

12. Facilitate collaboration among individuals, groups, and organizations

13. Engage in performance management

Domain 8: Leadership and Systems Thinking Skills

Note: The competency statements listed in each domain should be interpreted as broadly as possible to apply to your position.

Rate yourself to what degree are you able to effectively…

1 = None I am unaware or have very little knowledge of the skill
2 = Aware I have heard of, but have limited knowledge or ability to apply the skill
3 = Knowledgeable I am comfortable with my knowledge or ability to apply the skill
4 = Proficient I am very comfortable, am an expert, or could teach this skill to others

1. Create opportunities to achieve cross-sector alignment (e.g., community coalitions, academic health department partnerships)

2. Implement a vision for a healthy community

3. Address facilitators and barriers impacting delivery of the 10 Essential Public Health Services

4. Create opportunities for creativity and innovation

5. Respond to emerging needs

6. Manage organizational change

7. Engage politicians, policymakers, and the public to support public health infrastructure (e.g., funding, workforce, legal authority, facilities, data systems)

8. Advocate for public health

Section III. The Foundational Public Health Services Framework

Questions in this section are related to the unique responsibilities of governmental public health and defines a minimum set of 5 foundational areas that must be available in every community.

Foundational Area 1. Communicable Disease Control

Note: The competency statements listed in each foundational area should be interpreted as broadly as possible to apply to your position.

Rate yourself to what degree are you able to effectively…

1 = None I am unaware or have very little knowledge of the skill
2 = Aware I have heard of, but have limited knowledge or ability to apply the skill
3 = Knowledgeable I am comfortable with my knowledge or ability to apply the skill
4 = Proficient I am very comfortable, am an expert, or could teach this skill to others

1. Provide timely, statewide, and locally relevant and accurate information to the health care system and community on communicable diseases and their control.

2. Identify statewide and local communicable disease control community partners and their capacities, develop, and implement a prioritized communicable disease control plan, and ability to seek and secure funding for high priority initiatives.

3. Receive laboratory reports and other relevant data; conduct disease investigations, including contact tracing and notification; and recognize, identify, and respond to communicable disease outbreaks for notifiable conditions in accordance with local, national, and state mandates and guidelines.

4. Assure the availability of partner notification services for newly diagnosed cases of communicable diseases according to CDC guidelines.

5. Assure the appropriate treatment of individuals who have reportable communicable diseases, such as TB, STIs, and HIV in accordance with local and state laws and CDC guidelines.

6. Support the recognition of outbreaks and other events of public health significance by assuring capacity for the identification and characterization of the causative agents of disease and their origin, including those that are rare and unusual.

7. Coordinate and integrate categorically-funded communicable disease programs and services.

Foundational Area 2. Chronic Disease and Injury Prevention

Note: The competency statements listed in each foundational area should be interpreted as broadly as possible to apply to your position.

Rate yourself to what degree are you able to effectively…

1 = None I am unaware or have very little knowledge of the skill
2 = Aware I have heard of, but have limited knowledge or ability to apply the skill
3 = Knowledgeable I am comfortable with my knowledge or ability to apply the skill
4 = Proficient I am very comfortable, am an expert, or could teach this skill to others

1. Provide timely, statewide, and locally relevant, complete, and accurate information to the health care system and community on chronic disease and injury prevention and control.

2. Identify statewide and local chronic disease and injury prevention community partners and their capacities, develop, and implement a prioritized prevention plan, and ability to seek and secure funding for high priority initiatives. Reduce statewide and community rates of tobacco use through a program that conforms to standards set by state or local laws and CDC's Office on Smoking and Health, including activities to reduce youth initiation, increase cessation, and reduce secondhand exposure to harmful substances.

3. Reduce statewide and community rates of tobacco use through a program that conforms to standards set by state or local laws and CDC's Office on Smoking and Health, including activities to reduce youth initiation, increase cessation, and reduce secondhand exposure to harmful substances.

4. Work actively with statewide and community partners to increase statewide and community rates of healthy eating and active living through a prioritized approach focusing on best and promising practices aligned with national, state, and local guidelines for healthy eating and active living.

5. Coordinate and integrate categorically-funded chronic disease and injury prevention programs and services.

Foundational Area 3. Environmental Public Health

Note: The competency statements listed in each foundational area should be interpreted as broadly as possible to apply to your position.

Rate yourself to what degree are you able to effectively…

1 = None I am unaware or have very little knowledge of the skill
2 = Aware I have heard of, but have limited knowledge or ability to apply the skill
3 = Knowledgeable I am comfortable with my knowledge or ability to apply the skill
4 = Proficient I am very comfortable, am an expert, or could teach this skill to others

1. Provide timely, statewide, and locally relevant, complete, and accurate information to the state, health care system, and community on environmental public health threats and health impacts from common environmental or toxic exposures.

2. Identify statewide and local community environmental public health partners and their capacities, develop, and implement a prioritized plan, and ability to seek and secure action funding for high priority initiatives.

3. Conduct mandated environmental public health laboratory testing, inspections, and oversight to protect food, recreation sites, and drinking water; manage liquid and solid waste streams safely; and identify other public health hazards related to environmental factors in accordance with federal, state, and local laws and regulations.

4. Protect workers and the public from chemical and radiation hazards in accordance with federal, state, and local laws and regulations.

5. Participate in broad land use planning and sustainable development to encourage decisions that promote positive public health outcomes and resilient communities (e.g., housing and urban development, recreational facilities, transportation systems and climate change).

6. Coordinate and integrate categorically-funded environmental public health programs and services.

Foundational Area 4. Maternal and Child Health

Note: The competency statements listed in each foundational area should be interpreted as broadly as possible to apply to your position.

Rate yourself to what degree are you able to effectively…

1 = None I am unaware or have very little knowledge of the skill
2 = Aware I have heard of, but have limited knowledge or ability to apply the skill
3 = Knowledgeable I am comfortable with my knowledge or ability to apply the skill
4 = Proficient I am very comfortable, am an expert, or could teach this skill to others

1. Provide timely, statewide, and locally relevant, complete, and accurate information to the health care system and community on emerging and on-going maternal child health trends.

2. Identify local maternal and child health community partners and their capacities; using life course expertise and an understanding of health disparities, develop a prioritized prevention plan; and ability to seek and secure funding for high priority initiatives.

3. Identify, disseminate, and promote emerging and evidence-based early interventions in the prenatal and early childhood period that promote lifelong health and positive social emotional development.

4. Assure newborn screening as mandated by a state or local governing body including wraparound services, reporting back ,following up, and service engagement activities.

5. Coordinate and integrate categorically funded maternal, child, and family health programs and services.

Foundational Area 5. Access to and Linkage with Care

Note: The competency statements listed in each foundational area should be interpreted as broadly as possible to apply to your position.

Rate yourself to what degree are you able to effectively…

1 = None I am unaware or have very little knowledge of the skill
2 = Aware I have heard of, but have limited knowledge or ability to apply the skill
3 = Knowledgeable I am comfortable with my knowledge or ability to apply the skill
4 = Proficient I am very comfortable, am an expert, or could teach this skill to others

1. Provide timely, statewide, and locally relevant, complete, and accurate information to the health care system and community on access and linkage to clinical care (including behavioral health), healthcare system access, quality,

and cost.
2. Inspect and license healthcare facilities, and license, monitor, and discipline healthcare providers, where applicable.

3. In concert with national and statewide groups and local providers of healthcare, identify healthcare partners and competencies, develop prioritized plans for increasing access to health homes and quality health care, and seek funding for high priority policy initiatives.

Section IV. Addressing Public Health Issues

This section asks about how important a skill is in your day-to-day work and your current skill level.

Please refer to these definitions to answer the next 2 questions.

Health Equity:
Health equity means all people, regardless of who they are, where they came from, how they identify, where they live, or the color of their skin, have a fair and just opportunity to live their healthiest possible lives - in body, mind, and community. Achieving health equity requires removing social, economic, contextual, and systemic barriers to health, and a continuous and explicit commitment to prioritize those affected by historical disadvantages. (CityHealth)

Racism as a Public Health Crisis:
States, cities, and counties have increasingly declared racism to be a public health crisis or emergency. These declarations are driven by a recognition that systemic, institutional, and other forms of racism drive disparities across employment, housing, education, the justice system, healthcare, and other determinants of health. The declarations also reflect a growing acknowledgment that state and local governments must anchor efforts to eradicate the impacts of racism in order to truly achieve the conditions that create optimal health for all. (Network for Public Health Law)

Social Determinants of Equity:
The social determinants of equity are systems of power like racism, sexism, heterosexism, ableism, and economic systems like capitalism. The social determinants of equity determine the range of contexts available and who is found in which context. They govern the distribution of resources and populations through decision-making structures, policies, practices, norms, and values, and too often operate as social determinants of in-equity by differentially distributing resources and populations (Jones, 2014)

Social Determinants of Health:
The social determinants of health are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Domains of the social determinants of health include economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context (U.S. Department of Health and Human Services)

Structural Racism:
A system in which public policies, institutional practices, cultural representations, and other norms work in various, often reinforcing ways to perpetuate racial group inequity. It identifies dimensions of our history and culture that have allowed privileges associated with “whiteness” and disadvantages associated with “color” to endure and adapt over time. (Aspen Institute)

Environmental Justice:
Environmental justice is the fair treatment and meaningful involvement of all people regardless of race,

color, national origin, or income, with respect to the development, implementation, and enforcement of environmental laws, regulations, and policies. (US EPA)

1. How much, if anything, have you heard of the following concepts in public health?

	Not at All	**Not Much**	**A Little**	**A Lot**
Health Equity				
Social Determinants of Equity				
Social Determinants of Health				
Structural Racism				
Environmental Justice				

2. How confident are you in addressing the follow public health concepts in your work?

	Not at All	**Not Much**	**A Little**	**A Lot**
Health Equity				
Social Determinants of Equity				
Social Determinants of Health				
Structural Racism				
Environmental Justice				

3. Please add any comments or questions you would like about workforce development, recruitment, retention, and training.

Appendix B: Submitted Comments for Section I: Ques. 18-20 and Section IV. Q.3

Section I. Question 18. What brought you to field of public health?
A permanent position in my field that gave me the chance to broaden my skillset
AmeriCorps program (n=2)
change in employment
Covid-19 (n=2)
Desire to contribute to the health and wellbeing of WIC participants.
Drafted
fell in love with it during college
Honestly I came to work here due to wanting a certain position, not because I was overly interested in public health. Now that I am here and know what public health is, I am much more excited about it and proud to work here.
I am passionate about prevention and health across the lifespan.
I have always wanted to be in a field that helps people. But, I wanted to find an avenue that could let me help people BEFORE they needed it. Prevention is key!
I like public health science
I love the WIC program. I have family members that used WIC, and I love(d) everything that the program provided for them- the community health promotion, helping others thrive, nutrition education, BF education, ect.
I wanted a career in science that allowed me to teach others how to best protect themselves and their customers from illness.
I wanted to help the community in a way that wasn't medicinal. I found the public health program in college and saw a lot of similarities in community-based work I grew around and I wanted to be a part of that field.
interest in food safety
Interest in working in the social service field.
It was accidental - I was looking for a job that would allow me to grow and the job I have now at public health allows that.
Management position in my field.
My degree (n=2)
New employment and pay
Nonprofit career and experience in mental health and medical field-interest in impacting community level.
Passion for systems level work that makes real change.
The desire to help others.
The desire to work upstream and prevent illness, disease, disability, and death.
The need for Public Health preparedness activities aligned with my skill set
Wanting to help others.
working overseas really opened my eyes as to how much public health spans into so many areas
Section I. Question 19. What brought you to work at LCPH?
A permanent position in my field that gave me the chance to broaden my skillset
Advancement opportunity
Again, it was accidental. At my last job, I was not happy and there was not room for growth.
AmeriCorps program

County provides good wage and benefits for Helena area in addition to interest in new behavioral health program opportunity.
Covid-19 (n=2)
Culture of leadership. Flexible schedule options. Supportive environment. Strong leadership.
Drafted
Everyone seemed friendly and nice. I was really interested in the job that was being offered to me.
I am passionate about prevention and support for pregnant and parenting moms.
I have worked in public health for 20+ years
I like to be engaged in work that directly impacts the community I live in
I live in Lewis and Clark County
I was employed in CA in environmental Health. We wanted to return to MT to raise our family. My husband had a job in Helena, and I applied and was given a job with Lewis and Clark County.
I was interested in a specific position. It seemed to fit my skills and my interests, and it paid a lot more than the position that I was in at the time.
I was matched with LCPH through I program I applied for at the CDC.
Job opening in my field. (n=4)
Location, position
New employment and pay
opportunity to supervise others
Opportunity to work in WIC
position became open
Same- WIC
The programs. The good reputation and good pay.
The right opening at the right time
Working with one of the community coalitions.
Section I. Question 19. What keeps you working at LCPH?
1. Not gonna lie - the pay is a huge factor. I don't know of any other positions that I would qualify for that pay as much as I earn right now. The benefits are also great. 2. The people - I think very highly of my supervisor, and I am close to and fond of a number of my coworkers. Even those whom I do not know well I find to be very impressive, intelligent, and interesting people. 4. Pride in my work - I'm proud to be able to tell people what my job is and where I work. 5. Being in a position where I get to help people. The fact that so many of my clients are appreciative of my work. 5. Flexible schedule. If that goes away, I would be much less happy with my job, in spite of the other positive factors. 6. Management's apparent concern for employee satisfaction and wellbeing. 7. LCPH is proactive and a leader in the community. I get to partner with other amazing agencies and people through my work at LCPH.
Challenge of work; coworkers
Covid-19 (n=2)
co-workers are great to work with; the job itself is challenging, fulfilling, and interesting; desire for advancement at LCPH
Co-workers, the benefits, the office atmosphere.
co-workers, the opportunity for growth, and at times the public.
Culture of strong leadership. Positive work culture. Great colleagues. Using public health theory, evidence and practice on a daily basis.

culture, professionalism, core values, high standards
Enjoy my work in area of mental health and medical community-interest in impacting larger community level with ability to utilize my experiences while continuing to learn at my pace and availability.
good co-workers
I love public health and the potential to make a difference in the lives of those in our community. We have awesome leadership in our Health Officer which gives me the support necessary to be successful at my job.
Lots of flexibility, supportive administration, my own office, shared core values, an venue to pursue my own professional goals
Love for WIC and LCPH's supportive work environment.
love my job
Love the work that I do. Still in science but a different field than my original studies.
My coworkers and my work
My opinion is heard, valued, and respected. Everyone works as a team. We get adequate paid leave for sick days/vacations/holidays. My hours work well for raising a family.
My supervisor is fantastic. There is room for new ideas in my role. My colleagues are supportive. I trust upper management.
People I work with. Like the work.
people who work at LCPH seem to be really dedicated and care about the work they do. I like the culture of innovation and creativity that's embraced at LCPH.
The many learning opportunities and guidance is what motivates me to continue to work for LCPH.
The people and the ability to make a difference
The people I work with. We have an amazing team of dedicated people that I enjoy being part of.
The people, the purpose, room to grow.
The population I serve and work with correlates to my personal passion and my work allows me to help parents and children have a positive start.
The staff and public health
The vital and effective work we do.
Wanting to create and develop a more effective system and program
Work environment, work duties
Section IV. Question 3. Please add any comments or questions you would like about workforce development, recruitment, retention, and training.
I appreciate all the development and training that I can get. I never know how to fill out this survey - I never feel confident enough to say that I could teach others about any of these topics, and I sometimes have trouble knowing exactly what is meant by some of the descriptions, yet I seem to be performing fine in my job.....? In the future maybe the survey can be worded a bit differently.
I think we need to prioritize a consistent orientation checklist for on-boarding all new staff regardless of position and status (temp or perm) on public health basics, PH 3.0, health equity, SDOH, 10 essential public health services, and how local PH fits into the broader state and national landscape. I also think orientation should include meeting briefly with division staff or watching a pre-recorded division presentation like all staff meeting, so that all staff know the basics of what LCPH offers.
Providing ongoing access to training is key to the success of our staff. I would like stronger public health theory/best practice training for staff, not just new staff.
These topics are still very new and important to review/discuss regularly.

Workforce Assessment Survey

Lewis and Clark Public Health

Its purpose is to identify the strengths of our staff, as well as areas in which we might benefit from training. You may remember taking a similar survey in 2017. The survey asks about some demographics and skills and knowledge required to effectively provide public health services.

The questions are based on core competencies identified by the Council on Linkages Between Academia and Public Health Practice, Building Skills for a More Strategic Public Health Workforce: A Call to Action from the National Consortium for Public Health Workforce Development and deBeaumont Foundation specific public health professional organizations, the 2022 Lewis and Clark Public Health Widerstand Anti-Racism Audit Report, and recommendations from LCPH senior leadership. Modifications have been made for clarity and brevity.

Some questions in this survey are based on questions from the Public Health Workforce Interests and Needs Survey (PH WINS). PH WINS was developed by the de Beaumont Foundation and the Association of State and Territorial Health Officials to understand the interests and needs of the state and local governmental public health workforce in the United States, and was fielded in 2014, 2017, and 2021. For more information, visit phwins.org

The information from this survey will be used to revise and update the Workforce Development Plan and guide professional development, training, recruitment, retention, and workplace culture improvements, goals, and activities for the 2022-2025 period. Your involvement is crucial to the development of a valid and useful plan.

LCPH will be sending out an employee satisfaction/workplace culture survey in the coming months.

Our goal is 100% participation in the survey. It will take approximately 45 minutes to complete and is due on Friday, October 14, 2022.

Your responses are confidential and the data will be summarized in report that will inform the workforce development training plan for LCPH.

Section I: Workforce Characteristics and Demographics

This section will ask you to provide some demographic information, which will give us an idea of the diversity of our staff and of future staff

recruitment needs.

1. To which gender do you most identify? *

Female
Male
Transgender Female
Transgender Male
Gender Variant/Non-Conforming
Prefer Not to Answer

2. Which of the following race categories best describes you? *

Asian or Pacific Islander
Black or African American
Native American or Alaskan Native
White or Caucasian
Multiracial or Biracial
Prefer Not to Answer

3. Which of the following ethnicity categories best describes you? *

Hispanic or Latino
Not Hispanic or Latino
Prefer Not to Answer

4. Do you identify as a person with a disability or are you a person with accessibility needs? *

Yes
No
Prefer Not to Answer

5. Do you identify as being part of the LGBTQ+ community? *

Yes
No
Prefer Not to Answer

6. What age group are you in? *

Under 20 years
20-29 years
30-39 years
40-49 years
50-59 years
60 years or older

Prefer Not to Answer

7. What is the highest level of education you have completed? *

- High School graduate
- Associate's degree
- Bachelor's degree
- Master's degree
- Doctoral degree
- Not Applicable
- [ ]

8. For your highest level of education completed, what is your field of study? *

- Biological Sciences
- Communication
- Dietetics
- Environmental Sciences
- Epidemiology
- General Studies
- Nursing
- Public Health
- Social Sciences
- Not Applicable
- [ ]

9. Please select other/additional areas of education you have completed? *

- ☐ Biological Sciences
- ☐ Communication
- ☐ Dietetics
- ☐ Environmental Sciences
- ☐ Epidemiology
- ☐ General Studies
- ☐ Nursing
- ☐ Public Health
- ☐ Social Sciences
- ☐ Not Applicable
- ☐ [ ]

10. Please identify any additional credentials you have attained? Check all that apply. *

- ☐ Breastfeeding/Lactation Certification (CLC, CLE, or IBCLC)
- ☐ Certification in Public Health
- ☐ Certified Health Education Specialist (CHES or Master CHES)
- ☐ Emergency Management
- ☐ Laboratory Certification

Licenses Clinical Social Worker(LCSW)
Registered Dietitian (RD)
Registered Sanitarian
Not Formally Certified
Not Applicable

11. Are you interested in pursuing additional education? *

Yes
No
I am currently enrolled in an educational program

12. If Yes, what level? *

Certification
Associates
Bachelors
Masters
PhD

13. Which division of the Health Department do you work in? *

- [ ] Administration
- [ ] Community Health Promotion
- [ ] Disease Control and Prevention
- [ ] Environmental Health

14. What is your employment status? *

Permanent
Temporary
Contract

15. How many years have you worked for LCPH? *

Less than 1 year
1-2 years
3-4 years
5-10 years
11-20 years
More than 20 years

16. How many years have you worked in the field of public health? *

Less than 1 year
1-2 years

3-
4 years

5-10 years
11-20 years
More than 20 years

17. In how many years do you plan to retire or seek employment outside of the Health Department? *

0-5 years
6-10 years
More than 10 years
Not sure

18. What brought you to field of public health?

19. What brought you to work at LCPH?

20. What keeps you working at LCPH?

Section II. Training and Needs Assessment

This section, will ask about crosscutting knowledge and skills for the broad practice of public health, as defined by the 10 Essential Public Health Services. These questions are organized into 8 skill areas, or domains, that cut

across public health disciplines. The purpose of this assessment is to help you explore your level of competence within these 8 domains.

Domain 1: Data Analytics and Assessment Skills

Note: The competency statements listed in each domain should be interpreted as broadly as possible to apply to your position.

D1. Rate yourself to what degree are you able to effectively…

	1 = None I am unaware or have very little knowledge of the skill	2 = Aware I have heard of, but have limited knowledge or ability to apply the skill	3 = Knowledgeable I am comfortable with my knowledge or ability to apply the skill	4 = Proficient I am very comfortable, am an expert, or could teach this skill to others
1. Describe factors that affect the health of a community (e.g., income, education, laws, environment, climate change, resilience, homelessness, food security, access to healthcare, racial equity, distribution of resources and power, social and community engagement, changing demographics)				
2. Access existing quantitative and qualitative data (e.g., community input, big data, vital statistics, electronic health records, transportation patterns, employment statistics, environmental monitoring, health equity impact assessments, revenue and expenditures)				
3. Collect quantitative and qualitative data				
4. Analyze quantitative and qualitative data				
5. Manage quantitative and qualitative data				
6. Use quantitative and qualitative data				
7. Apply public health informatics in using data, information, and knowledge				

8. Assess community health status

Domain 2: Policy Development and Program Planning Skills

Note: The competency statements listed in each domain should be interpreted as broadly as possible to apply to your position.

D2. Rate yourself to what degree are you able to effectively…

	1 = None I am unaware or have very little knowledge of the skill	2 = Aware I have heard of, but have limited knowledge or ability to apply the skill	3 = Knowledgeable I am comfortable with my knowledge or ability to apply the skill	4 = Proficient I am very comfortable, am an expert, or could teach this skill to others
1. Develop policies, programs, and services				
2. Implement policies, programs, and services (e.g., within the organization, external to the organization, in collaboration with others)				
3. Evaluate policies, programs, services, and organizational performance (e.g., outputs, outcomes, processes, procedures, return on investment)				
4. Improve policies, programs, services, and organizational performance				
5. Influence policies, programs, and services external to the organization (e.g., zoning, transportation, housing, education)				
6. Engage in organizational strategic planning				

7. Engage in community health improvement planning

Domain 3: Communication Skills

Note: The competency statements listed in each domain should be interpreted as broadly as possible to apply to your position.

D3. Rate yourself to what degree are you able to effectively…

	1 = None I am unaware or have very little knowledge of the skill	2 = Aware I have heard of, but have limited knowledge or ability to apply the skill	3 = Knowledgeable I am comfortable with my knowledge or ability to apply the skill	4 = Proficient I am very comfortable, am an expert, or could teach this skill to others
1. Determine communication strategies				
2. Communicate with internal and external audiences (e.g., staff, elected officials, students, volunteers, community-based organizations, healthcare professionals, the public)				
3. Respond to information, misinformation, and disinformation (e.g., through social media, town hall meetings, commentaries, letters to the editor)				
4. Facilitate communication among individuals, groups, and organizations				

Domain 4: Health Equity Skills

Note: The competency statements listed in each domain should be interpreted as broadly as possible to apply to your position.

D4. Rate yourself to what degree are you able to effectively…

	1 = None I am unaware or have very little knowledge of the skill	2 = Aware I have heard of, but have limited knowledge or ability to apply the skill	3 = Knowledgeable I am comfortable with my knowledge or ability to apply the skill	4 = Proficient I am very comfortable, am an expert, or could teach this skill to others
1. Apply principles of ethics, diversity, equity, inclusion, and justice (e.g., Public Health Code of Ethics, Health Insurance Portability and Accountability Act)				
2. Engage in continuous self-reflection about one's biases (e.g., perceptions, assumptions, stereotypes)				
3. Recognize the diversity of individuals and populations				
4. Reduce systemic and structural barriers that perpetuate health inequities (e.g., racism, sexism, bigotry, poverty, gender discrimination)				
5. Implement organizational policies, programs, and services to achieve health equity and social and environmental justice				
6. Contribute to achieving and sustaining a diverse, inclusive, and competent public health workforce				
7. Advocate for health equity and social and environmental justice (e.g., for reforming systems contributing to racism, advancing fair housing practices, changing labor laws and policies, protecting communities from environmental hazards)				

Domain 5: Community Partnership Skills

Note: The competency statements listed in each domain should be interpreted as broadly as possible to apply to your position.

D5. Rate yourself to what degree are you able to effectively…

	1 = None I am unaware or have very little knowledge of the skill	2 = Aware I have heard of, but have limited knowledge or ability to apply the skill	3 = Knowledgeable I am comfortable with my knowledge or ability to apply the skill	4 = Proficient I am very comfortable, am an expert, or could teach this skill to others
1. Describe conditions, systems, and policies affecting community health and resilience (e.g., social and institutional inequities, determinants of health, structural racism, historical trauma, gender discrimination, power dynamics, natural disasters, poverty, housing, trust, local politics, competition, redlining)				
2. Establish relationships to improve community health and resilience (e.g., partnerships with organizations serving the same population, health departments, healthcare institutions, academic institutions, politicians and other policymakers, environmental agencies and organizations, emergency response organizations, businesses, financial institutions, housing authorities, public transit, customers/clients)				
3. Maintain relationships that improve community health and resilience				
4. Collaborate with community members and organizations				
5. Share power and ownership with community members and others				

Domain 6: Public Health Sciences Skills

Note: The competency statements listed in each domain should be interpreted as broadly as possible to apply to your position.

D6. Rate yourself to what degree are you able to effectively…

	1 = None I am unaware or have very little knowledge of the skill	2 = Aware I have heard of, but have limited knowledge or ability to apply the skill	3 = Knowledgeable I am comfortable with my knowledge or ability to apply the skill	4 = Proficient I am very comfortable, am an expert, or could teach this skill to others
1. Describe systems, policies, and events impacting public health (e.g., slavery, colonialism, John Snow and the London cholera outbreak, smallpox eradication, development of vaccines, Tuskegee Syphilis Study, fluoridation of drinking water, Jim Crow laws, establishment of Medicare and Medicaid, Americans with Disabilities Act, seatbelt legislation, banning tobacco in public buildings, death penalty, gun violence, globalization, deforestation, climate change, COVID-19 pandemic)				
2. Apply public health sciences (e.g., biostatistics, epidemiology, environmental health, health services administration, social and behavioral sciences, and public health informatics) in delivering the 10 Essential Public Health Services				
3. Use evidence in developing, implementing, evaluating, and improving policies, programs, and services				
4. Contribute to the evidence base for improving health				

Domain 7: Management and Finance Skills

Note: The competency statements listed in each domain should be interpreted as broadly as possible to apply to your position.

D7. Rate yourself to what degree are you able to effectively…

	1 = None	2 = Aware	3 = Knowledgeable	4 = Proficient
	I am unaware or have very little knowledge of the skill	I have heard of, but have limited knowledge or ability to apply the skill	I am comfortable with my knowledge or ability to apply the skill	I am very comfortable, am an expert, or could teach this skill to others
1. Describe factors that affect the health of an organization (e.g., equitable and fair treatment of employees, support from the governing body and community, sustainability of funding, training of managers)				
2. Secure human resources (e.g., staff, interns, consultants, volunteers)				
3. Manage human resources				
4. Engage in professional development (e.g., training, mentoring, peer advising, coaching, drills, exercises)				
5. Secure financial resources				
6. Manage financial resources				
7. Implement organizational policies, programs, and services to achieve diversity, equity, inclusion, and justice				
8. Manage programs and services				

9. Engage in contingency planning (e.g., for emergencies, succession, cross-training staff, continuity of operations, economic downturns)

10. Apply critical thinking in decision making

11. Engage individuals and teams to achieve program and organizational goals

12. Facilitate collaboration among individuals, groups, and organizations

13. Engage in performance management

Domain 8: Leadership and Systems Thinking Skills

Note: The competency statements listed in each domain should be interpreted as broadly as possible to apply to your position.

D8. Rate yourself to what degree are you able to effectively…

	1 = None I am unaware or have very little knowledge of the skill	2 = Aware I have heard of, but have limited knowledge or ability to apply the skill	3 = Knowledgeable I am comfortable with my knowledge or ability to apply the skill	4 = Proficient I am very comfortable, am an expert, or could teach this skill to others
1. Create opportunities to achieve cross-sector alignment (e.g., community coalitions, academic health department partnerships)				
2. Implement a vision for a healthy community				
3. Address facilitators and barriers impacting delivery of the 10 Essential Public Health Services				
4. Create opportunities for creativity and innovation				

5. Respond to emerging needs

6. Manage organizational change

7. Engage politicians, policymakers, and the public to support public health infrastructure (e.g., funding, workforce, legal authority, facilities, data systems)

8. Advocate for public health

Section III. The Foundational Public Health Services Framework

Questions in this section are related to the unique responsibilities of governmental public health and defines a minimum set of 5 foundational areas that must be available in every community.

Foundational Area 1. Communicable Disease Control

Note: The competency statements listed in each foundational area should be interpreted as broadly as possible to apply to your position.

F1. Rate yourself to what degree are you able to effectively…

	1 = None I am unaware or have very little knowledge of the skill	2 = Aware I have heard of, but have limited knowledge or ability to apply the skill	3 = Knowledgeable I am comfortable with my knowledge or ability to apply the skill	4 = Proficient I am very comfortable, am an expert, or could teach this skill to others	Not Applicable
1. Provide timely, statewide, and locally relevant and accurate information to the health care system and community on communicable diseases and their control.					

2. Identify statewide and local communicable disease control community partners and their capacities, develop, and implement a prioritized communicable disease control plan, and ability to seek and secure funding for high priority initiatives.

3. Receive laboratory reports and other relevant data; conduct disease investigations, including contact tracing and notification; and recognize, identify, and respond to communicable disease outbreaks for notifiable conditions in accordance with local, national, and state mandates and guidelines.

4. Assure the availability of partner notification services for newly diagnosed cases of communicable diseases according to CDC guidelines.

5. Assure the appropriate treatment of individuals who have reportable communicable diseases, such as TB, STIs, and HIV in accordance with local and state laws and CDC guidelines.

6. Support the recognition of outbreaks and other events of public health significance by assuring capacity for the identification and characterization of the causative agents of disease and their origin, including those that are rare and unusual.

7. Coordinate and integrate categorically-funded communicable disease programs and services.

Foundational Area 2. Chronic Disease and Injury Prevention

Note: The competency statements listed in each foundational area should be interpreted as broadly as possible to apply to your position.

F2. Rate yourself to what degree are you able to effectively…

	1 = None I am unaware or have very little knowledge of the skill	2 = Aware I have heard of, but have limited knowledge or ability to apply the skill	3 = Knowledgeable I am comfortable with my knowledge or ability to apply the skill	4 = Proficient I am very comfortable, am an expert, or could teach this skill to others	Not Applicable
1. Provide timely, statewide, and locally relevant, complete, and accurate information to the health care system and community on chronic disease and injury prevention and control.					

2. Identify statewide and local chronic disease and injury prevention community partners and their capacities, develop, and implement a prioritized prevention plan, and ability to seek and secure funding for high priority initiatives.

Reduce statewide and community rates of tobacco use through a program that conforms to standards set by state or local laws and CDC's Office on Smoking and Health, including activities to reduce youth initiation, increase cessation, and reduce secondhand exposure to harmful substances.

3. Reduce statewide and community rates of tobacco use through a program that conforms to standards set by state or local laws and CDC's Office on Smoking and Health, including activities to reduce youth initiation, increase cessation, and reduce secondhand exposure to harmful substances.

4. Work actively with statewide and community partners to increase statewide and community rates of healthy eating and active living through a prioritized approach focusing on best and promising practices aligned with national, state, and local guidelines for healthy eating and active living.

5. Coordinate and integrate categorically-funded chronic disease and injury prevention programs and services.	

Foundational Area 3. Environmental Public Health

Note: The competency statements listed in each foundational area should be interpreted as broadly as possible to apply to your position.

F3. Rate yourself to what degree are you able to effectively…

	1 = None I am unaware or have very little knowledge of the skill	2 = Aware I have heard of, but have limited knowledge or ability to apply the skill	3 = Knowledgeable I am comfortable with my knowledge or ability to apply the skill	4 = Proficient I am very comfortable, am an expert, or could teach this skill to others	Not Applicable
1. Provide timely, statewide, and locally relevant, complete, and accurate information to the state, health care system, and community on environmental public health threats and health impacts from common environmental or toxic exposures.					
2. Identify statewide and local community environmental public health partners and their capacities, develop, and implement a prioritized plan, and ability to seek and secure action funding for high priority initiatives.					

3. Conduct mandated environmental public health laboratory testing, inspections, and oversight to protect food, recreation sites, and drinking water; manage liquid and solid waste streams safely; and identify other public health hazards related to environmental factors in accordance with federal, state, and local laws and regulations.

4. Protect workers and the public from chemical and radiation hazards in accordance with federal, state, and local laws and regulations.

5. Participate in broad land use planning and sustainable development to encourage decisions that promote positive public health outcomes and resilient communities (e.g., housing and urban development, recreational facilities, transportation systems and climate change).

6. Coordinate and integrate categorically-funded environmental public health programs and services.

Foundational Area 4. Maternal and Child Health

Note: The competency statements listed in each foundational area should be interpreted as broadly as possible to apply to your position.

F4. Rate yourself to what degree are you able to effectively…

	1 = None I am unaware or have very little knowledge of the skill	2 = Aware I have heard of, but have limited knowledge or ability to apply the skill	3 = Knowledgeable I am comfortable with my knowledge or ability to apply the skill	4 = Proficient I am very comfortable, am an expert, or could teach this skill to others	Not Applicable
1. Provide timely, statewide, and locally relevant, complete, and accurate information to the health care system and community on emerging and on-going maternal child health trends.					
2. Identify local maternal and child health community partners and their capacities; using life course expertise and an understanding of health disparities, develop a prioritized prevention plan; and ability to seek and secure funding for high priority initiatives.					
3. Identify, disseminate, and promote emerging and evidence-based early interventions in the prenatal and early childhood period that promote lifelong health and positive social-emotional development.					
4. Assure newborn screening as mandated by a state or local governing body including wraparound services, reporting back,following up, and service engagement activities.					

5. Coordinate and integrate categorically funded maternal, child, and family health programs and services.	

Foundational Area 5. Access to and Linkage with Care

Note: The competency statements listed in each foundational area should be interpreted as broadly as possible to apply to your position.

F5. Rate yourself to what degree are you able to effectively…

	1 = None I am unaware or have very little knowledge of the skill	2 = Aware I have heard of, but have limited knowledge or ability to apply the skill	3 = Knowledgeable I am comfortable with my knowledge or ability to apply the skill	4 = Proficient I am very comfortable, am an expert, or could teach this skill to others	Not Applicable
1. Provide timely, statewide, and locally relevant, complete, and accurate information to the health care system and community on access and linkage to clinical care (including behavioral health), healthcare system access, quality, and cost.					
2. Inspect and license healthcare facilities, and license, monitor, and discipline healthcare providers, where applicable.					

3. In concert with national and statewide groups and local providers of healthcare, identify healthcare partners and competencies, develop prioritized plans for increasing access to health homes and quality health care, and seek funding for high priority policy initiatives.

Section IV. Addressing Public Health Issues

This section asks about how important a skill is in your day-to-day work and your current skill level.

Please refer to these definitions to answer the next 2 questions.

Health equity means all people, regardless of who they are, where they came from, how they identify, where they live, or the color of their skin, have a fair and just opportunity to live their healthiest possible lives - in body, mind, and community. Achieving health equity requires removing social, economic, contextual, and systemic barriers to health, and a continuous and explicit commitment to prioritize those affected by historical disadvantages. (CityHealth)

States, cities, and counties have increasingly declared racism to be a public health crisis or emergency. These declarations are driven by a recognition that systemic, institutional, and other forms of racism drive disparities across employment, housing, education, the justice system, healthcare, and other determinants of health. The declarations also reflect a growing acknowledgment that state and local governments must anchor efforts to eradicate the impacts of racism in order to truly achieve the conditions that create optimal health for all. (Network for Public Health Law)

The social determinants of equity are systems of power like racism, sexism, heterosexism, ableism, and economic systems like capitalism. The social determinants of equity determine the range of contexts available and who is found in which context. They govern the distribution of resources and populations through decision-making structures, policies, practices, norms, and values, and too often operate as social determinants of in-equity by differentially distributing resources and populations (Jones, 2014)

The social determinants of health are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Domains of the social determinants of health include economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context (U.S. Department of Health and Human Services)

A system in which public policies, institutional practices, cultural representations, and other norms work in various, often reinforcing ways to perpetuate racial group inequity. It identifies dimensions of our

history and culture that have allowed privileges associated with “whiteness” and disadvantages associated with “color” to endure and adapt over time. (Aspen Institute)
Environmental justice is the fair treatment and meaningful involvement of all people regardless of race, color, national origin, or income, with respect to the development, implementation, and enforcement of environmental laws, regulations, and policies. (US EPA)

1. How much, if anything, have you heard of the following concepts in public health?

	Not at All	Not Much	A Little	A Lot
Health Equity				
Social Determinants of Equity				
Social Determinants of Health				
Structural Racism				
Environmental Justice				

2. How confident are you in addressing the follow public health concepts in your work?

	Not at All	Not Much	A Little	A Lot
Health Equity				
Social Determinants of Equity				
Social Determinants of Health				
Structural Racism				
Environmental Justice				

3. Please add any comments or questions you would like about workforce development, recruitment, retention, and training.

Submit

Anti-racism Audit Report

For Lewis and Clark Public Health Department

May 2022

Widerstand Auditors
Erica Littlewolf
Murray Pierce
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Table of Contents

Introduction

More than anything else, an audit is an opportunity to take stock, evaluate, reflect, and garner the resources and will to move forward, do better, correct past errors, and create a new future. We are grateful to have had the opportunity to walk alongside the staff and leadership of Lewis and Clark Public Health Department in this essential work of reflection, evaluation, and improvement. We think that you have significant opportunities before you that can create a meaningful and robust means of integrating anti-racism into your work and mission.

By way of summary, our biggest findings are that the Lewis and Clark Public Health Department needs to:

- Foster and develop a shared analysis of racism that attends to both the interpersonal and the systemic;
- Incorporate data collection systems that allow for more sophisticated and nuanced analysis of the racial demographics in your county;
- Develop stronger and more proactive connections and alliances with BIPOC community groups in your area;
- Institute regular goal setting, accountability measures, and accountability for the work of dismantling racism;
- Develop programming that better serves the BIPOC community building on relationships with those communities.

What follows is a collection of observations, themes, and both corrective and forward-looking recommendations based on our collective synthesis of the current research and our lived experience working at dismantling racism in racially homogenous organizations across the country for more than three decades.

We have organized our comments in sync with the “Markers of Institutional Transformation” chart to help provide a framework for your consideration. Each section includes 1) an identification of where we think you are now on the continuum; 2) the barriers and opportunities that you face; 3) and recommendations for next steps. Do note that the order of the subsections – moving down the chart from Identity and Mission to Structure and Constituency – suggests a priority for action from the most immediate to the most long-term.

When we first met with your design team, we noted that there is often a grief process associated with anti-racism audits. Frequently, organizations discover that they are not who they thought that they were. Processing the results of an assessment such as the one we have just completed involves the whole being. Like any grieving process, it can be messy and may include elements of anger, denial, bargaining, depression, and acceptance. You will find your way forward, but we encourage you to be prepared to encounter, recognize, and acknowledge these emotions on both individual and organizational levels.

We offer these findings with deepest respect for what you have done, who you are now as an organization, and what you can yet do and become in the future.

Our experience also informs the importance of taking this report in its entire context. The danger is that one section, phrase, or sentence report will be taken out of context. Any given comment only will make sense when considered in the report as a whole.

Markers of Anti-racism Institutional Transformation

The chart that follows is what we call “the continuum.” This continuum specifies the markers that capture what anti-racism institutional transformation looks like. It helps us identify what stage your organization is at based on six core aspects: Identity & Mission, Organizational Culture, Program Initiatives, Staffing Patterns, Accountability, and Structure & Constituency. We evaluate each section individually. We reference the continuum throughout the report.

WIDERSTAND CONSULTING

Markers of Anti-racism Institutional Transformation

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	1 Overt	2 Neutral	3 Cosmetic	4 Proclamation	5 Implementation	6 Realization
Identity & Mission	Claims exclusion	Claims color-blindness	States multicultural commitments	Claims anti-racist commitments; articulates core principles	Promotes anti-racist commitments and enacts core principles	Fulfills anti-racist commitments and principles
Organizational Culture	Celebrates White Supremacy Culture (WSC)	Unaware of WSC	Denies WSC	Acknowledges WSC	Addresses WSC	No longer practices WSC
Program Initiatives	Intends to serve only White people	Claims program neutrality	Initiatives focus on celebration of diversity	Programs address hierarchy, privilege, and oppression	Programs address systemic inequality	Programs fully embody anti-racist values
Staffing Patterns	Whites only	Token representation	Less than 20% BIPOC staff; short-stays	Goals for greater than 20%; mid-term stays	Above 20%; stable duration	Sustained staffing; balanced representation
Accountability	To Whites exclusively	Deemed unnecessary	"Safe" BIPOC connections	Commits to accountability	Implements accountability	Fully integrates accountability
Structure & Constituency	Designed for White control and access	Keeps control and access hidden	Leaves control and access untouched	Examines and analyzes control and access	Engages in restructuring to undermine White Power structures	Realizes restructuring

Glossary

- **Anti-racism**: proactive and deliberate efforts by individuals and collectives to oppose and dismantle racism in its individual, institutional, systemic, and cultural forms
- **Anti-racism audit**: a focused examination of all levels of an institution's life based on an analysis of the results of an institution's actions rather than just its intentions
- **Cultural appropriation**: the unacknowledged use and employment of another group's cultural practices, symbols, and other representations for use or financial gain without accountability or connection to the original community
- **Cultural racism**: forcing members of one group to "do life" according to standards, norms, and ways of being as defined by another group
- **Implicit bias:** attitudes or stereotypes that affect our understanding, actions, and decisions in an unconscious manner (kirwaninstitute.osu.edu)
- **Identity power**: racism's ability to define racial identities according to the status of inferior and superior
- **Individual racism**: acting out racial prejudices by individuals in a context where those prejudices are reinforced by society
- **Institutional racism**: the support for and promotion of control and access to organizations in a manner that benefits one group and oppresses another; stated intent to provide race-based privilege and engage in racial oppression is not necessary for institutional racism to be at work
- **Internalization of racism**: the psychological acceptance of, belief in, and acting upon the associated identities of inferiority by People of Color and superiority by White community members
- **Oppressive power**: racism's ability to oppress, demean, and harm People of Color
- **Race**: a biological myth and a social reality constructed in the 17th and 18th centuries by Europeans as part of the colonial project, entrenched with notions of White superiority; in the United States, a caste system that mediates privilege, power, resources, and status
- **Racism**: race prejudice plus the systemic misuse of power
- **Systemic racism**: the macro-level distribution of power and privilege to one group and the oppression of another through the institutions that constitute that system; examples include the educational, health care, and transportation systems
- **White privilege**: unearned benefits – both financial and psychological – afforded individuals and groups with light enough skin and European facial features to be perceived as White

- **White power**: racism's ability to provide power and privilege to White people and White society based on the perception of White identity
- **White supremacy**: the pervasive system that directs, sustains, normalizes, and socializes messages about the supremacy of White people and White cultural norms, standards, and ways of being
- **White Supremacy Culture**: the practices evident in predominantly White organizations that perpetuate harm through urgency, focus on the written word, information hoarding, conflict avoidance, etc.

Identity & Mission

1 Overt	2 Neutral	3 Cosmetic	4 Proclamation	5 Implementation	6 Realization
Claims exclusion	Claims color-blindness	States multicultural commitments	Claims anti-racist commitments; articulates core principles	Promotes anti-racist commitments and enacts core principles	Fulfills anti-racist commitments and principles

Overview

Our inquiry places you in the Proclamation Phase on the road to organizational racial equity. This means in general Lewis and Clark Public Health views itself and promotes itself as an organization committed to anti-racism. However, there is descriptive evidence to the contrary which indicates this promotion does not necessarily pan out in actuality.

Primary Barriers

What aided in pinpointing this characterization?

1. There was a general congratulatory feeling in focus groups by virtue of Lewis and Clark Public Health declaring a racial equity audit a necessity in moving the dial forward regarding organizational identity.

2. The director in particular drew acclaim in that there was a general recognition of a great deal of push-back in implementing the audit process and how she pressed on and triumphed over negative narratives.

3. Although these claims are well supported, we would caution you that enthusiasm alone cannot provide the mechanism which will bring about meaningful change. Lewis and Clark Public Health must harness this support for leadership and channel it into organization-wide support for the cause of internal equity.

4. The statement was made that Lewis and Clark Public Health is bringing awareness to employees in the health care system in ways heretofore unseen.

5. One participant exclaimed in this process that they have a deeper appreciation for the historic distrust relative to the health care system - in particular how it evidenced health violence against women of color through testing. This statement was insightful and demonstrated a willingness to explore deeper instances of race-based health disparities and bodes well for future engagement.

6. In at least one instance, an individual cited the existence of civil rights laws and the 14th amendment as evidence of Lewis and Clark Public Health not participating in racism. This is indicative of the misdirected belief that having a law in place is enough to inhibit any sense of racial impropriety.

Primary Opportunities

What are Some Identified Areas of Needed Improvement?

Our inquiry revealed the following:

1. **The need to develop a more comprehensive understanding of the manifold incarnations of racism.** Our audit unveiled a seemingly one-dimensional view of the subject of racism centered on the individual/interpersonal impact of racist behaviors with less attention to how racism manifests itself institutionally and systemically. This pattern was significant because it often keeps an organization from understanding how it participates in and perpetuates racism.

2. **The need to better understand White Fragility.** i.e. when attempting to come to an understanding of what racism is, there will necessarily be some degree of egocentric heartburn. In the present instance, irrespective of the eventual capitulation of the contrarians, many in the Lewis and Clark Public Health family appear to have perseverated on how this discomfort is settled as opposed to what the actual work moving forward requires. Navigating this maelstrom of anger, guilt, and fear under the guise of fragility reinforces racism by the practitioner persistently attempting to wrest control of the narrative instead of sharing the stage, all the while protecting the present-day racial hierarchy. Here's a litmus test—the next time someone says to you "I am not a racist," ask them to explain to you what racism is. Chances are, you'll see their answer serves to protect a myopic worldview which disallows any contrary information and ultimately, contributes to continually placing the weight of race-based change on the shoulders of People of Color. In this instance, Lewis and Clark Public Health seems to have triumphed over individual fragility's ability to stall, alter, or divert efforts towards organizational equity; however, it is our collective sense that having a better tactical understanding of its power and impact will aid in both current as well as future endeavors as you move ahead on the anti-racist timeline.

3. **The need to unpack definitions.** One participant stated, "the discussion in whether or not to do the audit came around to critical race theory (CRT)" This is of import in that CRT at root is looking at society through a racial lens. Even your own organization in an internal policy cites looking at POC health related issues in the county through a "Health Equity Lens" i.e., "A health equity lens is a way of adjusting how we look at individual and population health. It takes into consideration the unique concerns of disadvantaged groups and helps to identify strategies to address health inequities." We do not need

critical race theory to do essential work on anti-racism. We do need a common analysis about the way racism operates in society.

4. **The need to help White people understand the entrenched nature of racism, in order to deepen one's understanding of the challenges faced by People of Color.** Many focus group participants expressed that it should not "have been so hard" to get the audit approved. It is our belief that the "getting there process" was not hard for some who have at least a rudimentary understanding of racism and realize the multiple uphill battles fought daily. However, for those who see this as unfamiliar ground, it can be overwhelming and also indicative of how much energy they are intent upon contributing to this cause.

Recommendations

<u>In the next three to six months:</u>

1. Continue to build on the anti-racism training process you have begun and foster additional discussion about the historical derivation of race-based concepts and definitions, variations between individual/institutional/systemic racism.
2. Institute this kind of training on a mandatory basis for staff, administration, and board members.

<u>In the next six to nine months:</u>

1. Contract with area-wide individuals and/or organizations which concentrate on racial equity learning and bring in facilitators to discuss White fragility and its impact on organizational equity (Prior training efforts in these areas were not discussed at length; however, irrespective of their past involvement with previous training, interviewees as well as existing documentation reviewed demonstrated a need for further clarification in these particular areas.)
2. Contract with professionals to hold workshops on how certain attitudes and behaviors perpetuate racist ideas and beliefs and ultimately contribute to curtailing progress towards organizational equity

<u>In the next twelve to eighteen months:</u>

1. Create a standing committee to develop a roadmap for progress, identifying specific steps Lewis and Clark Public Health will take towards organizational equity. The committee should pay particular attention to:
    - How racism is presently being defined;
    - How the use of the term racism impacts policies, procedures, and interactions;
    - Alternative definitions which may better express the organization's commitment to racial equity;
    - A framework for implementing necessary changes in a timely manner;
    - Publicizing and distributing findings to board, staff, and impacted communities;

    - Holding regular trainings/workshops designed to reinforce these concepts as well as distribute and discuss new directions/materials in this area.
2. Establish a list of “Indicators of Change.” Real change is measurable. The metrics used to gauge forward movement are equally as important as the path charted to reach that goal.

Once you have identified areas requiring change, take time to develop and implement an instrument which will serve as a guidepost in tracking your trajectory paying particular attention to the following areas:

- Retention and promotion
- Hiring and recruitment
- Diversification of leadership
- Professional development
- Inclusion
- Board membership and training
- Stakeholder education

Organizational Culture

1 Overt	2 Neutral	3 Cosmetic	4 Proclamation	5 Implementation	6 Realization
Celebrates White Supremacy Culture (WSC)	Unaware of WSC	Denies WSC	Acknowledges WSC	Addresses WSC	No longer practices WSC

Overview

In terms of organizational culture, our inquiry places you in the Cosmetic category on the road to internal racial equity. This means on the whole, at this juncture, Lewis and Clark Public Health denies the impact and influence of White Supremacy Culture within the organization. Its effects are noted by example in the section above (identify and mission), manifested in the pushback originally seen at the request of the audit. However, in its ability to remain hidden (WSC), one can look at the reticence to proceed with the audit as emanating from a "few bad apples" or "some folks adopting a defensive posture at the prospect of being called racist," as opposed to structurally ingrained presence of White supremacy in almost every aspect of discourse and interchange. Please note, this is not an unusual assessment of any number of similar organizations and is central to why racial equity audits are necessary.

The good news is that there are a number of dedicated, conscientious individuals who have championed these issues and all indications are that they will continue to champion the development of an anti-racist ethos within the organization.

Compounding issues relative to the audit, Lewis and Clark Public Health was able to offer up only a limited number of individuals to participate in the focus groups, effectively truncating this team's ability to obtain a significant cross-section of associated opinions and concerns. We were therefore left to glean a broader sense of organizational culture from the documents provided.

With this in mind, we looked for themes and were able to offer improvement suggestions regarding areas containing directives, policies and guidelines which require further organizational scrutiny as they relate to questions of equity.

Most Prominent Theme Noted:
Perhaps what leapt out most forcefully from our audit centers on the difference between how Lewis and Clark Public Health articulates policy and how those expressions are acted out in practice i.e., there are multiple policies ostensibly relating to diversity, equity, and inclusion, but less work has been done on how to implement them and evaluate their impact. Lewis and Clark Public HealthD appears to be further down the road in defining policy and plotting matrices but less so regarding how to utilize the obtained data to assist in charting an anti-racist course forward.

Primary Barriers

What aided in pinpointing this characterization?
As indicated below, there are several areas highlighted in various pieces of documentation put forth by Lewis and Clark Public Health that speak to the structure of policies and practices related to diversity, equity, and inclusion. We provide auditor commentary as it relates to our findings.

Workforce profile
Auditor Comment:
There is limited ethnic and cultural diversity within the current staff. The organization recognizes the need to apply more effort in the areas of recruitment and retention in creating a more diverse workforce. However laudable, until such time diversity hires are made, you may be better served in shifting resources into examining areas with similar demographics which have achieved this goal. Some options include: advertising in minority publications (print and electronic media sources), scrutinizing the language used in your ad, highlighting policies and procedures that appeal to diverse candidates. These examples can lead towards hiring competent, diverse employees.

Barriers to hiring minority candidates
Your document reads - “The population of Lewis and Clark County and of Montana in general is predominantly White. Given the tiny pool of people of diverse ethnicities and language skills, it’s difficult to hire and retain a diverse workforce.”

Auditor Comment:
Irrespective of this consideration, there are no clearly defined efforts currently in place to address this concern.

Furthermore, the documentation we reviewed states that cultural competency training is a staff requirement within one year of hiring. However, there was limited information which clearly expressed what terms and conditions the current training entails. We could not locate public information advising who the presenters were and how frequently the training curriculum was updated, all pertinent considerations in assessing the value aspect of the directive.

Evaluation and Tracking
From your document:
“Evaluation of training will provide Lewis and Clark Public Health with useful feedback regarding its efforts, including content, delivery, vendor preferences, and training effectiveness. Accurate evaluation and tracking are necessary, particularly for professional continuing education documentation and quality improvement purposes. This section describes how evaluation and tracking of training will be
conducted.”

Training

From your document:

Training offered by the department will be evaluated using course evaluation surveys. Pre- and posttests on course content may be used where appropriate. External training will be assessed in the training planning and review activities overseen by the health officer through interviews with supervisors and staff. The department will also repeat the all-staff competency assessment every two years to evaluate the level of knowledge and competency of the staff as a whole and the effectiveness of ongoing training programs and policies.

Mandatory staff trainings will be tracked with the goal of 100 percent staff participation. The number of staff who complete additional trainings, and the nature of the trainings, will also be tracked.

Auditor Comment:

In all of the above, we did not detect information as to how feedback/evaluative criteria from these areas was assessed or applied.

Recruitment protocols

Auditor Comment:

As regards the candidate interview evaluation form, it may be helpful to have delineated specific areas of evaluation. Similarly lacking was a description of where are you advertising, a critical question when it comes to the stated desire to hire minority personnel.

This section raised the further questions: Are there Lewis and Clark Public HealthD internships geared towards minority candidates? Also in terms of expanding your application base, are there recruitment meetings in minority communities? We would suggest you explore educational academic institutional partnerships where internships and “shadowing” opportunities may present themselves. The Health Careers Opportunity Program or “HCOP” at the University of Montana serves as one example.

Reference check form

Auditor Comment:

This form as well as in other instances provides Lewis and Clark Public HealthD an opportunity to replace out of date pronoun usage (him/her) with broader identity defining terminology (them/they/their).

Recruitment checklist

Auditor Comment:

In selecting a diverse hiring team, representatives should where possible include BIPOC individuals as well as those possessing multiple identity definitions

Quarantine policies

Auditor Comment:

Nowhere could we ascertain how Lewis and Clark Public HealthD assessed how these considerations impact Native communities. If you are inquiring as to how quarantine policies are played out in these areas what are the concerns? They could have been delineated in one of your many newsletters.

Inclusivity

Auditor Comment:

Your policy statement on inclusivity advises you welcome “all people and (Lewis and Clark Public Health) is committed to creating an environment that supports full access and participation for each and every person. We value the diversity of our community and appreciate the contribution that all individuals can bring based on their diverse abilities, skills, backgrounds and/or culture. It shall be the policy of Lewis and Clark Public Health to strive to develop and continually maintain a culture of inclusion in all of our activities, services, and facilities.”

Auditor Comment:

In order to move forward towards an anti-racist organization, it is imperative you not only state in policy terms what your intent is, you must also provide documented evidence of how this strategy plays out in application. Lacking that specific clarification, it weakens your original stated intent.

Under best practices you include “input and feedback from individuals with lived experiences from underrepresented groups.” This statement begs the question, “Where is this borne out? What meetings have you held? Who were the individuals invited?”

Further along in the document it states, “all staff will have the opportunity to attend inclusiveness training annually.” Mandate language here would offer much more clarity.

In the next three to six months:

1. Establish better lines of communication between Lewis and Clark Public HealthD and BIPOC communities (contact tribal leaders, community stakeholders).

2. Highlight internal events and group presentations relative to DEI work underway within the organization e.g., through increased social media education presence, “brown bag lunch sessions,” expanded content in organizational newsletter to include BIPOC community/employee narrative articles on health care and race.

3. Consider developing and implementing a diversity, equity, and inclusion statement to plan along with mission vision and values (expand on values statement to include diversity and equity).

4. Include in Wellness Program (1.2.15) attention to stress reduction from issues of systemic racism, etc.

5. Include in Performance Review policy (1.2.14) a statement about evaluating efforts to dismantle racism in areas of responsibility.

6. Integrate attention to responses for workplace harm due to racism as a part of Workplace Safety Program (1.2.13) and education on how to avoid them.

7. Add “or racial identity” to Complaint Procedures: Employee Grievances and Unlawful Discrimination Complaints (1.2.12) A.1.c Employee Complaint Procedures - General; and make it clearer that reports do not only have to be given to the H. R. director;

8. Add language about time off for cultural events and family responsibilities in General Work Rules - Hours of Work, Overtime and Travel (1.2.10).

9. Add “or racially harass or condone racial harassment” to #2 of Lewis and Clark County Code of Ethics.

10. Expand K. Bereavement Leave Pay of Employee Benefits - Leave Provisions (1.2.8) to include close family members such as uncles or aunts; update legal holidays list to include Juneteenth holiday;

11. In Recruitment and Selection policy (1.2.4) consider including preference points or consideration for being members of a BIPOC community as part of the evaluation process for new hires (E.10.b and F. 8.b.); add in diverse news outlets such as Historic Black Newspaper and Indian Country Today to list of postings (F.1.b.); Specifically name “sexual and racial harassment” as part of C. 1. of General Personnel Policies, and Policy Statements and Definitions (1.2.1).

Recommendations

<u>In the next six to nine months:</u>

1. Create and implement an annual Lewis and Clark Public Health DEI report card.This is a clear way to promote transparency and gauge organizational progress on the provided timeline to becoming an anti-racist organization.

2. Hire a Lewis and Clark Public Health Tribal Outreach Specialist. This individual can act as liaison between Lewis and Clark Public Health and Indian County with the described intent of increasing your application pool as well as assisting established Tribal Education entities centered on health care and nutrition.

3. Consider working with/expanding your relationship with existing minority health organizations in the local community e.g., the Helena Indian Alliance. This level of outreach will aid in cementing your identified need to expand diversity hiring, identifying

heretofore unknown important health care related issues particular to minority communities and may present as an opening to diversify board membership

<u>In the next twelve to eighteen months:</u>

1. Develop and implement a Racial Equity Assurance Team. This team is tasked with the review and assessment of existing organization components directed towards racial equity with the directed end of operationalizing and implementing these findings. Its central aim is to ensure both transparency and uniform movement towards the stated goal of anti-racism within the organization. This team should have representation at all levels of the organization (board members, leadership, management, and staff) and should be granted some level of agency to make changes.

2. Commit to issuing racial impact statements, particularly as they pertain to the likely impact programs will have in identified minority communities. Implementation of this strategic consideration will aid in developing/expanding collaborative relationships with impacted communities and individuals central to the decision-making process in these areas.

Program Initiatives

1 Overt	2 Neutral	3 Cosmetic	4 Proclamation	5 Implementation	6 Realization
Intends to serve only White people	Claims program neutrality	Initiatives focus on celebration of diversity	Programs address hierarchy, privilege, and oppression	Programs address systemic inequality	Programs fully embody anti-racist values

Overview

Our audit places Lewis and Clark Public Health in the Neutral stage on the continuum. When looking through programming initiatives, it was evident programming was designed with a "neutral" lens, meaning one way will work for all people. Neutral also means that "White Supremacy Culture" and "Whiteness" are not being recognized or pointed out, rather they are accepted as the norm. Neutral also means there is a tone of color-blindness, meaning one would not see "race" nor ask for race on questionnaires or other surveys conducted.

We also see positive movement forward in this area through Widerstand training and audit process. As Lewis and Clark Public Health becomes more aware of the importance of shared analysis and common language around racism, then we believe this type of awareness beyond neutrality will ensue.

Primary Barriers

- One barrier is through funding and what is expected through that funding. Currently, funding to pursue these initiatives is limited. One way to increase that funding, is to access grants that will support your efforts to diversify your programming.

- As noted above, the lack of BIPOC staff at Lewis and Clark Public Health is another barrier.

- Historical harms done through healthcare to BIPOC communities and building trust with those communities is an additional barrier. Although Lewis and Clark may not have done the harm, you will need to see yourselves as part of a system that has done harm and therefore bears responsibility for the healing of that harm through trust building.

- Cultural differences in understanding "health" and "healthcare." In particular, many indigenous communities view healthcare from a holistic perspective that incorporates family dynamics, traditional practices, community knowledge, and cultural world views. Our conversations with you and your staff indicate that many in your department are aware of these issues. They just need to be more widely held and disseminated.

- Using data in healthy ways that do not discredit BIPOC experiences of racism. For example, using statistics to reinforce a personal story as to why BIPOC should do cancer screening.

Primary Opportunities

- Talented and committed staff who are committed to implementing and developing these ideas;
- A commitment to serving the entire community through your programming initiatives;
- An observed understanding that health is a community-wide concern deserving of programming that reaches across the community;
- Strong partners in the community who share similar concerns about developing programming that serves the entire community.

Recommendations

<u>In the next three to six months:</u>

1. Consider revising CDC Hepatitis-C brochure to include images specific to the racial diversity and composition in Montana; likewise offer more racial diversity in Hepatitis-B brochure/fliers.

2. Revise graphics on vaccine requirements. The animal icons are confusing.

3. Examine distribution methods for paper-focused information on things like child care rules. Is there a need for this to be translated into Spanish? How can they be developed alongside community-based education initiatives?

4. Revise healthcare recommendations. It is currently overwhelming with technical data.

5. Make all your handouts available in English and Spanish (like PREP 101).

6. Again, use images specific to Montana in HIV testing fliers. It's a simple and effective presentation otherwise.

<u>In the next six to nine months:</u>

1. Revise and make more accessible the Behavioral Health Pathways document. Purpose and audience is unclear and needs more racially specific data.

2. Research Native American programs already in existence on "Tobacco." Have conversations on partnering with or information sharing. You have the opportunity to work with Native American communities on "Tobacco free" campaigns so that Lewis and Clark's messaging can be culturally competent and relevant. Many tribal communities view tobacco as sacred and use it in prayer.

3. Work with Native American communities on "Suicide" programming. Provide Native American specific hotlines and contacts.

In the next twelve to eighteen months:

1. Begin gathering water quality data with specific demographic information to allow for more detailed assessment of the effectiveness of the services you are providing.

2. As previously noted, pursue grant programs to fund diversity efforts so you can bring in new resources.

3. Initiate one new, specific program that seeks to address and educate about the historic harm perpetuated by the healthcare system as a first step toward building trust with communities harmed by those practices.

Staffing Patterns

1 Overt	2 Neutral	3 Cosmetic	4 Proclamation	5 Implementation	6 Realization
Whites only	Token representation	Less than 20% BIPOC staff; short-stays	Goals for greater than 20%; mid-term stays	Above 20%; stable duration	Sustained staffing; balanced representation

Overview

Although this section was difficult to scale, we believe at this point in time, Lewis and Clark Public Health is between a 2 and 3. The in-between rating is due to the transition the organization is currently in regarding the Widerstand learnings online and the audit. It is evident through focus groups that prior to these initiatives, Lewis and Clark was in the "Neutral" stage, but because of the commitment to learning about White Supremacy Culture and taking steps towards becoming anti-racist, LCCHD has begun the journey to stage 3.

Primary Barriers

- The geographic location of Lewis and Clark Public Health in a relatively homogenous community
- Current lack of BIPOC staff members.
- Lack of community support from some sectors to address "racism" or change current practices.

Primary Opportunities

- A willingness to and interest in building partnerships with organizations that are diverse so the relationship can be mutually beneficial, i.e. tribal communities;
- A readiness to consider, if permanent staffing positions do not allow for flexibility, entering into contracting possibilities;
- An openness to work with other organizations on recruitment & advertising in diverse communities.

Recommendations

<u>In the next three to six months:</u>

1. Include in the qualifications section, a statement in all new job descriptions about interest in and facility with serving a racially and culturally diverse population; ask for a willingness to support and engage with the department's commitment to anti-racism and DEI.

2. Add to WIC Clinic Coordinator job description: Gathers height, weight, and biochemical information as needed *in a culturally sensitive and appropriate manner*; in Knowledge Skills & Abilities, add *connections with or ability to develop connections in our county's*

diverse populations, especially among the Native communities in our county. Insert similar language where appropriate in other job descriptions.

<u>In the next six to nine months:</u>

1. Look at job descriptions that face the public and add language around “able to engage with diverse” populations and make it a point of evaluation.

2. Explore contracts and contracting for catering, etc. and use BIPOC vendors.

3. Explore non-traditional recruitment and advertising methods for new hires.

<u>In the next twelve to eighteen months:</u>

1. Reflect on staffing goals for the past year and move forward with implementation. How will you know you have achieved what you wanted to achieve?

2. Start thinking about BIPOC retention. After recruitment and hiring, how will your space be “safe” for BIPOC and keep them working for you?

Accountability

1 Overt	2 Neutral	3 Cosmetic	4 Proclamation	5 Implementation	6 Realization
To Whites exclusively	Deemed unnecessary	"Safe" BIPOC connections	Commits to accountability	Implements accountability	Fully integrates accountability

Overview

The majority of public health departments in the country pay scant to little attention to the broad topic of accountability. In short, this area of institutional life refers to the internal and external mechanisms and relationships through which actions to dismantle racism are evaluated, assessed, and encouraged. Many public health departments confuse the *intention* to address and remove barriers of institutional racism with the *realization* of those goals. Setting up and fostering clear and identifiable accountability processes and relationships is the first step toward making your goals in this area become a reality.

Primary Barriers

Our assessment is that the idea of accountability for anti-racist action is simply not on the radar of Lewis and Clark staff and leadership. As a result, you are at Stage 2 on the continuum - where accountability is deemed unnecessary. Our introduction of the idea in formal and informal conversations and discussions has generally been met by blank stares and lack of comprehension about what that might mean or look like. This is not unusual. Such a lack of familiarity with the idea of principled accountability for anti-racist action is further compounded by tightly regulated internal structure that will make fostering those relationships more challenging.

Primary Opportunities

At the same time, we noted how many of your public health workers - especially those who do community-based work - are attuned to the importance of maintaining healthy relationships in the community for purposes of education and delivery of services. Likewise, as our experience leading your training for trainers indicated, you have strong relationships with a variety of organizations in the community who - like you - are invested in building an anti-racist future. These local networks and history of relationally focused services will provide an important foundation for developing and pursuing accountable practices. Likewise, you have clear policies in place for staff evaluation that can be incorporated to this end.

Recommendations

<u>In the next three to six months:</u>

1. Set expectations to all subunits of the Lewis and Clark Public Health to submit their specific goals for dismantling racism in their areas of responsibility coming out of this audit process;

2. Support all supervisors to assist their reporting staff to identify individual goals for the same in their areas of responsibility. Goals can include specific recommendations found throughout this report, pursuing further anti-racism education and reading in the area of public health, participating in internal reflection and support groups, and/or developing new intercultural competency skills.

3. Set clear timetables for meeting these goals.

In the next six to nine months:

1. Include in all job descriptions clear expectations about the DEI goals of the department.

2. Implement any necessary changes needed in human resources policies to allow for regular and periodic assessment of employees' progress toward the anti-racism goals identified above. One of the most powerful tools for implementing institutional change comes at the level of employee performance review. Employ it.

3. Set up a task force to identify the best relationally focused mechanism for establishing external accountability relationships. Other public health departments have, for example, established advisory boards made up of leaders of the racially marginalized community in which they are situated, compensated them for their time, and had them give supportive and constructive feedback on the goals you have set for your anti-racism work and your progress toward meeting those goals. Many times this requires going to the recognizable community group organizations, seeking out leaders, and listening to their concerns. As noted above, you have field workers who are connected to the local community in substantive ways. Build on those networks.

In the next twelve to eighteen months:

1. Implement the review process for all staff and leaders as described above.

2. Hold at least one conduct of your accountability group (we encourage you to think creatively about what community accountability can look like in its practical form. It may not be a formal meeting but rather a set of focused conversations). The key issue here is fostering and maintaining relationships that will call you out should you back away from your expressed anti-racism commitments.

3. As needed, provide members of your accountability community with anti-racism training resources so that you are operating from a common set of assumptions and frameworks about the issue of racism. As noted elsewhere in this report, our experience with your focus groups makes evident that there is a deep divide within your organization around definitions of racism. The vast majority of your leaders and staff limit their definitions of and approach to racism to overt displays of hostility and violence, but have not yet

understood the institutional nature of racism as expressed in policies, procedures, and structures. The work of developing a common framework for dismantling racism is ongoing and essential to making such accountability relationships work.

Structure & Constituency

1 Overt	2 Neutral	3 Cosmetic	4 Proclamation	5 Implementation	6 Realization
Designed for White control and access	Keeps control and access hidden	Leaves control and access untouched	Examines and analyzes control and access	Engages in restructuring to undermine White Power structures	Realizes restructuring

Overview

Public health workers as a subset of the medical profession community are especially well prepared to think about and respond to issues of structure and constituency. By necessity, public health measures are fundamentally structural and require careful consideration of the dynamics of politically and socially diverse constituencies. Your department already has rich - if controversial - experience and history of dealing with those issues through your efforts to address the ongoing COVID pandemic. The following discussion is focused first and foremost on the internal structures of your organization and means for addressing them.

Primary Barriers

We find you to be between the cosmetic and proclamation stages in terms of implementing anti-racist values into your structure and understanding of constituency. In terms of the former, the principal barrier is one faced by many public health departments - the structures in place are deeply affected by the political process, both in terms of ultimate accountability and in terms of periodic shifts in priorities based on electoral results. Unlike private medical institutions - by comparison - the relationship with your constituency is often fraught with challenges arising from that political process. Constituency members can quickly become polarized and anti-racist measures receive disproportionate public scrutiny.

Primary Opportunities

At the same time, we have been impressed by the transparency and clarity present within your system around structure and constituency. The policies we reviewed make evident that the organization has clear, relatively uncomplicated lines of authority. There are principled and transparent means for addressing change within your department. Your staff leadership has also been non-anxious and non-defensive around the power they hold over control and access to the resources of your department.

You also have a clear mandate to serve the entire constituency of Lewis and Clark County. This later point, more than any other, positions you well for the work of dismantling racism. In essence, you are tasked with serving all members of your constituency and, as such, need to prepare yourselves for doing so, especially as you see new members moving into your area, whether from the international immigrant community or a growing Latinx community.

Recommendations

In the next three to six months:

1. Develop and release a new set of educational materials on public health issues related to racism such as historical trauma, implicit bias, community access to medical care, etc. with the goal of fostering a more informed and supportive constituency in the county.

2. Debrief this anti-racism audit process with political leaders in the county. Explain the initiatives you will be taking. Identify the rationale for doing so drawing on the resources contained in this report. Maintain open lines of communication and invite participation in ongoing work in this area.

3. As suggested above, create an internal anti-racism task force - building on the team that invited this audit to begin with - and give them both budget authority and financial resources to work with. The most successful teams we have seen in other predominantly White institutions invest a minimum of 5% of their annual budget to support DEI efforts. Replicate this in your structure as well.

In the next six to nine months:

1. Develop clear, direct mechanisms for tracking public health delivery of service by race and ethnicity. In the absence of these data sets, you end up relying on anecdotes and supposition rather than evidence. Race-specific aggregate data is absolutely necessary for developing public health programming that reach and meet the needs of the diversity within your county.

2. Conduct a focused listening project run by staff members on the specific public health needs of underserved constituency members within the county. First, identify a set of clear, direct questions about the public health issues that are important to interviewees. This can be done effectively by inviting them to talk with you about health and safety challenges they have faced in the last several years, the resources that they currently can draw upon to meet them, and what they would like to see in place to help them meet those needs.

3. Have the anti-racism task force give regular updates on the department's progress toward dismantling racism. Expect that this will be a normal and appreciated component of your collective work together.

In the next twelve to eighteen months:

1. Identify the top three changes emerging from your listening project of currently underserved constituency members. Develop a plan for implementing them in the course of the next six months. Again, build in clear mechanisms for evaluation, assessment, adjustment, and implementation with identifiable time tables.

2. Structure in an every six-month review of your delivery of service based on the statistics gathered through the new tracking measures put in place as suggested above. Make adjustments in service delivery models based on that assessment, particularly in resources invested in community outreach and connection.

Long-term Recommendations

This report has been set up around the expectation of a one-year planning cycle. As is often the case in pursuing public health measures, however, effective work is long-term work. Thus, we encourage you to also develop a longer-term plan for dismantling racism looking ahead toward a scope of 5-10 years ahead.

Begin by identifying the kind of organization you want to be by that point. Ask yourselves:

- What will our staffing look like in terms of racial diversity?
- What kind of exciting new programming and service delivery will allow us to reach all members of our county?
- What new or re-invested resources do we need to reach these goals?
- How can we build on the accountability relationships in which we have invested time and energy? Are there any suggestions emerging from the listening project in which we have engaged?
- What kind of new partnerships can we envision?

The work of public health will, of course, also change and develop in this time. New research, new health challenges, and new means of meeting them will also develop. You will be equipped for meeting those challenges in anti-racist way if you begin now to project ahead what your work will look like. Let that vision guide you.

In an early meeting with our organization, your staff leaders indicated that they wanted to be leaders in the work of anti-racism not only in the county but across the state. We believe you are situated to do this very thing by leading by example to find your way forward and model how you can do so even when the decision to even begin preparing to do the work proves controversial.

Closing Comments

As we mentioned at the outset, when we do honest introspection we may find that we are not who we believed ourselves to be. The feeling of hurt, fear, and frustration may arise. When that happens we should grieve the loss of who we thought we were. The grief/loss process is not a linear process. The stages are Denial, Anger, Bargaining, Depression, and finally Acceptance.

The challenge is how to identify these stages in a corporate context. Denial is the easiest: “there has been a mistake. This is not who we are at all.” Anger and bargaining will be just as obvious: “There was something wrong with this process or these people clearly don’t know us or maybe we should have another group take a second look at us.” Depression may manifest as loss of energy for the programs we currently run: “Well if everything we do is racist why should we do anything? Damned if we do and damned if we don’t.” Acceptance is as it suggests: “This is who we are, these suggestions are how we change.”

As you work through the process of acceptance, you will become more dependent on your relationships with the accountability relationships discussed above. That is crucial. As you progress, you will become more independent as you see the results of your long-term educating and organizing. Interdependence: you continue to set and reach milestones and benchmarks in your long-term plans and work with, receive support from and give support to like-minded organizations.

Follow-up

We recognize the potential difficulty of implementing the recommendations we've made in this report. This is difficult work and can be tricky to navigate. If you find yourself stuck or needing support, we are available in the following ways:

- Additional consultation and support on implementation;
- Additional anti-racist analysis training for congregation and local partners;
- Additional training on accountability;
- Check in at the six-month point.

If you find yourself in this place, you can initiate contact directly with Tobin Miller Shearer by emailing him at tobin@widerstandconsulting.org.

Public Health Workforce Calculator:
Basic (Streamlined) Outputs

PHAB phnci

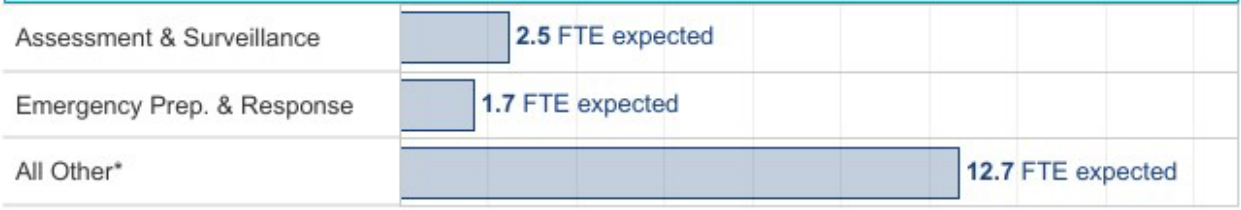
Results are shown below. Click the buttons (left) to navigate to previous screens; note that the results are preserved unless you change them. To export and save these results, click the "Download" icon in the gray Tableau toolbar at the bottom of the calculator.

Lewis and Clark Public Health (MT)
Estimated FTEs Required to Provide Foundational Public Health Services
Scenario: 2023 Workforce Capacity Assessment

While expanded services and community needs are part of what your FTEs are providing, given the inputs you provided, the calculator estimates that a local health department (LHD) serving a population of 71,000 requires a total **37.4** FTEs providing FPHS, to meet the needs that you identified. The bar graphs below show detailed estimates of the full staffing required for such a LHD to provide FPHS to its population.

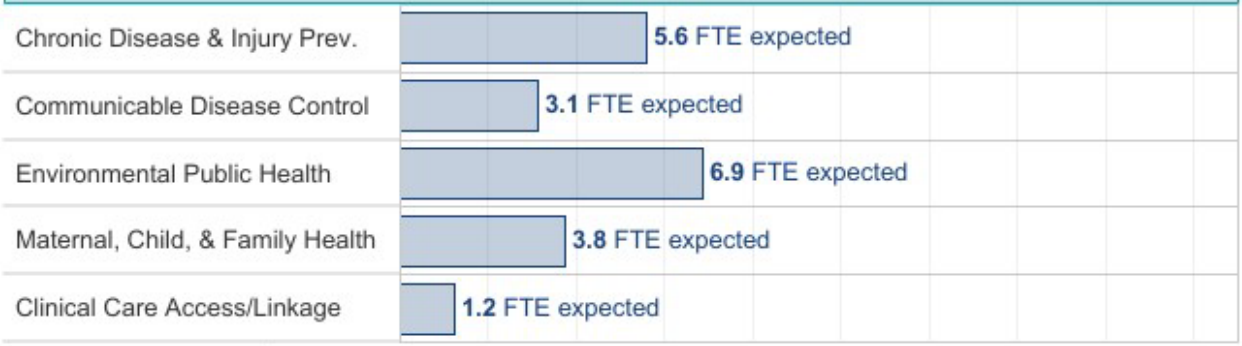
Detailed Estimates of Full FPHS Staffing Required

Foundational Capabilities require **16.8** FTEs.



* Includes the following Capabilities: Equity, Organizational Competencies, Policy Development & Support, Accountability & Performance Management, and Communications.The Expanded version of the calculator provides experimental estimates for each of those six Capabilities.

Foundational Areas require **20.6** FTEs.



de Beaumont

Development of the Public Health Workforce Calculator was supported by the de Beaumont Foundation and the Centers for Disease Control and Prevention, Center for State, Tribal, Local and Territorial Support.

LCPH Annual Training Plan – working document
March 2023 - 2024

REQUIRED

What	How	Source/Who	When	Status
Ethics *per policy Share review of ethics in COVID	online modules All Staff meeting	APHA Laurel, Brett, Drenda	Annually January Upon completion	
Inclusiveness *per policy	varies	Inclusiveness Committee determine topic and source of training	annually	Topics covered in the Cultural Competency area cross over (I.e. Disability, LGBTQ+)
PHI/HIPAA *per policy	Online module	IT	Annually February	
Cultural Competency, humility, sensitivity *per policy	lunch and learns	Various experts to present on a wide variety of cultures identified by Racial Equity workgroup	Strive for monthly, success = 6-9 throughout the year	April – American Indian P.1 May – American Indian P.2 Sept – Afghan refuge Oct – Disability Nov – LGBTQ+
Language Link (interpretation service)	Virtual all-staff session	Staff who have experience (WIC, HV, LE)	Annually August	
Quality Improvement *per plan	Varies, video	Quality Council	Annually March	
Blood Borne Pathogens *per policy **Nurses, WIC	In person	PH Nurse	Annually September	
QPR	In person, classroom	POC Jess Hegstrom x 8970	Annually	
ACEs – start with the basic, build upon each year	In person, classroom, videos, books, trauma informed tool, online		Annually Basic 1x Advanced 1x	

CPR *Nurses required Offered to all as space available	In person		Annually	
HR Talks Required for supervisors	Virtual *Discuss content at monthly STAR-T	County HR	Monthly (ish)	
Safety	Staff meetings	Safety reps	Monthly	
CONNECT/211/988/LIFTS	All-staff meeting (virtual or in-person)	Julie, Jolene	Annually May	
Core Competency training (2022 WAS) Data Analytics & Assessment skills Policy Development and Program Planning Skills Management and Finance skills	Webinar hosted by MT PHTC Competencies, Capabilities, and Strategic Skills: an Introduction to 21st Century Public Health Fundamentals Part 1 and 2 (not sure if these will be recorded and available at a later date)	Webinar hosted by MT PHTC Session trainer: Stefanie Tassaro		
Foundational PH training (2022 WAS) Access to and Linkage with Care	Can this be achieved by the CONNECT – 211 – 988 – LIFTS training already planned?			

OPTIONAL

What	How	Source/Who	When	Status
LCPH will provide or otherwise ensure that training in human-subject protections will be provided to employees as needed if it is deemed appropriate for their role in a research project.			**If human research is needed**	
Defensive Driving			As available	
ICS 200, 300, 400, 800 Dependent on position	In person		As available	
STAR-T (leadership and staff)	In person for leadership As needed for all staff	Senior Leadership Team	Monthly for leadership As needed for all staff	

LEWIS & CLARK CITY/COUNTY BOARD OF HEALTH
Helena, Montana

BOARD AGENDA ITEM

Meeting Date	**Agenda Item No.**
March 23, 2023	**6**

___Minutes ___Board Member Discussion _X___Staff & Other Reports ___Action ___Hearing of Delegation

AGENDA ITEMS: Health Officer's Report

PERSONNEL INVOLVED: Public Health Staff

BACKGROUND: Strategic Plan Update; Legislative Update; Local Governing Body By-Laws Update

HEALTH DIRECTOR'S RECOMMENDATION: N/A

___ADDITIONAL INFORMATION ATTACHED

BOARD ACTION: **NOTES:**

	MOTION	SECOND	AYE	NAY	ABSTAIN	OTHER
Bedell						
Collins						
Harris						
Kaufman						
MacLaurin						
Murgel						
Rolfe						
Weber						
Weltz						

Lewis & Clark Public Health

LEWIS & CLARK CITY/COUNTY BOARD OF HEALTH
Helena, Montana

BOARD AGENDA ITEM

Meeting Date	**Agenda Item No.**
March 23, 2023	**7**

___Minutes __X_Board Member Discussion ____Staff & Other Reports ___Action ___Hearing of Delegation

AGENDA ITEMS: Public Comment

PERSONNEL INVOLVED: Public and Board Members

BACKGROUND: Time is allowed for public comment on matters not mentioned in the agenda within the Board of Health's jurisdiction.

HEALTH DIRECTOR'S RECOMMENDATION: n/a

___ADDITIONAL INFORMATION ATTACHED

BOARD ACTION: **NOTES:**

	MOTION	SECOND	AYE	NAY	ABSTAIN	OTHER
Bedell						
Collins						
Harris						
Kaufman						
MacLaurin						
Murgel						
Rolfe						
Weber						
Weltz						

Lewis & Clark Public Health

Attendance Record for the
Lewis & Clark City-County Board of Health

FY 2023

	Jul	Aug	Sept	Oct	Nov/ Dec	Jan	Feb	Mar	Apr	May	Jun
Bedell	X	O	X	X	X	X	X				
Collins	O	O	X	X	O	O	X				
Harris	X	X	X	X	X	O	X				
Kaufman	X	X	X	X	O	O	X				
MacLaurin	X	O	X	X	X	X	X				
McCormick	X	X	X	X	X	---	---	---	---	---	---
Murgel	X	X	X	O	X	X	X				
Rolfe	---	---	---	---	---	X	X				
Weber	X	X	X	O	X	O	X				
Weltz	O	O	X	O	X	O	X				

Legend:

X = Present

X_p = Present by phone

--- = Not a member of the board at that time.

O = Absent

* = No meeting held

P = Strategic Planning Session

T = Training

Lewis & Clark Public Health

1930 Ninth Avenue
Helena, MT 59601
PH: 457-8900
Fax: 406.457.8990

Tom Rolfe
County Commissioner
316 N. Park
Helena, Montana 59623
447-8304 (W) 447-8370 (Fax)
E-mail: trolfe@lccountymt.gov

(1)
Pleasure of L & C County Commission

Mayor Wilmot Collins
City Commissioner
316 N. Park
Helena, Montana 59623
447-8410 (W)
E-mail: wcollins@helenamt.gov

(2)
Pleasure of City of Helena Commission

Rex Weltz
Superintendent, Helena School Dist. No. 1
55 S. Rodney
Helena, Montana 59601
324-2001 (W)
E-mail: rweltz@helenaschools.org

(3,a)
Superintendent of Schools

Dr. Mikael Bedell -vice chair
710 Madison Ave
Helena, MT 59601
208-630-3848 (C)
E-mail mbedell@sphealth.org

(3,b)
Term expires - June 30, 2025

Lisa Kaufman
4322 Paso Fino Lane
Helena, MT 59602
438-1194(H) 444-5313 (W)
E-mail: lkaufman@mt.gov

(3,c)
Term expires - June 30, 2024

Mayor Kelly Harris
P.O. Box 1170
East Helena, MT 59635
438-1031(C)
E-mail: kharris@easthelenamt.us

(3,d)
Pleasure of East Helena City Council

Brie MacLaurin
710 N. Davis St.
Helena, MT 59601
461-0784 (C)
E-mail: brie@hmhb-mt.org

(3,e)
Term expires - June 30, 2025

Katherine Weber
3135 Bannack Drive
Helena, MT 59602
215-499-0050 (C)
E-mail: Katherine.weber@hotmail.com

(3,f)
Term expires - June 30, 2024

Justin Murgel- chair
2502 Gold Rush Ave.
Helena, MT 59601
422-9928 (H)
E-mail: Justin.Murgel@PacificSource.com

(3,g)
Term expires - June 30, 2024

Updated January 2023

"To Improve and Protect the Health of all Lewis and Clark County Residents."

LEWIS AND CLARK CITY-COUNTY BOARD OF HEALTH

1930 Ninth Avenue
Helena, MT 59601
PH 406.457.8900
Fax: 406.457.8990

MEMBERS

Katherine Weber	Term expires - June 30, 2024	First Term
Justin Murgel	Term expires - June 30, 2024	Second Term
Mikael Bedell	Term expires - June 30, 2025	Second Term
Brie MacLaurin	Term expires - June 30, 2025	Second Term
Lisa Kaufman	Term expires - June 30, 2024	First Term
Rex Weltz	Superintendent of Schools	
Tom Rolfe	Pleasure of Lewis & Clark County Commission	
Mayor Wilmot Collins	Pleasure of Helena City Commission	
Mayor Kelly Harris	Pleasure of East Helena City Council	

MEETING DATES FOR FISCAL YEAR 2023

Scheduled for 1:00 p.m. in Room 330 of the City-County Building.

July 28, 2022

August 18, 2022

September 22, 2022

October 27, 2022

December 1, 2022

January 26, 2023 Strategic Planning Session

February 23, 2023

March 23, 2023

April 27, 2023

May 25, 2023

June 22, 2023

January 2023