

Special Report: Inclusion Evaluators at Points of Dispensing

PHED Ex 2017 identified three official exercise objectives to test operations during a public health emergency. In addition, some local public health agencies elected to participate in an evaluation project that assessed inclusive practices at their open points of dispensing (PODs). POD sites have the most direct interface with community members during a public health emergency. Identifying strengths and challenges at points where emergency operations meet the people we serve can help us to build more effective, responsive and inclusive emergency systems.

INCLUSION EVALUATORS

Sixteen of 18 open PODs that operated during the exercise hosted an inclusion evaluator. These PODs represented each of Colorado's 9 All-Hazards Regions, as well as urban, rural, and frontier communities, providing an inclusive snapshot of Colorado's practices in 2017.

Local or state public health partners invited local community leaders and service providers to be Inclusion Evaluators. The 22 individuals serving as PHED Ex 2017 inclusion evaluators represented a wide diversity of personal and professional expertise:

- Area Agencies on Aging
- Independent Living Centers
- local housing authority
- long term care facility
- home care services
- Community Center Boards
- Early Learning
- multicultural organizations
- public health programs
- community members

Inclusion Evaluator training, guidance, and evaluation forms were developed by the Colorado Community Inclusion Workgroup based on the CMIST (Communication, Maintaining Health, Independence, Safety/Support/Services, and Transportation) framework for Access and Functional Needs (AFN). "The Community Inclusion Evaluation Form 2017" and other community inclusion resources used during PHED Ex 2017 can be found on the CDPHE webpage for [Exercise Series 2015-2017](#).

FINDINGS

The Inclusion Evaluators were asked to report what they observed on the day of the exercise to better understand what resources and strategies were available to support access and functional needs in the POD environment. The community inclusion criteria captured by the inclusion evaluators were not part of other exercise planning.

Each inclusion evaluator answered "Overall, how would you rate the quality of community inclusion in the exercise?" from poor (1) to excellent (5). The state average (16)* was 3.69.

The ranked questions and the state average* (on a 5-point "Strongly Disagree [1] to Strongly Agree [5]" scale) are provided in Table 1. The Inclusion Evaluators also provided open-ended observations to explain their ratings. Their insights and recommendations inform the *Strengths* and *Areas of Improvement* sections that follow.

Table 1. Inclusion Evaluator Rated Questions and Averages

| | |
|--|-------------|
| 1. POD staff were briefed on who may come to the POD with access and functional needs (AFN) | 3.93 (14)^ |
| 2. POD staff were trained on how to deliver access and functional needs resources (i.e. interpretation) | 3.81 (15)^ |
| 3. Communication capacities and resources were available to support access and functional needs | 3.72 (16) |
| 4. Health capacities and resources were available to support access and functional needs | 4.13 (16)^ |
| 5. Independence capacities and resources were available to support access and functional needs | 3.80 (16)^ |
| 6. Safety/Support/Services capacities and resources were available to support access and functional needs | 3.82 (15)^' |
| 7. Transportation/Movement capacities and resources were available to support access and functional needs. | 3.43 (16)^ |
| 8. Staff/coordinator requested feedback from the members of the public who participated | 4.35 (13)^ |

*number of PODs reporting. Multiple Inclusion Evaluators at one site were averaged for one rating per POD.

^other inclusion evaluator(s) indicated answers was NA (did not observe or attend briefing/hotwash)

'other inclusion evaluator(s) gave no response

Strengths

Different community profiles and populations across Colorado invite public health response partners to use different strategies to respond to their people. General strengths included:

- Briefing ALL staff on what access and functional needs may be expected in their community, and how to access support or resources for those needs at the POD (i.e. non-English forms, entry points for people with mobility difficulty)
- Communication:
 - Prepared materials in alternate formats and languages
 - Language services (staff; onsite or telephonic interpreters) that were able to accompany non-English speaking individuals through an entire POD, so individuals wouldn't have to restart explanations at each station
 - Low tech (pen/paper) solutions to fill temporary gaps in communication resources
- Health:
 - Having behavioral health and paramedics onsite.
 - Educating communities and practicing delivery processes to off-site locations with folks who would be unable to come to a public POD due to health fragility - Mobile PODs and closed PODs.
- Independence
 - People were given support tailored to their requests and needs
 - "When [staff] saw pin on participant saying 'face me to speak' she made sure to."
- Safety/Support/Services
 - The staff/volunteer to community member ratio during the exercise allowed runners to assist, help with flow, and fill out forms when needed.
- Transportation: there was generally good flow and adequate space through POD stations for people with mobility devices.

- Having a grant activity to invite non-traditional partners and having some funding available to support the inclusion evaluators helped to integrate inclusion efforts into the exercise and to spread understanding of public health preparedness in the community.
- Community members and community providers were asked for feedback, which revealed new resources for dispensing operations and access and functional needs.

Areas of Improvement

- Expressed concerns pointed to public information needs outside of POD sites to ensure that community members knew what AFN services would be available (i.e. advertising when and where interpreters would be available), and how questions could be answered after leaving the site (“Just handing folks a sheet of paper with directions and a bottle of meds isn’t enough”).
- Communication
 - Language resources were available selectively for some forms of communication and not others - i.e. non-English languages were used on signs that were then not available in forms, handouts or ability to communicate with staff.
 - “Personnel well trained, but when there were many people, one interpreter is not enough.”
- Health: How to ensure people understood instructions for taking medicine, especially if people were picking up medicine for others
- Independence: It was hard to test the effectiveness of some AFN strategies with low flow, or lack of attendance by representative community members. For example, when staff portrayed a wheelchair user, other staff consistently pushed the person (without asking permission), when permission would be expected etiquette for a wheelchair user.
- Safety/Support/Services: Inclusion Evaluators sometimes heard from staff that there would be separate PODs for access and functional needs and therefore, the public PODs did not need to have AFN resources. People with AFN could arrive in all locations.
- Transportation:
 - Some exercise PODs were not accessible by public transportation
 - ADA accessible exits and entrances were not integrated into POD flow, causing hard-to-follow detours for people with AFN or other resource-intensive tactics.
- State inclusion coordinator initiated inclusion evaluator project late in exercise planning, making it difficult for some local partners to participate in or coordinate.

CORRECTIVE ACTIONS

Based on these themes and other community inclusion feedback from PHED Ex 2017, five corrective action areas are suggested:

1. Standardize and fund inclusion evaluation projects and integrate them earlier into exercise planning.
2. Work toward more community representation and participation in exercises in order to test response systems closer to real conditions.
3. Plan some exercises for public education rather than system operations (i.e. Community Inclusion POD hosted by Rocky Mountain MRC and Tri-County Health Dept.)
4. Continue to develop AFN training and recommendations for public health responses.
5. Encourage local partners to integrate community experts and feedback into planning.