

## Appendix A

	Collaborative Score	Department A Score	Department B Score
<b>#1: Monitor Health Status and Understand Health Issues Facing the Community</b>	1.934	1.508	2.36
A: Data Collection, Processing and Maintenance	2.14	1.86	2.43
B: Disease Reporting Relationships	1.75	1.75	1.75
C: Community Health Assessment	2.4	1.6	3.2
D: Integrating and Sharing Data w/ Community Partners	1.63	1	2.25
E: Data Analysis	1.75	1.33	2.17
<b>#2: Protect People from Health Problems and Health Hazards</b>	3.37	3.32	3.42
A: Routine Outbreak Investigations	2.67	2.67	2.67
B: Alleviate Health Problems and Adverse Health Events	3.13	3.25	3
C: Coordination w/ Governmental Agencies on Investigation	3.25	2.75	3.75
D: Take Lead in Emergencies that are Public Health in Nature	3.83	3.83	3.83
E: Participate When Others are in the Lead	3.83	4	3.67
F: Access to Lab and Biostats Resources	3.38	3.75	3
G: Capacity for Emergency Communications and Data Exchange	3.5	3	4
<b>#3: Give People Information They Need to Make Healthy Choices</b>	2.60	2.58	2.62
A: Develop and Implement Media Strategies	3.13	3.25	3
B: Data and Information Exchange on Population Health Issues	2.9	3	2.8
C: Provide Health Information to Individuals for Behavior Change	1.92	1.83	2
D: Provide Health Promotion Programs	2.44	2.22	2.67
<b>#4: Engage the Community to Identify and Solve Health Problems</b>	2.33	1.52	3.13
A: Engage Partners in Community Planning Process	1.55	0.91	2.18
B: Raise Awareness and Support for the Plan and Activities	1.75	0.5	3
C: Support Partners to Implement Action	3	2	4
D: Develop Partnerships to Support Public Health	2.7	2.2	3.2
E: Reporting Progress and Advocating for Resources	2.63	2	3.25
<b>#5: Develop Public Health Policies and Plans</b>	2.68	2.14	3.22
A: Primary Resource for Policy Change in Public Health	3.06	2.63	3.5
B: Policy Advocacy for Health Improvement	2.1	1.8	2.4
C: LHD Role in Implementing Community Health Improvement Plan	2.88	2	3.75

	<b>Collaborative Score</b>	<b>Department A Score</b>	<b>Department B Score</b>
<b>#6: Enforce Public Health Laws and Regulations</b>	3.44	3.35	3.52
A: Review and Update Public Health Authority	3.36	3	3.71
B: Link LHD Practice to Existing Law and Regulation	3.5	3.25	3.75
C: Educate on Meaning, Benefit, and Purpose of Laws	4	4	4
D: Tracking and Understanding Compliance with Regulation	2.88	2.75	3
E: Competent and Fair Enforcement Actions	3.88	3.75	4
F: Notify Other Government Agencies of Enforcement Violations	3	3.33	2.67
<b>#7: Help People Receive Health Services</b>	1.81	1.16	2.47
A: Community-Oriented Program Planning	1.83	1.17	2.5
B: Prevention and Personal Healthcare System Building	1.6	0.8	2.4
C: Individual-Focused Linkages to Needed Care	2	1.5	2.5
<b>#8: Maintain a Competent Public Health Workforce</b>	2.53	2.12	2.93
A: Overall Human Resources Function/Workforce Capacity	2.38	1.75	3
B: Public Health Competencies of Existing Workforce	2.75	2.2	3.3
C: Developing the Future Workforce	2	1	3
D: Effective Public Health Practices Used by Other Practitioners	1.5	1.67	1.33
E: Provide Adequate Resources for Job Performance	4	4	4
<b>#9: Evaluate and Improve Programs</b>	1.17	0.67	1.67
A: LHD Evaluation Strategy Focuses on Community Outcomes	1.33	0.17	2.5
B: Use of Evidence-Based Methodology for Evaluation	1.17	0.67	1.67
C: Evaluate LHD Programs	1.67	1.33	2
D: External Evaluation of Other's Programs	0.5	0.5	0.5
<b>#10: Contribute to and Apply the Evidence Base of Public Health</b>	1.76	1.37	2.16
A: Participate in Research Activities	1.2	0.6	1.8
B: Disseminate Research Findings	1.83	2	1.67
C: Apply Research Results in LHD Activities	2.25	1.5	3

**Appendix B**

Collaborative Score	Department A Score	Department B Score
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**No Capacity---Minimal Capacity**

Themes: Evaluation, Data Analysis, Research Activities, Community Planning

9D: External Evaluation of Other's Programs	0.5	0.5	0.5
9B: Use of Evidence-Based Methodology for Evaluation	1.17	0.67	1.67
10A: Participate in Research Activities	1.2	0.6	1.8
9A: LHD Evaluation Strategy Focuses on Community Outcomes	1.33	0.17	2.5
8D: Effective Public Health Practices Used by Other Practitioners	1.5	1.67	1.33
4A: Engage Partners in Community Planning Process	1.55	0.91	2.18
7B: Prevention and Personal Healthcare System Building	1.6	0.8	2.4
1D: Integrating and Sharing Data w/ Community Partners	1.63	1	2.25
9C: Evaluate LHD Programs	1.67	1.33	2
1B: Disease Reporting Relationships	1.75	1.75	1.75
1E: Data Analysis	1.75	1.33	2.17
4B: Raise Awareness and Support for the Plan and Activities	1.75	0.5	3
10B: Disseminate Research Findings	1.83	2	1.67
7A: Community-Oriented Program Planning	1.83	1.17	2.5
3C: Provide Health Information to Individuals for Behavior Change	1.92	1.83	2

**Moderate Capacity**

Themes: Public Health Workforce, Health Education, Partnerships

8C: Developing the Future Workforce	2	1	3
7C: Individual-Focused Linkages to Needed Care	2	1.5	2.5
5B: Policy Advocacy for Health Improvement	2.1	1.8	2.4
1A: Data Collection, Processing and Maintenance	2.14	1.86	2.43
10C: Apply Research Results in LHD Activities	2.25	1.5	3
8A: Overall Human Resources Function/Workforce Capacity	2.38	1.75	3
1C: Community Health Assessment	2.4	1.6	3.2
3D: Provide Health Promotion Programs	2.44	2.22	2.67
4E: Reporting Progress and Advocating for Resources	2.63	2	3.25
2A: Routine Outbreak Investigations	2.67	2.67	2.67
4D: Develop Partnerships to Support Public Health	2.7	2.2	3.2
8B: Public Health Competencies of Existing Workforce	2.75	2.2	3.3
5C: LHD Role in Implementing Community Health Improvement Plan	2.88	2	3.75
6D: Tracking and Understanding Compliance with Regulation	2.88	2.75	3
3B: Data and Information Exchange on Population Health Issues	2.9	3	2.8

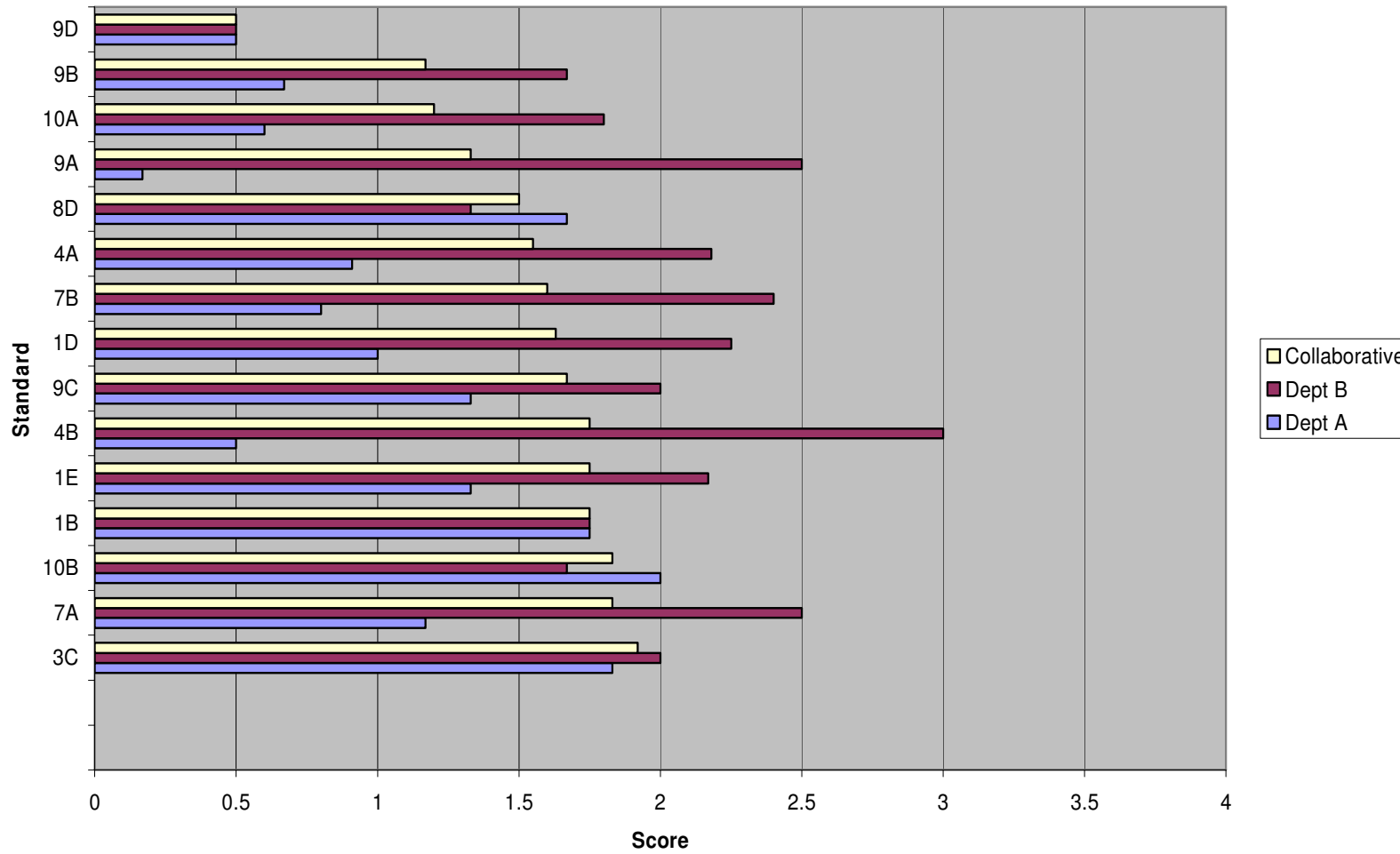
**Significant Capacity---Optimal Capacity**

Themes: Public Health Laws and Regulations, Health Problems and Health Hazards

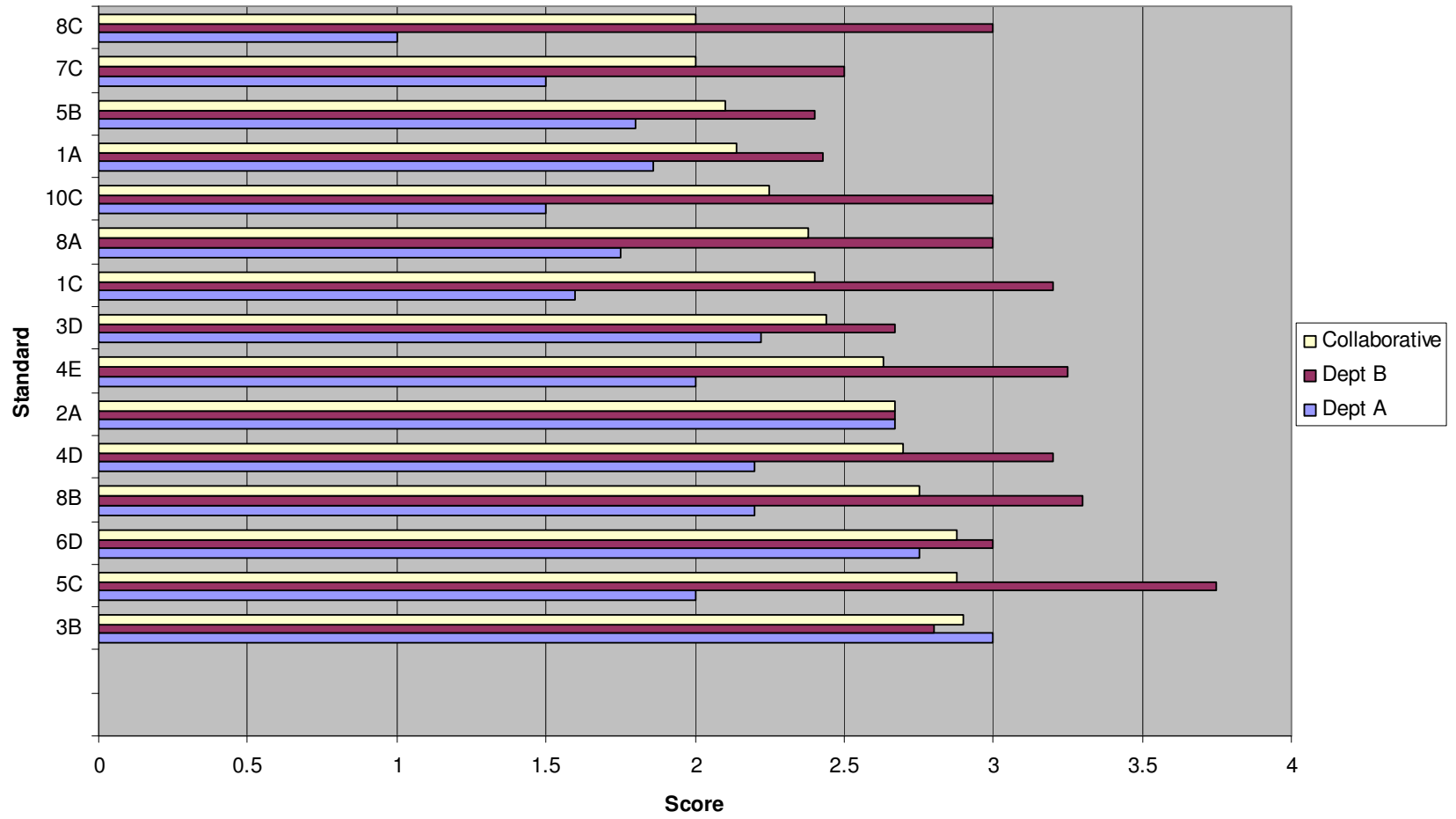
6F: Notify Other Government Agencies of Enforcement Violations	3	3.33	2.67
4C: Support Partners to Implement Action	3	2	4
5A: Primary Resource for Policy Change in Public Health	3.06	2.63	3.5
2B: Alleviate Health Problems and Adverse Health Events	3.13	3.25	3
3A: Develop and Implement Media Strategies	3.13	3.25	3
2C: Coordination w/ Governmental Agencies on Investigation	3.25	2.75	3.75
6A: Review and Update Public Health Authority	3.36	3	3.71
2F: Access to Lab and Biostats Resources	3.38	3.75	3
2G: Capacity for Emergency Communications and Data Exchange	3.5	3	4
6B: Link LHD Practice to Existing Law and Regulation	3.5	3.25	3.75
2D: Take Lead in Emergencies that are Public Health in Nature	3.83	3.83	3.83
2E: Participate When Others are in the Lead	3.83	4	3.67
6E: Competent and Fair Enforcement Actions	3.88	3.75	4
6C: Educate on Meaning, Benefit, and Purpose of Laws	4	4	4
8E: Provide Adequate Resources for Job Performance	4	4	4

Appendix C

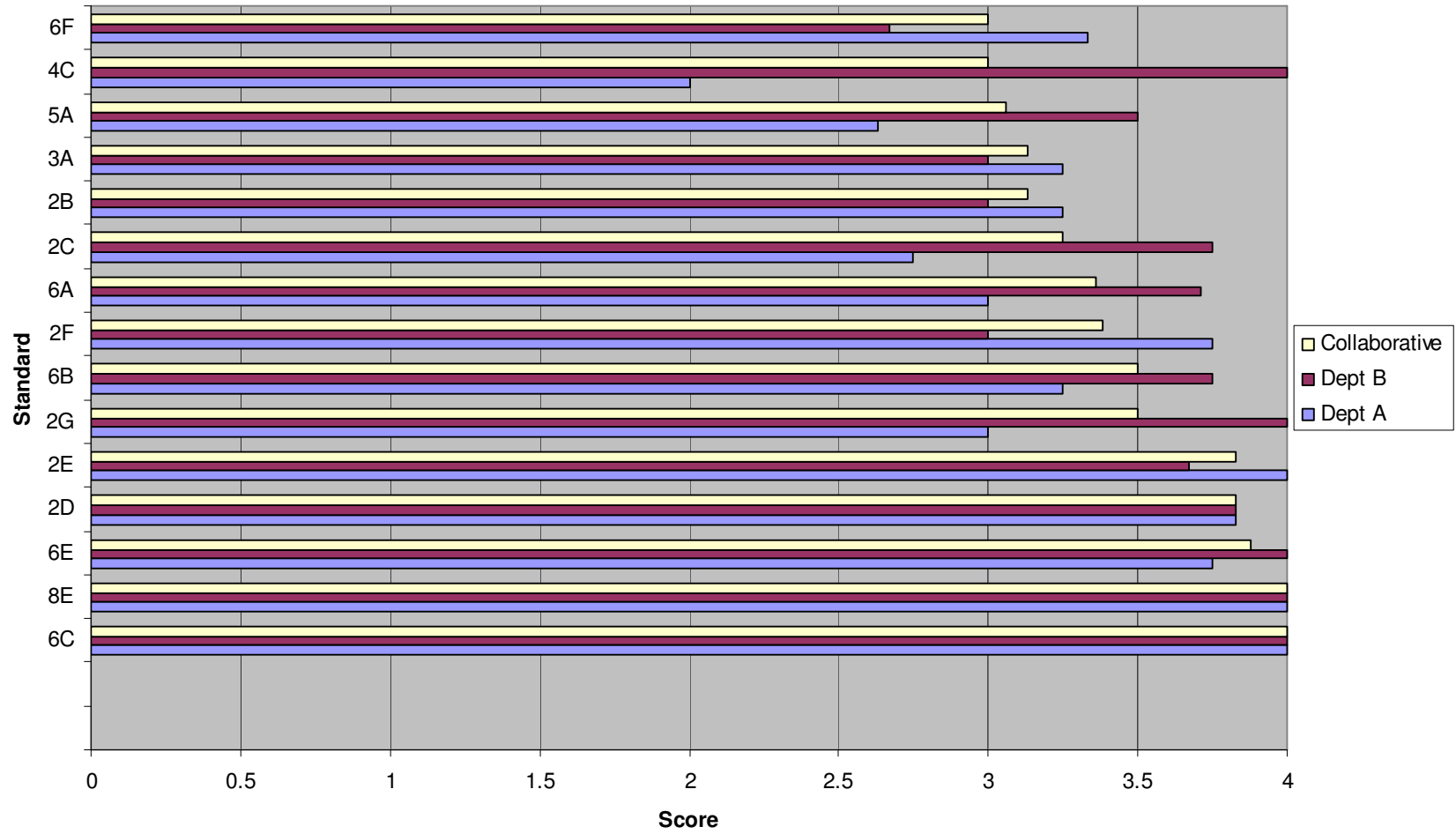
Standard Scores  
No Capacity---Minimal Capacity



### Standard Scores Moderate Capacity



### Standard Scores Significant Capacity---Optimal Capacity



<b>Appendix D</b>			
<b>Standard: 2A Routine Outbreak Investigations</b>			
Indicators	Documents/Activities that Demonstrate Indicator has been met	LHD Scores*	
		LHD 1	LHD 2
LHD has personnel on staff that can carry out an outbreak investigation	<ul style="list-style-type: none"> <li>○ Assess competency level of staff that provide routine outbreak investigations and report competency level, any additional training received to increase competency</li> <li>○ Updated list of names, degrees/credentials of those providing outbreak investigations; reviewed annually</li> </ul>	4	3
LHD has a surveillance system that triggers investigations	<ul style="list-style-type: none"> <li>○ Written documentation of the type of surveillance system that is used to trigger investigations and criteria for initiation of an investigation</li> </ul>	2	2
LHD uses appropriate investigation techniques	<ul style="list-style-type: none"> <li>○ Written protocols document the investigation process, including identifying information about the disease, case investigation steps, reporting requirements, contact and clinical management, use of emergency protocols, and the process for exercising legal authority for disease control</li> <li>○ Information on leading industry in the community and any associated health risks</li> <li>○ Information on local employment and related occupational risks</li> <li>○ Report showing review process of health problems and environmental health hazards</li> <li>○ Electronic database is used with standardized case investigation protocols</li> </ul>	2	3
<b>Standard 3B: General Data and Information Exchange on Issues Affecting Population</b>			

<b>Health</b>			
LHD works within a network of stakeholders to gather and share data and information	<ul style="list-style-type: none"> <li>○ Notes from meetings with community stakeholders demonstrating communication and exchange with key community partners</li> </ul>	3	2
LHD continuously develops current information on health issues that affect the community	<ul style="list-style-type: none"> <li>○ LHD has protocols and/or strategies in place to guide the development of up to date information to communicate to the community</li> </ul>	3	3
Responds to requests for information in a timely manner	<ul style="list-style-type: none"> <li>○ LHD has a written protocol in place to respond to specific information requests</li> <li>○ Log of responses to requests for health information</li> </ul>	3	4
LHD uses principles of social marketing to understand the information needs of specific populations	<ul style="list-style-type: none"> <li>○ Process in place to assess the information needs of specific populations and also the type of information and venue to use in providing the information</li> <li>○ Evaluation process in place to assess the outcome of the provision of information</li> <li>○ Log of information provided to specific population</li> </ul>	2	3
The public knows how to obtain health data and information from the department	<ul style="list-style-type: none"> <li>○ Communication plan includes educating the public in how to obtain data and information from the department</li> </ul>	3	3

\* Scores:

- 0= No Capacity
- 1=Minimal Capacity
- 2=Moderate Capacity
- 3=Significant Capacity
- 4=Optimal Capacity

Appendix E					
<b>Evaluation Pomperaug and Naugatuck Valley Health Districts--NACCHO Collaborative</b>					
<b>June 13, 2008</b>					
	<b>A</b>	<b>B</b>	<b>C</b>	<b>D</b>	<b>E</b>
<i>Please rate <u>all</u> questions by placing a check under the appropriate letter (A being the highest and E being the lowest rating).</i>	<b>Strongly Agree</b>	<b>Agree</b>	<b>Somewhat Agree</b>	<b>Disagree</b>	<b>Strongly Disagree</b>
Q1. The facilitators were knowledgeable and well prepared.					
Q2. The information regarding the summary reports was clear.					
Q3. Having summary data presented in different formats was helpful.					
Q4. Establishing criteria for determining priority areas was helpful.					
Q5. The group exercise was helpful in identifying potential priority areas.					
Q6. I was provided sufficient opportunity for input.					
<b>Additional Comments:</b>					
Do you have any suggestions for presenting the summary data?					
Did you find any of the summary reports more helpful?					
Do you have any other suggested methods for identifying priority areas?					

## Appendix F

### **Mutual Aid Agreement Between Naugatuck Valley Health District and Pomperaug Health District**

This Agreement, made this 18<sup>th</sup> day of November 2008 by and among the Naugatuck Valley Health District and the Pomperaug Health District.

WHEREAS, these Health Districts recognize that outbreaks of communicable diseases may exceed the response and recovery capabilities of a single health District to preserve and protect the health, safety, and welfare of its residents; and

WHEREAS, local Health Departments in Connecticut lack the resources to effectively respond in isolation to large scale disease outbreaks and associated follow-up; and

WHEREAS, the Connecticut Department of Public Health can provide technical support and assistance but may also lack sufficient staff resources; and

WHEREAS, the Health Districts recognize the need to develop standardized protocols, processes and procedures to effectively address and enhance mutual aid and assistance in the event of an outbreak of a communicable disease that exceeds the capability of any one District; and

WHEREAS, there have historically been informal agreements between the Districts to provide mutual aid in response to incidents that exceed the resources of any one jurisdiction; and

WHEREAS, local governments may elect to enter into mutual aid agreements to prevent and combat the effects of a public health emergency as defined in Public Act 03-236 of the Connecticut General Statutes and the Public Health Emergency Response Act.


NOW THEREFORE, IN CONSIDERATION OF THE FOREGOING RECITALS, the Parties hereto agree as follows:

1. To work cooperatively to establish a mutually agreed upon set of standardized protocols, processes and systems for the identification and investigation of communicable disease outbreaks.
2. To work cooperatively to establish triggering mechanisms for requesting assistance from the other health District.
3. To work collaboratively on the design of an electronic surveillance system and corresponding database using standard case definitions.
4. To work collaboratively to develop baseline training requirements of Health District staff that would support outbreak investigations.
5. To furnish public health personnel, equipment, supplies and facilities and render such public health services to each other as may be necessary to respond to a communicable disease outbreak that requires a sustained level of response and recovery exceeding the capabilities of any single jurisdiction.
6. It is mutually agreed that each District's foremost responsibility is to citizens or its member towns and that the rendering of aid and assistance under the terms of this Mutual Aid Agreement are voluntary.
7. No liability of any kind or nature shall be attributed to or assumed by any District, either expressly or by implication, as a result of its refusal to render aid and assistance in response to a request pursuant to the terms of this Agreement. Further, no such liability shall be attributed to or assumed by any District, as a result of its withdrawal of aid and assistance once provided pursuant to the terms of this Agreement

8. *The assurance of mutual aid set forth herein constitutes the sole consideration for the performance hereof and no Party is obligated to reimburse any other for any action taken or aid rendered hereunder. No Party to this Agreement is obligated to reimburse any other Party to this Agreement for any personnel, equipment, or facility resources or expenses provided; or for any damage to equipment or facilities; or for liability incurred in the course of rendering public health mutual aid and assistance herein provided for. Exceptions to the foregoing may include consumable supplies, which are subject to reimbursement by the requesting jurisdiction OR reimbursement for staff time only after mutually agreed upon written parameters are established. The timing and method of reimbursement for consumable supply costs and/or staff time will be negotiated by the Parties after the incident is fully resolved.*
9. All functions and activities performed under this Agreement are declared to be governmental functions. Functions and activities performed under this Agreement are carried out for the benefit of the general public and not for the benefit of any specific individual or individuals. Accordingly, this Agreement is not construed as or deemed to be an agreement for the benefit of any third parties or persons, and no third parties or persons have any right of action under this Agreement for any cause whatsoever. All immunities and defenses provided by law shall be retained by the Parties hereto and none of the provisions of this Agreement shall be construed as a waiver thereof.
10. *Each Party to the Agreement waives all claims against the other Parties for compensation for any loss, damage, personal injury, or death occurring as a consequence of the performance of this Agreement, except in cases of willful and wanton misconduct, gross negligence, or bad faith of any officer, employee, or agent of another Party to this Agreement.*
11. This Agreement remains in full force and effect from the date herein above written unless sooner terminated by any of the Parties giving to the others thirty (30) days written notice of such termination. This Agreement may be amended only by the mutual written consent of the Parties.
12. Nothing herein supersedes or replaces any existing Mutual Aid Agreements for situations other than those involving a public health emergency.

In witness whereof, the Parties hereof have caused this Agreement to be executed as of the day and year first, herein above written.

  
11/22/2008

  
11/28/2008