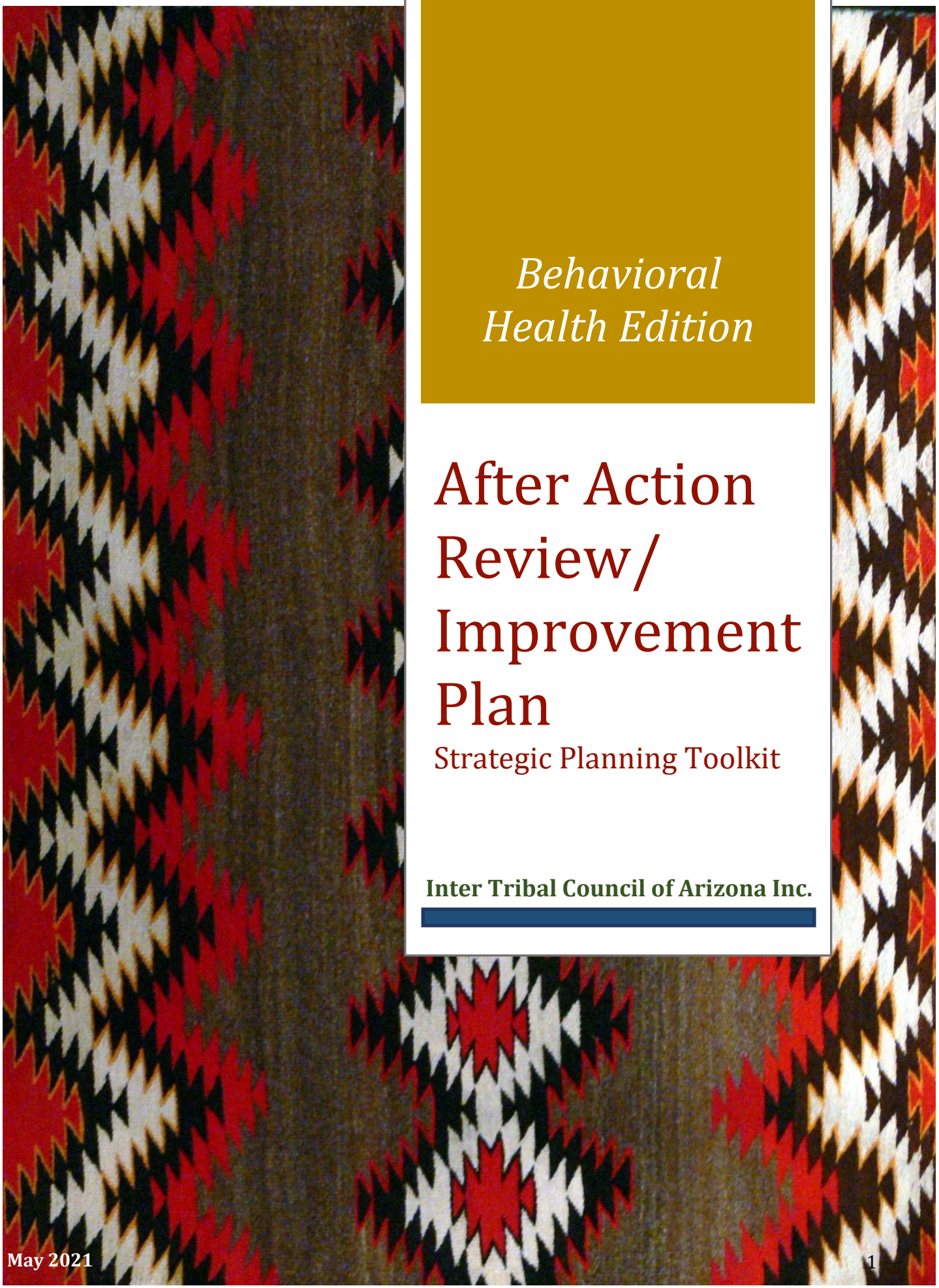

Behavioral Health Edition

After Action Review/ Improvement Plan

Strategic Planning Toolkit

Inter Tribal Council of Arizona Inc.

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Acknowledgments

This toolkit was commissioned by the Inter Tribal Council of Arizona: Tribal Epidemiology Center. The toolkit was developed and compiled by Blue Stone Strategy Group.

Inter Tribal Council of Arizona Inc.
Tribal Epidemiology Center

Background

Inter Tribal Council of Arizona Inc.

The Inter Tribal Council of Arizona was established in 1952 to provide a united voice for Tribal governments in the state of Arizona to address common issues of concerns. On July 9, 1975, the Council established a private, non-profit corporation, Inter Tribal Council of Arizona, Inc. (ITCA), under the laws of the State of Arizona to promote American Indian self-reliance through public policy development. ITCA provides an independent capacity to obtain, analyze, and disseminate information vital to American Indian community self-development. The mission of ITCA is to *provide its Member Tribes with a united voice and the means for united action on matters that affect them collectively or individually.*

Tribal Epidemiology Center

The Inter Tribal Council of Arizona, Inc. Tribal Epidemiology Center values trust, service, and integrity above all else. We provide responsive, confidential, reliable, practical, high-quality professional epidemiologic services and products that address current and future public health challenges among tribal nations. We do this by promoting tribal self-determination, partnerships, innovation, resourcefulness, accountability, and sustainability. Our goal is to eliminate health inequities among American Indian Nations within three generations.

Our mission is to build Tribally-driven public health and epidemiologic capacity among Tribes in the Phoenix and Tucson Indian Health Service Areas by assisting Tribes with health surveillance, research, prevention, and program evaluation for planning and policy decision making in order to improve community health and wellness.

We envision our group to be a strong, interwoven group of centers working together to develop a National Tribal Epidemiology Center narrative; enhanced data access and stewardship; respected multi-directional public health collaborations; and a diverse sustainable funding base. We work together for the betterment of the health of American Indian and Alaska Native people living in a variety of settings in the United States.

Our mission is to build Tribally-driven public health and epidemiologic capacity among Tribes in the Phoenix and Tucson Indian Health Service Areas by assisting Tribes with health surveillance, research, prevention, and program evaluation for planning and policy decision making in order to improve community health and wellness. The goal of the ITCA TEC is to build independent tribal capacities to collect and use community health information in directing programs, managing resources, and building relations with local, state, and federal public health systems.

The ITCA TEC provides technical assistance in the following areas:

- Improving disease surveillance capabilities through data analyses, interpretation, and dissemination of information;
- Providing communication and education for disease outbreak investigation and response;
- Developing epidemiologic studies; and
- Assisting with disease prevention and health promotion activities.

Figure 1. TEC Service Areas

Cover Page Photo:
Sauber, W. (2008, April 20). Philbrook - Navajo Satteldecke [Philbrook Museum in Tulsa, Oklahoma. Navajo single saddle blanket (1880s).]. Retrieved August 05, 2020, from https://commons.wikimedia.org/wiki/File:Philbrook_-_Navajo_Satteldecke.jpg

Abbreviations and Acronyms

AAR	After Action Review
ACEs	Adverse Childhood Experiences
BIA	Bureau of Indian Affairs
CDC	Centers for Disease Control and Prevention
CNC	Corporation for National and Community
FEMA	Federal Emergency Management Agency
HICS	Hospital Incident Command System
ICS	Incident Command Team
IHS	Indian Health Services
IP	Improvement Plan
MOA	Memorandum of Agreement
MOU	Memorandum of Understanding
NDRF	National Disaster Recovery Framework
NIMS	National Incident Management System
NRF	National Response Framework
PPE	Personal Protective Equipment
USACE	United States Army Corps of Engineers
WHO	World Health Organization

Introduction to the After Action Review (ARR) Toolkit

Purpose of the AAR Toolkit

This toolkit serves as a planning tool outlining the After Action Review process (i.e. designing, planning, preparing, and conducting) complete with tools that can be found in the appendices. Each step in the toolkit can be tailored to fit your Tribe's needs to develop and improve your operations after a public health response.

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The purpose for developing a Behavioral Health Edition is to feature best practices, programmatic/funding resources, and improvement planning concepts for the following behavioral health areas:

1. Adverse Childhood Experiences
2. Suicide Prevention
3. Intimate Partner Violence

Who is this Toolkit for?

The guidance for after action review (AAR) and the AAR toolkit is meant for Tribal government leaders, behavioral health professionals and management, Tribal community health representatives, public health practitioners, and other stakeholders who are planning for an AAR to review actions taken in response to an incident of public health concern within Tribal communities. These stakeholders may include Tribal executive staff and government employees, such as: planners, emergency managers, healthcare professionals, public safety, social services, healthcare administrators and professionals, CHRs, elderly and children's programming, and ICWA professionals.

Planners of AAR should bear in mind that each Tribe, agency and organization is different. The principles in this guide should be adapted to the traditional and institutional culture, practice and needs around which the review is taking place.

How to Use this Toolkit

This toolkit is designed to be read in the order that is most helpful to you by first providing an introduction to the AAR. Throughout the toolkit, you will see key highlights on the side panels for easy reading and concept absorption.

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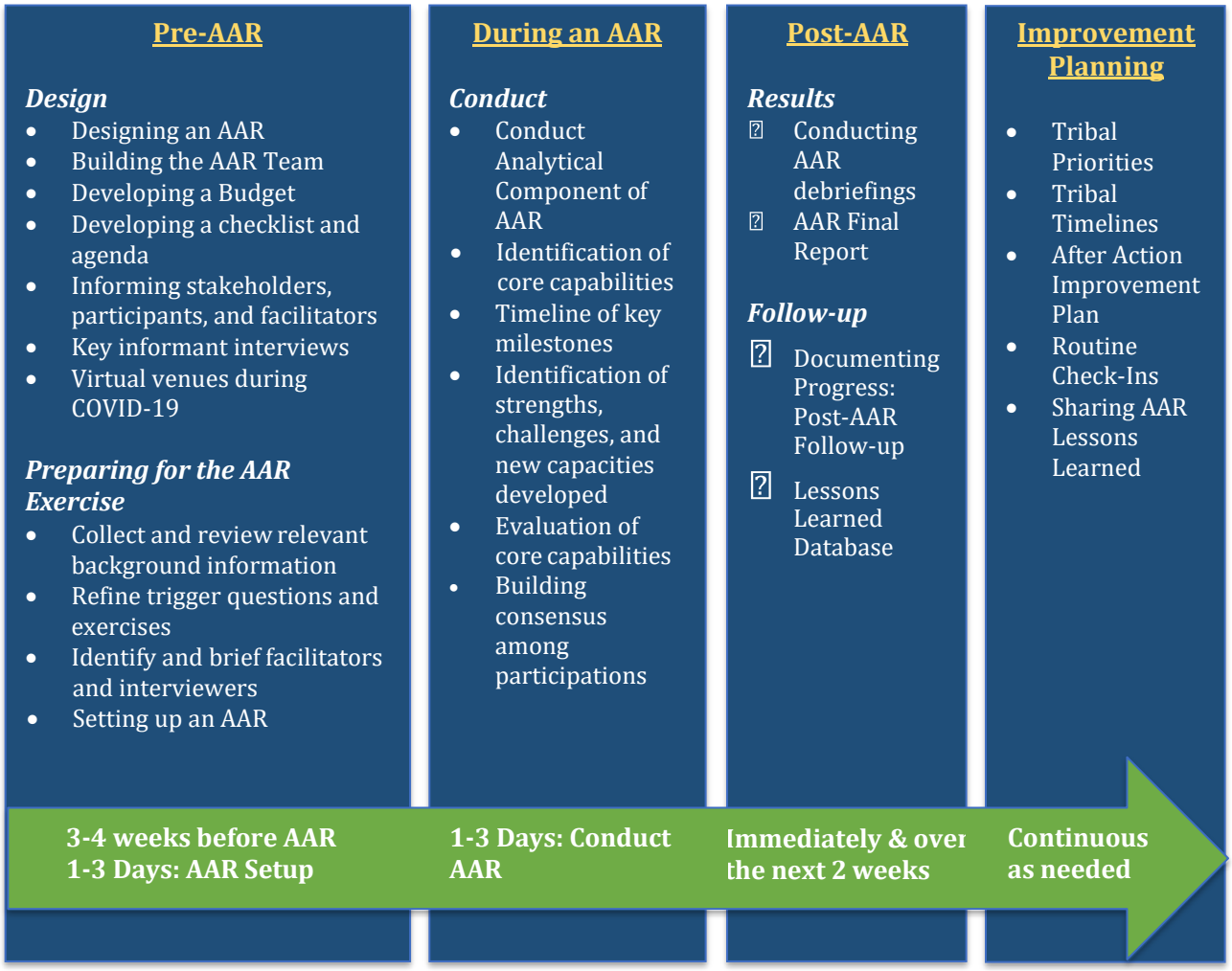
At the core of this toolkit, there are three process phases to the AAR (planning, conducting, and following up) and a final section on improvement planning:

- **Part 1: Pre-AAR**
- **Part 2: During an AAR**
- **Part 3: Post-AAR**
- **Part 4: Improvement Planning**

See Figure 2 (below) to view the four process phases and the estimated timelines for starting and completing each phase.

Figure 2: AAR Planning Roadmap



COVID-19 Virus Information

As with previous health crises, Tribes and Native communities have been disproportionately affected by the COVID-19 pandemic, often facing challenges such as lack of testing, shortages of personal protective equipment (PPE), overcrowding, and detrimental effects to mental health. As of February 15, 2021, the Indian Health Services (IHS) reported[1] 183,791 positive cases of coronavirus based on voluntary reporting from IHS, tribal, and urban Indian organization facilities (see Table 1). Across Indian Country, Tribes have imposed stay-at-home orders, social distancing regulations, curfews, and mandatory mask orders to help mitigate the spread of COVID-19 to their communities.

The After Action Review is the exact tool for Tribes to use to better prepare for global pandemics and to strengthen overall resiliency.

In addition to the health impact, multiple industries across the country are facing extreme disruptions in operations ultimately affecting Tribal government systems and economies. Tribes are now faced with aligning various departments (i.e. health, crisis management, communications, finance, etc.) with business continuity strategies in hopes to flatten the curve of coronavirus cases and simultaneously work to stabilize their economies.

Table 1: COVID 19 Cases by IHS Area

IHS Area	Tested	Positive	Negative
Alaska	500,526	11,000	422,875
Albuquerque	86,544	7,895	58,655
Bemidji	134,490	9,883	121,181
Billings	92,614	7,215	82,130
California	66,460	6,966	55,756
Great Plains	130,706	13,671	116,493
Nashville	65,999	5,667	59,257
Navajo	222,358	30,532	150,375
Oklahoma City	437,922	58,454	374,726
Phoenix	158,601	22,852	134,778
Portland	96,220	6,995	88,417
Tucson	23,677	2,661	20,863
TOTAL	**2,016,117**	**183,791**	**1,685,506**

*Data reflect cases reported to the IHS through 11:59 pm on February 15, 2021.

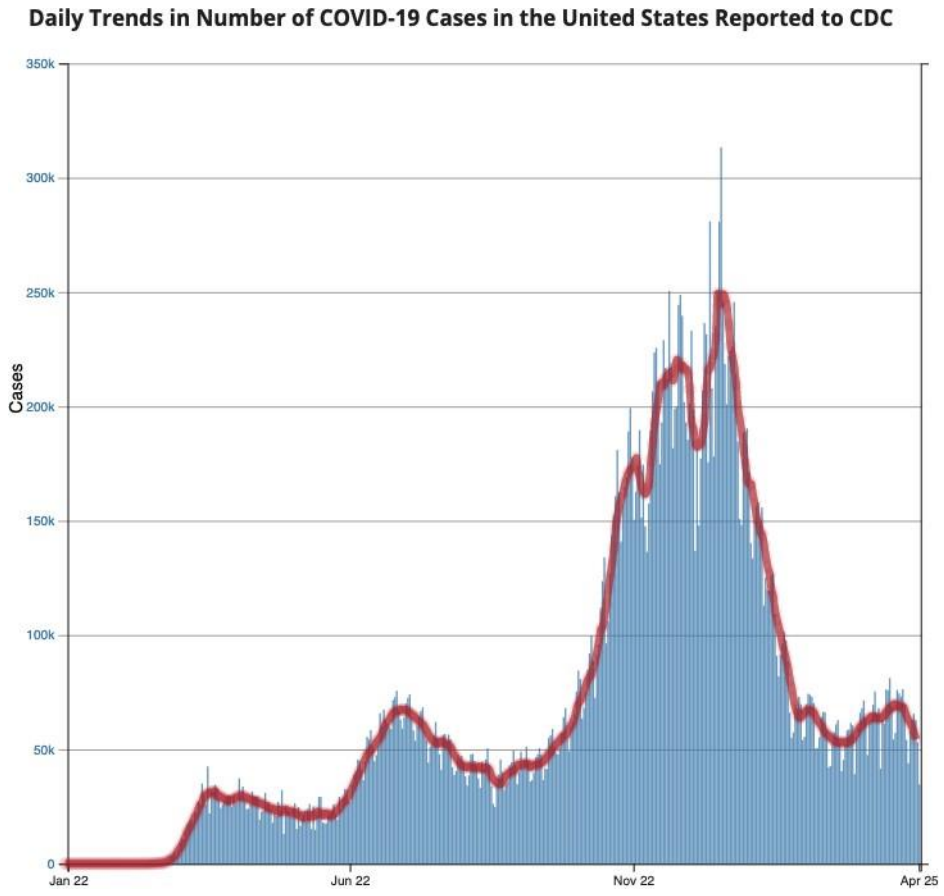
[1] Indian Health Services. (February 15, 2021). COVID-19 Cases by IHS Area. Retrieved February 15, 2021, from https://www.ihs.gov/coronavirus/

Nationally, as of February 16, 2021, a total of 27,542,421 positive cases of the coronavirus have been reported to the Centers for Disease Control and Prevention (CDC) since the beginning of the outbreak (see new cases by day in Figure 2).

As the total number of cases decrease, governments, local agencies, and organizations are encouraged to take the time to assess responses to the COVID-19 pandemic. As shown in Figure 3, this novel coronavirus has the ability to incur multiple outbreaks over a long period of time. The unfolding of the widespread response allows for unique organizational opportunities and continuous improvement; and the After Action Review is the exact tool for Tribes to use to better prepare for global pandemics and to strengthen overall resiliency.

The unfolding of the widespread response allows for unique organizational opportunities and continuous improvement.

Figure 3: CDC New Cases by Day[2]



The novel coronavirus has the ability to incur multiple outbreaks over a long period of time.

[2] Centers for Disease Control and Prevention. (April 26, 2021). Cases in the U.S. Retrieved April 26, 2021, from https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html

Introduction to an AAR

What is an AAR?

An After Action Review (AAR) is a structured, qualitative review of actions taken in response to an incident of public health concern. Generally, an AAR is a simple, powerful tool used to assess performance, document lessons learned, and identify areas for improvement.

An AAR is a simple, powerful tool used to assess performance, document lessons learned, and identify areas for improvement.

An AAR seeks to identify:

- actions that need to be implemented immediately, to ensure better preparation for the next incident; and
- medium- and long-term actions needed to strengthen and institutionalize the necessary capabilities of the public health system[3].

Designed to be flexible, an AAR can be adapted to fit the incident under review, as well as the organization and systems involved. Stakeholders involved in preparedness activities relevant to the incident under review are encouraged to be invited to an AAR to assess the impact of preparedness on the response.

An AAR features:

- An open and honest professional dialogue,
- Participation by all relevant stakeholders,
- A focus on the results of an incident, and
- Recommendations to improve performance.

The success of an AAR is contingent on the ability to bring relevant response stakeholders together in an environment where they can analyze actions taken during the response in a critical and systematic manner. AARs are not intended to assess individual performances or competences, but rather to identify functional challenges that must be addressed, and best practices to be maintained[4].

An AAR is NOT:

- A critique or lecture,
- Judge of performance,
- A means to embarrass, or
- A tool to blame.

The added value of an AAR is its focus on collective learning and experience sharing, with emphasis on the knowledge of stakeholders.

An AAR offers participants an opportunity to translate their experiences from the response into actionable road maps or plans so they can do better the next time. The added value of an AAR is its focus on collective learning and experience sharing, with emphasis on the knowledge of stakeholders. One way in which an AAR can add value is by turning tacit knowledge into learning, and building trust and confidence among team members. In this way, AARs can become a key aspect of an organization's internal system of

[3] Guidance for after action review (AAR). Geneva, Switzerland: World Health Organization; 2019 (WHO/WHE/CPI/2019.4). Licence: CC BY-NC-SA 3.0 IGO
[4] Ibid.

learning and quality improvement, and can contribute to strengthening the capacity at the organization and Tribal levels[5].

AARs should ideally be conducted as soon as possible after an incident or outbreak is declared over by the Tribe or other authorized entity (or within three months). For prolonged crises, multiple AARs can be conducted after each major phase. Similarly, for large-scale emergencies that involve many different capacities, separate AARs can be conducted for each major component of the response[6].

What are the objectives of an AAR?

An AAR aims to identify (1) capacities in place before the response, (2) any challenges that came to light during it, (3) the lessons identified, and (4) any best practices observed during the response, including the development of new capacities[7].

An AAR aims to identify:

1. ***capacities in place before the response,***
2. ***challenges that came to light during it,***
3. ***lessons identified, and***
4. ***best practices observed during the response, including the development of new capacities***

An AAR answers the following questions:

1. What was expected to happen?
2. What actually occurred?
3. Why were there differences?
4. What went well and why?
5. What didn't work and why?
6. What can be improved and how?[8]

As a form of group reflection, AARs are designed to foster organizational learning and to facilitate continuous improvements of performance.

AARs seek to gather the following:

- **Unbiased observations:** in retrospect, establish how actions were actually implemented, rather than how they would ideally have happened according to existing plans and procedures.
- **Analysis of gaps, best practices, and contributing factors:** identify gaps between planning and practice; analyze what worked and what did not work, and why.
- **Identification of areas for improvement:** identify actions to strengthen or improve performance, and determine how to follow up on them[9].

What are the benefits of conducting an AAR?

AARs are powerful tools of assessment that produce quick results. In fact, the U.S. Army is one of few organizations that have implemented AAR processes to review their most recent missions and to identify possible improvements[10]

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[5] Ibid, 12.
[6] Ibid., 12.
[7] Ibid., 12.
[8] Salem-Schatz, S., Ordin, D., & Mittman, B. (2010). Guide to the After Action Review [PDF]. Nashville: Vanderbilt University.
[9] Ibid., 4
[10] David A Garvin, "Learning In Action, A Guide to Putting the Learning Organization to Work" (Boston: Harvard Business School Press, 2000), 106-116.

The phrase "leave your rank at the door" positively outlines a major benefit to conducting AARs: it allows teams to share their views and ideas to help develop collective, organizational solutions.

Additional benefits include:

- **Intentional critical thinking around an incident.** AARs foster an environment for the team to use root cause analysis. This helps assess the underlying factors that led to any failures and successes encountered during the response.
- **Team consensus.** As team members work together during the AAR to assess performance and identify lessons learned, they also develop strategies to improve.
- **Documentation of lessons learned.** AARs allow documentation to be used for future incidents.
- **Cross-sectoral learning.** As responses to many complex incidents (for example, the COVID-19 pandemic) involve more stakeholders than just those in the health sector, participants in the AAR can come from multiple sectors involved in the response. These might include animal health departments, hospital management boards, security authorities, and State and Tribal government departments. This can result in additional lessons being identified across sectors, bringing together new perspectives and strengthening relationships and coordination across sectors.
- **Builds capacity for preparedness and response.** Gaps and best practices identified in the AAR can be respectively addressed for improvement, and documented and institutionalized[11].

AAR Benefits Include:

1. ***Quick results***
2. ***Collective, organizational solutions***
3. ***Intentional critical thinking***
4. ***Team consensus***
5. ***Documentation of lessons learned***
6. ***Cross-sectoral learning***
7. ***Helps build capacity for the next incident***

When should an AAR be carried out?

Ideally, AARs should be considered immediately after a response to any incident with public health significance. An AAR is usually conducted within three months of the official declaration of the end of the incident by the Tribe. The reason for immediacy is to ensure response stakeholders are still present and have clear memories of what happened.

The same methodology can be applied while an incident is still continuing; for example, an AAR during the COVID-19 pandemic is a form of real-time analysis, covering a specific period or phase of the response.

An AAR is usually conducted within three months of the official declaration of the end of the incident by the Tribe.

[11] Ibd, 12.

Tribal Specific Considerations

Tribal Priorities

Each American Indian and Alaska Native Tribe has immeasurable responsibilities to their Tribal members, to their Tribal culture, the Tribal history, and the future of their Tribe. Tribal governments are entrusted with authority for all aspects of Tribal matters, including self-governance, provision of social services, health, education, energy, and land management, while upholding and exercising Tribal sovereignty.

Tribes are free to coordinate and collaborate with any outside partner to further the resilience and safety of their citizens. During times of disaster, Tribes can look to partners in health, wildland fire, structural fire, emergency management, and law enforcement, to bolster the inherent ability to serve their Tribal members, after an incident, emergency or disaster.

Tribal governments may consider the adoption of nationally accepted incident management concepts, to enhance internal and external emergency response and recovery capabilities and resources. This toolkit utilizes concepts from the World Health Organization (WHO), Centers for Disease Control and Prevention (CDC), and the Federal Emergency Management Agency (FEMA) for After Action Report and Improvement Planning.

Additional planning resources would include the National Response Framework (NRF) and the Incident Command System (ICS). The NRF is an ever-improving guide as to how governments within the United States respond to all types of disasters and emergencies; It is built on scalable, flexible, and adaptable concepts identified in the National Incident Management System (NIMS) to align key roles and responsibilities across the Nation.

In a behavioral health setting, Tribes should consider the resources offered from the Substance Abuse and Mental Health Services Administration (SAHMSA). SAMHSA's mission is "To reduce the impact of substance misuse and mental illness on America's communities." SAMHSA's strategic priorities for FY2019-2023 are:

1. Combating the Opioid Crisis through the Expansion of Prevention, Treatment, and Recovery Support Services.
2. Addressing Serious Mental Illness and Serious Emotional Disturbances.
3. Advancing Prevention, Treatment, and Recovery Support Services for Substance Use.
4. Improving Data Collection, Analysis, Dissemination, and Program and Policy Evaluation.
5. Strengthening Health Practitioner Training and Education.

Tribal governments may consider the adoption of nationally accepted incident management concepts, to enhance internal and external emergency response and recovery capabilities and resources.

This toolkit utilizes concepts from the following organizations and includes tribal specific considerations:

1. ***WHO***
2. ***CDC***
3. ***FEMA***
4. ***NRF***
5. ***ICS***
6. ***NIMS***
7. ***HICS***

Tribal Leadership Consultation

In order to ensure applicability, the term Tribal Leadership will refer to the Tribe's governing authorities such as a Tribal Council, Executive Committee, or Business Committee.

It is a possibility that the After Action Report Team may have limited Tribal Leadership participation; however, it may be necessary for the AAR Team to present findings and progress along the way in order to gain support and provide updates. It would be ideal to present the After Action Report once a draft is developed prior to moving into the Improvement Plan. It would likely be necessary to present the final draft Implementation Plan to the Tribal Leadership to garner support and approval to finalize and begin implementation of improvements.

The After Action Report Team may not include all of the Tribal Leadership; it may be necessary for the AAR Team to present findings and progress along the way in order to gain support and provide updates.

Tribal Capability Considerations

Capability standards are a guide to looking at overall response to emergencies within an organization. There are additional factors that should be added per the specific Tribal community's custom and traditional components as well as specific regional components. Examples of other areas to consider in reviewing response and planning for improvements are listed in the following table.

Capability standards are a guide to looking at overall response to emergencies within an organization.

Table 2: Additional Tribal/Regional Specific Considerations

- Tribal cultural and traditional medicine
- Scheduled Tribal ceremonial/gathering events
- Ceremonial, custom, and cultural rituals related to burials
- Tribal community closures to the public/visitors with barriers, checkpoints, signage, notifications
- Access to infrastructure needs in rural/underserved areas for Tribal Members (water, electricity, etc.)
- Multi-generational and multi-family homes

Adverse Childhood Experiences (ACEs)

Adverse Childhood Experiences (ACEs) refers to the potentially traumatic events that occur before the age of 18 years that is defined by various forms:

Abuse

- **Emotional abuse:** A parent, stepparent, or adult living in your home swore at you, insulted you, put you down, or acted in a way that made you afraid that you might be physically hurt.
- **Physical abuse:** A parent, stepparent, or adult living in your home pushed, grabbed, slapped, threw something at you, or hit you so hard that you had marks or were injured.
- **Sexual abuse:** An adult, relative, family friend, or stranger who was at least 5 years older than you ever touched or fondled your body in a sexual way, made you touch his/her body in a sexual way, attempted to have any type of sexual intercourse with you.

Household Challenges

- **Mother treated violently:** Your mother or stepmother was pushed, grabbed, slapped, had something thrown at her, kicked, bitten, hit with a fist, hit with something hard, repeatedly hit for over at least a few minutes, or ever threatened or hurt by a knife or gun by your father (or stepfather) or mother's boyfriend.
- **Substance abuse in the household:** A household member was a problem drinker or alcoholic or a household member used street drugs.
- **Mental illness in the household:** A household member was depressed or mentally ill or a household member attempted suicide.
- **Parental separation or divorce:** Your parents were ever separated or divorced.
- **Incarcerated household member:** A household member went to prison.

Neglect[12]

- **Emotional neglect:** Someone in your family helped you feel important or special, you felt loved, people in your family looked out for each other and felt close to each other, and your family was a source of strength and support.2
- **Physical neglect:** There was someone to take care of you, protect you, and take you to the doctor if you needed it2, you didn't have enough to eat, your parents were too drunk or too high to take care of you, and you had to wear dirty clothes.

Adverse Childhood Experiences (ACEs) refers to the potentially traumatic events that occur before the age of 18 years that can be categorized into the following:

- **Abuse**
- **Household Challenges**
- **Neglect**

[12] April 13, 2020 - Content source: National Center for Injury Prevention and Control, Division of Violence Prevention

Women and racial/ethnic minority groups are at greater risk for having experienced 4 or more types of ACEs. The COVID-19 pandemic has worsened conditions and is expected to increase the already alarming risk[13].

Women and racial/ethnic minority groups are at greater risk for having experienced 4 or more types of ACEs.

CDC-Kaiser ACE Study and Historical Trauma

According to the CDC, the original ACE Study was conducted at Kaiser Permanente from 1995 to 1997 with two waves of data collection. In this study, over 17,000 Health Maintenance Organization members from Southern California receiving physical exams completed confidential surveys regarding their childhood experiences and current health status and behaviors. From the study's findings, researchers developed three categories of potential childhood experiences (abuse, neglect, and household challenges) that can be linked to chronic health problems, substance abuse, and mental illnesses in adulthood. The ACE Study further developed the ACE Questionnaire, a series of 10 questions, that individuals can take to determine their ACE score (see Appendix A), or likelihood of facing certain health problems that correlate to childhood stress and adverse experiences.

Although the ACE Study serves as a great tool for raising awareness of how ACEs may impact individuals into adulthood, it doesn't take into account the unique experiences of Native youth, as well as, the intergenerational trauma caused by federal policies (i.e., boarding school era). Below are some excerpts from studies that take historical and intergenerational trauma into account:

Although the ACE Study serves as a great tool for raising awareness of how ACEs may impact individuals into adulthood, it doesn't take into account the unique experiences of Native youth, as well as, the intergenerational trauma caused by federal policies (i.e., boarding school era).

> "Understanding the intersection of ACES and historical trauma within the context of grief and trauma for AI/AN populations is critical. Historical trauma impacts populations who have experienced long-term widespread trauma over the span of generations. Public health science practices identify that, "understanding how historical trauma influences the current health status of racial/ethnic populations in the U.S may provide new directions and insights for eliminating health disparities" (Sotero, 2006, p. 94). Taking historical trauma into account, it is to be expected that current AI/AN populations are reconciling the grief inherited from generations before them.[14]"
>
> "Intergenerational trauma isn't just a pattern of behavior that's learned and repeated. It's a brain development issue. Some family members may exhibit a behavior called "learned helplessness". A person with this condition accepts a feeling of powerlessness in the face of repeated and seemingly insurmountable adverse experiences. Eventually, the person may stop trying to improve their situation, even when positive alternatives are presented. Recent studies in neuroscience seem to indicate that the brain's default setting is to assume lack of control and that it is the "helpfulness", solution-seeking, and resilience that are actually learned.[15]"

[13] Bryant, D. J., Oo, M., & Damian, A. J. (2020). The rise of adverse childhood experiences during the COVID-19 pandemic. Psychological Trauma: Theory, Research, Practice, and Policy, 12(S1), S193–S194. https://doi.org/10.1037/tra0000711

[14] BigFoot, D. S., Lamb, K., & Delmar, M. (2018, November). Honoring children: Treating trauma and adverse childhood experiences in American Indian and Alaska Native communities. *CYF News*. http://www.apa.org/pi/families/resources/newsletter/2018/11/native-american-trauma

[15] Jamieson, K. (2020, March 26). Aces and intergenerational trauma. Retrieved February 18, 2021, from https://www.centerforchildcounseling.org/aces-and-intergenerational-trauma/

ACEs Prevention Best Practices

The following are prevention best practices for families and programs to promote within Tribal communities to reduce the likelihood of Native youth experiencing ACEs. The capability reference column aligns these programs with the CDC's Public Health Emergency Preparedness and Response Capabilities to evaluate the Tribe's performance in response to an incident or event.

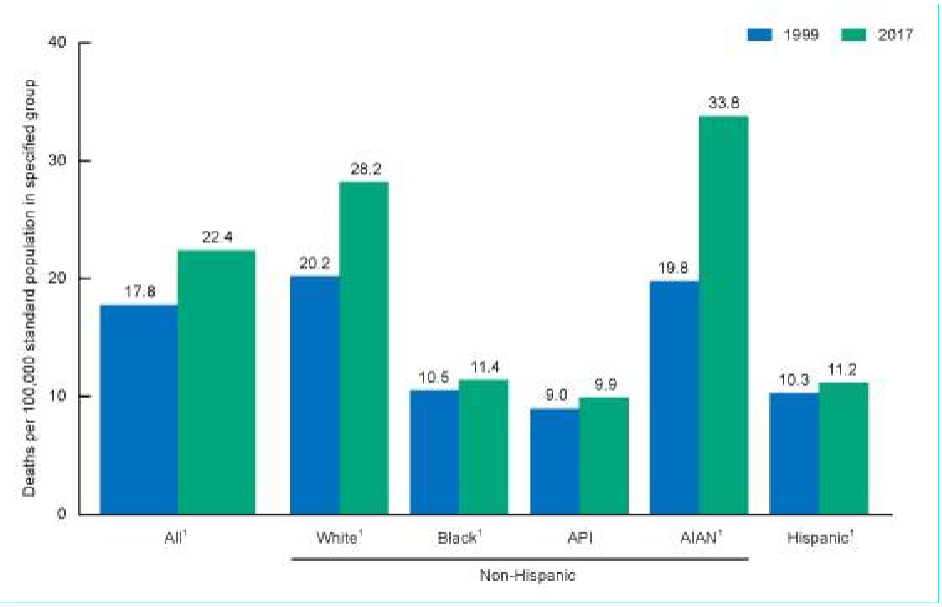
Table 3: ACEs Prevention Best Practices

Strategy	Approach	Capability Reference
Strengthen economic supports to families	• Strengthening household financial security • Family-friendly work policies	• 1 – Community Preparedness • 6 – Information Sharing
Promote social norms that protect against violence and adversity	• Public education campaigns • Legislative approaches to reduce corporal punishment • Bystander approaches • Men and boys as allies in prevention	• 1 – Community Preparedness • 2 – Community Recovery • 6 – Information Sharing • 13 – Public Health Surveillance and Epidemiological Investigation
Ensure a strong start for children	• Early childhood home visitation • High-quality child care • Preschool enrichment with family engagement	• 1 – Community Preparedness • 2 – Community Recovery • 13 – Public Health Surveillance and Epidemiological Investigation
Teach skills	• Social-emotional learning • Safe dating and healthy relationship skill programs • Parenting skills and family relationship approaches • Resiliency training	• 1 – Community Preparedness • 6 – Information Sharing
Connect youth to caring adults and activities	• Mentoring programs • After-school programs	• 1 – Community Preparedness • 2 – Community Recovery • 13 – Public Health Surveillance and Epidemiological Investigation
Intervene to lessen immediate and long-term harms	• Enhanced primary care • Victim-centered services • Treatment to lessen the harms of ACEs • Treatment to prevent problem behavior and future involvement in violence • Family-centered treatment for substance use disorders	• 1 – Community Preparedness • 2 – Community Recovery • 6 – Information Sharing • 13 – Public Health Surveillance and Epidemiological Investigation

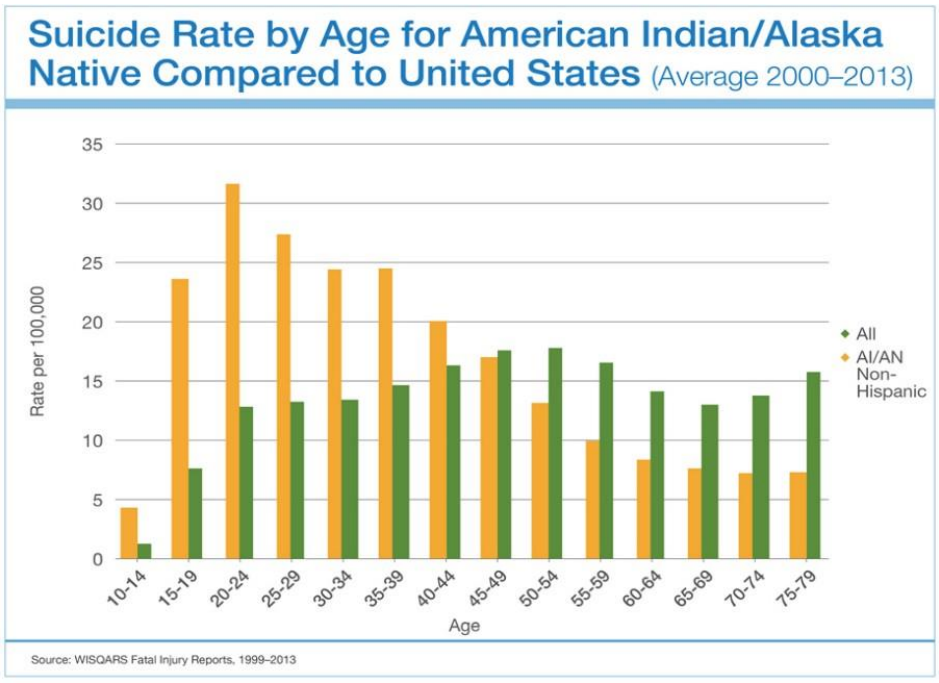
Suicide Prevention

Native communities experience higher rates of suicide compared to all other racial and ethnic groups in the U.S., with suicide being the eighth leading cause of death for American Indians and Alaska Natives across all ages. For Native youth ages 10 to 24, suicide is the second leading cause of death; and the Native youth suicide rate is 2.5 times higher than the overall national average, making these rates the highest across all ethnic and racial groups[16].

Native communities experience higher rates of suicide compared to all other racial and ethnic groups in the U.S.



Native youth suicide rate is 2.5 times higher than the overall national average, making these rates the highest across all ethnic and racial groups



16 SAMHSA. Suicide Clusters within American Indian and Alaskan Native Communities, 2017.

There are many contributing factors to suicide ideation for Native communities which the COVID-19 pandemic has only amplified.

- **Rural communities** – many individuals live in rural Tribal lands that have limited access to recreation and entertainment businesses. They also have limited access to resources for behavioral health, either physical brick and mortar or virtual resources. The lack of these can increase the feeling of isolation and depression among individuals.
- **Community and family gatherings** – the COVID-19 pandemic has put restrictions on gatherings of many types. Tribal communities hold gatherings many times to celebrate and also to get through times of hardship. Being unable to gather and gain a communal sense of support can increase depression and anxiety.
- **Ceremonial and traditional events** – for many Tribal communities, there are annual ceremonial and traditional events that promote Tribal values and customs. Some of these are intended for wellness and healing, some are intended to support individuals through the mourning and grief processes. With social distancing and restrictions on gathering, these methods of community support and healing are unable to be practiced.

(Alaska Department of Health and Social Services: Division of Behavioral Health)

There has been an increase in programming efforts that are community-driven to address the need for suicide prevention, intervention, and postvention in Tribal communities over the past few years as well as funding at the Federal level for implementation. School programming has also increased awareness around bullying and provided education and resources

Contributing factors to suicide ideation for Native communities caused by the COVID-19 pandemic:

- ***Rural communities (limited access to recreation and entertainment; isolation)***
- ***Restrictions on family and community gatherings***
- ***Halting of ceremonial and traditional events due to social distancing requirements***

for students and educators to proactively teach social acceptance and diversification. While these programs have typically included social and community gatherings as mentioned earlier, in the light of the pandemic, there needs to be an approach that can still utilize the fundamental approach of these in other fashions such as virtual interactions and reinforcement of cultural values in the implementation.

There has been an increase in programming efforts that are community-driven to address the need for suicide prevention, intervention, and postvention in Tribal communities

Suicide Prevention Best Practices

The following are best practices that provide support in suicide prevention, intervention, and postvention for Tribal communities. The capability reference aligns these programs with the CDC's Public Health Emergency Preparedness and Response Capabilities to evaluate the Tribe's performance in response to an incident or event.

Table 4: Suicide Prevention Best Practices

Strategy	Approach	Capability Reference
Community Development and Education	• Honoring Culture • Target early life course factors (ACES) • Reduce Stigma • Culture as Medicine • Education Campaign	• 1 – Community Preparedness • 6 – Information Sharing
Crisis Intervention Teams	• Quick response • Hospital diversion/Cost savings • Mental Health advocacy vs Criminal justice adjudication	• 1 – Community Preparedness • 7 – Mass Care • 10 – Medical Surge
Behavioral Health Integrated Teams/Individual	• Easy point of care • Imbedded with medical care • Lessens stigma of mental health • Early identification of at-risk population • Normalization of mental health treatment and awareness	• 1 – Community Preparedness • 2 – Community Recovery • 7- Mass Care
Peer/ Elder Support programs	• Volunteer and Certified peers • Culturally supportive • Mentoring • Engaging with peoples with lived experience • Address stigma	• 1 – Community Preparedness • 2 – Community Recovery • 5- Fatality Management • 7- Mass Care • 11 – Non-pharmaceutical Interventions
Lethal means reduction	• Means reduction • Psychoeducational focused on gun safety • Lock box for medications • Focus is on "how" instead of "why"	• 2 – Community Recovery • 7- Mass Care • 10 – Medical Surge

Crisis lines and Crisis Text/Chat lines (Local and National)	• Centralized dispatch, emotional support, crisis evaluation and prevention, confidential • Youth prefer Text over direct phone calls • Local, National or both	• 1 – Community Preparedness • 2 – Community Recovery • 3 – Emergency Operations Coordination • 10 – Medical Surge
Telehealth	• Cost effective • Expands access to care • Saves patients travel costs, children miss less school • Saves money from unnecessary hospital visits	• 1 – Community Preparedness • 10 – Medical Surge • 11 – Non-pharmaceutical Interventions
QPR training	• National evidence-based program • Question Persuade and Refer • Teaches people without professional mental health backgrounds to recognize the signs of suicide	• 1 – Community Preparedness • 2 – Community Recovery • 3 – Emergency Operations Coordination • 7- Mass Care • 13 – Public Health Surveillance and Epidemiological Investigation
Partnerships and Collaboration	• Individuals and organizations representing your target population • Healthcare and Behavioral Health Providers • Key leaders and influencers from the community • Others with an interest in suicide prevention (especially those with lived experience)	• 1 – Community Preparedness • 2 – Community Recovery • 5- Fatality Management • 6 – Information Sharing • 13 – Public Health Surveillance and Epidemiological Investigation

Intimate Partner Violence

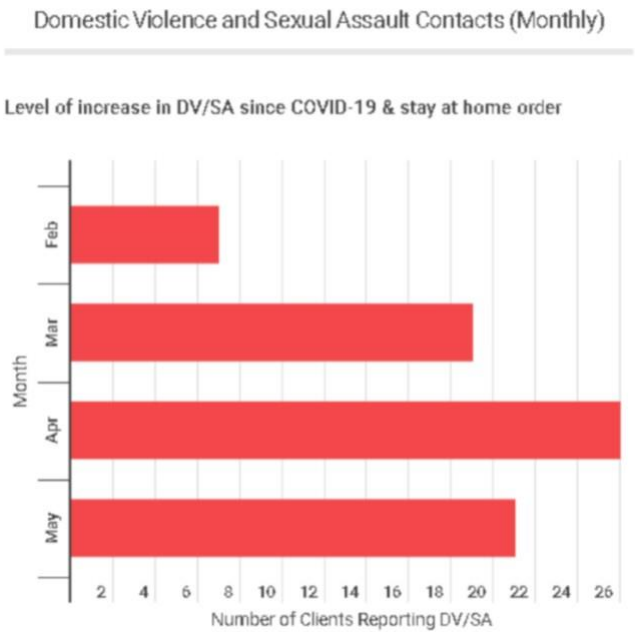
Intimate partner violence is defined as the physical violence, sexual violence, stalking, or psychological harm by a current or former partner or spouse, either heterosexual or same-sex partners and does not require sexual intimacy.

- **Physical violence**: when a person hurts or tries to hurt a partner by hitting, kicking, or using another type of physical force.
- **Sexual violence**: forcing or attempting to force a partner to take part in a sex act, sexual touching, or non-physical sexual event when the partner does not or cannot consent
- **Stalking**: a pattern of repeated, unwanted attention and contact by a partner that causes fear or concern for one's own safety or the safety of someone close to the victim.
- **Psychological aggression**: use of verbal and non-verbal communication with the intent to harm another person mentally or emotionally and/or to exert control over another person. (CDC)

American Indian and Alaskan Native women experience higher levels of violence than other women across the United States.

American Indian and Alaskan Native women experience higher levels of violence than other women across the United States. Nearly 84 percent of AI/AN women experience violence in their lifetime (National Institute of Justice, 2016). Research shows more than a third of women who have been raped have contemplated suicide, and 13 percent have attempted, according to the National Sexual Violence Resource Center. American Indian and Alaska Natives also experience PTSD more than twice as often as the general population, according to the Substance Abuse and Mental Health Services Administration (SAMHSA).

Nearly 84 percent of AI/AN women experience violence in their lifetime.



During the COVID-19 pandemic, the instances of intimate partner violence have increased substantially across Indian Country.

www.nativehealthphoenix.org

During the COVID-19 pandemic, the instances of intimate partner violence have increased substantially across Indian Country. Contributing factors are related to interruptions to daily routines, increased isolation within the home, loss of employment and income, food insecurity, increased substance and alcohol use, and increased stress and anxiety factors.

Intimate Partner Violence Prevention Best Practices

The following best practices provide programs and models that are meant to promote awareness and response within Tribal communities. The capability reference aligns these programs with the CDC's Public Health Emergency Preparedness and Response Capabilities to evaluate the Tribe's performance in response to an incident or event.

Table 5: Intimate Partner Violence Prevention Best Practices

Strategy	Approach	Capability Reference
Crisis Line/Hot Line	• Direct access to information or assistance • Provide support, solutions and guidance • Referral • Confidential • National and Local	• 3 – Emergency Operations Coordination • 7- Mass Care
Crisis intervention	• Quick response • Safety planning • Lethality Assessments • De-escalation • Work autonomously and/or with Law Enforcement	• 3 – Emergency Operations Coordination • 7- Mass Care • 10 – Medical Surge
Community education and outreach	• Advocacy • Traditional Healers • Health Care Providers • Legal Aid • Social Services • Schools • Women's groups	• 1 – Community Preparedness • 2 – Community Recovery • 6 – Information Sharing
Safe Harbor programs	• Shelter • Safe Homes • Crisis Nursery • Confidentiality is paramount	• 3 – Emergency Operations Coordination • 2 – Community Recovery
Restabilization	• A transitional program part of a comprehensive cluster of services bridging crisis services to more independent living, with on-going support. • Difference between this and a Shelter is length of time	• 2 – Community Recovery • 7- Mass Care

	• Counseling	
Children Resources	• Food security • If possible, children's programs should be separated by age groups. This separation helps to ensure that each child will be addressed on his/her development level. • Counseling	• 1 – Community Preparedness • 10 – Medical Surge • 11 – Non-pharmaceutical Interventions

The following chart is taken from the National Center for Injury Prevention and Control's technical package about intimate partner violence. It shows the interlinked strategies that are intended for impacts to "individual behaviors and also the relationships, families, schools, and communities" that play a larger part of on the risk and protectives factors for intimate partner violence.

Table 6: Preventing Intimate Partner Violence

Strategy	Approach
Teach safe and healthy relationship skills	• Social-emotional learning programs for youth • Healthy relationship programs for couples
Engage influential adults and peers	• Men and boys as allies in prevention • Bystander empowerment and education • Family-based programs
Disrupt the developmental pathways toward partner violence	• Early childhood home visitation • Preschool enrichment with family engagement • Parenting skill and family relationship programs • Treatment for at-risk children, youth and families
Create protective environments	• Improve school climate and safety • Improve organizational policies and workplace climate • Modify the physical and social environments of neighborhoods
Strengthen economic supports for families	• Strengthen household financial security • Strengthen work-family supports
Support survivors to increase safety and lessen harms	• Victim-centered services • Housing programs • First responder and civil legal protections • Patient-centered approaches • Treatment and support for survivors of IPV, including TDV
Source: National Center for Injury Prevention and Control. 2017. *Preventing Intimate Partner Violence Across the Lifespan: A Technical Package of Programs, Policies, and Practices.*	

Before an AAR

Designing an AAR Working Group

Having an AAR Working Group involves having work sessions with a diverse group of individuals who work in various capacities within the Tribe related to health services, emergency services, human resources, planning, utilities and maintenance, social services, education, housing, elders' services, and Tribal Leadership.

There may be others involved who work in different departments and programs. Invitations to local municipalities and governments may also be a consideration if there are partnerships, MOAs or MOUs, and other contracted services established.

The design of a working group is to provide a forum for the participants to speak openly regarding the focus areas, experiences, and to provide opportunities for collective learning. The following table shows further points of a Working Group design.

Having an AAR Working Group involves having work sessions with a diverse group of individuals who work in various capacities within the Tribe.

The design of a working group is to provide a forum for the participants to speak openly regarding the focus areas, experiences, and to provide opportunities for collective learning.

Table 7: Working Group Design[17]

When to Use	Planning Considerations	Outcomes
• With larger groups of diverse stakeholders where there are more than three focus areas • When those involved in the response can be brought together for a face-to-face meeting • When participants are willing to speak freely and honestly about their experiences in a group setting and share their experience for collective learning	• More than three pillars for review • Can involve up to 50 individuals • Preparations should begin 4-6 weeks prior • Takes 2-3 days to conduct • For each working group, one facilitator and note taker proficient in the functions assigned to the group • Requires more resources than a debrief	• Shared learning between pillars and between stakeholders participating in the review • Shared experience and space for discussion • Report drafted that will include the findings from the review

[17] Guidance for after action review (AAR). Geneva, Switzerland: World Health Organization; 2019 (WHO/WHE/CPI/2019.4). Licence: CC BY-NC-SA 3.0 IGO

Building the AAR Team

The AAR Team will be the assigned team to assist in planning the working group, facilitating the working group, and developing the after action report and improvement plan. Depending upon the size of the Tribe and the stakeholders involved, the AAR Team size could vary, but overall should include the following roles (see Table 4).

Table 8: AAR Team Members and Roles

Team Member	Role
AAR Lead	• Initiator of the AAR • Develops the scope and objectives of the review • Ensures coordination and support • Prepares and disseminates relevant background information • Identifies AAR team members and participants • Supervises team logistics • Reviews final drafts of plan and approvals • Presents final report to Tribal Leadership and other key stakeholders
Lead Facilitator	• Lead facilitation of AAR as an unbiased party • Develops trigger questions • Informs other facilitation team members of process, activities, and exercises • Provides support to facilitators • Conducts debriefings as required
Facilitators	• Supports in facilitation capacities in an unbiased manner • Guides discussions with excellent interpersonal and communication skills • Facilitates questions and seeks responses which are addressing the objectives and scope of the AAR • Summarizes responses and provides support to Note Takers and the Report Writer as necessary to develop the final written AAR • For Tribal communities, it may be necessary to have team members familiar with the community, language, and traditions
Note Takers	• Takes notes on working group participants in attendance • Takes notes of group discussions • Takes notes regarding identified exercises
Report Writer	• Prepares drafts and final written After Action Report
Tribal Improvement Plan Leader	• Is an individual from within the Tribal government to oversee the improvement plan process • Has the authority, or delegated authority, to plan, implement, and complete all identified corrective action items in the improvement plan • Is solely focused on the improvement plan • Avoids adding to the responsibilities of implementation on an already tasked individual • Assumes the responsibility for the identified issues during development of the improvement plant, while also making decisions about the initial list of appropriate corrective actions to resolve the identified issues

Developing a Budget

Once you have decided how to structure the AAR process and team, it is important to outline a budget for activities planning which can include, but not limited to the items listed in the following table.

Table 9: Example Items to Build into a Budget for AAR Activities

- Team member wages
- Translator services
- Materials/Supplies (e.g. flip boards, markers, notepads, sticky notes, pens)
- Food/Snacks/Beverages
- Printing
- Communication aids (projectors, A/V equipment, recording equipment)
- Usage fees of meeting spaces
- Virtual meeting platforms
- Travel expenses/per diem amounts
- Lodging

It may be possible to outline a budget for implementation of improvement plan actionable items ahead of completion of the plan. Information on funding opportunities is available in the section regarding developing the Improvement Plan.

Developing a Checklist and Agenda

As a best practice, having a checklist of materials and logistics for each meeting helps to streamline planning. The checklist should include supplies and equipment, meeting room/virtual meeting logistics, assignments of team members, participant information (invitations, notes, reminders), special accommodations needed for accessibility, meals/catering details if needed, and any materials to be handed out.

As a best practice, having a checklist of materials and logistics for each meeting helps to limit any unnecessary hassle.

An agenda for the Working Group should be developed to provide details on location, dates, start and end times of the day, topics to be covered and length of time for each. Topics may include Welcome and Introductions, Review of the AAR Process, Expectations of the Working Group, Capabilities, Exercises, etc.

Informing Stakeholders, Participants, and Facilitators

When informing stakeholders, participants, and facilitators, having an AAR Launch memo or email containing information of what an AAR is, the process, logistical meeting information, expected timelines to completion, and what you are asking of the participants, tailoring information for each specific group of stakeholders as needed.

The AAR Lead should at this point develop and distribute the background information to help ensure all stakeholders have a similar level of understanding.

Virtual Venues During COVID-19 Pandemic

During the COVID-19 pandemic, there have been various safety precautions recommended by the World Health Organization, Center for Disease Control, and other health agencies that limit gatherings and interactions. Since the virus is highly contagious and transmitted through direct, indirect, and close contact with infected individuals, one of the precautions is social distancing, staying at a minimum 6 feet away from others.

For the safety of those involved, it may be beneficial to all parties to avoid large gatherings and opt for virtual meeting spaces. There are many virtual meeting platforms available such as Zoom, Google Hangouts, Adobe Connect, etc. It may be necessary to research these platforms and select the best option based on time limitations, activities (whiteboards, polls, etc.), security, and compatibility with technical systems.

For the safety of those involved, it may be beneficial to all parties to avoid large gatherings and opt for virtual meeting spaces

Preparing for the AAR Exercise

Collect and Review Relevant Background Documentation

Before beginning the AAR Working Group, all AAR facilitators and interviewers of key informants should have a common understanding of the necessary background information that will allow focus on the response actions that have been implemented. A best practice would be to have the AAR Team and participants review the relevant documentation in order to begin with the same level of understanding for review and development of improvement plans. The AAR facilitators should become familiar with the information in order to adequately guide the trigger questions and discussions within the AAR Working Group.

A best practice would be to have the AAR Team and participants review the relevant documentation in order to begin with the same level of understanding for review and development of improvement plans.

Table 10: Example Relevant Background Documents

- Strategic plans developed in response to the incident
- Status reports from key Leadership, Incident Command Teams, and other Emergency Management Teams
- Operations Assessments
- Statistical reports of outbreak information
- Public Health information issued by CDC, WHO, FEMA on start dates of infections, key milestones, clinical symptoms, demographic vulnerabilities, treatment developments
- Media reports
- Tribal Emergency Response resolutions or addresses
- Tribal Community communication materials
- Tribal health clinic/medical center data as necessary

Refine Trigger Questions and Exercises

Prior to the AAR Working Group, the Lead Facilitator should develop and refine trigger questions to guide the session. Trigger questions are open-ended questions used to guide discussion through the AAR Working Group based upon the objective, capabilities, and areas of focus. These questions can be refined after meeting with the AAR Team. Below are examples of additional questions for specific areas based on the WHO's working group templates.

Trigger questions are open-ended questions used to guide discussion through the AAR Working Group based upon the objective, capabilities, and areas of focus.

- What was in place before the response?
  - A plan, capabilities, procedures, resources, etc.
- What happened during the response?
  - Timeline, key milestones, etc.?
- What went well? What went less well? Why?
  - What were the strengths and challenges? Funds or resources related? Process gaps?
- What can we do to improve for next time?
  - Addressing challenges? Implementation for best practice?

Timeline Leading Up to an AAR Working Group

Table 11: Example Timeline Prior to Working Group

Task	Timeline
Send out invitations to Working Group participants	10 - 20 Days Prior to AAR Working Group
Distribute Relevant Background Documentation	5 - 10 Days Prior to AAR Working Group
Coordination meeting with AAR Lead, Lead Facilitator, facilitators, and note takers to review roles, objectives of meeting, meeting preparation, last minute preparations/adjustments	3 - 5 Days Prior to AAR Working Group
Distribute finalized materials (e.g. agenda, etc.)	2 - 3 Days Prior to AAR Working Group
Review checklist and confirm logistics	2 - 3 Days Prior to AAR Working Group

Tip: The AAR Lead should coordinate with the Lead Facilitator to ensure alignment in timeline and content.

During an AAR

Conducting an AAR

Conducting a working group AAR will likely take two to three days. During this time AAR participants conduct a thorough review of the response. The working group will identify achievements, challenges and actions needed to implement best practices. The objective is to develop methods to strengthen future capacity. Prior to conducting the analysis, the group should identify specific areas of focus for the review. The analysis itself should include objective observation, gap analysis and identification of areas for improvement.

The working group will identify achievements, challenges and actions needed to implement best practices. The objective is to develop methods to strengthen future capacity.

Activities during an AAR

During the AAR, participants will engage in a number of exercises including:

1. Creating an inventory of capabilities
2. Agreeing upon a timeline of key events during the incident
3. Selecting a focus for the AAR
4. Conducting an evaluation of response
5. Creating a performance improvement plan

Using Capability Standards for an AAR

State, local, tribal, and territorial public health agencies exist within a landscape of diverse governance, organizational structures, legal authorities, partnerships, stakeholders, risks, demographics, and resources that influence jurisdiction-to-jurisdiction public health emergency preparedness priorities.

CDC's Public Health Emergency Preparedness and Response Capabilities provide an interrelated framework for communities to prepare for, respond to, and recover from threats and emergencies. The capability standards serve as a resource to assess, build, and sustain Tribal public health agency preparedness and response capacity by further defining the Tribal public health agency ESF #8 role[18] while guiding program improvement initiatives to address preparedness and response planning gaps. It is important that Tribal public health agencies must remain aware of new and emerging public health threats.

The definitions described within the capability standards are broad. Tribal health agencies are not expected to simultaneously and completely address all identified issues, gaps, and needs across all capabilities in the short term. Instead, Tribes should periodically reprioritize the capability standards they pursue based on regularly updated jurisdictional inputs, including risk assessment findings.

Tribes should periodically reprioritize the capability standards they pursue based on regularly updated jurisdictional inputs, including risk assessment findings.

[18] Emergency Support Function (ESF) #8 -Public Health and Medical Services provides the mechanism for coordinated Federal assistance to supplement Tribal resources in response to a public health and medical disaster, potential or actual incidents requiring a coordinated Federal response, and/or during a developing potential health and medical emergency.

The resources and functions described within each capability are not intended to be all inclusive. It is important to identify any additional resources, specific to your Tribe and your community, which may be necessary to achieve capability tasks. Identifying these additional resources will allow for customization of the plan. Your stakeholders can assist in doing this.

Tip: Identify all capability resources specific to your community to customize your plan.

In Table 8 (see below) find the CDC's fifteen Public Health Emergency Preparedness and Response Capabilities along with definitions and corresponding functions. This is important for the next section: Creating an Inventory of Capabilities for your AAR Working Group.

Table 12: Capability Definitions and Functions[19]

Capability	Definition	Functions
Capability #1: Community Preparedness	Community preparedness is the ability of communities to prepare for, withstand, and recover from public health incidents in both the short and long term. Through engagement and coordination with a cross-section of state, local, tribal, and territorial partners and stakeholders, the public health role in community preparedness is to: • Support the development of public health, health care, human services, mental/behavioral health, and environmental health systems that support community preparedness • Participate in awareness training on how to prevent, respond to, and recover from incidents that adversely affect public health • Identify at-risk individuals with access and functional needs that may be disproportionately impacted by an incident or event • Promote awareness of and access to public health, health care, human services, mental/behavioral health, and environmental health resources that help protect the community's health and address the access and functional needs of at-risk individuals Engage in preparedness activities that address the access and functional needs of the whole community as well as cultural, socioeconomic, and demographic factors	• **Function 1:** Determine risks to the health of the jurisdiction • **Function 2:** Strengthen community partnerships to support public health preparedness • **Function 3:** Coordinate with partners and share information through community social networks • **Function 4:** Coordinate training and provide guidance to support community involvement with preparedness efforts

[19] Redd, S., M.D., Kosmost, C., R.N., B.S.N., M.S., & Talbert, T., M.A. (2019). *Public health emergency preparedness and response capabilities: National standards for state, local, tribal, and territorial public health*. Atlanta, GA: Centers for Disease Control and Prevention, Center for Preparedness and Response.

	• Convene or participate with community partners to identify and implement additional ways to strengthen community resilience • Plan to address the health needs of populations that have been displaced because of incidents that have occurred in their own or distant communities, such as after a radiological or nuclear incident or natural disaster	
Capability #2: Community Recovery	Community recovery is the ability of communities to identify critical assets, facilities, and other services within public health, emergency management, health care, human services, mental/behavioral health, and environmental health sectors that can guide and prioritize recovery operations. Communities should consider collaborating with jurisdictional partners and stakeholders to plan, advocate, facilitate, monitor, and implement the restoration of public health, health care, human services, mental/behavioral health, and environmental health sectors to at least a day-to-day level of functioning comparable to pre-incident levels and to improved levels, where possible.	• **Function 1:** Identify and monitor community recovery needs • **Function 2:** Support recovery operations for public health and related systems for the community • **Function 3:** Implement corrective actions to mitigate damage from future incidents
Capability #3: Emergency Operations Coordination	Emergency operations coordination is the ability to coordinate with emergency management and to direct and support an incident or event with public health or health care implications by establishing a standardized, scalable system of oversight, organization, and supervision that is consistent with jurisdictional standards and practices and the National Incident Management System (NIMS)	• **Function 1:** Conduct preliminary assessment to determine the need for activation of public health emergency operations • **Function 2:** Activate public health emergency operations • **Function 3:** Develop and maintain an incident response strategy • **Function 4:** Manage and sustain the public health response • **Function 5:** Demobilize and evaluate public health emergency operations
Capability #4: Emergency Public Information and Warning	Emergency public information and warning is the ability to develop, coordinate, and disseminate information, alerts, warnings, and notifications to the public and incident management personnel.	• **Function 1:** Activate the emergency public information system • **Function 2:** Determine the need for a Joint Information System

		• **Function 3:** Establish and participate in information system operations • **Function 4:** Establish avenues for public interaction and information exchange • **Function 5:** Issue public information, alerts, warnings, and notifications
Capability #5: Fatality Management	Fatality management is the ability to coordinate with partner organizations and agencies to provide fatality management services. The public health agency role in fatality management activities may include supporting • Recovery and preservation of remains • Identification of the deceased • Determination of cause and manner of death • Release of remains to an authorized individual • Provision of mental/behavioral health assistance for the grieving The role also may include supporting activities for the identification, collection, documentation, retrieval, and transportation of human remains, personal effects, and evidence to the examination location or incident morgue.	• **Function 1:** Determine the public health agency role in fatality management • **Function 2:** Identify and facilitate access to public health resources to support fatality management operations • **Function 3:** Assist in the collection and dissemination of antemortem data • **Function 4:** Support the provision of survivor mental/behavioral health services • **Function 5:** Support fatality processing and storage operations
Capability #6: Information Sharing	Information sharing is the ability to conduct multijurisdictional and multidisciplinary exchange of health-related information and situational awareness data among federal, state, local, tribal, and territorial levels of government and the private sector. This capability includes the routine sharing of information as well as issuing public health alerts to all levels of government and the private sector in preparation for and in response to events or incidents of public health significance.	• **Function 1:** Identify stakeholders that should be incorporated into information flow and define information sharing needs • **Function 2:** Identify and develop guidance, standards, and systems for information exchange • **Function 3:** Exchange information to determine a common operating picture
Capability #7: Mass Care	Mass care is the ability of public health agencies to coordinate with and support partner agencies to address, within a congregate location (excluding shelter-in-place locations), the public health, health care, mental/behavioral health, and human services needs of those impacted by an incident. This capability includes coordinating ongoing surveillance and public health assessments to	• **Function 1:** Determine public health role in mass care operations • **Function 2:** Determine mass care health needs of the impacted population • **Function 3:** Coordinate public health, health care, and mental/behavioral

	ensure that health needs continue to be met as the incident evolves.	health services • **Function 4:** Monitor mass care population health
Capability #8: Medical Counter-measure Dispensing and Administration	Medical countermeasure dispensing and administration is the ability to provide medical countermeasures to targeted population(s) to prevent, mitigate, or treat the adverse health effects of a public health incident, according to public health guidelines. This capability focuses on dispensing and administering medical countermeasures, such as vaccines, antiviral drugs, antibiotics, and antitoxins.	• **Function 1:** Determine medical countermeasure dispensing/administration strategies • **Function 2:** Receive medical countermeasures to be dispensed/administered • **Function 3:** Activate medical countermeasure dispensing/administration operations • **Function 4:** Dispense/administer medical countermeasures to targeted population(s) • **Function 5:** Report adverse events
Capability #9: Medical Materiel Management and Distribution	Medical materiel management and distribution is the ability to acquire, manage, transport, and track medical materiel during a public health incident or event and the ability to recover and account for unused medical materiel, such as pharmaceuticals, vaccines, gloves, masks, ventilators, or medical equipment after an incident.	• **Function 1:** Direct and activate medical materiel management and distribution • **Function 2:** Acquire medical materiel from national stockpiles or other supply sources • **Function 3:** Distribute medical materiel • **Function 4:** Monitor medical materiel inventories and medical materiel distribution operations • **Function 5:** Recover medical materiel and demobilize distribution operations
Capability #10: Medical Surge	Medical surge is the ability to provide adequate medical evaluation and care during events that exceed the limits of the normal medical infrastructure of an affected community. It encompasses the ability of the health care system to endure a hazard impact, maintain or rapidly recover operations that were compromised, and support the delivery of medical care and associated public health services, including disease	• **Function 1:** Assess the nature and scope of the incident • **Function 2:** Support activation of medical surge • **Function 3:** Support jurisdictional medical surge operations • **Function 4:** Support demobilization of medical

	surveillance, epidemiological inquiry, laboratory diagnostic services, and environmental health assessments.	surge operations
Capability #11: Non-pharmaceutical Interventions	Nonpharmaceutical interventions are actions that people and communities can take to help slow the spread of illness or reduce the adverse impact of public health emergencies. This capability focuses on communities, community partners, and stakeholders recommending and implementing nonpharmaceutical interventions in response to the needs of an incident, event, or threat. Nonpharmaceutical interventions may include • Isolation • Quarantine • Restrictions on movement and travel advisories or warnings • Social distancing • External decontamination • Hygiene • Precautionary protective behaviors	• **Function 1:** Engage partners and identify factors that impact nonpharmaceutical interventions • **Function 2:** Determine nonpharmaceutical interventions • **Function 3:** Implement nonpharmaceutical interventions • **Function 4:** Monitor nonpharmaceutical interventions
Capability #12: Public Health Laboratory Testing	Public health laboratory testing is the ability to implement and perform methods to detect, characterize, and confirm public health threats. It also includes the ability to report timely data, provide investigative support, and use partnerships to address actual or potential exposure to threat agents in multiple matrices, including clinical specimens and food, water, and other environmental samples. This capability supports passive and active surveillance when preparing for, responding to, and recovering from biological, chemical, and radiological (if a Radiological Laboratory Response Network is established) public health threats and emergencies.	• **Function 1:** Conduct laboratory testing and report results • **Function 2:** Enhance laboratory communications and coordination • **Function 3:** Support training and outreach
Capability #13: Public Health Surveillance and Epidemiological Investigation	Public health surveillance and epidemiological investigation is the ability to create, maintain, support, and strengthen routine surveillance and detection systems and epidemiological investigation processes. It also includes the ability to expand these systems and processes in response to incidents of public health significance.	• **Function 1:** Conduct or support public health surveillance • **Function 2:** Conduct public health and epidemiological investigations • **Function 3:** Recommend, monitor, and analyze mitigation actions

		• **Function 4:** Improve public health surveillance and epidemiological investigation systems
Capability #14: Responder Safety and Health	Responder safety and health is the ability to protect public health and other emergency responders during pre-deployment, deployment, and post-deployment.	• **Function 1:** Identify responder safety and health risks • **Function 2:** Identify and support risk-specific responder safety and health training • **Function 3:** Monitor responder safety and health during and after incident response
Capability #15: Volunteer Management	Volunteer management is the ability to coordinate with emergency management and partner agencies to identify, recruit, register, verify, train, and engage volunteers to support the jurisdictional public health agency's preparedness, response, and recovery activities during pre-deployment, deployment, and post-deployment.	• **Function 1:** Recruit, coordinate, and train volunteers • **Function 2:** Notify, organize, assemble, and deploy volunteers • **Function 3:** Conduct or support volunteer safety and health monitoring and surveillance • **Function 4:** Demobilize volunteers

Create an Inventory of Core Capabilities

The inventory of the capabilities that existed prior to the incident, and which could have been used to support the response, should be established. Identification of core capabilities will help inform the focus for the AAR.

Identification of core capabilities will help inform the focus for the AAR.

The capabilities are typically grouped in the following capability elements:

1. ***Plans and Policies:*** Review the plan for a multisector response
    a. Leadership, partner coordination, information management, health operations, operations support and logistics (supply chain management), financial management, IT
2. ***Resources:*** Availability of sufficient resources (human, material and financial) available for multisectoral coordination at all levels?
3. ***Coordination Mechanisms:*** Collaboration with local, state and federal partners
4. ***Preparedness activities:*** including prevention measures such as testing and immunization (if available)
5. **Others:** Communications, IT, Broadband, Education

Select a Focus for the AAR

Prior to conducting the review, the group should identify specific areas of focus. Selecting areas of focus is necessary to structure the AAR and make it more customized and meaningful to your Tribal Nation. In order to determine the focus of the AAR, Tribes should select from the capabilities outlined earlier on pages 24 - 29. Not all capability standards need to be included in the AAR; only those which are most relevant and important to your community. Subsequently, not all functions within each capability need to be evaluated. In addition, some functions may fall within and across different capabilities depending on how your emergency response effort is structured.

Selecting areas of focus is necessary to structure the AAR and make it more customized and meaningful to your Tribal Nation.

Table 9 (see below) is an example of focusing on capabilities relevant to the incident and the response by the Tribe.

Table 9. Example AAR Selected Capability and Function

Selected Capabilities	Functions/Activities for Review
Capability #1: Community Preparedness	• Function 2: Strengthen community partnerships to support public health preparedness • Function 3: Coordinate with partners and share information through community social networks • Function 4: Coordinate training and provide guidance to support community involvement with preparedness efforts
Capability #2: Community Recovery	• Function 1: Identify and monitor community recovery needs • Function 3: Implement corrective actions to mitigate damage from future incidents
Capability #3: Emergency Operations Coordination (*Since the actual emergency operations coordination is the core of an AAR, typically all associated functions are included in the review.)*	• Function 1: Conduct preliminary assessment to determine the need for activation of public health emergency operations • Function 2: Activate public health emergency operations • Function 3: Develop and maintain an incident response strategy • Function 4: Manage and sustain the public health response • Function 5: Demobilize and evaluate public health emergency operations
Capability #4: Emergency Public Information and Warning	• Function 2: Determine the need for a Joint Information System • Function 4: Establish avenues for public interaction and information exchange • Function 5: Issue public information, alerts, warnings, and notifications
Capability #8: Medical Countermeasure	• Function 1: Determine medical countermeasure dispensing/administration strategies • Function 2: Receive medical countermeasures to be dispensed/administered • Function 3: Activate medical countermeasure dispensing/administration operations • Function 4: Dispense/administer medical countermeasures to targeted population(s)

	• Function 5: Report adverse incidents
Capability #10: Medical Surge	• Function 1: Assess the nature and scope of the incident • Function 2: Support activation of medical surge • Function 3: Support jurisdictional medical surge operations • Function 4: Support demobilization of medical surge operations
Capability #11: Non-pharmaceutical Interventions	• Function 1: Engage partners and identify factors that impact nonpharmaceutical interventions • Function 2: Determine nonpharmaceutical interventions • Function 3: Implement nonpharmaceutical interventions • Function 4: Monitor nonpharmaceutical interventions
Capability #14: Responder Safety and Health	• Function 1: Identify responder safety and health risks • Function 2: Identify and support risk-specific responder safety and health training • Function 3: Monitor responder safety and health during and after incident response

Key Milestones of an Incident

At the outset of the AAR, the facilitator will work with the group to identify key milestones for the incident. The timeline is important to the analysis in order to determine if elements of the response effort occurred timely. The Tribal milestone timeline should be compared to the epi curve of the disease to evaluate the impact of interventions on controlling the outbreak. Typical key milestones and their definitions can be found below.

The Tribal milestone timeline should be compared to the epi curve of the disease to evaluate the impact of interventions on controlling the outbreak.

Table 10: Key Milestones Definitions

Key Milestone	Definition
Start of the Outbreak/Event	Date of symptom onset in the first case as defined by the epidemiology definition of a case
Detection of the Outbreak on the Reservation	Date the outbreak is first recorded by any source
Declaration of Emergency	Date Tribal Leadership officially announced declaration of emergency
Emergency Operations Center activated	EOC activated
Date of Tribal community communication	Date of first official release of information to the community
Date of outbreak intervention	Earliest date of public health intervention to control the outbreak
Date outbreak is under control or ended	Date outbreak is declared under control or over by public health authority

Identification, Evaluation and Rating of Strengths, Challenges, and New Capacities Developed

Identifying, evaluating, and rating the strengths and challenges of your recent response efforts is the first major step in a two-step process for developing and updating an infectious disease response plan. The second step is creating a performance improvement plan. Within each capability area, participants should work together to identify key strengths, challenges and new capabilities developed through the response to the outbreak. This evaluation will serve as the basis of the performance improvement plan for AAR. Create a template to track each function within a particular capability.

Identifying, evaluating, and rating the strengths and challenges of your recent response efforts is the first major step in a two-step process for developing and updating an infectious disease response plan.

Rating Performance for Each Capacity

As part of the evaluation process, performance for each capacity should be rated. The typical rating scale recommended by FEMA and associated definitions are as follows:

- ***Performed without challenges (P):*** The targets and critical tasks associated with the core capability were completed in a manner that achieved the objective(s) and did not negatively impact the performance of other activities. Performance of this activity did not contribute to additional health and/or safety risks for the community or for emergency workers, and it was conducted in accordance with applicable plans, policies, procedures, regulations, and Tribal and Federal laws.
- ***Performed with Some Challenges (S):*** The targets and critical tasks associated with the core capability were completed in a manner that achieved the objective(s) and did not negatively impact the performance of other activities. Performance of this activity did not contribute to additional health and/or safety risks for the public or for emergency workers, and it was conducted in accordance with applicable plans, policies, procedures, regulations, and laws. However, opportunities to enhance effectiveness and/or efficiency were identified.
- ***Performed with Major Challenges (M):*** The targets and critical tasks associated with the core capability were completed in a manner that achieved the objective(s), but some or all of the following were observed: demonstrated performance had a negative impact on the performance of other activities; contributed to additional health and/or safety risks for the public or for emergency workers; and/or was not conducted in accordance with applicable plans, policies, procedures, regulations, and laws.
- ***Unable to be Performed (U):*** The targets and critical tasks associated with the core capability were not performed in a manner that achieved the objective(s)

For each capability, the group should agree upon a description including a short narrative of key issues, milestones, and challenges which will help identify the function and activities included for review and frame subsequent areas for the evaluation. Below is a selected, non-all-inclusive example evaluation template.

Table 13: Example Evaluation for Capability #1 - Community Preparedness

Function	Performance Rating (P, S, M, U)	Strength	Challenge	New Capability
Strengthen community partnerships to support public health preparedness	S	Internal partnerships were already strong and several external partnerships in place	Some key external partnerships weren't established	N/A
Function 3: Coordinate with partners and share information through community social networks	M	Coordination helped with consistency of response efforts	Missing partnerships were difficult to obtain in the middle of a crisis	N/A
Function 4: Coordinate training and provide guidance to support community involvement with preparedness efforts	S	Internal partnerships allowed for ease of coordination for training within the community	N/A	N/A

Table 14: Example Evaluation for Capability #2 – Community Recovery

Function	Performance Rating (P, S, M, U)	Strength	Challenge	New Capability
Function 1: Identify and monitor community recovery needs	M	Internal inventory of assets existed	Jurisdictional partner information was either missing or out of date	Knowledge of jurisdictional partners and services was updated
Function 3: Implement corrective actions to mitigate damage from future incidents	M	Over time, the various stakeholders became more agile in responding to frequently changing information and standards	Communication and coordination was at times challenging	Developed more formal channels of communication and established daily briefings.

Table 15: Example Evaluation for Capability #3 - Emergency Operations

Function	Performance Rating (P, S, M, U)	Strength	Challenge	New Capability
Function 1: Conduct preliminary assessment to determine the need for activation of public health emergency operations	P	Team engaged quickly and gained Leadership support swiftly.	NA	NA
Function 2: Activate public health emergency operations	P	Team engaged quickly and gained Leadership support swiftly.	NA	NA
Function 4: Manage and sustain the public health response	M	Over time, the response effort stabilized and adapted to changing conditions.	Understanding all components and identifying appropriate partners was challenging at times	Formal MOA's signed with multiple partners.

Table 16: Example Evaluation for Capability #8 - Medical Countermeasure

Function	Performance Rating (P, S, M, U)	Strength	Challenge	New capability
Function 1: Determine medical countermeasure dispensing/ administration strategies (for a pandemic this can include testing)	M	N/A	No testing supplies immediately available	Suppliers identified, contracts signed, secure storage identified, stockpile created

Function 2: Receive medical countermeasures to be dispensed/ administered	M	Identified Local and state level partners with assistance from Federal agencies including IHS and CDC	No testing supplies immediately available	Suppliers identified, contracts signed, secure storage identified, stockpile created
Function 3: Activate medical countermeasure dispensing/ administration operations	S	Coordinated with local partners once testing equipment became available	Timeline in establishing agreement with local partners	Created new policies and procedures which may be applied in future situations

How to use your Evaluation for Improvement Planning

Creating an identification and evaluation of your response activity is the first step in updating your plan. The evaluation should then be used to develop your performance improvement plan. There is no prescribed way to determine which capacities and functions should be included in the performance improvement plan. You may choose to include each capacity, only those rated "performed with some or major challenges" or a hybrid.

Building Consensus Among Participants

Upon completion of the identification and evaluation of strengths, challenges, and new capacities the group should conduct a final review of each and reach agreement. This review is important to build consensus and generate buy in. This creates responsibility within the group and increases the likelihood that the performance improvement plan will be completed and implemented.

A final review creates responsibility within the group and increases the likelihood that the performance improvement plan will be completed and implemented.

Presenting Results and Follow-Up Actions

Inter-Tribal Debriefing

The AAR debriefing shares with Leadership, stakeholders, and partners the overall planning, preparation, and conduct of the AAR. If desired, the debriefing can also share the roles, responsibilities, and timelines for completion of the AAR reports and other deliverables. Ideally, the AAR debriefing should occur within one week of completing the AAR. The AAR debrief typically takes the form of a combination of a formal presentation and discussion. The debrief can be led by the AAR facilitator, someone appointed by the group, or a combination of group participants depending on areas of expertise. The focus should be on lessons learned and best practices. The AAR debrief may also include a discussion on how to improve the AAR process in the future.

When presenting an AAR debrief to Tribal Leadership, in addition to sharing information and best practices, this is an opportunity to gain support and approval for the resources needed to implement the AAR improvement plan. It may also be an opportunity to gain support to share the AAR findings with others including external partners and the Tribal community. This more widespread sharing of results can garner greater cooperation and understanding for actions during future incidents.

When presenting an AAR debrief to Tribal Leadership, this is an opportunity to gain support and approval for the resources needed to implement the AAR improvement plan.

External Debriefing

In response to most emergency incidents, particularly public health emergencies, Tribal governments collaborate with other external partners: local, state, federal and NGO's to coordinate the response. For this reason, when appropriate, it is often a best practice to conduct an AAR with these external partners. This is particularly important when there are segments of the action plan which include and rely on external partners for implementation. This helps strengthen partnerships and future collaborations. The same format used for the internal Tribal debriefing may be used with minor adjustments for this external debrief.

External debriefing helps strengthen partnerships and future collaborations.

AAR Final Report

An author for the final report should be the assigned Report Writer from the AAR Team. The Report Writer should gather all notes and the action/work plan developed during the AAR for integration into the report. Once the initial draft is completed, it should be circulated to a review committee to review for accuracy and completeness. The most critical component of the AAR is the action plan for key activities and recommendations including timelines, budget information and assigned staff/departments/individuals. Activities should be separated into those which can be completed within a short amount of time and those which are longer term. (e.g. building alternate housing for those who must be quarantined.)

At a minimum, the final report for the AAR should include the following sections:

I. Executive summary
II. Background and description of the incident under review
III. Scope/focus of the review
IV. Findings/Evaluation/Action plan
V. Next Steps
VI. Conclusions

The plans for disseminating the final AAR report should be agreed upon during the AAR planning process. It is advisable to consider an abbreviated report with classified and/or sensitive information removed. For example, if the action plan assigns specific individuals, this may not be allowed according to human resource policies. Once the report is finalized, it should be shared with everyone in the AAR planning group, Tribal Leadership and anyone else Tribal Leadership determines.

After the AAR: Documenting Progress

It is important to keep in mind that the action plan for the AAR is a living document and should be followed and amended as the action plan is implemented. Not until the improvement plan is finalized has the AAR come to completion. A best practice is to assign a coordinator to oversee the ongoing implementation of the improvement plan. This is different from the team members responsible for implementing the plan. The role of the coordinator is twofold:

1. Act as a convener of the group, whether that means weekly, monthly or quarterly gatherings depending on the activities and availability of members.
2. Facilitation of access to resources needed to get the work done i.e. support from procurement and finance to seek vendors for PPE's and funding to purchase

It is important to keep in mind that the action plan for the AAR is a living document and should be followed and amended as the action plan is implemented.

Lessons Learned Database

The AAR Team should document their work and notes provided by the Note Taker to create a database of "lessons learned". The purpose of this database is to record and share information gained during the emergency and the AAR process with others. As stated previously, keeping a record of the performance ratings for each capability will be important when it comes to the next phase of Improvement Planning.

Improvement Planning

Improvement planning is the essential next step, once the AAR has been completed. The identification of strengths, areas for improvement, and corrective actions that result from incidents help Tribal organizations build capabilities as part of a larger continuous improvement process. An effective corrective action program develops improvement plans that are dynamic documents, which are continually monitored and implemented as part of the larger system of improving Tribal response to incidents.

Improvement Planning is a process by which the areas for improvement from an incident are turned into tangible and quantifiable corrective actions that strengthen capabilities. Improvement planning activities can help shape preparedness priorities and support continuous improvement in Tribal organizations

Improvement Planning is a process by which the areas for improvement from an incident are turned into tangible and quantifiable corrective actions that strengthen capabilities.

Improvement Plan Authority

The completion of an AAR and the subsequent Improvement Plan (IP) by a Tribe should have the full backing of all levels of Tribal Leadership, as there are personnel, financial, policy, legal, and at times, sovereignty issues related to the adoption and implementation of the IP.

Each Tribe that completes an IP should consider the internal business practices of the Tribe, including the role and authorities of Tribal Leadership, to assure that each of the corrective actions can be addressed at the proper location within the organization, to assure completion of the corrective action items.

The completion of an AAR and the subsequent Improvement Plan (IP) by a Tribe should have the full backing of all levels of Tribal Leadership.

Tribal Leadership and Tribal government officials must be included in the lifespan of the IP and the completion of the corrective action items. They can provide strategic direction for the IP program as well as specific guidance necessary for achieving the desired outcomes of the IP. Routine engagement during the IP process with Tribal Leadership and Tribal government officials can bolster internal and external support necessary for the success of the project.

Tribal Improvement Plan Leadership

It is essential to have an assigned individual from within the Tribal government to oversee the IP process, through to completion. This individual should have the authority, or a delegated authority, to plan, implement, and complete all the identified corrective action items in the IP. It is preferable that this individual is solely focused on the IP, avoiding adding the responsibilities of the IP implementation on an already tasked individual. During the IP implementation period the development of corrective actions, the Tribal IP Leader, as the Tribal IP project manager, will assume the responsibility for the identified issues, while also making decisions about the initial list of appropriate corrective actions to resolve the identified issues.

Tribal Timelines

There are numerous factors that impact the timeline for the implementation of the Tribal IP. Once the IP has been approved at the final reporting, the proper internal Tribal Leadership approvals and resolutions have been obtained, and the Tribal IP Leader is identified, the project management aspects of the IP process are now of greatest concern. These issues include financial/funding matters and staffing to complete the corrective action items for the IP.

After Action Improvement Plan

Improvement Plan (IP) Development:

The Improvement Plan (IP) is a document that generally includes an overview of the event or incident that is being evaluated, including an analysis of capabilities, and a list of accepted and approved corrective actions. The length, format, and development timeframe of the IP depend on the incident type and scope of the involvement of each participating entity. The IP should include an overview of performance related to each incident objective and associated capabilities required.

The Improvement Plan (IP) is a document that generally includes an overview of the event or incident that is being evaluated, including an analysis of capabilities, and a list of accepted and approved corrective actions.

The ability to communicate exercise evaluation results to stakeholders is crucial to the improvement planning process.

Gathering Stakeholder Observations

Time spent planning for data collection, the actual collection of data, and conducting analysis supports the development of clear observations and recommendations for inclusion in the Improvement plan.

It is recommended the database information be provided to additional stakeholders who did not participate in the AAR Working Group to identify areas for further improvement, provide feedback on improvement implementation activities, and provide their recommended resources and timelines for implementation.

After the After Action Review working group is completed, it is recommended that the capabilities ranked as "Unable to Perform" or "Performed with Major Challenges" be at the top of the priority list to be included in the improvement plan. The capabilities ranked as "Performed with Some Challenges" and "Performed without Challenges" do not need to be added but may be included at the discretion of the Tribal IP Leader.

The observations developed for the capabilities should be categorized as either strengths or areas for improvement and can be found in the database of lessons learned from the AAR Working Group. Additional recommendations for improvement can be gathered from other stakeholders to gain more insight into specific improvement actions.

Mechanisms to discover observations from stakeholders include:

- Written Observations
- Verbal Interviews
- Written/Online surveys
- Group Discussions

Feedback should include:

- Clear and direct statement of the issue identified
- A brief description of the analysis
- The impact or result of the issue

Observation Strengths and Weaknesses:

- Actions that went exceptionally well given the circumstances
- The impact of positive performance on desired or expected outcomes
- Activities that yielded better results than could have been expected
- Outcomes did not meet expectations or intent
- The negative impact of actual performance on desired or expected outcomes
- The factors that contributed to the inability to meet critical tasks, capability targets, or desired outcomes

Other areas of emphasis when organizing observations into the Improvement Plan:

- Focus on issues that are critical to the success of a mission or represent a trend
- Observations help guide corrective action planning by focusing time and resources on issues that have the greatest impact
- Include data on consequences and likelihood of reoccurrences or what would happen if no action is taken

It is recommended the database information be provided to additional stakeholders who did not participate in the AAR Working Group to identify areas for further improvement.

SMART Corrective Actions

The Homeland Security Exercise and Evaluation Program (HSEEP) Guide from January 2020 recommends the use of SMART Corrective Actions. Specific, measurable, achievable, relevant, and time-bound (SMART) corrective actions are steps intended to resolve capability gaps and shortcomings identified prior to, during, and after an incident.

Table 17: SMART Corrective Actions

SMART Guidelines for Corrective Actions	
Specific	Objectives should address the five Ws: who, what, when, where, and why. The objective specifies what needs to be done with a timeline for completion.

Measurable	Objectives should include numeric or descriptive measures that define quantity, quality, cost, etc. Their focus should be on observable actions and outcomes.
Achievable	Objectives should be within the control, influence, and resources of exercise play and participant actions.
Relevant	Objectives should be instrumental to the mission of the organization and link to its goals or strategic intent.
Time-Bound	A specified and reasonable timeframe should be incorporated into all objectives.

After reviewing the AAR database and reviewing the improvement recommendations, the Tribal IP Leader should begin inputting the information into the Improvement Plan Matrix.

The Improvement Plan Matrix will show the steps to implement the improvement plan for each core capability, the issue to be resolved, the action to be taken, responsibilities, and timelines. Below is an example Improvement Plan Matrix.

Table 18: Improvement Plan Matrix

Core Capability	Issue/ Area for Improvement	Corrective Action	Capability Element	Primary Responsible Organization	Organization POC	Start Date	Completion Date
Core Capability 1: Operational Coordination	1. Delay in situational status reporting from individual Tribal clinics	1. Provide situational status reporting education to Tribal clinic department heads	Training	Education	John Doe	10/21/20	11/04/20

Implementation Funding

Funding of the IP is an essential aspect of the Tribal IP Leader and the IP process. The AAR, including the IP, is a flexible process, allowing for management of incidents, emergencies, and disasters of all sizes. The size of the incident will normally influence the size and cost of the IP process. Although many incidents that impact Tribes may be handled internally, without a financial impact to the Tribe, funding for corrective actions due to large incidents can overwhelm a Tribe. After large incidents, Tribes can struggle with the costs of the response and recovery phases of the incidents. When a Tribe struggles with the cost of response and recovery, there may not be additional internal funding available for the implementation of the IP. The following sections will review potential sources of funding if internal resources have been exhausted.

The size of the incident will normally influence the size and cost of the IP process.

When a Tribe struggles with the cost of response and recovery, there may not be additional internal funding available for the implementation of the IP.

Direct Requests for Assistance

The United States has a trust responsibility with federally recognized Tribes and recognizes their right to self-government. This "Government to Government" relationship requires the United States Federal Government to protect Tribal treaty rights, lands, assets, and resources while providing support through statutory authority and other programs. Under the Robert T. Stafford Disaster Relief and Emergency Assistance Act (Stafford Act), federally recognized Tribes impacted by an incident, emergency, or disaster, may directly request their own emergency and/or major declaration from the United States Federal Government or they may request for assistance in coordination with a state.

As outlined in the National Response Framework (NRF) and the National Disaster Recovery Framework (NDRF) federally recognized Tribes can request federal assistance for incidents that impact the Tribe, but do not result in a Stafford Act declaration. Tribes can elect to request assistance from a singular federal department or agency acting under their own federal authorities. Tribes can also request Federal Emergency Management Agency (FEMA) assistance to coordinate federal governmental assistance from multiple federal sources.

External funding resources include:

1. ***Direct Requests for Assistance***
2. ***Partnerships***
3. ***Post Disaster Grants and Assistance***

Partnerships

Although there are numerous Tribally related groups that are associated with emergencies and disasters, The Tribal Assistance Coordination Group (TAC-G) is recognized in the National Response Framework (NRF) as the Multi Agency Coordination (MAC) group that assists federally recognized Tribes during emergencies and disasters and provides information and technical assistance for Tribal emergency management programs in coordination with federal partners.

The TAC-G is led and managed by the Bureau of Indian Affairs (BIA) Emergency Management Program. The TAC-G consists of partners from all levels of government (local, state, Tribal, territorial, insular, or federal), as well as nonprofit aid organizations and the private sector. In addition to the BIA, other major contributors to the TAC-G include the Federal Emergency Management Agency (FEMA), the Indian Health Service (IHS), and the United States Army Corps of Engineers (USACE).

Post Disaster Grants and Assistance

The most familiar type of assistance that Tribes utilize, after an overwhelming incident, is managed by the Federal Emergency Management Agency (FEMA) as delegated by the President of the United States, in support of the Robert T. Stafford Disaster Relief and Emergency Assistance Act (Stafford Act). The Stafford Act authorizes the President to provide federal assistance when the magnitude of an incident or threat of an incident exceeds the affected state, territorial, Tribal, and local governments' capability to respond or recover.

When a Tribe is approved for an emergency or major disaster declaration from the President through the Federal Emergency Management Agency (FEMA), Tribes may receive assistance in the form of grants or cooperative agreements through FEMA Public Assistance (PA), Individual Assistance (IA), and the Hazard Mitigation Grant Programs (HMGP). Most Tribally declared disaster financial assistance does require a Tribal cost share with the federal government.

States, on their own for state level incidents, or in partnership with FEMA and other federal entities, also have the ability to assist Tribes with grants. Non-Government Organizations (NGO) also have internal grant making abilities.

Behavioral Health Funding

The Substance Abuse and Mental Health Services Administration (SAMHSA), an agency within the U.S. Department of Health and Human Services (HHS), leads public health efforts to advance the behavioral health of the nation and offers funding and technical assistance to Tribes and behavioral health organizations to support their programmatic efforts. Other funding sources include the following:

- Indian Health Services (IHS) Division of Behavioral Health
- Health Resources and Services Administration (HRSA)
- National Indian Health Board (NIHB)
- National Institute of Mental Health (NIMH)

Further details about current projects and upcoming FY2021 funding available can be found in Appendix B.

Behavioral Health Funding Sources:

- ***SAMHSA***
- ***CDC***
- ***IHS***
- ***HRSA***
- ***NIHB***
- ***NIMH***

Implementation Staffing

After the financial solutions have been identified, the Tribal IP Leader needs to address staffing issues for the IP process. On larger IP scenarios, the Tribal IP Leader will need to form numerous teams to complete the IP. These teams can include management, safety, design, operations, logistics, financial and construction teams.

After the financial solutions have been identified, the Tribal IP Leader needs to address staffing issues for the IP process.

Internal Staffing

The use of an internal staffing may be sufficient for smaller incidents. Internal staff members, including full time, part-time, and volunteers, already know the Tribal systems and can be efficient with assisting with many aspects of the IP. Tribal Leadership, including managers and supervisors, can assign existing staff to assist in their specific areas of expertise. Workload balance issues can arise when the priorities of a staff member's normal duties are usurped by the IP assignments and duties.

External Staffing Resources

Throughout the Tribal enterprise, there is a group of known contractors that assist the Tribe with tasks and assignments. The Tribe may elect to obtain the services of the known contractors, as with the internal staff, are familiar with collaborating with the Tribe, the Tribal Leadership, and are culturally aware.

External Staffing Resources:

1. ***Trusted contractors***
2. ***CNCS (AmeriCorps, Senior Corps, the Social Innovation Fund, and the Volunteer Generation Fund)***

One of the most active post disaster organizations from the federal government is the Corporation for National and Community Service (CNCS). CNCS is the federal agency that encompasses four main program areas: AmeriCorps, Senior Corps, the Social Innovation Fund, and the Volunteer Generation Fund.

Thousands of citizens from around the country serve in an AmeriCorps program in communities across the country each year. AmeriCorps state and national members serve to meet education, public safety, health and environmental needs of the community. The AmeriCorps VISTA program collaborates with faith-based and community organizations and public agencies, focusing on issues of poverty. Members of AmeriCorps National Civilian Community Corps (NCCC) can work in partnership with nonprofits, faith-based organizations, local municipalities, state governments, Tribes and schools on a variety of service projects. AmeriCorps NCCC-FEMA Corps specifically partners with FEMA to address emergency management and disaster relief projects.

Voluntary Organizations Active in Disaster (VOAD) are another resource available to the Tribal IP Leader. VOAD member agencies can support a variety of needs including individual and community needs assessments, accessible construction (repair/rebuild) support and coordination, debris removal from Tribal, public, and private property, and assistance with obtaining grants.

Improvement Planning to Support Continuous Improvement

Continuous Improvement:

Continuous improvement is a method in which capabilities are periodically examined to make sure they are sufficient, accurate, and effective to handle the threats, hazards, and risks a Tribe may face. Identifying strengths, areas for improvement, and corrective actions that result from incidents can assist a Tribe to build, sustain, and deliver capabilities as part of a continuous improvement process.

Corrective Action Tracking and Implementation Corrective actions captured in the IP should be tracked and continually reported on until completion by the Tribal IP Leader. These efforts are part of a more comprehensive continuous improvement process that applies before, during, and after an incident. Stakeholders should also ensure a system is in place to validate previous corrective actions that were successfully implemented.

Corrective Action Tracking and Implementation Corrective actions captured in the IP should be tracked and continually reported on until completion by the Tribal IP Leader.

Corrective Action Tracking and Implementation

Corrective Action Tracking and Implementation captured in the AAR/IP should be tracked and continually reported on until completion. Tribes should assign points of contact responsible for tracking and reporting on their progress in implementing corrective actions. By tracking corrective actions to completion, Tribes and their stakeholder partners can demonstrate that the capture, identification, and review of AAR related corrective action issues and solutions can yield tangible improvements. Tribes should also ensure there is a system in place to validate previous corrective actions that have been successfully implemented. These efforts should be considered part of a wider continuous improvement process that applies prior to, during, and after an incident.

By tracking corrective actions to completion, Tribes and their stakeholder partners can demonstrate that the capture, identification, and review of AAR related corrective action issues and solutions can yield tangible improvements.

Appendices

Appendix A. ACEs Questionnaire

Adverse Childhood Experience (ACE) Questionnaire

Finding your ACE Score ra hbr 10 24 06

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often** …
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?
   Yes No If yes enter 1 _____

2. Did a parent or other adult in the household **often** …
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   Yes No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you **ever**…
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Try to or actually have oral, anal, or vaginal sex with you?
   Yes No If yes enter 1 _____

4. Did you **often** feel that …
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes No If yes enter 1 _____

5. Did you **often** feel that …
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No If yes enter 1 _____

6. Were your parents **ever** separated or divorced?
   Yes No If yes enter 1 _____

7. Was your mother or stepmother:
   Often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   Yes No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No If yes enter 1 _____

9. Was a household member depressed or mentally ill or did a household member attempt suicide?
   Yes No If yes enter 1 _____

10. Did a household member go to prison?
    Yes No If yes enter 1 _____

Now add up your "Yes" answers:_____This is your ACE Score

Performance Rating of Capabilities

Capability				
Function	**Performance Rating (P, S, M, U)**	**Strength**	**Challenge**	**New Capability**

Capability				
Function	**Performance Rating (P, S, M, U)**	**Strength**	**Challenge**	**New Capability**

Capability				
Function	**Performance Rating (P, S, M, U)**	**Strength**	**Challenge**	**New Capability**

Appendix C. Improvement Plan Matrix

Improvement Plan Matrix

This IP has been developed specifically for [Tribe or Tribal Organization as a result of the [Working Group Name] conducted on [date of working group].

Core Capabilities	Area for Improvement	Corrective Action	Capability Element[20]	Primary Responsible Organization	Organization POC	Start Date	Completion Date
Capability 1: [Capability Name]	1. [Area for Improvement]	[Corrective Action 1]					
Capability 1: [Capability Name]	1. [Area for Improvement]	[Corrective Action 2]					
Capability 1: [Capability Name]	2. [Area for Improvement]	[Corrective Action 1]					
Capability 1: [Capability Name]	2. [Area for Improvement]	[Corrective Action 2]					
Capability 2: [Capability Name]	1. [Area for Improvement]	[Corrective Action 1]					
Capability 2: [Capability Name]	1. [Area for Improvement]	[Corrective Action 2]					
Capability 2: [Capability Name]	2. [Area for Improvement]	[Corrective Action 1]					

[20] Capability Elements are: Planning, Organization, Equipment, Training, or Exercise.

[Working Group Name]

After-Action Report/Improvement Plan

[Date]

Working Group Executive Summary

Working Group Name	[Insert the formal name of working group, which should match the name in the document header]
Date & Location	This working group was conducted on [date] over [duration] at [location].
Incident/Event Under Review	[List the incident/event being responded to (e.g. natural/hurricane, health emergency technological/radiological release)]
Scope of Review	[Details of the reason for providing a response to the recent incident or event]
Key Milestones of Incident/Event	[Details/dates of the incident/event such as start, detection, verifications, testing, public communications, vaccine development, declared over]
Core Capabilities	[List the capabilities being focused on and reviewed identified in creation of an inventory of core capabilities]

Key Takeaways from Evaluations	[List the key takeaways from the working group and evaluations completed around the capabilities and functions.]
Sponsor	[Insert the name of the sponsor organization, as well as any grant programs being utilized, if applicable]
Participating Departments/ Programs	[Insert a brief summary of the total number of participants and participation level (i.e., Federal, State, local, Tribal, non-governmental organizations (NGOs), and/or international agencies).]
After Action Review Team	[Insert the name, title, agency, phone number, and email address of the AAR Lead, Lead Facilitator, Facilitators, Note Takers, Report Writer, Tribal Improvement Plan Leader]

Findings and Evaluations

The following sections provide an overview of the performance related to each capability and function focused on during the working group, highlighting strengths and areas for improvement to address identified challenges. (The completed Performance Rating of Capabilities Charts may be attached in addition to the summary information below)

[Capability 1]

The strengths and areas for improvement for each core capability aligned to this objective are described in this section.

[Function 1]

Description of the function under this capability being reviewed.

Strengths

The [full or partial] capability level can be attributed to the following strengths:

Strength 1: [Observation statement]

Strength 2: [Observation statement]

Strength 3: [Observation statement]

Challenges

The following areas require improvement to achieve the full capability level:

Challenge 1: [Observation statement. This should clearly state the problem or gap; **it should not include a recommendation or corrective action**, as those will be documented in the Improvement Plan.]

Reference: [List any relevant plans, policies, procedures, regulations, or laws.]

Analysis of Root Cause: [Provide a root cause analysis or summary of why the full capability level was not achieved.]

Challenge 2: [Observation statement]

Reference: [List any relevant plans, policies, procedures, regulations, or laws.]

Analysis of Root Cause: [Provide a root cause analysis or summary of why the full capability level was not achieved.]

[Function 2]

Strengths

The [full or partial] capability level can be attributed to the following strengths:

Strength 1: [Observation statement]

Strength 2: [Observation statement]

Strength 3: [Observation statement]

Challenges

The following areas require improvement to achieve the full capability level:

Challenge 1: [Observation statement. This should clearly state the problem or gap; **it should not include a recommendation or corrective action**, as those will be documented in the Improvement Plan.]

Reference: [List any relevant plans, policies, procedures, regulations, or laws.]

Analysis of Root Cause: [Provide a root cause analysis or summary of why the full capability level was not achieved.]

Challenge 2: [Observation statement]

Reference: [List any relevant plans, policies, procedures, regulations, or laws.]

Analysis of Root Cause: [Provide a root cause analysis or summary of why the full capability level was not achieved.]

[Capability 2]

The strengths and areas for improvement for each core capability aligned to this objective are described in this section.

[Function 1]

Description of the function under this capability being reviewed.

Strengths

The [full or partial] capability level can be attributed to the following strengths:

Strength 1: [Observation statement]

Strength 2: [Observation statement]

Strength 3: [Observation statement]

Challenges

The following areas require improvement to achieve the full capability level:

Challenge 1: [Observation statement. This should clearly state the problem or gap; **it should not include a recommendation or corrective action**, as those will be documented in the Improvement Plan.]

Reference: [List any relevant plans, policies, procedures, regulations, or laws.]

Analysis of Root Cause: [Provide a root cause analysis or summary of why the full capability level was not achieved.]

Challenge 2: [Observation statement]

Reference: [List any relevant plans, policies, procedures, regulations, or laws.]

Analysis of Root Cause: [Provide a root cause analysis or summary of why the full capability level was not achieved.]

Evaluation Conclusions

This section describes the primary conclusions drawn from the evaluations of each focus capability and function. This section will not include recommended improvements as that will be in the next phase of Improvement Plan.

Next Steps

This section describes the next steps after completion of the working group AAR such as:

- Communication of drafts with internal Tribal Leadership review
- Any communication to be provided to Tribe or other stakeholders
- Process for Improvement Plan pre-planning steps such as team organization, review of documents, outreach to additional stakeholders for observations.
- Using the capabilities rated as "Unable to Perform" or "Performed with Major Challenges" will be the focus of the Improvement Plan areas.

Improvement Plan Report

Method for Stakeholder Observations	[Method of collecting additional stakeholder observations outside of the AAR Working Group. (Written observations, verbal interviews, written/online surveys, group discussions.)]
Stakeholders Involved	This working group was conducted on [date] over [duration] at [location].
Key Stakeholder Observations	[List the incident/event being responded to (e.g. natural/hurricane, health emergency technological/radiological release)]
Core Capabilities	[List the capabilities being focused on and included in the improvement plan. It is suggested to focus on those which were rated “Unable to Perform” or “Performed with Some Challenges” for the improvement plan.]

Overview of Corrective Actions	[High-level list of corrective actions to be implemented to accomplish improvement plan]
Timeline to Completion of Implementation	[Estimated timeline to complete improvement implementations recommended]
Implementation Funding Options	[Insert the name of the sponsor organization, as well as any grant programs being utilized, if applicable]
Implementation Staffing Needs	[Insert a brief summary of the total number of participants and participation level (i.e., Federal, State, local, Tribal, non-governmental organizations (NGOs), and/or international agencies).]

Stakeholder Communication	[Insert the name, title, agency, phone number, and email address of the AAR Lead, Lead Facilitator, Facilitators, Note Takers, Report Writer, Tribal Improvement Plan Leader]

Findings and Evaluations

The following sections provide an overview of the improvement plan matrix with a focus on the core capability and area for improvement, the corrective action, responsibilities, and timeline. (The completed Performance Rating of Capabilities Charts may be attached in addition to the summary information below)

[Capability 1]

The capability under the function is related to.

[Function 1]

Description of the function under this capability being reviewed.

Area for Improvement

The [full or partial] description of the specific issue or area for improvement in the Tribe's ability to perform the function.

Issue/Area for Improvement 1: [Observation statement]

Issue/Area for Improvement 2: [Observation statement]

Issue/Area for Improvement 3: [Observation statement]

Corrective Actions

The following corrective actions are recommended for implementation to be able to perform the function.

Corrective Action 1: [SMART Corrective Action]

Responsible Party: [Who will be the responsible party to carry out this corrective action?]

Timeline: [What are the anticipated start and completion dates for implementation of this corrective action?]

Corrective Action 2: [SMART Corrective Action]

Responsible Party: [Who will be the responsible party to carry out this corrective action?]

Timeline: [What are the anticipated start and completion dates for implementation of this corrective action?]

[Function 2]

Description of the function under this capability being reviewed.

Area for Improvement

The [full or partial] description of the specific issue or area for improvement in the Tribe's ability to perform the function.

Issue/Area for Improvement 1: [Observation statement]

Issue/Area for Improvement 2: [Observation statement]

Issue/Area for Improvement 3: [Observation statement]

Corrective Actions

The following corrective actions are recommended for implementation to be able to perform the function.

Corrective Action 1: [SMART Corrective Action]

Responsible Party: [Who will be the responsible party to carry out this corrective action?]

Timeline: [What are the anticipated start and completion dates for implementation of this corrective action?]

Corrective Action 2: [SMART Corrective Action]

Responsible Party: [Who will be the responsible party to carry out this corrective action?]

Timeline: [What are the anticipated start and completion dates for implementation of this corrective action?]

[Capability 2]

The capability under the function is related to.

[Function 1]

Description of the function under this capability being reviewed.

Area for Improvement

The [full or partial] description of the specific issue or area for improvement in the Tribe's ability to perform the function.

Issue/Area for Improvement 1: [Observation statement]

Issue/Area for Improvement 2: [Observation statement]

Issue/Area for Improvement 3: [Observation statement]

Corrective Actions

The following corrective actions are recommended for implementation to be able to perform the function.

Corrective Action 1: [SMART Corrective Action]

Responsible Party: [Who will be the responsible party to carry out this corrective action?]

Timeline: [What are the anticipated start and completion dates for implementation of this corrective action?]

Corrective Action 2: [SMART Corrective Action]

Responsible Party: [Who will be the responsible party to carry out this corrective action?]

Timeline: [What are the anticipated start and completion dates for implementation of this corrective action?]

Implementation Funding

This section will include any required funding details for implementation such as grant assistance, direct requests for assistance, and partnerships. Details of process to obtain funding should be included as well.

Implementation Staffing

This section should consider the staffing needs necessary for implementation of the corrective actions. This would include:

- Teams to complete implementation
- Specific external staffing resources necessary
- New positions or modified positions, responsibilities, reporting.

Continuous Improvement Tracking

This section provides details on how the implementation of corrective actions will be tracked and progress check-ins and the assigned individual responsible for tracking. This section will also include details of how to make modifications to the corrective actions should changes need to be made during implementation. The method for tracking and recording when corrective actions have successfully been implemented will also be included in this section.