Mike Escaname

From: eddie.olivarez <eddie.olivarez@hchd.org>
Sent: Monday, March 19, 2012 4:35 PM
To: mike.escaname@hchd.org
Subject: Fw: 2012 PPCPS HAZARDS - DSHS CONTRACT AMENDMENT NO. 2011-038671-001A
Attachments: PPCPS HAZARDS HIDALGO SIGN PAGES 001A.pdf; PPCPS HAZARDS HIDALGO BUDGET 001A.pdf; PPCPS HAZARDS HIDALGO EQUIP 001A.pdf; PPCPS HAZARDS HIDALGO EXH A 001A.pdf

Eduardo Olivarez
Chief Administrative Officer
Hidalgo County Health & Human Services
1304 South 25th Ave.
Edinburg, Texas 78542

956-383-8858 Office
eddie.olivarez@hchd.org
Twitter.com/hidalgohealth

-----Original Message-----
From: <Charlotte.Jackson@dshs.state.tx.us>
Sent 3/19/2012 4:16:00 PM
To: Eddie.Olivarez@hchd.org, Evangelina.Rubio@hchd.org, nancy.trevino@hchd.org
Cc: Lucia.Lundry@dshs.state.tx.us
Subject: FW: 2012 PPCPS HAZARDS - DSHS CONTRACT AMENDMENT NO. 2011-038671-001A

Hello Contractor,

Attached are files containing your Department of State Health Services (DSHS) contract AMENDMENT. Please print two copies of each, in the order they appear in this email, sign and return both copies to this unit as soon as possible. Your contract will be signed by DSHS and returned to your agency.

Changes made to any portion of the contract document (s) are considered a counter-offer and are not valid without DSHS written concurrence.

DSHS will not pay for reimbursements submitted/postmarked more than 60 days after the end of the contract term. Additional information regarding this policy is available on the DSHS website at http://www.dshs.state.tx.us.

NOTE: Return both copies of the contract in their entirety to one of the two addresses below. Contracts returned to any other address may result in contract delays.

Physical Address for Overnight Mail	**Mailing Address for Regular Mail**
Client Services Contracting Unit MC 1886 Department of State Health Services	Client Services Contracting Unit MC 1886 Department of State Health Services

1100 W.49th Street Austin, TX 78756	PO Box 149347 Austin, TX 78714- 9347

Please reference the DSHS contract and attachment number in all future correspondence. If you have questions, contact Charlotte Jackson at 512.776.6418 or via email at charlotte.jackson@dshs.state.tx.us.

Thank you.

Charlotte Jackson, CTPM, Contract Coordinator
Department of State Health Services
Client Services Contracting Unit, Tower Bldg. - Rm 502
1100 West 49th Street
Austin, TX 78756
US Mail: PO Box 149347, Austin TX 78714-9347

512-776-6418
512-776-7470
Fax: 512-776-7351
charlotte.jackson@dshs.state.tx.us

Click here for Contracting Resources: http://online.dshs.state.tx.us/finance/cscu.htm

DEPARTMENT OF STATE HEALTH SERVICES

Amendment
To

The Department of State Health Services (DSHS) and HIDALGO COUNTY HEALTH DEPARTMENT (Contractor) agree to amend the Program Attachment # 001 (Program Attachment) to Contract # 2011-038671 (Contract) in accordance with this Amendment No. 001A : Public Health Emergency Preparedness (PHEP) , effective 03/01/2012 .

The purpose of this Amendment is to add carry forward funds to the contract, revise due dates for affected reports, and to extend due date for equipment purchases.

Therefore, DSHS and Contractor agree as follows:

PROGRAM ATTACHMENT NO. ~~001~~ 001A

SECTION I. STATEMENT OF WORK, is revised as follows:

DSHS reserves the right, where allowed by legal authority, to redirect funds in the event of financial shortfalls. DSHS will monitor Contractor's expenditures on a quarterly basis. If expenditures are below that projected in Contractor's total Contract amount, **as shown in SECTION VI. BUDGET,** Contractor's budget may be subject to a decrease for the remainder of the Contract term. Vacant positions existing after ninety (90) days may result in a decrease in funds.

SECTION II. PERFORMANCE MEASURES, is revised as follows:

D. ~~**Submit H1N1 After-Action Report Improvement Plan Status Reports.**~~ **Contractor shall submit H1N1 AAR Improvement Plan Status Reports to DSHS by November 30, 2011 in a format to be determined by DSHS.**

SECTION II. PERFORMANCE MEASURES, B. Demonstrated adherence to PHEP reporting deadlines, is revised as follows:

1. **Submit** PHEP mid-year progress report, ~~**due to DSHS**~~ **on a template provided by DSHS and shall be submitted** to DSHS ~~**on or before January 27, 2012, including**~~ **within established timeframe designated by DSHS so as to complete consolidation of the statewide report to CDC. Activities to report shall include** a status update on work plan activities, Pandemic and All-Hazards Preparedness Act (PAHPA) benchmarks, performance measurement and demonstration plan activities, a five-year timeline for addressing the public health preparedness capabilities, and risk-based funding activities (if applicable).

2. **Submit** End-of-year progress report, ~~**due to DSHS**~~ **on a template provided by DSHS and shall be submitted** to DSHS ~~**on or before August 15, 2012, including**~~ **within established timeframe designated by DSHS so as to complete consolidation of statewide report to CDC. Activities to report shall include** an update on work plan activities, risk-based funding activities (if applicable), a budget expenditure report, performance measurement, and

demonstration plan activities.

SECTION II. PERFORMANCE MEASURES, D. Submit H1N1 After-Action Report Improvement Plan Status Reports, is revised as follows:

1. ~~**Contractors**~~ **Contractor** shall submit H1N1 AAR Improvement Plan Status Reports to DSHS by ~~**October 31,**~~ **November 30,** 2011 in a format to be determined by DSHS. Submission of the H1N1 After-action Report (AAR) Improvement Plan Status Report for 2011 is intended to provide summary status updates of the key improvement plan items from H1N1 AAR and Improvement Plans following the 2009-2010 H1N1 influenza pandemic response. Submission of these reports fulfills the pandemic influenza plan submission requirement.

SECTION VII. BUDGET, is revised as per attached Categorical Budget and Equipment List, if applicable.

SECTION VIII. SPECIAL PROVISIONS, is revised to include:

General Provisions, General Business Operations of Contractor Article, Equipment Purchases, is revised as follows:

Contractor is required to initiate the purchase of equipment approved under the March 2012 amendment no later than April 30, 2012 as documented by issue of a purchase order or written order confirmation from the vendor on or before April 30, 2012. In addition, all equipment must be received no later than 60 calendar days following the end of the Program Attachment term.

EXHIBIT A, is revised as per attached Exhibit A.

All other terms and conditions not hereby amended are to remain in full force and effect. In the event of a conflict between the terms of this contract and the terms of this Amendment, this Amendment shall control.

Department of State Health Services

_____
Signature of Authorized Official

Date: _____

Bob Burnette, C.P.M., CTPM

Director, Client Services Contracting Unit

1100 WEST 49TH STREET
AUSTIN, TEXAS 78756

(512) 458-7470

Bob.Burnette@dshs.state.tx.us

Contractor

_____
Signature of Authorized Official

Date: _____

Name: _____

Title: _____

Address: _____

_____

Phone: _____

Email: _____

DEPARTMENT OF STATE HEALTH SERVICES

1100 WEST 49TH STREET
AUSTIN, TEXAS 78756-3199

CATEGORICAL BUDGET CHANGE REQUEST

DSHS PROGRAM: Public Health Emergency Preparedness (PHEP)
CONTRATOR: HIDALGO COUNTY HEALTH DEPARTMENT
CONTRACT NO: 2011-038671
CONTRACT TERM: 08/01/2011 THRU: 07/31/2012
BUDGET PERIOD: 08/01/2011 THRU: 07/31/2012 CHG: 001A

DIRECT COST (OBJECT CLASS CATEGORIES)			
	Current Approved Budget (A)	Revised Budget (B)	Change Requested
Personnel	$425,885.00	$453,474.00	$27,589.00
Fringe Benefits	$112,227.00	$120,604.00	$8,377.00
Travel	$5,051.00	$20,917.00	$15,866.00
Equipment	$0.00	$3,886.00	$3,886.00
Supplies	$1,634.00	$3,377.00	$1,743.00
Contractual	$0.00	$126,312.00	$126,312.00
Other	$15,531.00	$21,692.00	$6,161.00
Total Direct Charges	$560,328.00	$750,262.00	$189,934.00
INDIRECT COST			
Base ($)	$0.00	$0.00	$0.00
Rate (%)	0.00%	0.00%	0.00%
Indirect Total	$0.00	$0.00	$0.00
PROGRAM INCOME			
Program Income	$0.00	$0.00	$0.00
Other Match	$50,939.00	$68,206.00	$17,267.00
Income Total	$50,939.00	$68,206.00	$-17,267.00
LIMITS/RESTRICTIONS			
Advance Limit	$0.00	$0.00	$0.00
Restricted Budget	$0.00	$0.00	$0.00
SUMMARY			
Cost Total	$560,328.00	$750,262.00	$189,934.00
Performing Agency Share	$50,939.00	$68,206.00	$17,267.00
Receiving Agency Share	$509,389.00	$682,056.00	$172,667.00
Total Reimbursements Limit	$509,389.00	$682,056.00	$172,667.00
JUSTIFICATION			
To add carry-forward funding to the contractors HAZARDS contract.			

Financial status reports are due: 11/30/2011, 03/01/2012, 05/30/2012, 10/01/2012

DEPARTMENT OF STATE HEALTH SERVICES

1100 WEST 49TH STREET
AUSTIN, TEXAS 78756-3199

EQUIPMENT LIST CHANGE REQUEST

DSHS PROGRAM: Public Health Emergency Preparedness (PHEP)
CONTRACTOR: Hidalgo County Health Department
CONTRACT TERM: 08/01/2011 THRU: 07/31/2012
BUDGET PERIOD: 08/01/2011 THRU: 07/31/2012
CONTRACT NO: 2011-038671 CHG: 001A

PREVIOUS EQUIPMENT LIST

Item #	Equipment Description	Units	Unit Cost	Total
			$	$
			$	$
			$	$

NEW EQUIPMENT LIST

Item #	Equipment Description	Units	Unit Cost	Total
1	TCPN TECHNOLOGY SOLUTIONS-- AXISP5522-EPTZ Dome Network CAMERA - Mfg.#AXI-0422-004	2	$1,943.00	$3,886.00
			$	$
			$	$
			$	$

DSHS DOC. NO. 2011-038671-001A

EXHIBIT A

Public Health Emergency Preparedness Work Plan
For
Local Health Departments
PPCPS/HAZARDS

Budget Period 11

(August 2011 through July 2012)

Introduction

DSHS developed this work plan in support of the Public Health Emergency Preparedness Cooperative Agreement (Funding Opportunity Number CDC-RFA-TP11-1101) from the Centers for Disease Control and Prevention (CDC). CDC's new five-year Public Health Emergency Preparedness (PHEP) Cooperative Agreement seeks to advance public health preparedness as noted in Section I. Statement of Work of the Program Attachment.

DSHS also developed this work plan in the spirit of flexibility and continuous quality improvement providing local health departments the ability to accomplish the intent of the PHEP Cooperative Agreement with as much latitude as possible while adhering to the guidance of the funding opportunity announcement.

The work plan consists of the following sections that describe the activities and deliverables for PHEP 2011 to 2012, Budget Period 11 (August 1, 2011 to July 31, 2012):

I. Public Health Preparedness Capabilities
II. Annual Requirements
III. CDC-Defined Performance Measures
IV. Evidence-based Benchmarks and Objective Standards and Pandemic Influenza Plans (PAHPA Benchmarks)

I. Public Health Preparedness Capabilities

Public health departments continue to face multiple challenges, including an ever-evolving list of public health threats. The Centers for Disease Control and Prevention (CDC) developed fifteen (15) capabilities to assist health departments with assessing preparedness capacity as well as developing strategic plans. The CDC's *Public Health Preparedness Capabilities: National Standards for State and Local Planning* is a published document found at the following link:
http://www.cdc.gov/phpr/capabilities/Capabilities_March_2011.pdf

The activities associated with this work plan link directly to the standardized capabilities briefly outlined in Section I. Statement of Work of the Program Attachment and found in full detail in the PDF document referenced above.

CDC developed a Public Health Capabilities Planning Model that describes a high-level planning process public health departments may wish to follow. The planning model consists of a three phase process to assist public health departments in using the public health preparedness capabilities to determine preparedness priorities, plan appropriate preparedness activities, and demonstrate and evaluate achievement of capabilities.

To develop a complete assessment of Texas state preparedness, the Texas Department of State Health Services (DSHS) with consultation from the CDC has determined the benefit of local health departments using the CDC Public Health Preparedness Capabilities

Planning Model for conducting assessments of capacities related to the fifteen (15) public health capabilities.

Appendix 3 of Exhibit A is a set of instructions on how to complete the capability assessment worksheets to assist Contractors in assessing preparedness capacity of the fifteen (15) capabilities. The worksheets and instructions provide Contractors with a tool to organize planning activities, determine priorities, and select which capabilities health departments have the resources to build or sustain. The worksheets will be provided to Contractor by DSHS at a later date.

This assessment includes a three (3) phase process for year one of the new project period. Contractors may conduct Phases I and II concurrently.

Phase 1: Perform a Capabilities Assessment

The CDC public health preparedness capabilities evaluation process provides a tool for Contractors to:

A) Assess their current preparedness state, including organizational roles and responsibilities.

B) Determine the extent to which the priority and recommended resource elements for each capability function exist in the jurisdiction. Contractors are encouraged to first self-assess their ability to address the priority resource elements of each capability followed by their ability to demonstrate the functions and tasks within each capability.

Note: Contractors are not expected to "own" each resource element. Contractors are encouraged to partner with both internal and external jurisdictional partners to have or have access to resources as needed (e.g. DSHS Regions or DSHS Central Office).

C) Determine performance of each capability and function and whether or not it meets the jurisdiction's needs.

Due Date: ~~**Due to DSHS by January 31, 2012.**~~ **Contractor shall complete and report to DSHS Phase 1 activities within established timeframe designated by DSHS.**

Phase 2: Perform a Jurisdictional Risk Assessment

Phase two of the Public Health Preparedness Capability Model consists of a jurisdictional risk assessment performed by the Contractor to determine vulnerabilities and hazards unique to each jurisdiction. Contractors may use the Hazard Risk Assessment Instrument from the University of California, Los Angeles UCLA Center for Public Health and Disasters (http://www.cphd.ucla.edu/npdfs/HRAI_Workbook.pdf) to conduct this assessment. The UCLA tool is recommended by CDC because the tool includes an assessment of the impact to public health and medical needs of communities/jurisdictions. The jurisdictional risk assessment is a tool for Contractors to:

A) Determine goals by identifying needs and gaps using jurisdictional inputs such as hazards and vulnerability analyses, emergency management plans, after-action reports/improvement plans, and previous performance measurement results.

B) Prioritize capabilities and functions and develop plans. The capability definitions are broad. No Contractor is expected to be able to address all issues, gaps, and needs across all capabilities in the immediate short term.

C) Review jurisdictional inputs, analyze priorities, and determine both short-term (one year) and long-term goals (two years to five years).

Due Date: ~~**Due to DSHS by January 31, 2012.**~~ **Contractor shall complete and report to DSHS Phase 2 activities within established timeframe designated by DSHS.**

Phase 3: Develop or Revise Plans

The final phase of the Public Health Capabilities Planning Model is plan development.

A) Contractors will revise existing plans or develop additional plans by engaging in concrete initiative planning, particularly for the short-term goals.

B) For each capability and function, Contractors generally will either build, sustain, or, perhaps, scale back the capability and/or function, depending on the needs, gaps, priorities, and goals that have been identified.

C) For "build" and "sustain" scenarios, Contractors are encouraged to pursue partnerships, through memoranda of understanding with other agencies, partners, and jurisdictions.

D) For "scale back" scenarios, Contractors should identify the challenges and barriers causing them to scale back their efforts.

E) Develop plans for demonstrating and evaluating the capabilities and functions, especially those that have been newly developed. Demonstrations of capabilities can be through many different means such as exercises, planned events, and real incidents. Contractors are strongly encouraged to use routine public health activities to demonstrate and evaluate their capabilities. Documentation of the exercise, event, or incident, and the use of quality improvement-focused After Action Reports/Improvement Plans is a vital part of this process.

F) For those capabilities and functions where CDC-defined performance measures have been developed, Contractors will collect data for those measures.

Due Date: Contractor ~~**will**~~ **shall** provide demonstrations of methods for evaluating capabilities and functions as described above to DSHS **on a template provided by DSHS and shall be submitted to DSHS within established timeframe designated by**

DSHS so as to complete consolidation of the statewide report to CDC. ~~by August 15, 2012 in a format provided by DSHS.~~

Additional Resources:
In addition to the CDC Public Health Preparedness Capabilities Planning Model, the DSHS Community Preparedness Section developed additional resources to assist Contractors with adopting the capability model and developing preparedness plans which will be provided to Contractor either electronically or hard copy within 60 days of the beginning of the contract term:

- Texas Public Health and Medical Emergency Management 5-Year Strategic Plan 2012 to 2016: a guide for planning throughout the five year project period.

- Tactical Guide: a companion document to the Texas Public Health and Medical Emergency Management 5-Year Strategic Plan 2012-2016 outlining specific tactics, activities, and tasks for implementing the goals outlined in the strategic plan associated with each of the fifteen (15) capabilities.

- Strategic Planning Document from CDC: http://www.cdc.gov/phpr/capabilities/usingthisdocument.pdf

Year One Priority Goals: DSHS consulted with public health and community leaders responsible for public health and emergency preparedness activities to select the three capabilities for Texas to address in the first year of the new project period. These capabilities include: 1) Public Health Surveillance and Epidemiological Investigation, 2) Community Preparedness and 3) Community Recovery. DSHS acknowledges that local and regional jurisdictional needs and preferences may lead to the selection of other capabilities. DSHS also acknowledges the existence of cross-over functions, tasks, and resources between and among the capabilities.

If a Contractor chooses capabilities different than those listed above, the Contractor must provide justification for this decision based on the capability and jurisdictional risk assessments to DSHS as notification of completion of the capabilities assessment and jurisdictional risk assessment.

II. Annual Requirements

Contractors are required to submit plans, status reports, and program and financial data, including progress in achieving evidence-based benchmarks and objective standards and the outcomes of annual preparedness exercises including strengths, weaknesses and associated corrective actions. Reports must describe the preparedness activities that were conducted with PHEP funds, the purposes for which PHEP funds were spent and the recipients of the funds; describe the extent to which the Contractor has met stated goals and objectives; and describe the extent to which funds were expended consistent with the contractor's funding application. DSHS will provide a template for planning and

reporting to assist Contractors.

Following is a summary of the PHEP annual planning/reporting program requirements for 2011-2012:

A) Submit status reports on how the Contractor will address the following elements:

1) Administrative Preparedness Strategies (Capability 1. Community Preparedness): Describe administrative processes and approaches to receive and use emergency funds to respond to emergency situations in a timely manner and actions to overcome challenges and barriers. Capability 1: Community Preparedness.

2) Volunteer Recruitment and Management (Capability 15, Volunteer Management): Document efforts for volunteer recruitment and management such as development of a Medical Reserve Corps or community equivalent and use of the Texas Disaster Volunteer Registry. Contractors will provide volunteer recruitment data to DSHS and indicate whether this number is increasing, declining or remaining level.

3) Stakeholder Engagement (Capability 1, Community Preparedness and Capability 2, Community Recovery): Identify the appropriate jurisdictional partner to address the emergency preparedness, response, and recovery needs of the elderly regarding public health, medical and mental health behavioral needs including planned improvements and accomplishments to meet these needs.

4) Public Comment Solicitation on Emergency Preparedness Plans (Capability 1, Community Preparedness): Describe processes for solicitation of public comment on emergency preparedness plans and their implementation such as the establishment of an advisory committee or similar mechanism to ensure ongoing public comment. Include a description for performance measures for public comment solicitation.

5) National Incident Management System (NIMS) (Capability 3, Emergency Operations Centers): Meet NIMS compliance requirements.

6) Public Health and Medical Needs of At-risk Individuals (Capability 1, Community Preparedness; Capability 2, Community Recovery; Capability 4, Emergency Public Information and Warning; Capability 7, Mass Care; Capability 10, Medical Surge; and Capability 13, Public Health Surveillance and Epidemiological Investigation): Describe plans to address the public health and medical needs of at-risk individuals in the event of a public health emergency.

7) Hospital Preparedness Program Coordination (Capability 10m Medical

Surge): Provide current status of coordination with the local Hospital Preparedness Program representatives to inform and educate hospital staff on their roles in public health emergency preparedness and response and describe improvement.

8) Pandemic Influenza Plan Updates: Submit Pandemic Influenza Plan Updates annually to DSHS per the Evidence-based Benchmarks and Objective Standards and Pandemic Influenza Plans Section 319C of the Public Health Service (PHS) Act as amended by the Pandemic and All-Hazards Preparedness Act (PAHPA) of 2006 requiring that CDC's PHEP cooperative agreement meet evidence-based benchmarks and objective standards.

B) Contractors will have in place fiscal and programmatic systems to document accountability and improvement.

C) Contractors will conduct at least one (1) preparedness exercise annually according to the Contractor's exercise plan and developed in accordance with Homeland Security Exercise and Evaluation Program (HSEEP) standards. Submit to DSHS within 60 days of the exercise a final After Action Review/Improvement Plan.

D) Contactors will provide DSHS with situational awareness data generated through interoperable networks of electronic data systems. (Capability 6, Information Sharing)

III. CDC-Defined Performance Measures

DSHS with consultation from the CDC has determined the benefit of Contractors reporting on these capability-based performance measures. While Contractors will not have to report on all performance measures every year, Contractors will be required to collect and report select performance measure data annually on the following public health preparedness capabilities:

A) Community Preparedness
B) Emergency Operations Coordination
C) Medical Countermeasures Dispensing
D) Medical Material Management and Distribution
E) Public Health Surveillance and Epidemiological Investigation

Performance measures, associated parameters, and data requirements for these capabilities are under development by CDC and will be provided to Contractors at a later date.

Contractors may be required to collect and report performance measure data for other public health preparedness capabilities. The list and requirements for reporting annual and other performance measures may change as performance measures are developed and

refined. Further detail on performance measures and reporting requirements for 2011-2012 will be provided to DSHS by the CDC in the future, and DSHS will share this information with Contractors.

III. Evidence-based Benchmarks and Objective Standards and Pandemic Influenza Plans (PAHPA Benchmarks)

DSHS and CDC expect all Contractors to achieve, maintain, and report benchmarks throughout the five-year project period. CDC and DSHS reserve the right to modify benchmarks annually as needed and in accordance with CDC goals, objectives, and directives. Contractors shall maintain all documentation that substantiates achievement of benchmarks and make those documents available to DSHS staff as requested during site visits or through other requests.

DSHS has identified the following CDC benchmarks for year one. Contractors that fail to "substantially meet" the benchmarks are subject to withholding of funds with penalties to be applied the following fiscal year. Contractors that demonstrate achievement of these requirements are not subject to withholding of funds.

Contractors will meet all performance measures noted in Section II: Statement of Work Performance Measures of the Program Attachment.

Supplemental information for the benchmarks referenced in the Statement of Work follows:

Staff Assembly:
Contractors are strongly encouraged to report data from multiple exercises and/or real incidents; however, Contractors are required at a minimum to report data on the quickest staff assembly demonstration that occurs during the first six months of year one. The demonstration must occur during one of the following:

1) Drill
2) Functional exercise
3) Full-scale exercise
4) Real incident (preferable, if possible)

Receiving, Staging, Storing, Distributing, and Dispensing Medical Countermeasures:
Non-Cities Readiness Initiative (CRI) Contractors must meet a minimum overall Medical Countermeasure Distribution and Dispensing (MCMDD) composite score of 43 for budget period year one. The overall composite score will be derived from:

1) Contractors will conduct a minimum of three (3) different drills (not the same drill performed three times) conducted within each planning/local jurisdiction during year one. The range in scope of available drills provides Contractors with flexibility in meeting the annual drill requirements. The three (3) required drills may be chosen from any of the eight (8) available drills as indicated on the

Division of Strategic National Stockpile (DSNS) Extranet website. Drill data and/or Homeland Security Exercise and Evaluation Program (HSEEP) After Action Reports/Improvement Plans for drills (as indicated) must be submitted to DSHS by a date to be determined by DSHS.

2) Contractors must conduct one (1) full-scale exercise performed during any one of the five budget periods of the new PHEP cooperative agreement that tests and validates medical supplies distribution and dispensing plans and submit results and documentation to DSNS. Results and documentation of medical countermeasure distribution and dispensing full-scale exercise(s) must be developed in accordance with HSEEP standards and can be performed during any one of the five budget periods of the new PHEP project period. Each Contractor will be required to participate in one (1) exercise that demonstrates capabilities for medical countermeasure dispensing operations. Contractors are encouraged to work with other emergency response agencies or hospital preparedness programs to develop or leverage existing activities to meet the medical countermeasure distribution and dispensing exercise objectives. Details on the scope and format for reporting these exercise requirements will be provided by DSHS through subsequent guidance at a later date.

3) Contractors will demonstrate compliance with established medical countermeasure distribution and dispensing standards. Target measures and required data submission will be detailed in supplemental guidance at a later date.

Appendix 1

Definitions

All Hazards Response Planning refers to the systems used to respond and recover from Chemical, Biological, Radiological, Nuclear, Explosive (CBRNE) events, as well as natural disasters. In the case of the CDC Cooperative Agreement, standard operating procedures (SOP) or guidelines (SOG) (formally referred to as "all-hazards plans") developed by local heath departments (LHD) and DSHS health service regions (HSR) to respond to all public health emergencies.

First Responders are personnel who would be critical in the first phase of response efforts.

The **Implementation** process includes all steps necessary to complete the tasks; installation, training, and technical assistance**.**

The tracking of **Long-Term health consequences** identifies trends in physical or mental health resulting from the exposure to Chemical, Biological, Radiological, Nuclear, Explosive (CBRNE) elements during an all-hazards event. The length of tracking would be dependent upon the type of event.

Public health is the effort to protect, promote, maintain and restore a population's health.

A **Public Health Emergency** is an immediate threat from a naturally occurring or intentional event 1) that poses a high risk of fatalities or serious long-term disability to large numbers of people, and/or 2) where there is substantial risk of public exposure because of a high level of contagion and the particular means of transmission of the infectious agent.

The **Public Health Information Network (PHIN)** is an interoperable information system for public health. The PHIN is a national initiative to implement a multi-organizational business and technical architecture for public health information systems which includes web-based and radio based communications with multiple levels of redundancy.

Public Health Preparedness is the capacity of public health jurisdictions to respond to a public health emergency. The CDC Cooperative Agreement enables public health jurisdictions to upgrade their preparedness and response capacity.

Public Health First Responders (PHFRs) are health department personnel who are required to deploy in the wake of a public health emergency. Hospital personnel may be considered PHFRs if their activities are aligned to support public health response

efforts. Emergency Medical Service (EMS) Responders are mostly covered through Department of Homeland Security (DHS).

Standard Operating Guidelines (SOG)/Standard Operating Procedures (SOP) are approved methods for accomplishing a task or set of tasks and are typically prepared at the department or agency level.

A **Project Plan** is a narrative of activities for the year, describing program activities/goals, how activities/goals will be accomplished, who will carry out activities/goals, when activities/goals will be accomplished.

Appendix 2

Overview: CDC Public Health Capability Planning Model

Contractors are encouraged to use the CDC Public Health Preparedness Capabilities Planning Model to assess preparedness capacities. The CDC Public Health Preparedness Capabilities are numbered and presented alphabetically. Each of the fifteen (15) capabilities includes a definition of the capability and list of the associated functions, performance measures, tasks, and resource considerations.

A) The **Capability Definition** defines the capability as it applies to state, local, tribal, and territorial public health.

B) The **Function** describes the critical elements that need to occur to achieve the capability.

C) The **Performance Measure(s)** section lists the CDC-defined performance measures, if any, associated with a function.

D) The **Tasks** section describes the steps that need to occur to complete the functions.

E) The **Resource Elements** section lists resources, including priority items and other considerations, needed to build and maintain the ability to perform the function and its associated tasks. These resource elements are organized as follows:

1) *Planning:* standard operating procedures or emergency operations guidance, including considerations for legal authorities and at-risk populations, for a Contractor's plans for delivering the capability.

2) *Skills and Training:* baseline competencies and skills personnel and teams should possess or have access to when delivering a capability.

3) *Equipment and Technology:* equipment Contractors should have or have access to in jurisdictionally defined quantities sufficient to achieve the capability.

4) **Note**: Certain resource elements have been identified as priority resource elements. Contractors may not require all resource elements to fully achieve all of the functions within a capability, but they must *have* or *have access to* the priority resource elements. Remaining resource elements are recommended for consideration by Contractors.

The public health preparedness capabilities are listed below in their corresponding domains. These domains are intended to convey the significant dependencies between certain capabilities:

Biosurveillance
- Public Health Laboratory Testing
- Public Health Surveillance/Epidemiological Investigation

Community Resilience
- Community Preparedness
- Community Recovery

Countermeasures and Mitigation
- Medical Countermeasure Dispensing
- Medical Material Management and Distribution
- Non-pharmaceutical Interventions
- Responder Safety and Health

Incident Management
- Emergency Operations Coordination

Information Management
- Emergency Public Information and Warning
- Information Sharing

Surge Management
- Fatality Management
- Mass Care
- Medical Surge
- Volunteer Management

Appendix 3

Worksheet Instructions: How to complete the Capability worksheets
The following section provides instructions on how to complete the fifteen (15) Capability Worksheets associated with the CDC Public Health Preparedness Capability Model.

Functions

General instructions for completing the Capability Worksheets
Submit an entry for every function for every capability. Each function entry must include the following data items:

(1) Function Current Status
(2) Function Current Status Narrative
(3) Function Goal
(4) Function Goal Narrative (or Planned Activity)
(5) Function Funding Type
(6) Function Other Funding Sources Funding Type

A) Function Current Status

Select a current status option in the table below that best reflects the current status of this function across the jurisdiction.

Option	Description
Infrastructure Fully in Place - Fully Evaluated and Demonstrated	Select this option only if all the following conditions are met: 1. All priority resource elements are fully in place and/or accessible via MOU or other written agreement. 2. Any other resource elements or other infrastructure that the Contractor has identified as required to meet jurisdictionally defined needs are fully in place and/or accessible via MOU or other written agreements. 3. Contractor has fully evaluated and demonstrated performance of this function within the past 24 months (August 2009 or later) and found that it meets jurisdictionally defined needs.

Infrastructure Fully in Place - Not Fully Evaluated and Demonstrated	Select this option if all of the following conditions are met: 1. All priority resource elements are fully in place and/or accessible via MOU or other written agreement. 2. Any other resource elements or other infrastructure that the Contractor has identified as required to meet jurisdictionally defined needs are fully in place and/or accessible via MOU or other written agreement. 3. Contractor has not attempted demonstration of this function, the demonstration was more than 24 months ago (before August 2009), **or** contractor has evaluated and demonstrated this function but found that it did not meet jurisdictionally defined needs.
Infrastructure Not Fully in Place	Select this option only if any priority resource elements and any other resource elements or other infrastructure that the Contractor has identified as required to meet jurisdictionally defined needs are not fully in place.
No Infrastructure in Place	Select this option only if the Contractor has no resource elements or any other infrastructure in place to perform this function.

B) Function Current Status Narrative:

Provide a function current status narrative.

Option	Description
Infrastructure Fully in Place - Fully Evaluated and Demonstrated	The narrative should include the following: 1. Date of demonstration (must be in past 24 months) 2. Type of demonstration (exercise, planned event, real incident, or routine activity) 3. Outcome (result) of demonstration 4. Evidence that the demonstration aligns to the function's definition.
Infrastructure Fully in Place - Not Fully Evaluated and Demonstrated	The current status narrative should include the following: 1. If the function was partially demonstrated, succinctly describe what has been demonstrated, how it was demonstrated, and what has not been demonstrated. 2. If the function was demonstrated but issues were identified, succinctly describe

	the issues that were identified. 3. If the function has not been demonstrated, describe what, if any, are the barriers / challenges to demonstrating this function. 4. If the function is to be demonstrated in a future budget period, identify the projected timeframe for demonstration.
Infrastructure Not Fully in Place	The narrative should include a succinct description of any missing resource elements or other infrastructure and any related barriers that are not described in the Resource Element section.
No Infrastructure in Place	The narrative should include a succinct description of any barriers to having the infrastructure fully in place that are not described in the Resource Element section.
No Information Available at this time	If any of the specific information requested is not available at the time of application, enter "information not available at this time" or similar language and indicate when this information will be available.

C) Function Goal

Select the function goal from the list below that most closely represents the result or achievement toward which the effort is being directed across the jurisdiction for the budget period.

Option	Description
Build	Contractor plans to increase the level of resource elements and/or performance for this function. This could be via any or all of the following (not intended to be an exhaustive list): 1. Resource element(s) will be developed/ purchased/assured via MOU or other written agreement. 2. Performance improvement steps are to be implemented.
Sustain	Contractor plans to maintain the current state/ status/level of resource elements for this function. Sustain may or may not require related activities, resources, and funding. **Note: "**Sustain" is not an available option if current state is "no infrastructure."

Scale Back	Contractor plans to reduce, downsize, remove, or downgrade the resource elements within a function. **Note:** The "scale back" option is not intended to include situations where reducing resource elements results in no or minimal impact to overall performance. For example, scaling back may include situations where excess capacity is purposely reduced. In those cases, "sustain" may be a more accurate selection. "Scale back" is intended to denote situations where needed capacity and/or performance is being lost or reduced in some way. **Note**: "Scale back" is not an available option if current state is "no infrastructure."
No Goal	Contractor has no current infrastructure and no plans to develop any infrastructure this year. **Note:** "No goal" is an option only if Contractor selects "no infrastructure" in current status. If current status is "fully in place" or "partially in place," then goal must be either "build," "sustain,." or "scale back."

D) **Function Goal Narrative**

Submit a function goal narrative.

Note: In the function goal narrative, the contractor should provide information about the function goal (or planned activities) that cannot be captured in the resource element goal narrative. If any requested information below is present in a resource element goal narrative, then do not repeat it.

Option	Description
Build or Sustain	The narrative should include a brief description of what is intended to be built or sustained and how this is intended to be achieved.
Function current status is "fully in place – fully evaluated and demonstrated" and the function goal is "Build"	Explain why the Contractor is continuing to build.
Function current status is "not fully in place – fully evaluated and demonstrated," and function goal is "sustain".	Provide a brief description of why there are no plans to fully build and/or demonstrate this function.
Scale Back	Provide a brief description of what is being

	scaled back and why.
No Goal	Provide a brief description of why there is no goal. Include a brief description of how this function is planned to be implemented.

D) Function Funding Type

Select the types of funding that will be used to fund that function from the options defined below.

Option	Description
PHEP	The function is entirely funded by the PHEP cooperative agreement (includes match)
Partial PHEP	The function is funded by PHEP **and** by other funding source(s).
Other Funding Sources	The function is funded by sources **other than** PHEP.
No Funding	There is no funding for the function.

E) Other Funding Sources

If the funding type is "partial PHEP" or "other funding sources," select one or more "other funding sources" to provide additional information about funding. The options are:

Option
State Funds
Local Funds
Hospital Preparedness Program (HPP) Funds
Epi/Lab Capacity (ELC) Funds
DHS Funds
In-Kind/Partner Funds
Other (please specify)

Resource Elements

General Instructions:

- **Priority Resource Elements**
  Submit an entry for all priority resource elements for all functions for all capabilities.

- **Recommended Resource Elements**
  Submit an entry for any recommended resource element that has planned activities for this budget period to either build or sustain the element.

- **Contractor-Defined Resource Elements**
  Submit an entry for any contractor-defined resource element that has planned activities for this budget period to either build or sustain the element. It is not necessary to provide contractor-defined resource elements. This task is optional.

  Contractor-defined resource elements must be categorized as either "planning," "skills and training," or "equipment and technology."

  Contractor-defined resource elements must be within scope of the associated function and must directly contribute to the Contractor's ability to carry out the associated capability, function, and/or task.

Resource Element Entry
Each resource element entry submitted according to the instructions defined above must consist of the following data items:

- Resource Element Current Status
- Resource Element Current Status Narrative
- Resource Element Goal
- Resource Element Goal Narrative

Instructions for each of these data items are described below.

A) Resource Element Current Status

Select the resource element's current status option below that most appropriately reflects the current status of the resource element across their jurisdiction.

Option	Description
Fully in Place	All items identified in the resource element definition* are in place.
Partially in Place	Some items identified in the resource element definition* are in place.
Not in Place	No items identified in the resource element definition* are in place.

*As defined in *Public Health Preparedness Capabilities: National Standards for State and Local Planning*.

Contractors should use their own judgment for contractor-defined resource elements as to whether these are fully in place, partially in place, or not in place.

B) Resource Element Current Status Narrative

Submit a resource element current status narrative.
Note: The information requested for the narrative will depend on the resource element's current status. See instructions below for more details.

1) If the resource element's current status is "fully in place" or "partially in place," then the narrative must include the following:

   i) Indication whether the resource element is via MOU or other written agreements.

   ii) If applicable, brief description of any aspects of this resource element that are above and beyond the resource element description as described in the *Public Health Preparedness Capabilities: National Standards for State and Local Planning*.

   iii) For a contractor-defined resource element, a brief description of what is in place.

   iv) If the current status is "partially in place," identify the parts of the resource elements that are in place and those that are not in place.

   v) A brief description of how this resource element is being implemented.

   vi) If the resource element is in place in some parts of the jurisdiction but not others, please explain.

2) If the current status is "not in place," the narrative should include a brief description of why this resource element is not in place.

3) If the specific information is not available at the time of application, state "information not available at this time" and indicate when this information will be available.

C) Resource Element Goal

Select the most appropriate match for the resource element goal for the current budget period as described in the table below that refers to their entire jurisdiction.

Option	Description
Fully in Place	All items identified in the resource element definition* will be in place
Partially in Place	Some items identified in the resource element definition* will be in place
Not in Place	No items identified in the resource element definition* will be in place

*As defined in the *Public Health Preparedness Capabilities: National Standards for State and Local Planning.*

Contractors should use their own judgment for contractor-defined resource elements as to whether these are planned to be fully, partially or not in place.

D) Resource Element Goal Narrative

1) Submit a resource element goal narrative that includes a description of any planned activities related to this resource element, including the following:

   i) A description of resource element aspects that will be built and/or sustained during the upcoming budget period.

   ii) The responsible/lead person or role for this activity.

   iii) A description of how this resource element is going to be built and/or sustained (or via MOU or other written agreements) this upcoming budget period.

   iv) Who will be involved in these activities, e.g., internal, contracts, partnerships.

   v) Milestones and defined deliverables/outputs. Milestones should be specific, measureable, achievable, realistic, and refer to what is being built/sustained. At a minimum, milestones should be established prior to and after the mid-year period.

   vi) For contractor-defined resource elements or when going "above and beyond" the resource element description, succinctly describe why the element or an excess are necessary.

2) For resource elements that have a resource element goal of "partially in place" or "not in place," include a brief description of the barriers to having this resource element fully in place across the jurisdiction.

3) For resource elements that have a resource element goal of "fully in place or "partially in place," contractors should include a brief description of how this resource element will be implemented.