DOCUMENT NO. 2013-041204
PROGRAM ATTACHMENT NO. 004
PURCHASE ORDER NO. 0000386000

CONTRACTOR: HIDALGO COUNTY

DSHS PROGRAM: Public Health Emergency Preparedness (PHEP)

TERM::09/01/2012 THRU: 08/31/2013

SECTION I. STATEMENT OF WORK:

Contractor shall perform activities in support of the Public Health Emergency Preparedness Cooperative Agreement (Funding Opportunity Number CDC-RFA-TP12-1201) from the Centers for Disease Control and Prevention (CDC). CDC's new five-year Public Health Emergency Preparedness (PHEP) – Hospital Preparedness Program (HPP) Cooperative Agreement seeks to align PHEP and HPP programs by advancing public health and healthcare preparedness.

Contractor shall address the following CDC PHEP Capabilities by prioritizing the order of the fifteen (15) public health preparedness capabilities in which the Contractor intends to invest based upon:

A. A jurisdictional risk assessment;
B. An assessment of current capabilities and gaps; and
C. CDC's recommended tiered strategy for capabilities as listed below.

Tier 1 Capabilities

Capability 12:	Public Health Laboratory Testing
Capability 13:	Public Health Surveillance and Epidemiological Investigations
Capability 1:	Community Preparedness
Capability 8:	Medical Countermeasure Dispensing
Capability 9:	Medical Material Management and Distribution
Capability 14:	Responder Safety and Health
Capability 3:	Emergency Operations Coordination
Capability 4:	Emergency Public Information and Warning
Capability 6:	Information Sharing

Tier 2 Capabilities

Capability 11:	Non-Pharmaceutical Intervention
Capability 10:	Medical Surge
Capability 15:	Volunteer Management

Capability 2: Community Recovery
Capability 5: Fatality Management
Capability 7: Mass Care

Capability 1 – Community Preparedness:

Definition: Community Preparedness is the ability of communities to prepare for, withstand, and recover – in both the short and long terms – from public health incidents.

Capability 2 – Community Recovery:

Definition: Community Recovery is the ability to collaborate with community partners, e.g., healthcare organizations, business, education, and emergency management) to plan and advocate for the rebuilding of public health, medical, and mental/behavioral health systems to at least a level of functioning comparable to pre-incident levels and improved levels where possible.

Capability 3 – Emergency Operations Center Coordination:

Definition: Emergency Operations coordination is the ability to direct and support an event or incident with public health or medical implications by establishing a standardized, scalable system of oversight, organization, and supervision consistent with jurisdictional standards and practices with the National Incident Management System.

Capability 4 – Emergency Public Information and Warning:

Definition: Emergency public information and warning is the ability to develop, coordinate, and disseminate information, alerts, warnings, and notifications to the public and incident management responders.

Capability 5 – Fatality Management:

Definition: Fatality management is the ability to coordinate with other organizations (e.g., law enforcement, healthcare, emergency management, and medical examiner/coroner) to ensure the proper recovery, handling, identification, transportation, tracking, storage, and disposal of human remains and personal effects; certify cause of death, and facilitate access to mental/behavioral health services to the family members, responders, and survivors of an incident.

Capability 6 – Information Sharing:

Definition: Information sharing is the ability to conduct multijurisdictional, multidisciplinary exchange of health-related information and situational awareness data among federal, state, local, territorial, and tribal levels of government, and the private sector. This capability includes the routine sharing of information as well as issuing of public health

alerts to federal, state, local, territorial, and tribal levels of government and the private sector in preparation for and in response to events or incidents of public health significance.

Capability 7 – Mass Care:

Definition: Mass Care is the ability to coordinate with partner agencies to address the public health, medical, and mental/behavioral health needs of those impacted by an incident at a congregate location. This capability includes the coordination of ongoing surveillance and assessment to ensure that local health needs will continue to be met as the incident evolves.

Capability 8 – Medical Countermeasure Dispensing:

Definition: Medical countermeasure dispensing is the ability to provide medical countermeasures (including vaccines, antiviral drugs, antibiotics, antitoxin, etc.) in support of treatment or prophylaxis (oral or vaccination) to the identified population in accordance with public health guidelines and/or recommendations.

Capability 9 – Medical Material Management and Distribution:

Definition: Medical material management and distribution is the ability to acquire, maintain (e.g., cold chain storage or other storage protocol), transport distribute, and track medical material (e.g., pharmaceuticals, gloves, masks, and ventilators) during an incident and to recover and account for unused medical material, as necessary, after an incident.

Capability 10 – Medical Surge:

Definition: 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 healthcare system to survive a hazard impact and maintain or rapidly recover operations that were compromised.

Capability 11 – Non-Pharmaceutical Interventions:

Definition: Non-pharmaceutical interventions are the ability to recommend to the applicable lead agency (if not public health) and implement, if applicable, strategies for disease, injury, and exposure control. Strategies include the following: isolation and quarantine; restrictions on movement and travel advisory/warnings; social distancing; external decontamination; hygiene; and precautionary behaviors.

Capability 12 – Public Health Laboratory Testing:

Definition: Public health laboratory testing is the ability to conduct rapid and conventional detection, characterization, confirmatory testing, data reporting, investigative support, and laboratory networking to address actual or potential exposure to all-hazards. Hazards include chemical, radiological, and biological, and biological agents in multiple matrices that may include clinical samples, food, and environmental samples (e.g., water, air, and soil). This

capability supports routine surveillance, including pre-event, incident and post-exposure activities.

Capability 13 – Public Health Surveillance and Epidemiological Investigations:

Definition: Public health surveillance and epidemiological investigation is the ability to create, maintain, support, and strengthen routine surveillance and detection systems and epidemiological investigation processes, as well as to expand these systems and processes in response to incidents of public health significance.

Capability 14 – Responder Safety and Health:

Definition: The responder safety and health capability describes the ability to protect public health agency staff responding to an incident and the ability to support the health and safety needs of hospital and medical facility personnel, if requested.

Capability 15 – Volunteer Management:

Definition: Volunteer management is the ability to coordinate the identification, recruitment, registration, credential verification, training, and engagement of volunteers to support the jurisdictional public health agency's response to incidents of public health significance.

DSHS encourages partnership and collaboration within, between, and among jurisdictions in the State of Texas related to preparedness activities. Partnership opportunities may include, but are not limited to, planning activities, exercises, training, and responding to incidents, events, or emergencies.

Contractor shall comply with all applicable federal and state laws, rules, and regulations including, but not limited to, the following:

- Public Law 107-188, Public Health Security and Bioterrorism Preparedness and Response Act of 2002;
- Public Law 109-417, Pandemic and All Hazards Preparedness Act of 2006; and
- Chapter 81, Texas Health and Safety Code.

Contractor shall comply with all applicable regulations, standards and guidelines in effect on the beginning date of this Program Attachment. This is an inter-local agreement under Chapter 791 of the Government Code.

Through this Program Attachment DSHS and Contractor are furnishing a service related to homeland security and under the authority of Texas Government Code § 421.062, neither agency is responsible for any civil liability that may arise from furnishing any service under this Program Attachment.

The following documents and resources are incorporated by reference and made a part of this Program Attachment:

- Department of Health and Human Services, Centers for Disease Control and Prevention (CDC), Public Health Emergency Preparedness Cooperative Agreement, Funding Opportunity Number: CDC-RFA-TP12-1201;
- *Public Health Preparedness Capabilities: National Standards for State and Local Planning, March 2011:* http://www.cdc.gov/phpr/capabilities/DSLR_capabilities_July.pdf;
- Presidential Policy Directive 8/PPD-8, March 30, 2011: http://www.hlswatch.com/wp-content/uploads/2011/04/PPD-8-Preparedness.pdf;
- Budget Period 1 Public Health Emergency Preparedness Work Plan for Local Health Departments, attached as Exhibit A;
- Contractor's FY13 Applicant Information and Budget Detail for FY13 base cooperative agreement;
- Texas Public Health and Medical Emergency Management 5-Year Strategic Plan;
- Tactical Guide, Companion Document to the Texas Public Health and Medical Emergency Management 5-Year Strategic Plan 2012 to 2016;
- Homeland Security Exercise and Evaluation Plan (HSEEP) Documents: https://hseep.dhs.gov/pages/1001_HSEEP7.aspx;
- Ready or Not? Have a Plan; Surviving Disaster: How Texans Prepare (videos): http://www.texasprepares.org/survivingdisaster.htm; and
- Preparedness Program Guidance(s) as provided by DSHS and CDC.

Funds awarded herewith must be matched by costs or third party contributions that are not paid by the Federal Government under another award, except where authorized by Federal statute to be used for cost sharing or matching. The non-federal contributions (match) may be provided directly or through donations from public or private entities and may be in cash or in-kind donations, fairly evaluated, including plant, equipment, or services. The costs that the Contractor incurs in fulfilling the matching or cost-sharing requirement are subject to the same requirements, including the cost principles, that are applicable to the use of Federal funds, including prior approval requirements and other rules for allowable costs as described in 45 CFR 74.23 and 45 CFR 92.24.

The Contractor is required to provide matching funds for this Program Attachment not less than 10% of total costs. Refer to the DSHS Contractor's Financial Procedures Manual, Chapter 9 (http://www.dshs.state.tx.us/contracts/cfpm.shtm) for additional guidance on match requirements, including descriptions of acceptable match resources. Documentation of match, including methods and sources, must be included in the Contractor's contract budget, and Contractor must follow procedures for generally accepted accounting practices as well as meet audit requirements.

Contractor shall coordinate activities and response plans within the jurisdiction, with state, regional, other local jurisdictions, and tribal entities (where appropriate), with local agencies, with hospitals and major health care entities, jurisdictional Metropolitan Medical Response Systems, and Councils of Government.

If Contractor agrees to perform public health preparedness services for another county in exchange for all or a portion of the other county's funding allocation, Contractor shall submit to DSHS a signed Memorandum of Agreement (MOA) between Contractor and the other county. The MOA shall outline services, timelines, deliverables and the amount of funds agreed upon by both parties.

Contractor shall notify DSHS in advance of Contractor's plans to participate in or conduct local exercises, in a format specified by DSHS. Contractor shall participate in statewide exercises planned by DSHS as needed to assess the capacity of Contractor to respond to bioterrorism, outbreaks of infectious disease, and other public health threats and emergencies. Contractor shall prepare and submit to DSHS After-Action Reports (AARs), documenting and correcting any identified gaps or weaknesses in preparedness plans identified during exercises in a format specified by DSHS and in compliance with Homeland Security Exercise and Evaluation Plan (HSEEP) standards.

Contractor shall cooperate with DSHS to coordinate all planning, training and exercises performed under this Program Attachment with the Texas Division of Emergency Management (TDEM) or other points of contact at the discretion of the division, to ensure consistency and coordination of requirements at the local level and eliminate duplication of effort between the various domestic preparedness funding sources in the state.

Contractor shall participate in the Texas Disease Reporting Program described in Chapter 81, Texas Health and Safety Code by:

A. Educating, training and providing technical assistance to local providers and hospitals on Texas reportable disease requirements;
B. Monitoring participation by local providers and hospitals in appropriately reporting notifiable conditions;
C. Conducting disease surveillance and reporting notifiable conditions to the appropriate DSHS regional office;
D. Coordinating with DSHS regional Epidemiology Response Team members to build an effective statewide system for rapid detection of unusual outbreaks of illness through notifiable disease and syndromic or other enhanced surveillance; and
E. Reporting immediately all illnesses resulting from bioterrorism, chemical emergencies, radiological emergencies, or other unusual events and data aberrations as compared to background surveillance data to the jurisdiction's respective DSHS Health Service Region (HSR) regional office or to DSHS.

Contractor shall coordinate all risk communication activities with the DSHS Communications Unit by using DSHS's core messages posted on DSHS's website, and submitting copies of draft risk communication materials to DSHS for coordination prior to dissemination.

In the event of a public health emergency involving a portion of the state, Contractor shall mobilize and dispatch staff or equipment purchased with funds from the previous PHEP

cooperative agreement and that are not performing critical duties in the jurisdiction served to the affected area of the state upon receipt of a written request from DSHS.

Contractor shall inform DSHS in writing if Contractor shall not continue performance under this Program Attachment within thirty (30) days of receipt of an amended standard(s) or guideline(s). DSHS may terminate the Program Attachment immediately or within a reasonable period of time as determined by DSHS.

Contractor shall develop, implement, and maintain a timekeeping system for accurately documenting staff time and salary expenditures for all staff funded through this Program Attachment, including partial FTEs and temporary staff.

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, 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:

Contractor must complete performance measures and benchmarks as outlined in the attached Exhibit A, Public Health Emergency Preparedness Work Plan for Local Health Departments, and as noted below:

A. Demonstrated adherence to PHEP reporting deadlines;
B. Demonstrated capability to receive, stage, store, distribute, and dispense material during a public health emergency; and
C. Submission of Pandemic Influenza Operations Plans.

Failure to meet these performance measures may result in withholding a portion of the fiscal year 2013 PHEP base award.

Contractor shall document the following Evidence-based Benchmarks and Pandemic Influenza Plans:

A. <u>Demonstrated adherence to PHEP reporting deadlines.</u>
   1. A PHEP Budget Period 1 mid-year progress report shall be submitted to DSHS within an established timeframe designated by DSHS pending release of the report template from CDC. This report will include a status update on Pandemic and All-Hazards Preparedness Act (PAHPA) benchmarks, an update on current preparedness status, and self-identified gaps based on the public health preparedness capabilities as they related to overall jurisdictional needs; and interim financial reports.
   2. Annual PHEP Budget Period 1 progress report shall be submitted to DSHS within an established timeframe designated by DSHS pending release of the report template from CDC. The report will include an update on work plan

activities, budget expenditure reports, PAHPA benchmarks, CDC-defined performance measurement activities and data, and preparedness accomplishments, success stories, and program impact statements.

B. Demonstrated capability to receive, stage, store, distribute, and dispense material during a public health emergency.

1. As part of their responses to public health emergencies, Contractor must be able to provide countermeasures to 100% of their identified population within 48 hours after the decision to do so. To achieve this standard, Contractor must maintain the capability to plan and execute the receipt, staging, storage, distribution, and dispensing of material during a public health emergency.

Using the framework and tools already established to assess capabilities to receive, distribute and dispense medical countermeasures, CDC has developed a composite measure to more fully represent preparedness and response activities.

The medical countermeasure distribution and dispensing (MCMDD) composite score will serve as a collective indicator of preparedness and operational capability within local/planning jurisdictions, Cities Readiness Initiative (CRI) areas, states, directly funded cities, territories, and freely associated states. Local, city, state, and territorial preparedness will be subsequently defined as a composite measure derived from results of the Technical Assistance Reviews (TARs), drill submissions, full-scale exercise, and compliance with programmatic standards.

Using the individual composite scores to represent local jurisdiction preparedness, CDC will compute an overall MCMDD composite score for Texas. During the progression of the 2011-2016, 2012-2017 PHEP cooperative agreement cycles, jurisdictions will be required to perform activities and submit documentation for a series of composite requirements to meet the advancing MCMDD composite benchmark. With the exception of the annual TAR and drill submission requirements, jurisdictions will have substantial flexibility in determining the order in which they perform or demonstrate capability to meet the composite measure. Local jurisdictions must submit all required supporting documentation by April 1, 2013. Supplemental information regarding this benchmark is found in Exhibit A.

C. Submission of Pandemic Influenza Operations Plans.

Submit Pandemic Influenza Operations Plans annually as required by Section 319C-1 of the PHS Act, as amended by PAHPA. DSHS will share further information upon release of such from ASPR and CDC in a separate guidance document.

The email address for submitting mid- and end-of-year reports, plus any additional programmatic reports is PHEP@dshs.state.tx.us

Contractor shall provide services in the following county(ies)/area: Hidalgo

SECTION III. SOLICITATION DOCUMENT:

Exempt - Governmental Entity

SECTION IV. RENEWALS:

DSHS may renew the Program Attachment for up to three (3) additional one-year terms at DSHS's sole discretion.

SECTION V. PAYMENT METHOD:

Cost Reimbursement.

Funding is further detailed in the attached Categorical Budget and, if applicable, Equipment List.

SECTION VI. BILLING INSTRUCTIONS:

Contractor shall request payment using the State of Texas Purchase Voucher (Form B-13) on a monthly basis and acceptable supporting documentation for reimbursement of the required services/deliverables. Additionally, the Contractor shall submit the Match/Reimbursement Certification (Form B-13A) and the Financial Status Report (FSR-269A) on a quarterly basis. Vouchers and supporting documentation should be mailed or submitted by fax or electronic mail to the addresses/number below.

Claims Processing Unit, MC1940
Texas Department of State Health Services
1100 West 49th Street
PO Box 149347
Austin, TX 78714-9347

The fax number for submitting State of Texas Purchase Voucher (Form B-13), Match/Reimbursement Certification Form (Form B-13A), and Financial Status Report to the Claims Processing Unit is (512) 458-7442. The email address is invoices@dshs.state.tx.us.

SECTION VII. BUDGET:

SOURCE OF FUNDS: *CFDA* # 93.069

DUNS NUMBER: 103110834

SECTION VIII. SPECIAL PROVISIONS:

General Provisions, **Compliance and Reporting** Article I, is revised to include:

Contractor shall submit programmatic reports as directed by DSHS in a format specified by DSHS. Contractor shall provide DSHS other reports, including financial reports, and any other reports that DSHS determines necessary to accomplish the objectives of this contract and to monitor compliance. If Contractor is legally prohibited from providing such reports, Contractor shall immediately notify DSHS in writing.

Contractor shall provide reports as requested by DSHS to satisfy information-sharing Requirements set forth in Texas Government Code, Sections 421.071 and 421.072 (b) and (c).

The email address for submitting mid-year reports, annual reports, and any additional programmatic reports is PHEP@dshs.state.tx.us

General Provisions, **Payment Methods and Restrictions** Article IV, **Billing Submission** Section 4.02, is amended to include the following:

Contractor shall submit requests for reimbursement or payment, or revisions to previous reimbursement request(s), no later than July 30, 2013 for costs incurred between the services dates of September 1, 2012 and June 30, 2013.

General Provisions, **Payment Methods and Restrictions** Article IV **Financial Status Reports (FSRs)** Section 4.05, is amended to include the following**:**

Contractor shall submit FSRs to Accounts Payable by the last business day of the month following the end of each term reported. The FSR period will be reported as follows: Quarter One shall include September 1, 2012 through November 30, 2012. Quarter two shall include December 1, 2012 through February 28, 2013. Quarter three shall include March 1, 2013 through June 30, 2013. Quarter four shall include July 1, 2013 through August 31, 2013. Contractor shall submit the final FSR no later than sixty (60) calendar days following the end of the applicable term.

General Provisions, **Terms and Conditions of Payment** Article IV, is revised to include:

DSHS will monitor Contractor's billing activity and expenditure reporting on a quarterly basis. Based on these reviews, DSHS may reallocate funding between contracts to maximize use of available funding.

General Provisions, **Allowable Costs and Audit Requirements** ArticleVI, is amended to include the following:

For the purposes of this Program Attachment, funds may not be used for: fundraising activities, lobbying, research; construction, major renovations, reimbursement of pre-award costs; clinical care; the purchase of vehicles of any kind, funding an award to another party or provider who is ineligible, or backfilling costs for staff new construction, or the purchase of incentive items.

General Provisions, **General Terms** Article VIII, **Amendment** Section 13.15, is amended to include the following:

> Contractor must submit all amendment and revision requests in writing to the Division Contract Management Unit at least 90 days prior to the end of the term of this Program Attachment.

General Provisions**, General Business Operations of Contractor** Article XII**, Equipment Purchases (Including Controlled Assets), Section 12.20,** is revised as follows**:**

> Contractor is required to initiate the purchase of approved equipment no later than August 31, 2013 as documented by issue of a purchase order or written order confirmation from the vendor on or before August 31, 2013. In addition, all equipment must be received no later than 60 calendar days following the end of the Program Attachment term.

Categorical Budget:

PERSONNEL	$528,160.00
FRINGE BENEFITS	$149,741.00
TRAVEL	$15,788.00
EQUIPMENT	$0.00
SUPPLIES	$12,835.00
CONTRACTUAL	$0.00
OTHER	$43,442.00
TOTAL DIRECT CHARGES	$749,966.00
INDIRECT CHARGES	$0.00
TOTAL	$749,966.00
DSHS SHARE	$681,787.00
CONTRACTOR SHARE	$68,179.00
OTHER MATCH	$68,179.00

Total reimbursements will not exceed $681,787.00

Financial status reports are due: 12/31/2012, 03/29/2013, 07/30/2013, 10/30/2013