



OHIO DEPARTMENT OF HEALTH

246 North High Street
Columbus, Ohio 43215

614/466-3543
www.odh.ohio.gov

John R. Kasich / Governor

Theodore E. Wymyslo, M.D. / Director of Health

To: Prospective Public Health Emergency Preparedness Grant Applicants

From: Will McHugh, Chief, Division of Prevention and Health Promotion, Ohio Department of Health

Subject: Notice of Availability of Funds – State Fiscal Year 2013 – Competitive Grant August 10, 2012 to June 30, 2013 Budget Period for Public Health Emergency Preparedness

The Ohio Department of Health (ODH), Bureau of Health Preparedness (BHP), announces the availability of grant funds to support the Public Health Emergency Preparedness (PHEP) Program. The goal of the PHEP program is to address bioterrorism, other outbreaks of infectious disease and other public health threats and emergencies at the county and regional public health level.

The total amount of funds to be awarded is \$11,593,463. The funds will be awarded as follows:

- **Core Public Health Emergency Preparedness** – Up to 88 grants will be awarded for a base amount of \$9,403,403.
- **Regional Public Health Planning** – Up to eight (8) grants will be awarded for a total amount of \$639,600.
- **Public Health Liaison** – Up to one (1) grant will be awarded for a total amount of \$46,800.
- **Cities Readiness Initiative** – Three (3) grants will be awarded for a total amount of \$1,495,660.
- **These funding levels are determined by the Centers for Disease Control and Prevention (CDC) and are contingent upon the availability of funds.**

All interested parties must submit a Notice of Intent to Apply for Funding (NOIAF) form, no later than **Monday April 2, 2012** to be eligible to apply for funding (attached to the RFP).

All potential applicants are encouraged to attend a Bidder's Conference call in April 2012. The Bidder's Conference will provide an opportunity for interested parties to learn more about the Request for Proposal. Information regarding date, time and instructions will be provided to those who submit a Notice of Intent to Apply for Funding (NOIAF).

All interested applicants must attend GMIS 2.0 training to be eligible to apply for funding. Unless previously done so, complete and return the GMIS 2.0 training form (attached to the RFP) if training for GMIS 2.0 is needed. This training will allow you to submit an application via the Internet using the Grants Management Information System (GMIS 2.0). All grant applications must be submitted via the Internet using the GMIS 2.0.

The RFP will provide detailed information about the background, intent and scope of the grant, policy, procedures, performance expectations, and general information and requirements associated with the administration of the grant.

Please contact Sayeh S. Shirvani, PHEP Program Manager at (614) 995-0611, or by e-mail at Sayeh.Shirvani@odh.ohio.gov, if you have any questions regarding this application.

Mail the original and two (2) copies of the material not electronically filed to:

**Ohio Department of Health
Grants Services Unit
Central Master Files, 4th Floor
246 N. High Street
Columbus, OH 43215**



ALL APPLICATIONS MUST BE SUBMITTED VIA THE INTERNET

OHIO DEPARTMENT OF HEALTH

**DIVISION OF
PREVENTION AND HEALTH PROMOTION**

**BUREAU OF
HEALTH PREPAREDNESS**

**PUBLIC HEALTH EMERGENCY PREPAREDNESS
REQUEST FOR PROPOSALS (RFP)
FOR
FISCAL YEAR 2013
(08/10/12 – 06/30/13)**

**Local Public Applicant Agencies
Non-Profit Applicants**

COMPETITIVE GRANT APPLICATION INFORMATION

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- H. Public Health Emergency Preparedness Grant Funding
- I. Notice of Intent to Apply for Funding (NOIAF)

I. APPLICATION SUMMARY and GUIDANCE

An application for an Ohio Department of Health (ODH) grant consists of a number of required parts – an electronic component submitted via the Internet Website: ODH Application Gateway – GMIS 2.0 which includes various paper forms and attachments. All the required parts of a specific application must be completed and submitted by the application due date. **Any required part that is not submitted on time will result in the entire application not being considered for review.**

The application summary information is provided to assist your agency in identifying funding criteria:

- A. Policy and Procedure:** Uniform administration of all the ODH grants is governed by the ODH Grants Administration Policies and Procedures (GAPP) Manual. This manual must be followed to ensure adherence to the rules, regulations and procedures for preparation of all subgrantee applications. The GAPP Manual is available on the ODH Website <http://www.odh.ohio.gov>. (Click on “Funding Opportunities” [located under At a Glance]; click on “ODH Grants” and then click on “GAPP Manual.”)
- B. Application Name:** Public Health Emergency Preparedness (PHEP)
- C. Purpose:** To develop and maintain strong local public health emergency preparedness capable of addressing and responding to a bioterrorism, terrorism, unintentional, or naturally occurring event that results in a public health threat or emergency.
- D. Qualified Applicants:** All applicants must be a local public health department. Applicant agencies must attend or document in writing prior attendance at Grants Management Information System 2.0 (GMIS) training and must have the capacity to accept an electronic funds transfer (EFT).

The application summary information below is provided to assist your agency in identifying funding criteria:

Foundation Public Health Emergency Preparedness (PHEP) Applicants

- Local health departments (LHD) must have a full-time administrative triad. This would include a full-time Health Commissioner and/or Administrator, a full-time Director of Nursing, and a full-time Environmental Health Director.
- For the counties where the LHD’s, do not meet the triad, they must work with another LHD in an adjacent county and within the same region to be their administrative agent. The administrative agent will submit the application and name the partnering LHD/County.

E. Service Area:

- **Core Public Health Emergency Preparedness** – No more than one project will be funded per county. Applications will be accepted for multi-county collaborative projects (letters of support must be submitted for multi-county collaborative projects).
- **Regional Public Health Planning** – Service area is defined as each Ohio Homeland Security

Planning Region. Please refer to Appendix D “Ohio Homeland Security Planning Region” map.

- **Cities Readiness Initiative** – Applicant’s metropolitan area as defined by the Centers for Disease Control and Prevention (CDC).
- **Public Health Liaison** – Service area is defined as the link between the PHEP subgrantee, Association of Ohio Health Commissioners (AOHC) and the Ohio Department of Health.

F. Number of Grants and Funds Available:

All funding is contingent upon the availability of federal funds (CFDA 93.069).

- **Core Public Health Emergency Preparedness** – Up to 88 grants will be awarded for a base amount of \$9,403,403.
- **Regional Public Health Planning** – Up to eight (8) grants will be awarded for a total amount of \$639,600.
- **Public Health Liaison** – Up to one (1) grant will be awarded for a total amount of \$46,800
- **Cities Readiness Initiative** – Three (3) grants will be awarded for a total amount of \$1,495,660. These funding levels are determined by the Centers for Disease Control and Prevention (CDC) and are contingent upon the availability of funds.

No grant award will be issued for less than **\$30,000**. The minimum amount is exclusive of any required matching amounts and represents only ODH funds granted. Applications submitted for less than the minimum amount will not be considered for review.

- G. Due Date:** Applications including any required forms and required attachments mailed or electronically submitted via GMIS 2.0 are due by **4:00 p.m. Monday, May 7, 2012**. Attachments and/or forms sent electronically must be transmitted by the application due date. Attachments and/or forms mailed that are non-Internet compatible must be postmarked or received on or before the application due date.

Questions regarding this RFP can be directed to the following:

- **Northeast & Northeast Central Region** – Amber Payne at 614-995-5901 or Amber.Payne@odh.ohio.gov
- **Central and West Central Regions** – Daniel Sweeney at 614-466-6243 or Daniel.Sweeney@odh.ohio.gov
- **Northwest Region** – Cathy Mockus at 614-728-7517 or Cathy.Mockus@odh.ohio.gov
- **Southwest Region** – Viola Webber at 614-728-4120 or Viola.Webber@odh.ohio.gov
- **Southeast Region** – (Vacant) 614-644-6133 or Amber Payne at 614-995-5901 or Amber.Payne@odh.ohio.gov

- H. Authorization:** Authorization of funds for this purpose is contained in the Catalog of Federal Domestic Assistance (CFDA) Number 93.069.

I. Goals:

Core Leadership

- To develop and maintain capability for effective response during public health emergencies.

Capabilities

Community Recovery

- To develop and maintain collaboration 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. This capability supports National Health Security Strategy Objective 8: Incorporate Post-Incident Health Recovery into Planning and Response. Post-incident recovery of the public health, medical and mental/behavioral health services and systems within a jurisdiction is critical for health security and requires collaboration and advocacy by the public health agency for the restoration of services, providers, facilities, and infrastructure within the public health, medical, and human services sectors. Monitoring the public health, medical and mental/behavioral health infrastructure is an essential public health service.

Community Preparedness

- Community preparedness is the ability of communities to prepare for, withstand, and recover, in both the short and long terms, from public health incidents. By engaging and coordinating with emergency management, healthcare organizations (private and community-based), mental/behavioral health providers, community and faith-based partners, state, local, and territorial, public health's role in community preparedness is to do the following:
 - Support the development of public health, medical, and mental/behavioral health systems that support recovery
 - Participate in awareness training with community and faith-based partners on how to prevent, respond to, and recover from public health incidents
 - Promote awareness of and access to medical and mental/behavioral health resources that help protect the community's health and address the functional needs (i.e., communication, medical care, independence, supervision, transportation) of at-risk individuals
 - Engage public and private organizations in preparedness activities that represent the functional needs of at-risk individuals as well as the cultural and socio-economic, demographic components of the community
 - Identify those populations that may be at higher risk for adverse health outcomes due to challenging social, environmental or economic challenges and/or health disparities
 - Receive and/or integrate the health needs of populations who have been displaced due to incidents that have occurred in their own or distant communities (e.g., improvised nuclear device or hurricane)

Information Sharing

- To develop or maintain 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.

Epidemiological Surveillance and Investigation

- Maintain the ability to create, 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.

Emergency Public Information and Warning

- Maintain the ability to develop, coordinate, and disseminate information, alerts, warnings, and notifications to the public and incident management responders.

Medical Countermeasure Dispensing

- Maintain 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.

Medical Materiel Management and Distribution

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

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

Regional Public Health

- Regional plans incorporate an accurate hazard analysis and risk assessment and ensure capabilities required to prevent, protect and mitigate against, respond to and recover from acts of terrorism, natural disasters, and other emergencies are available when and where they are needed. The outcome of the Planning is the successful achievement of the Concept of Operations.

Public Health Liaison

- Liaison activities to support LHDs' leadership ability to partner with ODH on bioterrorism and emergency preparedness and improve communications with the Ohio health commissioners.

Cities Readiness Initiative (CRI)

- To conduct Cities Readiness Initiative (CRI) activities. CRI is a program to aid cities in increasing their capacity to deliver medicines and medical supplies during a large-scale public health emergency such as a bioterrorism attack or a nuclear accident within 48 hours.

J. Program Period and Budget Period: The program period will begin August 10, 2012 and end on June 30, 2016. The budget period for this application is August 10, 2012 through June 30, 2013.

K. Local Health Districts Accreditation Standards:

Local Health Districts Accreditation Standards: Identify the Public Health Accreditation Board (PHAB) Standard(s) that will be addressed by grant activities. The PHAB standards are available at the following website:

<http://www.phaboard.org/wp-content/uploads/PHAB-Standards-Overview-Version-1.0.pdf>

Standard 2.1: Conduct timely investigations of health problems and environmental public health hazards.

Standard 2.2: Contain/mitigate health problems and environmental public health hazards.

Standard 2.3: Ensure access to Laboratory and Epidemiologic/Environmental Public Health expertise and capacity to investigate and contain/mitigate public health problems and environmental public health hazards.

Standard 2.4: Maintain a plan with policies and procedures for urgent and non-urgent communications.

Standard 3.2: Provide information on public health issues and public health functions through multiple methods to a variety of audiences.

Standard 4.1: Engage with the public health system and the community in identifying and addressing health problems through collaborative processes.

Standard 4.2: Promote the community's understanding of and support for policies and strategies that will improve the public's health.

Standard 5.1: Serve as a primary and expert resource for establishing and maintaining public health policies, practices, and capacity.

Standard 5.2: Conduct a comprehensive planning process resulting in a Tribal/State/Community health Improvement Plan

Standard 5.3: Develop and implement a Health Department organizational strategic plan

Standard 5.4: Maintain an all hazards Emergency Operations Plan

This grant program will address the Local Health Districts Improvement Goals and Standards as follows:

Goal 3701-36-04, Standards 3701-36-04-01 to 3701-36-04-05;

Goal 3701-36-05, Standards 3701-36-05-01 and 02;

Goal 3701-36-06, Standards 3701-36-06-02, 03, and 04;

Goal 3701-36-07, Standard 3701-36-07-02;

Goal 3701-36-08, Standard 3701-36-08-02; and,

Goal 3701-36-09, Standards 3701-36-09-03 and 04

The Local Health District Improvement Standards are available on the ODH Website <http://www.odh.ohio.gov>. (Click on “Local Health Departments” then “Local Health Districts Improvement Standards,” then click “Local Health District Improvement Goals/Standards/Measures.”)

ODH is committed to supporting the on-going development of Ohio’s public health infrastructure of which the Local Health District Improvement Standards are a critical component. Grantees that successfully perform under the PHEP grant can use that success to document their performance under the new Local Health District Improvement Standards. Furthermore, ODH will use the Centers for Disease Control and Prevention (CDC) bioterrorism indicators which are expected to provide the framework for the CDC grant.

This grant program will address Local Health District Improvement Standards as follows (*Note, while this grant addresses several goals and standards, please pay particular attention to Goal 3701-36-04, Goal 3701-36-06, and Goal 3701-36-09*):

Goal 3701-36-04: Protect People from Disease and Injury

- 3701-36-04-01 - *A surveillance and reporting system that identifies health threats.*
- 3701-36-04-02 - *Response plans that delineate roles and responsibilities in the event of communicable disease outbreaks and other health risks that threaten the health of people.*
- 3701-36-04-03 - *Communicable disease investigation and control procedures in place and actions documented.*
- 3701-36-04-04 - *Urgent public health messages received and communicated quickly and clearly and actions documented.*
- 3701-36-04-05 - *Disease and other health risk responses routinely evaluated for opportunities to improve public health system response.*

Goal 3701-36-05: Monitor Health Status

- 3701-36-05-01 - *Public health assessment processes and tools in place and continuously maintained and enhanced.*
- 3701-36-05-02 - *Information about environmental threats and community health status being collected, analyzed, and disseminated at defined intervals.*

Goal 3701-36-06: Assure a Safe and Healthy Environment

- 3701-36-06-02 - *Environmental health risks and environmental health illnesses being tracked, recorded, reported and monitored by the district.*
- 3701-36-06-03 - *Services available to respond to environmental events or other disasters that threaten the public’s health.*
- 3701-36-06-04 - *Compliance with public health regulation sought through enforcement actions.*

Goal 3701-36-07: Promote Healthy Lifestyles

- 3701-36-07-02 - *Community members actively involved in addressing prevention priorities.*

Goal 3701-36-08: Address the Need for Personal Health Services

- 3701-36-08-02 - *Information being available that describes the local health system, including resources critical for public health protection and information about health care providers, facilities, and support services.*

Goal 3701-36-09: Administer the Health District

- 3701-36-09-02 – *The health district assuring that staff are in compliance with licensure and certification requirements for public health professionals, that staff are properly oriented, and have access to in-service and continuing education.*
- 3701-36-09-04 – *Confidentiality of health data being protected and health information systems being secure.*

L. Public Health Impact Statement: All applicant agencies that are not local health districts must communicate with local health districts regarding the impact of the proposed grant activities on the Local Health Districts Accreditation Standards.

1. Public Health Impact Statement Summary - Applicant agencies are required to submit a summary of the program to local health districts prior to submitting the grant application to ODH. The program summary, not to exceed one page, must include:
 - a) The Public Health Accreditation Board (PHAB) Standard(s) to be addressed by grant activities:
 - A description of the demographic characteristics (e.g., age, race, gender, ethnicity) of the target population and the geographical area in which they live (e.g. census tracts, census blocks, block groups);
 - A summary of the services to be provided or activities to be conducted; and,
 - A plan to coordinate and share information with appropriate local health districts.

The applicant must submit the above summary as part of their grant application to ODH. This will document that a written summary of the proposed activities was provided to the local health districts with a request for their support and/or comment about the activities as they relate to the Local Health Districts Improvement Standards

2. Public Health Impact Statement of Support - Include with the grant application a statement of support from the local health districts, if available. If a statement of support from the local health districts is not obtained, indicate that when the program summary is submitted with the grant application. If an applicant agency has a regional and/or statewide focus, a statement of support must be submitted from at least one local health district, if available

M. Statement of Intent to Pursue Health Equity Strategies

The ODH is committed to the elimination of health inequities. Minority and low-income communities experience greater loss during disasters and public health emergencies because of existing social, environmental and economic challenges. These are sometimes referred to as Social Determinants of Health (SDOH). SDOH are the root causes of the disproportionate burden for a host of illnesses, including worse than expected health outcomes and increased mortality. These are referred to as health disparities. Complications from health disparities are greatly exacerbated

during disasters. Health disparities are sometimes referred to as health inequities when they are the result of the systematic and unfair distribution of social determinants.

Preparedness goals of **Capability: Community Preparedness** (CP1 through CP4); **Capability: Information Sharing**; **Capability: and Medical Countermeasure Dispensing** (CMD1, CMD2) provide exceptional opportunities to safeguard the lives and property of disadvantaged communities by developing action plans and procedures which are sensitive to challenging social determinants of health and existing health disparities. Selected sections of the Public Health Emergency Preparedness Program Plan (PHEP) provide a way for applicant agencies to describe how social determinants of health and health inequities can be addressed within proposed readiness activities. **Responses to the above sections will suffice for the Intent to Pursue Health Equity Strategies.** Preparedness staff and the ODH Health Equity Office consider the following sections of the PHEP critical to the elimination of health inequities. Responses to the following objectives and benchmarks will help ODH determine how health inequity issues will be addressed through disaster readiness activities:

- Develop or maintain documented legal and procedural framework for information exchange.
 - LHD will develop or maintain protocols to gather and analyze surveillance data.
 - LHD develops investigation report template.
 - LHD develop standard operating procedures to identify the medical countermeasures required for the incident or potential incident.
 - LHD develop protocols to govern the activation of dispensing modalities.
 - LHD develop protocols to govern the dispensing of medical countermeasures
 - Participate in annual CRI assessment.
- ***Basic Health Equity Concepts:***
Certain groups in Ohio experience a disproportionate burden with regard to the incidence, prevalence and mortality of certain diseases or health conditions. These are commonly referred to as ***health disparities***. Health disparities are not mutually exclusive to one disease or health condition and are measurable through the use of various public health data. Most health disparities affect groups marginalized because of socioeconomic status, race/ethnicity, sexual orientation, gender, disability status, geographic location or some combination of these factors. People in such groups also tend to have less access to resources like healthy food, good housing, good education, safe neighborhoods, freedom from racism and other forms of discrimination. These are referred to as ***social determinants***. Social determinants are necessary to support optimal health. The systematic and unjust distribution of social determinants among these groups is referred to as ***health inequities***. As long as health inequities persist, marginalized groups will not achieve their best possible health. The ability of marginalized groups to achieve optimal health (like those with access to social determinants) is referred to as ***health equity***. Public health interventions that incorporate social determinants into the planning and implementation of programs will contribute to the elimination of health disparities. For more resources on health equity, please visit the ODH website at:

<http://www.healthyohioprogram.org/healthequity/equity.aspx>.

- N. Appropriation Contingency:** Any award made through this program is contingent upon the availability of funds for this purpose. **In view of this, the subgrantee agency must be prepared to cover the costs of operating the program in the event of a delay in grant payments. The spreadsheet in Appendix E is an estimate and will be changed once the federal CDC guidance and funding amounts are received by ODH.**
- O. Programmatic, Technical Assistance and Authorization for Internet Submission:** Initial authorization for Internet submission will be distributed after your GMIS 2.0 Training Session (new agencies). All other agencies will receive their authorization after receipt of NOIAF (Appendix I). Questions regarding this RFP can be directed to the following:
- **Northeast & Northeast Central Regions** – Amber Payne at 614-995-5901 or Amber.Payne@odh.ohio.gov
 - **Central & West Central Regions** – Daniel Sweeney at 614-466-6243 or Daniel.Sweeney@odh.ohio.gov
 - **Northwest Region** – Cathy Mockus at 614-728-7517 or Cathy.Mockus@odh.ohio.gov
 - **Southwest Region** – Viola Webber at 614-728-4120 or Viola.Webber@odh.ohio.gov
 - **Southeast Region** – (Vacant) 614-644-6133 or Amber Payne at 614-995-5901 or Amber.Payne@odh.ohio.gov

Applicant must attend or must document, in writing, prior attendance at GMIS 2.0 training in order to receive authorization for Internet submission.

- P. Acknowledgment:** An ‘Application Submitted’ status will appear in GMIS 2.0 that acknowledges ODH system receipt of the application submission.
- Q. Late Applications:** Applications are dated the time of actual submission via the Internet utilizing GMIS 2.0. Required attachments and/or forms sent electronically must be transmitted by the application due date. Required attachments and/or forms mailed that are non-Internet compatible must be postmarked or received on or before the application due date of **4:00 p.m. Monday May 7, 2012.**

Applicants should request a legibly dated postmark, or obtain a legibly dated receipt from the U.S. Postal Service, or a commercial carrier. Private metered postmarks shall **not** be acceptable as proof of timely mailing. Applicants can hand-deliver attachments to ODH, Grants Services Unit, Central Master Files; but they must be delivered by **4:00 p.m.** on the application due date. FAX attachments will not be accepted. **GMIS 2.0 applications and required application attachments received late will not be considered for review.**

- R. Successful Applicants:** Successful applicants will receive official notification in the form of a

“Notice of Award” (NOA). The NOA, issued under the signature of the Director of Health, allows for expenditure of grant funds.

- S. Unsuccessful Applicants:** Within 30 days after a decision to disapprove or not fund a grant application for a given program period, written notification, issued under the signature of the Director of Health, or his designee shall be sent to the unsuccessful applicant.
- T. Review Criteria:** All proposals will be judged on the quality, clarity and completeness of the application. Applications will be judged according to the extent to which the proposal:
1. Contributes to the advancement and/or improvement of the health of Ohioans;
 2. Is responsive to policy concerns and program objectives of the initiative/program/ activity for which grant dollars are being made available;
 3. Is well executed and is capable of attaining program objectives;
 4. Describes specific objectives, activities, milestones and outcomes with respect to time-lines and resources;
 5. Estimates reasonable cost to the ODH, considering the anticipated results;
 6. Indicates that program personnel are well qualified by training and/or experience for their roles in the program and the applicant organization has adequate facilities and personnel;
 7. Provides an evaluation plan, including a design for determining program success;
 8. Is responsive to the special concerns and program priorities specified in the request for proposal;
 - 9. Has demonstrated acceptable past performance in areas related to programmatic and financial stewardship of grant funds;**
 - 10. Has demonstrated compliance to Grants Administration Policy and Procedures (GAPP), Chapter 100; and**
 - 11. Explicitly identifies specific groups in the service area who experience a disproportionate burden of the diseases or health condition(s) and explains the root causes of health disparities.**

The ODH will make the final determination and selection of successful/unsuccessful applicants and reserves the right to reject any or all applications for any given request for proposals. **There will be no appeal of the Department's decision.**

- U. Freedom of Information Act:** The Freedom of Information Act and the associated Public Information Regulations (45 CFR Part 5) of the U. S. Department of Health and Human Services require the release of certain information regarding grants requested by any member of the public. The intended use of the information will not be a criterion for release. Grant applications and grant-related reports are generally available for inspection and copying except that information considered to be an unwarranted invasion of personal privacy will not be disclosed. For specific guidance on the availability of information, refer to 45 CFR Part 5.

- V. **Ownership Copyright:** Any work produced under this grant will be the property of the Ohio Department of Health/Federal Government. The department's ownership will include copyright. The content of any material developed under this grant **must** be approved in advance by the awarding office of the ODH. All material(s) must clearly state:

Funded by Ohio Department of Health/Centers for Disease Control and Prevention
Bureau of Health Preparedness
Public Health Emergency Preparedness

- W. **Reporting Requirements:** Successful applicants are required to submit subgrantee program and expenditure reports. Reports must adhere to the ODH, GAPP manual. Reports must be received before the department will release any additional funds.

Note: Failure to assure quality of reporting such as submitting incomplete and/or late program or expenditure reports will jeopardize the receipt of future agency payments.

Reports shall be submitted as follows:

1. **Program Reports: Subgrantee Program Reports must be completed and submitted via the Grants Management Information System (GMIS) on the comments section of the application page** by the following dates: March 15, 2013 (Mid-Year Report including Performance Measures) and August 15, 2013 (End of Year Report including Performance Measures). Any paper non-Internet compatible report attachments must be submitted to Central Master Files by the specific report due date. **Program Reports that do not include required attachments (non-Internet submitted) will not be approved.** All program report attachments must clearly identify the authorized program name and grant number.

Public Health Emergency Preparedness

- A written report, including a revised Attachment #1, must be submitted to your PHEP Consultant within 15 business days, anytime there is a change in the core leadership. This report must identify the personnel change and the plan for maintaining core leadership both on a temporary and permanent basis.
- An HSEEP compliant multi-year (3 year 2013-2015) training and exercise plan must be submitted to ODH 30 days after Notice of Award (NOA).
- All Tabletop, Functional or Full-scale exercise After Action Reports (AAR) and Improvement Plans (IP) must be submitted within 90 days of completion of event and upon request.
- Jurisdictional public health emergency response plans must be reviewed, updated annually and submitted upon request.
- Crisis communication plan must be reviewed, updated annually and submitted upon request.
- Topic specific reports, summaries, surveys, metrics, performance measures, and other items must be completed and submitted to ODH upon request.
- A written response to a PHEP site visit is required within 30 days of receipt of the report

from ODH. The report must be signed by agency Health Commissioner or Administrator.

- A written response to a CRI L-TAR Assessment is required within 5 business days of receipt of the report.

Submission of Subgrantee Program Reports via the ODH’s GMIS indicates acceptance of the ODH GAPP.

2. **Subgrantee Program Expenditure Reports:** Subgrantee Program Expenditure Reports **must** be completed and submitted **via GMIS 2.0** by the following dates:

Expenditure Report Due Date	Report Timeframe
December 15, 2012	August 10, 2012 to November 30, 2012
March 15, 2013	December 1, 2012 to February 28, 2013
June 15, 2013	March 1, 2013 to May 31, 2013
July 15, 2013	June 1, 2013 to June 30, 2013
August 15, 2013	August 10, 2012 to June 30, 2013

Submission of Subgrantee Program Expenditure Reports via the ODH’s GMIS 2.0 system indicates acceptance of ODH GAPP. Clicking the “Approve” button signifies your authorization of the submission as an agency official and constitutes your electronic acknowledgment and acceptance of GAPP rules and regulations.

3. **Final Expenditure Reports:** A Subgrantee Final Expenditure Report reflecting total expenditures for the fiscal year must be completed and submitted **via GMIS 2.0** by **4:00 P.M.** on or before **August 15, 2013**. The information contained in this report must reflect the program’s accounting records and supportive documentation. Any cash balances must be returned with the Subgrantee Final Expense Report. The Subgrantee Final Expense Report serves as an invoice to return unused funds.

Submission of the Subgrantee Final Expenditure Report via the GMIS 2.0 system indicates acceptance of ODH GAPP. Clicking the “Approve” button signifies authorization of the submission by an agency official and constitutes electronic acknowledgment and acceptance of GAPP rules and regulations.

4. **Inventory Report:** A listing of all equipment purchased in whole or in part with **current** grant funds (Equipment Section of the approved budget) must be submitted via GMIS 2.0 as part of the Subgrantee Final Expenditure Report. At least once every two years, inventory must be physically inspected by the subgrantee. Equipment purchased with ODH grant funds must be tagged as property of ODH for inventory control. Such equipment may be required to be returned to ODH at the end of the grant program period.

- X. **Special Condition(s):** Responses to all special conditions **must be submitted via GMIS 2.0** within

30 days of receipt of the first quarter payment. A Special Conditions link is available for viewing and responding to special conditions. This link is viewable only after the issuance of the subgrantee's first payment. The 30 day time period, in which the subgrantee must respond to special conditions, will begin when the link is viewable. Failure to submit satisfactory responses to the special conditions or a plan describing how those special conditions will be satisfied will result in the withholding of any further payments until satisfied.

Submission of response to grant special conditions via the ODH's GMIS 2.0 system indicates acceptance of ODH GAPP. Checking the "selection" box and clicking the "approve" button signifies authorization of the submission by an agency official and constitutes electronic acknowledgment and acceptance of GAPP rules and regulations.

Y. Unallowable Costs: Funds **may not** be used for the following:

1. To advance political or religious points of view or for fund raising or lobbying; but must be used solely for the purpose as specified in this announcement;
2. To disseminate factually incorrect or deceitful information;
3. Consulting fees for salaried program personnel to perform activities related to grant objectives;
4. Bad debts of any kind;
5. Lump sum indirect or administrative costs;
6. Contributions to a contingency fund;
7. Entertainment;
8. Fines and penalties;
9. Membership fees -- unless related to the program and approved by ODH;
10. Interest or other financial payments;
11. Contributions made by program personnel;
12. Costs to rent equipment or space owned by the funded agency;
13. Inpatient services;
14. The purchase or improvement of land; the purchase, construction, or permanent improvement of any building;
15. Satisfying any requirement for the expenditure of non-federal funds as a condition for the receipt of federal funds;
16. Travel and meals over the current state rates (see OBM Website: <http://obm.ohio.gov/MiscPages/TravelRule> Then click on OBM Travel Rule.
17. Costs related to out-of-state travel, unless otherwise approved by ODH, and described in the budget narrative;
18. Training longer than one week in duration, unless otherwise approved by ODH;
19. Contracts for compensation with advisory board members;
20. Grant-related equipment costs greater than \$300, unless justified and approved by ODH;
21. Payments to any person for influencing or attempting to influence members of Congress or the Ohio General Assembly in connection with awarding of grants; and,
22. LHD's utilizing PHEP grant funds for staff training costs must have an agency training plan in place to determine approved trainings. In addition to meeting LHD training policy, approved

training must be content related to this grant. Tuition costs for coursework not content related to this grant are not allowable costs;

23. Purchase of radio communications that are not MARCS compliant and approved by ODH;
24. Purchases of hardware (e.g., handheld scanners) for PVS or alternative data system not compliant with ODH specifications;
25. Purchase of personal protective equipment (PPE) without first submitting to ODH a plan for use of the PPE, training on its use, and a respirator protection plan and receiving approval of those plans. PPE for standard precautions and N-95, as indicated in the Infectious Disease Control Manual (IDCM), are exempt from this requirement;
26. Purchase of vehicles;
27. Costs for Internet Service Provider or internet lines if connection to T1 is installed;
28. Land-Based Response System (LBRS);
29. No more than 10% of total award allowable for grant-related equipment without submitting a plan to ODH for approval that demonstrates a need for meeting required grant deliverable and how these purchases fit into the LHD's preparedness plan. The equipment cost to the PHEP can not exceed the percentage of PHEP program utilization. For example, if a printer is used by PHEP personnel 25% of the time and by other programs 75% of the time, then the PHEP grant cannot be charged more than 25% of the cost of the printer's purchase and maintenance. Usage records are required for equipment that is not used exclusively for PHEP. The Multi-Agency Radio Communication System (MARCS) purchased are excluded from the percentage cap.
30. Training, workshops, in-services, courses, or any travel that is not directly related to emergency preparedness or bioterrorism.
31. Purchase of Incentives;
32. Refreshments or Food;
33. New staff positions, unless justified and approved by ODH;
34. Advertising, other than for recruitment and/or procurement;
35. Out of Country travel;
36. Routine lab testing that is performed by ODH Lab or cost associated with private laboratory testing;
37. Cost Associated with Agro-Terrorism;
38. Overtime for salaried employees and health department's Triad members;
39. Ventilators;
40. Firearms/dangerous ordnance;
41. Any other unallowable costs as specified in the PHEP 2010 Standard, the GAPP Manual or CDC 2012-2013 PHEP Guidance .

Use of grant funds for prohibited purposes will result in the loss and/or recovery of those funds.

- Z.** *Audit: Subgrantees currently receiving funding from the ODH are responsible for submitting an independent audit report that meets OMB Circular A-133 requirements, a copy of the auditor's management letter, a corrective action plan (if applicable) and a data collection form (for single audits) within 30 days of the receipt of the auditor's report, but not later than 9 months after the end*

of the subgrantee's fiscal year.

Subgrantees that have an agency fiscal year that ends on or after January 1, 2004 (and expend \$500,000 or more in federal awards per fiscal year) are required to have a single audit. The fair share of the cost of the single audit is an allowable cost to federal awards provided that the audit was conducted in accordance with the requirements of OMB Circular A-133.

Subgrantees that have an agency fiscal year that ends on or after January 1, 2004 which expend less than the \$500,000 threshold require a financial audit conducted in accordance with Generally Accepted Government Auditing Standards. The financial audit is not an allowable cost to the program.

Once an audit is completed, **a copy must be sent to the ODH, Grants Services Unit, Central Master Files address within 30 days.** Reference: *GAPP Chapter 100, Section 108 and OMB Circular A-133, Audits of States, Local Governments, and Non-Profit Organizations for additional audit requirements.*

Subgrantee audit reports (finalized and published, and including the audit Management Letters, if applicable) **which include internal control findings, questioned costs or any other serious findings, must include a cover letter which:**

- Lists and highlights the applicable findings;
- Discloses the potential connection or effect (direct or indirect) of the findings on sub-grants passed-through the ODH;
- Summarizes a Corrective Action Plan (CAP) to address the findings. A copy of the CAP should be attached to the cover letter.

AA. Submission of Application:

Formatting Requirements:

- Properly label each item of the application packet (ex. budget narrative, program narrative, etc).
- Each section should use 1.5 spacing with one-inch margins.
- Program and Budget narratives must be submitted in portrait orientation.
- Number all pages (print on one side only).
- Program narrative should not exceed 25 pages (**excludes** appendices, attachments, budget and budget narrative).
- Use a 12 point font.
- Forms must be completed and submitted in the format provided by ODH.

The GMIS 2.0 application submission must consist of the following:

Complete & Submit Via Internet

1. Application Information
2. Project Narrative

3. Project Contacts
4. Budget
 - Primary Reason
 - Funding
 - Cash Needs
 - Justification
 - Personnel
 - Other Direct Costs
 - Equipment
 - Contracts
 - Compliance Section D
 - Summary
5. Civil Rights Review Questionnaire (EEO Survey)
6. Assurances Certification
7. Federal Funding Accountability and Transparency Act (FFATA) reporting form (Attachment B).
8. Attachments as required by Program
 - Attachment #1: Local Health Department Contact Information
 - Attachment #2: Public Health Emergency Preparedness Program Plan Instructions
 - Attachment #3: Community Preparedness
 - Attachment #4: Community Recovery
 - Attachment #5: Information Sharing
 - Attachment #6: Public Health Surveillance & Epidemiology Investigation
 - Attachment #7: Emergency Public Information and Warning
 - Attachment #8: Medical Countermeasure Dispensing
 - Attachment #9: Medical Materiel Distribution
 - Attachment #10: Medical Surge
 - Attachment #11: Regional Public Health
 - Attachment #12: Cities Readiness Initiative
 - Attachment #13: Public Health Emergency Preparedness (PHEP) Match Requirement
 - Attachment #14: Public Health Emergency Preparedness (PHEP) Budget Worksheet
 - Attachment #15: Strategic National Stockpile Drill, Exercise and After Action Report
 - Attachment #16: Optional “Resource Elements”

An original and one copy of the following forms, available on GMIS 2.0, must be completed, printed, signed in blue ink with original signature by the Agency Head or Agency Financial Head and mailed to the address listed below:

**Complete,
Sign &
Mail To
ODH**

1. Electronic Funds Transfer (EFT) Form (**Required if new agency, thereafter only if banking information has changed.**)
2. IRS W-9 Form (**Required if new agency, thereafter only when tax identification number or agency address information has changed.**)
One of the following forms must accompany the IRS W-9 Form:
 - a. Vendor Information Form (**New Agency Only**)
 - b. Vendor Information Change Form (**Existing Agency with tax identification number, name and/or address change(s).**)
 - c. Change request in writing on Agency letterhead (**Existing Agency with tax identification number, name and/or address change(s).**)

Two copies of the following documents must be mailed to the address listed below:

**Copy &
Mail To
ODH**

1. Public Health Impact Statement
2. Statement of Support from the Local Health Districts
3. **Statement of Intent to Pursue Health Equity Strategies**
4. Liability Coverage (**Non-Profit Organizations only; proof of current liability coverage and thereafter at each renewal period**)
5. Evidence of Non-Profit Status (**Non-Profit Organizations only; for competitive cycle only; for continuation, only if changed**).

One copy of the following documents must be mailed to the address listed below:

**Complete
Copy &
Mail To
ODH**

1. Current Independent Audit (latest completed organizational fiscal period; **only if not previously submitted**)
2. Declaration Regarding Material Assistance/Non Assistance to a Terrorist Organization (DMA) Questionnaire (**Required by ALL Non-Governmental Applicant Agencies**)
3. An original and as required by Program: None

**Ohio Department of Health
Grants Services Unit
Central Master Files, 4th Floor
246 N. High Street
Columbus, Ohio 43215**

II. APPLICATION REQUIREMENTS AND FORMAT

Access to the on-line GMIS 2.0, will be provided after GMIS 2.0 training for those agencies requiring training. All others will receive access after the RFP is posted to the ODH Website.

All applications must be submitted via GMIS 2.0. Submission of all parts of the grant application via the ODH's GMIS 2.0 system indicates acceptance of ODH GAPP. Submission of the Application signifies authorization by an agency official and constitutes electronic acknowledgment and acceptance of GAPP rules and regulations in lieu of an executed Signature Page document.

- A. Application Information:** Information on the applicant agency and its administrative staff must be accurately completed. This information will serve as the basis for necessary communication between the agency and the ODH.
- B. Budget:** Prior to completion of the budget section, **please review pages 13 - 14 of the RFP for unallowable costs.**

A match of 7.7% is required to be submitted as Attachment # 13. It is to be a separate budget from the application budget entered into GMIS. The budget entered into GMIS is only to include the GRANT FUNDS requested. *Every subgrantee must submit Match documentation (Attachment # 13) based on ODH guidance by 4:00 P.M. Monday May 7, 2012.*

- 1. Primary Reason and Justification Pages:** Provide a detailed budget justification narrative that describes how the categorical costs are derived. Discuss the necessity, reasonableness, and allocability of the proposed costs. Describe the specific functions of the personnel, consultants and collaborators. Explain and justify equipment, travel, (including any plans for out-of-state travel), supplies and training costs. If you have joint costs refer to GAPP Chapter 100, Section 103 and the Compliance Section D (9) of the application for additional information.
- 2. Personnel, Other Direct Costs, Equipment and Contracts):** Submit a budget with these sections and form(s) completed as necessary to support costs for the period **August 10, 2012 to June 30, 2013.**

Funds may be used to support personnel, their training, travel (see OBM Web site) <http://obm.ohio.gov/MiscPages/TravelRule> and supplies directly related to planning, organizing and conducting the Initiative/program activity described in this announcement.

When appropriate, retain all contracts on file. The contracts should not be sent to ODH. A completed "Confirmation of Contractual Agreement" (CCA) form must be submitted via GMIS 2.0 for each contract once it has been signed by both parties. The submitted CCA must be approved by ODH before contractual expenditures are authorized.

Submission of the "Confirmation of Contractual Agreement" (CCA) via the ODH's GMIS 2.0 system indicates acceptance of ODH GAPP. Clicking the "Approve" button signifies authorization of the submission by an agency official and constitutes electronic acknowledgment and acceptance of GAPP rules and regulations. CCAs cannot be submitted until after the 1st quarter grant payment has been issued.

Where appropriate, itemize all equipment (**minimum \$300 unit cost value**) to be purchased with grant funds in the Equipment Section.

3. Compliance Section D: Answer each question on this form as accurately as possible. Completion of the form ensures your agency's compliance with the administrative standards of ODH and federal grants.

4. Funding, Cash Needs and Budget Summary Sections: Enter information about the funding sources and forecasted cash needs for the program. Distribution should reflect the best estimate of need by quarter. Failure to complete and balance this section will cause delays in receipt of grant funds.

C. Assurances Certification: Each subgrantee must submit the Assurances (Federal and State Assurances for Subgrantees) form. This form is submitted as a part of each application via GMIS 2.0. The Assurances Certification sets forth standards of financial conduct relevant to receipt of grant funds and is provided for informational purposes. The listing is not all-inclusive and any omission of other statutes does not mean such statutes are not assimilated under this certification. Review the form and then press the "Complete" button. By submission of an application, the subgrantee agency agrees by electronic acknowledgment to the financial standards of conduct as stated therein.

D. Project Narrative:

1. Executive Summary: Specific objectives for each public health preparedness capability have been determined by ODH. These objectives state what is to be achieved and cover the range of desired outcomes to achieve a goal.

2. Description of Applicant Agency/Documentation of Eligibility/Personnel: Briefly discuss the applicant agency's eligibility to apply. Summarize the agency's structure as it relates to this program.

Describe the capacity of your organization, its personnel or contractors to communicate effectively and convey information in a manner that is easily understood by diverse audiences. This includes persons of limited English proficiency, those who are not literate, have low literacy skills, and individuals with disabilities.

Note any personnel or equipment deficiencies that will need to be addressed in order to carry out this grant. Describe plans for hiring and training, as necessary. Delineate all personnel who will be directly involved in program activities. Include the relationship between program staff members, staff members of the applicant agency, and other partners and agencies that will be working on this program. Include position descriptions for these staff.

3. Problem/Need: Specific objectives for each public health preparedness capability have been determined by ODH and through work with AOHC. These objectives state what is to be

achieved and cover the range of desired outcomes to achieve a goal.

- 4. Methodology:** Specific objectives for each public health preparedness capability have been determined by ODH. These objectives state what is to be achieved and cover the range of desired outcomes to achieve a goal. List the specific activities, staff that will be responsible for implementing the activity and the date the activity will be complete. It is not acceptable to list “on-going” or “at the end of the grant period” for all Activities.

In addition; all applicants will comply with ODH/CDC PHEP Program Standards and Performance Measures. A special condition will be applied to any of these listed points that are not addressed in the Program Narrative and Program Plans. **One comprehensive program plan must be submitted by the applicant agency. Multiple program plans from the applicant agency and subcontractors are not acceptable. Insufficient responses or lack of progress in meeting requirements will adversely affect subgrantees’ current and future funding.** Please complete and submit your responses as well as the PHEP Program Plans via GMIS 2.0. The RPH applicants must submit their program plans using Attachment #11, via GMIS 2.0.

Public Health Emergency Preparedness (PHEP) Program Narrative

Core Leadership and Grant Administration

Goal: To develop and maintain public health capacity and achieve and maintain core leadership.

CL1. For counties with multiple local health departments, describe the following: which local health departments participate in PHEP and how; PHEP funding is distributed including if any LHD in the county does not receive PHEP funding; how PHEP information and updates from ODH or PHEP sub-grantee are shared; how PHEP related activities are coordinated between health departments to ensure that the entire county population is served.

CL2. Provide one or two examples of success stories or promising practices your PHEP project has had in your county/region within the last grant year (e.g. collaboration among several LHDs or other local agencies in terms of planning efforts, volunteer recruitment and training, use of interoperable communications, staff training and development, etc.).

CL3. Describe how you will meet Core Leadership requirements (full-time health commissioner and/or administrator, full-time environmental health director, and full-time nursing director) during the course of this grant year. In the event of a vacancy, describe the steps you will take to meet the requirement, including official notification of ODH in writing.

CL4. Describe how you provide public health medical direction (including backup), 24 hours a day, seven days a week.

CL5. For Agencies that are the administering agent for other jurisdictions, describe your method of monitoring the use and administration of PHEP funds. Provide a letter of support from agency head for which the subgrantee is applying for.

CL6. Provide a statement of assurance that the agencies Board of Health will provide preapproval to refund grant funds within 45 days of the end of the grant fiscal year.

CL7. Provide a statement of assurance that you will complete and submit Mid-Year Program Report by March 15, 2013 and End-of-Year Report by August 15, 2013.

CL8. Provide a statement of assurance that you will complete and submit an updated Attachment #13 with your End of the Year Report.

CL9. Provide a statement of assurance that your agency will participate in Regional Public Health planning efforts.

Capability: Community Preparedness

Goal: Community preparedness is the ability of communities to prepare for, withstand, and recover — in both the short and long terms — from public health incidents. By engaging and coordinating with emergency management, healthcare organizations (private and community-based), mental/behavioral health providers, community and faith-based partners, state, local, and territorial, public health's role in community preparedness is to do the following:

- *Support the development of public health, medical, and mental/behavioral health systems that support recovery*
- *Participate in awareness training with community and faith-based partners on how to prevent, respond to, and recover from public health incidents*
- *Promote awareness of and access to medical and mental/behavioral health resources that help protect the community's health and address the functional needs (i.e., communication, medical care, independence, supervision, transportation) of at-risk individuals*
- *Engage public and private organizations in preparedness activities that represent the functional needs of at-risk individuals as well as the cultural and socio-economic, demographic components of the community*
- *Identify those populations that may be at higher risk for adverse health outcomes*
- *Receive and/or integrate the health needs of populations who have been displaced*

CP1. Provide the number of community sectors (0-11) that you have identified as key organizations to participate in public health, medical, and/or mental/behavioral health-related emergency preparedness efforts.

CP2. Provide the number of community sectors (0-11) that you utilized during the development

of Hazard and Vulnerability Assessment (HVA) data to determine local hazards, vulnerabilities, and risks that may impact public health, medical, and/or mental/behavioral health systems and services.

CP3. Provide the number of key organizations (0-11) that engaged in a significant public health emergency preparedness activity.

CP4. Provide the number of community sectors (0-11) that engaged in developing and/or reviewing a community recovery plan related to the restoration and recovery of public health, medical, and/or mental/behavioral health systems and services.

Capability: Information Sharing

Goal: 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.

IS1. Provide assurance that you will maintain 75% confirmation on monthly Multi-Agency Radio Communication System (MARCS) unannounced radio checks.

Capability: Public Health Surveillance & Epidemiological Investigation

Goal: 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.

EPI1. Provide assurance that you will comply with the Performance Measures reports that are listed in **Appendix E. Sub-grantees will be responsible for the Performance Measures.**

EPI2. Provide assurance that you will report summary data with your Mid-Year and End of Year Program Reports generated from real infectious disease outbreak investigations and investigation reports for the following diseases via Ohio Disease Reporting System (ODRS) and National Outbreak Reporting System (NORS), as applicable.

- Botulism (Clostridium botulinum), all types **excluding** infant botulism (confirmed)
- E. coli (STEC) (all reports)
- Hepatitis A, Acute (confirmed)
- Measles (confirmed and probable)
- Meningococcal Disease (Neisseria meningitides) (confirmed)
- Tularemia (Francisella tulanensis) (confirmed and probable)

EPI3. Provide assurance that you will report with your Mid-Year and End of Year Program Reports selected reportable diseases for which initial public health control measures were initiated within the appropriate timeframe.

- Botulism (*Clostridium botulinum*), all types **excluding** infant botulism (confirmed)
- E. coli (STEC) (all reports)
- Hepatitis A, Acute (confirmed)
- Measles (confirmed and probable)
- Meningococcal Disease (*Neisseria meningitidis*) (confirmed)
- Tularemia (*Francisella tularensis*) (confirmed and probable)

EPI4. Provide assurance that you will report summary data with your Mid-Year and End of Year Program Reports generated from real infectious disease outbreak investigations and investigation reports only that contain all minimal elements. Include the following elements:

- Context/Background
- Initiation of Investigation,
- Investigation methods
- Investigation findings/results
- Discussion and/or conclusion
- Recommendations for controlling disease and/or preventing mitigating exposure
- Key investigators and/or report authors

EPI5. Provide assurance that you will report summary data with your Mid-Year and End of Year Program Reports generated from real environmental investigations and investigation reports only (no drills) via Ohio Disease Reporting System (ODRS) and National Outbreak Reporting System (NORS), as applicable.

EPI6. Provide assurance that you will report summary data with your Mid-Year and End of Year Program Reports generated from real environmental investigations and investigation reports only that contain all minimal elements.

Include the following elements:

- Context/Background
- Initiation of Investigation,
- Investigation methods
- Investigation findings/results
- Discussion and/or conclusion
- Recommendations for controlling disease and/or preventing mitigating exposure
- Key investigators and/or report authors

Capability: Medical Countermeasure Dispensing

Goal: 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.

CMD1. Submit via GMIS 2.0, a complete Local Technical Assistance Review (L-TAR) self-assessment with your application. Provide a statement of assurance that you will submit with your End of the Year Report, an L-TAR self-assessment describing areas which show improvement from your initial self-assessment submitted with the application.

CMD2. Describe how you will address the identified gaps in the SNS L-TAR throughout the grant year in order to achieve a minimum score of 69%. Provide a statement of assurance that you will submit an Improvement Plan with your Mid-Year Report. Include in the Improvement Plan the action steps you will utilize to achieve a minimum score of 69% on the SNS L-TAR.

CMD3. Provide assurance that you will complete a DSNS Rand Drill with documentation submitted via email to your PHEP consultant by May 1, 2013.

Regional Public Health Planning

Agencies applying for Regional Public Health planning funds must answer the following questions. All others disregard.

RPH1. Provide an overview and update of your regional coordination decision making body, and any of its workgroups/sub-committees, including the Public Health Planning Committee (sometimes referred to as Public Health Executive Steering Committee) and any Additional committees. Describe how often the committees meet, their reporting structures, membership, and decision-making process that ensures full participation of membership. In addition, provide the dates the committee(s) will meet during this grant period.

RPH2. Describe how you will maintain and strengthen your collaboration with Regional Hospital Coordinators (RHC), LHDs, county Emergency Management Agencies (EMAs) and hospitals across the region to reinforce the objectives underlying regional planning.

RPH3. Describe how your region will facilitate the development and use of a consistent communication method and decision process for Public Health to request from the state, via county EMA, medical materiel for any regional assets, dispensing sites, hospitals, or other healthcare facilities.

Cities Readiness Initiative

Current CRI agencies applying for Cities Readiness Initiative funds must answer the following questions. All others disregard.

CRI1. Describe how CRI funding is allocated among the health departments in the MSA,

ensuring a signoff by the leadership of all jurisdictions.

CRI2. Describe how the CRI subgrantee ensures that information is shared with the health departments in the MSA and how CRI activities are coordinated with the health departments in the MSA to ensure the CRI goals and objectives are met.

CRI3. Provide a statement of assurance indicating the subgrantee will facilitate a L-TAR self-assessment process with each CRI MSA in the region, and will submit the L-TAR self-assessment, and all supporting documentation, for each CRI MSA in the region, two weeks prior to the ODH or CDC assessments are completed.

CRI4. Provide a statement of assurance indicating the subgrantee will facilitate monthly meetings and/or conference calls with all CRI MSAs in the region to discuss collaboration, planning, and CRI goals/objectives/deliverables. Submit a schedule of the meeting dates no later than 30 days after receipt of the Notice of Award (NOA).

E. Civil Rights Review Questionnaire - EEO Survey: The Civil Rights Review Questionnaire (EEO) Survey is a part of the Application Section of GMIS 2.0. Subgrantees must complete the questionnaire as part of the application process. This questionnaire is submitted automatically with each application via the Internet.

F. Federal Funding Accountability and Transparency Act (FFATA Requirements)

The Federal Funding Accountability and Transparency Act (FFATA) was signed on September 26, 2006. The intent is to empower every American with the ability to hold the government accountable for each spending decision. ODH is required to report all subgrants receiving \$25,000 or more of federal funds. All applicants applying for ODH grant funds required to complete the FFATA Reporting Form. A sample of the FFATA Reporting Form is attached to this RFP.

All applicants for ODH grants are required to obtain a Data Universal Number System (DUNS) and a Central Contractor Registration Number (CCR) and submit the information in the grant application, Appendix B. For information about the DUNS, go to <http://fedgov.dnb.com/webform>. For information about CCR go to www.ccr.gov.

Information on Federal Spending Transparency can be located at www.USAspending.gov or the Office of Management and Budget's website for Federal Spending Transparency at www.whitehouse.gov/omb/open.

(Required by all applicants, the FFATA form is located on the GMIS 2.0 Application Page and must be completed in order to submit the application.)

- G. Electronic Funds Transfer (EFT) Form:** Print in PDF format and mail to ODH, Grants Services Unit, Central Master Files address. The completed EFT form **must be** dated and signed, in blue ink, with original signatures. Submit the original and one copy. **(Required only if new agency, thereafter only when banking information has changed.)**
- H. Internal Revenue Service (IRS) W-9 and Vendor Forms:** Print in PDF format and mail to ODH, Grants Services Unit, Central Master Files address. The completed IRS W-9 form **must be** dated and signed, in blue ink, with original signatures. Submit the original and one copy. **(Required if new agency, thereafter only when tax identification number or agency address information has changed.) One of the following forms must accompany the IRS, W-9:**
1. **Vendor Information Form (New Agency Only), or**
 2. **Vendor Information Change Form (Existing Agency with tax identification number, name and/or address change(s).)**
 3. **Change request in writing on Agency letterhead (Existing Agency with tax identification number, name and/or address change(s).)**
- Print in PDF format and mail to ODH, Grants Services Unit, Central Master Files address. The completed appropriate Vendor Form **must be** dated and signed, in blue ink, with original signatures. Submit the original and one copy of each.
- I. Public Health Impact Statement Summary:** Submit two copies of a one-page program summary regarding the impact to proposed grant activities on the Local Health Districts Improvement Standards **(for competitive cycle only; for continuation, only if changed).**
- J. Public Health Impact & Intent to Pursue Health Equity Statements:** Submit two copies of the response/statement(s) of support from the local health district(s) to your agency's communication regarding the impact of the proposed grant activities on the PHAB Standards and Intent to Pursue Health Equity Statements. If a statement of support from the local health district is not available, indicate that and submit a copy of the program summary your agency forwarded to the local health district(s) **(for competitive cycle only; for continuation, only if changed).**
- K. Liability Coverage:** Liability coverage is required for all non-profit agencies. Non-profit organizations **must** submit documentation validating current liability coverage. Submit two copies of the Certificate of Insurance Liability **(Non-Profit Organizations only; current liability coverage and thereafter at each renewal period.)**
- L. Non-Profit Organization Status:** Non-profit organizations **must** submit documentation validating current status. Submit two copies of the Internal Revenue Services (IRS) letter approving non-tax exempt status **(Non-Profit Organizations only; for competitive cycle only; for continuation, only if changed.)**
- M. Declaration Regarding Material Assistance/Non-Assistance to a Terrorist Organization (DMA)**

Questionnaire: The DMA is a questionnaire that must be completed by all non-governmental grant applicant agencies to certify that they have not provided “material assistance” to a terrorist organization (Sections 2909.32, 2909.33 and 2909.34 of the Ohio Revised Code). The completed DMA Questionnaire **must be** dated and signed, in blue ink, with the Agency Head’s signature. The DMA Questionnaire (in PDF format. Adobe Acrobat is required) is located at the Ohio Department of Public Safety /Ohio Homeland Security website:

<http://www.publicsafety.ohio.gov/links/HLS0038.pdf>

- Print a hard copy of the form once it has been downloaded. The form must be completed in its entirety and your responses must be truthful to the best of your knowledge. **(Required by all Non-Governmental Applicant Agencies.)**

N. Attachment(s): Attachments are documents deemed necessary to the application that are not a part of the GMIS 2.0 system. Attachments that are non-Internet compatible must be postmarked or received on or before the application due date. An original and the required number of copies of non-Internet compatible attachments must be mailed to the ODH, Grants Services Unit Central Master Files address by **4:00 P.M.** on or before **Monday May 7, 2012**. All attachments must clearly identify the authorized program name and program number.

Attachments Required by Program:

- Attachment #1: Local Health Department Contact Information
- Attachment #2: Public Health Emergency Preparedness Program Plan Instructions
- Attachment #3: Community Preparedness
- Attachment #4: Community Recovery
- Attachment #5: Information Sharing
- Attachment #6: Public Health Surveillance & Epidemiology Investigation
- Attachment #7: Emergency Public Information and Warning
- Attachment #8: Medical Countermeasure Dispensing
- Attachment #9:
 - Medical Material Management and Distribution
- Attachment #10: Medical Surge
- Attachment #11: Regional Public Health Planning
- Attachment #12: Cities Readiness Initiative
- Attachment #13: Public Health Emergency Preparedness (PHEP) Match Requirement
- Attachment #14: Public Health Emergency Preparedness (PHEP) Budget Worksheet
- Attachment #15: Strategic National Stockpile Drill, Exercise and After Action Report
- Attachment #16: Epidemiology Surveillance Performance Measures
- Attachment #17: Optional “Required Elements”

III. APPENDICES

A. GMIS 2.0 Training Form

- B.** FFATA Reporting Form (SAMPLE ONLY)
- C.** Application Review Form
- D.** Ohio Homeland Security Planning Regions Map
- E.** Public Health Surveillance and Epidemiological Investigation Performance Measures
- F.** Community Preparedness Performance Measures
- G.** PHEP Subgrant Fiscal Penalty Withholding Guidance Document
- H.** Public Health Emergency Preparedness Grant Funding (estimated)
- I.** Notice of Intent to Apply for Funding (NOIAF)

Local Health Department Contact Information

(Submitted to ODH via GMIS)

1. List all LHDs within the county and designate if they participate in or receive support from the PHEP grant.

LHD (Name and Address)	Participate in PHEP Efforts	Receive PHEP Funds or Resources

2. Core leadership contact information:

Contact	Health Commissioner	Administrator	Director of Environmental Health	Director of Nursing
% of Time				
Name:				
Address:				
Office:				
Fax:				
Cell:				
Pager:				
E-mail:				

3. For all local health departments (other than the PHEP subgrantee) within your county, please identify the leadership (copy and paste tables as many times as needed):

Contact	Primary	Back-Up
LHD(s) Served		
Name:		

Address:		
Office:		
Fax:		
Cell:		
Pager:		
E-mail:		

4. For all local health departments covered by this application, please identify the lead contact for each of the following:

Contact	Program Director	Emergency Response Coordinator	Fiscal Officer
LHD(s) Served			
Name:			
Address:			
Phone:			
Fax:			
Cell:			
Pager:			
E-mail:			

Contact	Public Information Officer (Primary)	Public Information Officer (Secondary)
LHD(s) Served		
Name:		
Address:		
Phone:		
Fax:		
Cell:		
Pager:		
E-mail:		

5. Provide information regarding your health department(s) coordination of response plans with health care facilities as it relates to surveillance, epidemiologic investigation, and mass prophylaxis.

(a) List the number of health care facilities are there within your jurisdiction

Hospitals with EDs	
Hospitals without EDs	
Urgent Care Centers	
Free Clinics	
Other, please describe:	

(b) List the primary contact at these facilities

Type of Facility	Title

6. The designated epidemiologist(s) will be expected to participate in the quarterly statewide epidemiology meetings. List the designated epidemiologists in the table below. *(Grant requirement is one (1) Tier 1 FTE epidemiologist for an area less than or equal to 300,000 population. Please see attachment #6 for additional information on the Tier designation. Preferably, the Tier 1 FTE epidemiologist is one staff member; if this position is made up of multiple individuals, for the first 1.0 FTE required to meet this staff-to-population ratio, each individual must commit a minimum of 50% of his/her time to epidemiology and surveillance activities. There will be at least one (1) Tier 2 epidemiologist available for consultation to the Tier 1 epidemiologist. Complete table below. Repeat the table if you need more space).*

	Tier 1 or 2	Tier 1 or 2	Tier 2
LHDs Served:			
Percentage time:			
Name:			
Work Address:			
Office:			
Fax:			
Cell:			

Pager:			
E-mail:			
Total Population:			
MPH or MS in Public Health Yes/No Date			
Continuing education contact hours during the past 12 months			
If the epidemiologist does not hold an MPH or MS in Public Health, name of basic epidemiology class and date completed			
If the epidemiologist does not hold an MPH or MS in Public Health, name of graduate course in epidemiology or statistics and date completed			

Complete for each jurisdiction covered under this application; provide information that ODH can use to directly contact the person on-call after business hours:

	Class A Reporting Number during Business Hours	Class A Reporting Number after Business Hours
LHD:		
Phone:		
Cell:		
Pager/Other (explain):		

Complete the table below.

	Public Health Medical Director available 24/7	Back-up Public Health Medical Director available 24/7
LHDs served:		
Name:		
Work address:		
Office:		
Fax:		
Cell:		
Pager:		
E-mail:		

7. For all local health departments within your county, please identify the MARCS contact person (copy and paste tables as many times as needed):

Contact	MARCS Primary	MARCS Back-Up
LHD(s) Served		
Name:		
Address:		
Office:		
Fax:		
Cell:		
Pager:		
E-mail:		

8. For all local health departments within your county, please identify the OPHCS contact person (copy and paste tables as many times as needed):

Contact	OPHCS Primary	OPHCS Back-Up
LHD(s) Served		
Name:		
Address:		
Office:		
Fax:		
Cell:		
Pager:		
E-mail:		

9. Each PHEP Subgrantee must identify an OhioTRAIN coordinator who will serve as the administrator for OhioTRAIN, a Learning Management System for Public Health Training. The OhioTRAIN Coordinator will be responsible for all the local health departments covered by this application. Please complete the table below.

Contact Information for the OhioTRAIN Coordinator
Name
Title
Agency
LHDs Served
E-mail
Phone Number

10. CRI Applicants ONLY - For all CRI MSAs, please identify the CRI contact person:

Contact	CRI Primary	CRI Back-Up
LHD(s) Served		
Name:		
Address:		
Office:		
Fax:		
Cell:		
Pager:		
E-mail:		

Public Health Emergency Preparedness Program Plan Instructions

Outcome: The outcomes were derived from the Public Health Preparedness Capabilities: National Standards for State and Local Planning, March 2011, CDC. **One comprehensive program plan must be submitted by the applicant agency. Multiple program plans from the applicant agency and subcontractors are not acceptable.**

Objective: Specific objectives for each public health preparedness capability have been determined by ODH. These objectives state what is to be achieved and cover the range of desired outcomes to achieve a goal.

Activities: List the specific Activities proposed that will be done to implement each public health preparedness capability.

Person Responsible: List the staff that will be responsible for implementing the specific Activities.

Timeline: Indicate the date the Activities will be completed or accomplished. It is not acceptable to list “on-going” or “at the end of the grant period” for all Activities.

Benchmarks/Evaluation Measures: Specific Benchmarks/Evaluation Measures for each public health preparedness capability have been determined by ODH. The Benchmarks/Evaluation Measures describe how the Objectives will be measured and evaluated.

Progress/Accomplishments: The Progress/Accomplishments column on the program plans is not due at the time of the grant submission. A description of Progress/Accomplishments is due at two times. A mid-year Progress Report must be submitted via GMIS by March 15, 2013. An Annual Progress Report (APR) that uses PHEP Program Plan must be submitted via GMIS by August 15, 2013. These reports should describe the overall progress, including results to date and comparison of actual accomplishments with proposed goals for the period, any current problems or favorable or unusual developments, and work to be performed during the succeeding period. It is not acceptable to state “in progress”.

Program Grant Number: _____

ATTACHMENT #3

Public Health Emergency Preparedness Program Plan

Initial Program Plan Midyear Program Report End of the Year Report

Capability: Community Preparedness

Outcome: Community preparedness is the ability of communities to prepare for, withstand, and recover — in both the short and long terms — from public health incidents.¹ By engaging and coordinating with emergency management, healthcare organizations (private and community-based), mental/behavioral health providers, community and faith-based partners, state, local, and territorial, public health’s role in community preparedness is to do the following: Support the development of public health, medical, and mental/behavioral health systems that support recovery, participate in awareness training with community and faith-based partners on how to prevent, respond to, and recover from public health incidents, promote awareness of and access to medical and mental/behavioral health² resources that help protect the community’s health and address the functional needs (i.e., communication, medical care, independence, supervision, transportation) of at-risk individuals, engage public and private organizations in preparedness activities that represent the functional needs of at-risk individuals as well as the cultural and socio-economic, demographic components of the community, identify those populations that may be at higher risk for adverse health outcomes, Receive and/or integrate the health needs of populations who have been displaced due to incidents that have occurred in their own or distant communities (e.g., improvised nuclear device or hurricane)

Objective	Activities	Person Responsible	Timeline	Benchmarks/ Evaluation Measures	Progress/Accomplishments
<p><i>The objectives are provided by ODH guidance.</i></p> <p><i>The applicant must address all of the objectives associated with each target capability.</i></p>	<p><i>List the specific Activities proposed that will be done to implement each Objective.</i></p>	<p><i>List the staff that will be responsible for implementing the specific Activities</i></p>	<p><i>Indicate the date the Activities will be completed or accomplished.</i></p> <p><i>It is not acceptable to list “ongoing” or “at end of grant period” for all Activities.</i></p>	<p><i>The Benchmarks/Evaluation Measures describe how the Objectives will be measured and evaluated.</i></p> <p><i>Each Objective has Benchmark/Evaluation Measures associated with it. All Benchmarks/ Evaluation Measures associated with an objective must be addressed.</i></p>	<p><i>The Progress/Accomplishments column on the program plan is not due at the time of the grant submission.</i></p> <p><i>A description of the Progress/Accomplishments is due with the mid-year and Annual Progress Reports.</i></p> <p><i>The reports should describe the overall progress, including results to date and comparison of actual accomplishments with proposed goals for the period, any current problems or favorable or unusual developments, and work to be performed during the succeeding period.</i></p> <p><i>It is not acceptable to state “in progress”.</i></p>
Applicant completes this section					
<p>LHD develops plans to participate in coalition with the 11 community sectors.</p>				<ul style="list-style-type: none"> Written plans should include a policy and process to participate in existing (e.g., led by emergency management) or new partnerships representing at least the following 11 community sectors:¹⁴ business; community leadership; cultural and faith-based groups and organizations; emergency management; healthcare; social services; housing and sheltering; media; mental/behavioral health; state office of aging or its equivalent; education and childcare settings.¹⁵ 	

Objective	Activities	Person Responsible	Timeline	Benchmarks/ Evaluation Measures	Progress/Accomplishments
LHD solicits public comment on plans.				<ul style="list-style-type: none"> Written plans should include a process to provide mechanisms (e.g., town hall meetings, websites) to obtain public input. 	

Program Grant Number: _____

ATTACHMENT #4

Public Health Emergency Preparedness Program Plan

Initial Program Plan Midyear Program Report End of the Year Report

Capability: Community Recovery

Outcome: 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.

Objective	Activities	Person Responsible	Timeline	Benchmarks/ Evaluation Measures	Progress/Accomplishments
<p><i>The objectives are provided by ODH guidance.</i></p> <p><i>The applicant must address all of the objectives associated with each target capability.</i></p>	<p><i>List the specific Activities proposed that will be done to implement each Objective.</i></p>	<p><i>List the staff that will be responsible for implementing the specific Activities</i></p>	<p><i>Indicate the date the Activities will be completed or accomplished.</i></p> <p><i>It is not acceptable to list “ongoing” or “at end of grant period” for all Activities.</i></p>	<p><i>The Benchmarks/Evaluation Measures describe how the Objectives will be measured and evaluated.</i></p> <p><i>Each Objective has Benchmark/Evaluation Measures associated with it. All Benchmarks/ Evaluation Measures associated with an objective must be addressed.</i></p>	<p><i>The Progress/Accomplishments column on the program plan is not due at the time of the grant submission.</i></p> <p><i>A description of the Progress/Accomplishments is due with the mid-year and Annual Progress Reports.</i></p> <p><i>The reports should describe the overall progress, including results to date and comparison of actual accomplishments with proposed goals for the period, any current problems or favorable or unusual developments, and work to be performed during the succeeding period.</i></p> <p><i>It is not acceptable to state “in progress”.</i></p>

Objective	Activities	Person Responsible	Timeline	Benchmarks/ Evaluation Measures	Progress/Accomplishments
Applicant completes this section					
LHD maintains a written NIMS compliant Public Health Continuity of Operations Plan.				<p>Written plans should include the following elements (either as a stand-alone Public Health Continuity of Operations Plan or as a component of another plan):</p> <ul style="list-style-type: none"> • Definitions and identification of essential services needed to sustain agency mission and operations • Plans to sustain essential services regardless of the nature of the incident (e.g., all-hazards planning) • Scalable work force reduction • Limited access to facilities (social distancing, staffing or security concerns) • Broad-based implementation of social distancing policies if indicated • Positions, skills and personnel needed to continue essential services and functions (Human Capital Management) • Identification of agency vital records (legal documents, payroll, staff assignments) that support essential functions and/or that must be preserved in an incident • Alternate worksites • Devolution of uninterruptible services for scaled down operations • Reconstitution of uninterruptible services 	

Program Grant Number: _____

Public Health Emergency Preparedness Program Plan

Initial Program Plan Midyear Program Report End of the Year Report

Capability: Information Sharing

Outcome: 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.

Objective	Activities	Person Responsible	Timeline	Benchmarks/ Evaluation Measures	Progress/Accomplishments
<p><i>The objectives are provided by ODH guidance.</i></p> <p><i>The applicant must address all of the objectives associated with each target capability.</i></p>	<p><i>List the specific Activities proposed that will be done to implement each Objective.</i></p>	<p><i>List the staff that will be responsible for implementing the specific Activities</i></p>	<p><i>Indicate the date the Activities will be completed or accomplished.</i></p> <p><i>It is not acceptable to list “ongoing” or “at end of grant period” for all Activities.</i></p>	<p><i>The Benchmarks/Evaluation Measures describe how the Objectives will be measured and evaluated.</i></p> <p><i>Each Objective has Benchmark/Evaluation Measures associated with it. All Benchmarks/ Evaluation Measures associated with an objective must be addressed.</i></p>	<p><i>The Progress/Accomplishments column on the program plan is not due at the time of the grant submission.</i></p> <p><i>A description of the Progress/Accomplishments is due with the mid-year and Annual Progress Reports.</i></p> <p><i>The reports should describe the overall progress, including results to date and comparison of actual accomplishments with proposed goals for the period, any current problems or favorable or unusual developments, and work to be performed during the succeeding period.</i></p> <p><i>It is not acceptable to state “in progress”.</i></p>

Objective	Activities	Person Responsible	Timeline	Benchmarks/ Evaluation Measures	Progress/Accomplishments
Applicant completes this section					
LHD maintains a written role-based public health directory for public health alert messaging				<ul style="list-style-type: none"> • Written plans should include a role-based public health directory that will be used for public health alert messaging. • The directory profile of each user includes the following elements: <ul style="list-style-type: none"> ○ Assigned roles ○ Multiple device contact information ○ Organizational affiliation • Suggested resource <ul style="list-style-type: none"> ○ CDC’s Public Health Information Network: www.cdc.gov/phn <p>Ohio Note:</p> <ul style="list-style-type: none"> • 75% of LHD staff confirm OPHCS high (60 minutes), medium (24 hours), and low (72 hours) priority alerts within the timeframe indicated by ODH/CDC guidelines • 100% of OPHCS user’s change their password, update, and save profile every 60 days. 	
LHD will develop public health alert messages.				<ul style="list-style-type: none"> • Written plans should include a protocol for the development of public health alert messages that include the following elements: <ul style="list-style-type: none"> ○ Time sensitivity of the information ○ Relevance to public health ○ Target audience ○ Security level or sensitivity ○ The need for action may include <ul style="list-style-type: none"> ▪ Awareness ▪ Request a response back ▪ Request that specific actions be taken 	

Program Grant Number: _____

Public Health Emergency Preparedness Program Plan

Initial Program Plan Midyear Program Report End of the Year Report

Capability: Public Health Surveillance and Epidemiological Investigation

Outcome: 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.

Objective	Activities	Person Responsible	Timeline	Benchmarks/ Evaluation Measures	Progress/Accomplishments
<p><i>The objectives are provided by ODH guidance.</i></p> <p><i>The applicant must address all of the objectives associated with each target capability.</i></p>	<p><i>List the specific Activities proposed that will be done to implement each Objective.</i></p>	<p><i>List the staff that will be responsible for implementing the specific Activities</i></p>	<p><i>Indicate the date the Activities will be completed or accomplished. It is not acceptable to list “ongoing” or “at end of grant period” for all Activities.</i></p>	<p><i>The Benchmarks/ Evaluation Measures describe how the Objectives will be measured and evaluated.</i></p> <p><i>Each Objective has Benchmark/Evaluation Measures associated with it.</i></p> <p><i>All Benchmarks/ Evaluation Measures associated with an objective must be addressed.</i></p>	<p><i>The Progress/Accomplishments column on the program plan is not due at the time of the grant submission.</i></p> <p><i>A description of the Progress/Accomplishments is due with the mid-year and Annual Progress Reports.</i></p> <p><i>The reports should describe the overall progress, including results to date and comparison of actual accomplishments with proposed goals for the period, any current problems or favorable or unusual developments, and work to be performed during the succeeding period.</i></p> <p><i>It is not acceptable to state “in progress”.</i></p>
Applicant completes this section					

Objective	Activities	Person Responsible	Timeline	Benchmarks/ Evaluation Measures	Progress/Accomplishments
Develop or maintain documented legal and procedural framework for information exchange.				<ul style="list-style-type: none"> • Written plans should document the legal and procedural framework that supports mandated and voluntary information exchange with a wide variety of community partners, including those serving communities of color and tribes. <p>Ohio Note:</p> <ul style="list-style-type: none"> • Local health departments (LHD) maintain administrative control for granting their own LHD staff access to the Ohio Disease Reporting System (ODRS) and the National Retail Data Monitor (NRDM). Access to the National Outbreak Reporting System (NORS) and EpiCenter is maintained by ODH. 	
Develop or maintain protocols for accessing health information that protects personal health information.				<ul style="list-style-type: none"> • Written plans should include processes and protocols for accessing health information that follow jurisdictional and federal laws and that protect personal health information via instituting security and confidentiality policies. 	
LHD will develop or maintain protocols to gather and analyze surveillance data.				<ul style="list-style-type: none"> • Written plans should include processes and protocols to gather and analyze data from the following: <ul style="list-style-type: none"> ○ Reportable condition surveillance (i.e., conditions for which jurisdictional law mandates name-based case reporting to public health agencies). Jurisdictions should plan to receive Electronic Laboratory Reporting for reportable conditions from healthcare providers using national Meaningful Use standards. Syndromic surveillance systems. Jurisdictions are encouraged to establish or participate in such systems to monitor trends of illness or injury, and to provide situational awareness of healthcare utilization <ul style="list-style-type: none"> i. Participation in 	

Objective	Activities	Person Responsible	Timeline	Benchmarks/ Evaluation Measures	Progress/Accomplishments
				<p>the CDC BioSense data-sharing program is encouraged (For additional or supporting detail, see Capability 6: Information Sharing)</p> <ul style="list-style-type: none"> ○ Surveillance of major causes of mortality, including the use of vital statistics as a data source (For additional or supporting detail, see Capability 5: Fatality Management) ○ Surveillance of major causes of morbidity <ul style="list-style-type: none"> i. Suggested Resource: Natural Disaster Morbidity Surveillance Individual Form: http://www.bt.cdc.gov/disasters/surveillance/pdf/NaturalDisasterMorbiditySurveillanceIndividualForm.pdf ○ Written plans should be able to adapt to include novel and/or emerging public health threats. ● Gathering and analyzing data from the following sources should also be taken into consideration: <ul style="list-style-type: none"> ○ Environmental conditions ○ Hospital discharge abstracts ○ Information from mental/behavioral health agencies 	

Objective	Activities	Person Responsible	Timeline	Benchmarks/ Evaluation Measures	Progress/Accomplishments
				<ul style="list-style-type: none"> ○ Population-based surveys ○ Disease registries ○ Immunization registries/Immunization information systems ○ Active case finding (e.g., by healthcare logs and record reviews) (For additional or supporting detail, see Capability 1: Community Preparedness, Capability 6: Information Sharing, and Capability 10: Medical Surge) <p>Ohio Note:</p> <ul style="list-style-type: none"> ● Ohio Administrative Code (e.g. 3701-3) describes notifiable diseases and the timeframe for reporting. ODH coordinates Electronic Laboratory Reporting (ELR) for Ohio. ● Local health department staff use and monitor EpiCenter and the NRDM information systems to investigate alerts and to determine the appropriate course of public health intervention. ● According to national standards, Ohio must maintain one regularly reporting influenza sentinel provider per 250,000 population. ● For enteric infectious diseases, the suggested resource in Ohio is the Hypothesis Generating Questionnaire: http://www.odh.ohio.gov/pdf/IDCM/frmhgq.pdf ● The minimum dataset for reportable conditions is considered complete when the following variables are present: age, race, ethnicity, sex, county/jurisdiction and onset date (where applicable). In addition, timeliness of reporting will be assessed by measuring reporting lag. 	
LHD has procedures to ensure 24/7/365 health department access.				<ul style="list-style-type: none"> ● Written plans should include procedures to ensure 24/7 health department access (e.g., designated phone line or contact person in place to receive 	

Objective	Activities	Person Responsible	Timeline	Benchmarks/ Evaluation Measures	Progress/Accomplishments
				<p>reports) to collect, review, and respond to reports of potential health threats. (For additional or supporting detail, see Capability 3: Emergency Operations Coordination)</p> <p>Ohio Note:</p> <ul style="list-style-type: none"> This refers to Class A reporting and other calls of urgent health consequence. 	
<p>LHD has protocols to notify cases on the Nationally Notifiable Infectious Disease List</p>				<ul style="list-style-type: none"> Written plans should include processes and protocols to notify CDC of cases on the Nationally Notifiable Infectious Disease List within the time frame identified on the list, including immediate notification when indicated. Electronic exchange of personal health information should meet applicable patient privacy-related laws and standards, including state or territorial laws. These include the Health Insurance Portability and Accountability Act, the Health Information Technology for Economic and Clinical Health Act, and standards from the National Institute of Standards and Technology and the Office of the National Coordinator for Health Information Technology of the U.S. Department of Health and Human Services. Plans should include procedures to move to electronic case notification using CDC’s Public Health Information Network Case Notification Message Mapping Guides. <ul style="list-style-type: none"> Suggested resource Case Notification Message Mapping Guides: http://www.cdc.gov/phin/resources/guides/mmghomepagecasenotification.html <p>Ohio Note:</p> <ul style="list-style-type: none"> Local health departments report via ODRS or phone according to Ohio Administrative Code 3701-3. ODH is responsible for reporting 	

Objective	Activities	Person Responsible	Timeline	Benchmarks/ Evaluation Measures	Progress/Accomplishments
				<p>nationally notifiable infectious diseases to CDC.</p> <ul style="list-style-type: none"> The National Outbreak Reporting System (NORS) must be completed and closed no later than 60 days from the close of the investigation. 	
<p>LHD epidemiologist has at a minimum the Tier 1 Competencies and Skills for Applied Epidemiologists in Governmental Public Health Agencies.</p>				<ul style="list-style-type: none"> Public health staff conducting data collection, analysis, and reporting in support of surveillance and epidemiologic investigations should achieve, at a minimum, the Tier 1 Competencies and Skills for Applied Epidemiologists in Governmental Public Health Agencies. <ul style="list-style-type: none"> When creating new surveillance systems, consideration should be given to securing assistance (e.g., from academic institutions or state-level staff) from individuals with Tier 2 Competencies and Skills for Applied Epidemiologists in Governmental Public Health Agencies. Note: Formal educational degree requirement and masters' degree supervision requirement as specified in the link below. Suggested resources <ul style="list-style-type: none"> Tier 1 Competencies and Skills for Applied Epidemiologists in Governmental Public Health Agencies: http://www.cste.org/dnn/Portals/0/AEC_Summary_Tier1.pdf Tier 2 Competencies and Skills for Applied Epidemiologists in Governmental Public Health 	

Objective	Activities	Person Responsible	Timeline	Benchmarks/ Evaluation Measures	Progress/Accomplishments
				<p>Agencies: http://www.cste.org/dnn/Portals/0/AEC_Summary_Tier2.pdf</p> <p>Ohio Note:</p> <ul style="list-style-type: none"> One (1) Tier 1 FTE epidemiologist will cover an area less than or equal to 300,000 population. Additionally, there will be at least one (1) Tier 2 epidemiologist available for consultation to the Tier 1 epidemiologist. Preferably, the FTE Tier 1 epidemiologist is one staff member; if this position is made up of multiple individuals, for the first 1.0 FTE required to meet this staff-to-population ratio, each individual must commit a minimum of 50% of his/her time to epidemiology and surveillance activities. 	
LHD have access to health information infrastructure and surveillance systems				<ul style="list-style-type: none"> Have or have access to health information infrastructure and surveillance systems that are able to accept, process, analyze, and share data for surveillance and epidemiological investigation activities. (For additional or supporting detail, see Capability 6: Information Sharing) <ul style="list-style-type: none"> Electronic exchange of personal health information should meet applicable patient privacy-related laws and standards, including state or territorial laws. These include the Health Insurance Portability and Accountability Act, the Health Information Technology for Economic and Clinical Health Act, and standards from the National Institute of Standards and Technology and the Office of the National Coordinator for Health Information Technology of the U.S. Department of Health and Human Services. (For additional or 	

Objective	Activities	Person Responsible	Timeline	Benchmarks/ Evaluation Measures	Progress/Accomplishments
				<p>supporting detail, see Capability 6: Information Sharing)</p> <p>Ohio Note: Surveillance and health information systems include but are not limited to: ODRS, EpiCenter, NRDM, Ohio Public Health Communication System (OPHCS), Ohio Situational Awareness Portal (OSAP), NORS, BioSense, U.S. Outpatient Influenza-like Illness Surveillance Network (ILINet), Epi-X.</p>	
LHD develops investigation report templates.				<ul style="list-style-type: none"> • Written plans should include investigation report templates that contain the following minimal elements: <ul style="list-style-type: none"> ○ Context / Background – Information that helps to characterize the incident, including the following: <ul style="list-style-type: none"> i. Population affected (e.g., estimated number of persons exposed and number of persons ill) ii. Location (e.g., setting or venue) iii. Geographical area(s) involved iv. Suspected or known etiology ○ Initiation of Investigation – Information regarding receipt of notification and initiation of the investigation, including the following: <ul style="list-style-type: none"> i. Date and time initial notification was received by the agency ii. Date and time investigation was initiated by the agency ○ Investigation Methods - Epidemiological or other 	

Objective	Activities	Person Responsible	Timeline	Benchmarks/ Evaluation Measures	Progress/Accomplishments
				<p>investigative methods employed, including the following:</p> <ul style="list-style-type: none"> i. Any initial investigative activity (e.g., verified laboratory results) ii. Data collection and analysis methods (e.g., case-finding, cohort/case-control studies, environmental) iii. Tools that were relevant to the investigation (e.g., epidemic curves, attack rate tables, and questionnaires) iv. Case definitions (as applicable) v. Exposure assessments and classification vi. Review of reports developed by first responders, lab testing of environmental media, reviews of environmental testing records, industrial hygiene assessments, questionnaires <ul style="list-style-type: none"> ○ Investigation Findings/Results - all pertinent investigation results, including the following: <ul style="list-style-type: none"> i. Epidemiological results ii. Laboratory results (as applicable) iii. Clinical results (as applicable) iv. Other analytic findings (as applicable) 	

Objective	Activities	Person Responsible	Timeline	Benchmarks/ Evaluation Measures	Progress/Accomplishments
				<ul style="list-style-type: none"> ○ Discussion and/or Conclusions – analysis and interpretation of the investigation results, and/or any conclusions drawn as a result of performing the investigation. In certain instances, a Conclusions section without a Discussion section may be sufficient ○ Recommendations for Controlling Disease and/or Preventing/Mitigating Exposure – specific control measures or other interventions recommended for controlling the spread of disease or preventing future outbreaks and/or for preventing/mitigating the effects of an acute environmental exposure ○ Key investigators and/or report authors – names and titles are critical to ensure that lines of communication with partners, clinicians ,and other stakeholders can be established. <p>Ohio Note:</p> <ul style="list-style-type: none"> ● Utilize local jurisdictional epidemiologic response plans and outbreak report templates. ● Outbreak reports for enteric, foodborne, person-to-person, zoonotic, waterborne, and other outbreaks are entered into NORS within 30 days for all initial reports received and closed within 90 days according to national standards. 	
LHD maintains staffing capacity to manage the routine and surge epidemiological investigations				<ul style="list-style-type: none"> ● Maintain staffing capacity to manage the routine epidemiological investigation systems at the jurisdictional level as well as to support surge epidemiological investigations in response to natural or intentional threats or incidents. This is accomplished through the following: 	

Objective	Activities	Person Responsible	Timeline	Benchmarks/ Evaluation Measures	Progress/Accomplishments
				<ul style="list-style-type: none"> ○ Surge staff should be competent in Tier 1 Competencies and Skills for Applied Epidemiologists in Governmental Public Health Agencies ○ Consideration should be given to securing assistance (e.g., academic institutions or state-level staff) from an individual with Tier 2 Competencies and Skills for Applied Epidemiologists in Governmental Public Health Agencies ○ Note: Formal educational degree requirement and masters’ degree supervision requirement as specified in the link below. ● Suggested resources <ul style="list-style-type: none"> ○ Tier 1 Competencies and Skills for Applied Epidemiologists in Governmental Public Health Agencies: http://www.cste.org/dnn/Portals/0/AEC_Summary_Tier1.pdf ○ Tier 2 Competencies and Skills for Applied Epidemiologists in Governmental Public Health Agencies: http://www.cste.org/dnn/Portals/0/AEC_Summary_Tier2.pdf ○ (For additional or supporting detail, see Capability 15: Volunteer Management) <p>Ohio Note:</p> <ul style="list-style-type: none"> ● The requirement is at least one Tier 2 epidemiologist available for consultation to the Tier 1 epidemiologist. Identify the Tier 2 	

Objective	Activities	Person Responsible	Timeline	Benchmarks/ Evaluation Measures	Progress/Accomplishments
<p>LHD develops protocols for recommending and initiating, if indicated, containment and mitigation actions in response to public health incidents</p>				<p>epidemiologist in Attachment #1.</p> <ul style="list-style-type: none"> • Written plans should include protocols for recommending and initiating, if indicated, containment and mitigation actions in response to public health incidents. Protocols include case and contact definitions, clinical management of potential or actual cases, the provision of medical countermeasures, and the process for exercising legal authority for disease, injury, or exposure control. Protocols should include consultation with the state or territorial epidemiologist when warranted. <ul style="list-style-type: none"> ○ (For additional or supporting detail, see Capability 8: Medical Countermeasure Dispensing and Capability 11: Non-Pharmaceutical Interventions) <p>Ohio Note:</p> <ul style="list-style-type: none"> • Ensure protocols are in place to track notification of disease occurrence and the date/time of initial investigation. • Written public health recommendations and interventions shall be shared within 6 hours of identification of the agent. • If necessary, a health alert shall be distributed via OPHCS within 12 hours of an actual investigation or positive test result. 	

Program Grant Number: _____

Public Health Emergency Preparedness Program Plan

Initial Program Plan Midyear Program Report End of the Year Report

Capability: Emergency Public Information and Warning

Outcome: 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.

Objective	Activities	Person Responsible	Timeline	Benchmarks/ Evaluation Measures	Progress/Accomplishments
<p><i>The objectives are provided by ODH guidance.</i></p> <p><i>The applicant must address all of the objectives associated with each target capability.</i></p>	<p><i>List the specific Activities proposed that will be done to implement each Objective.</i></p>	<p><i>List the staff that will be responsible for implementing the specific Activities</i></p>	<p><i>Indicate the date the Activities will be completed or accomplished.</i></p> <p><i>It is not acceptable to list “ongoing” or “at end of grant period” for all Activities.</i></p>	<p><i>The Benchmarks/Evaluation Measures describe how the Objectives will be measured and evaluated.</i></p> <p><i>Each Objective has Benchmark/Evaluation Measures associated with it. All Benchmarks/ Evaluation Measures associated with an objective must be addressed.</i></p>	<p><i>The Progress/Accomplishments column on the program plan is not due at the time of the grant submission.</i></p> <p><i>A description of the Progress/Accomplishments is due with the mid-year and Annual Progress Reports.</i></p> <p><i>The reports should describe the overall progress, including results to date and comparison of actual accomplishments with proposed goals for the period, any current problems or favorable or unusual developments, and work to be performed during the succeeding period.</i></p> <p><i>It is not acceptable to state “in progress”.</i></p>
<p>Applicant completes this section</p>					

Objective	Activities	Person Responsible	Timeline	Benchmarks/ Evaluation Measures	Progress/Accomplishments
LHD will develop and maintain message templates that address jurisdictional vulnerabilities				<ul style="list-style-type: none"> • Written plans should include message templates that address jurisdictional vulnerabilities, should be maintained on a jurisdictionally defined regular basis, and include the following elements: <ul style="list-style-type: none"> ○ Stakeholder identification ○ Potential stakeholder questions and concerns ○ Common sets of underlying concerns ○ Key messages in response to the generated list of underlying stakeholder questions and concerns ○ Suggested resources <ul style="list-style-type: none"> i. Message Template for the First Minute for all Emergencies: http://www.emergency.cdc.gov/firsthours/resources/essagetemplate.asp ii. Communicating in the First Hours / First Hours Resources: http://www.emergency.cdc.gov/firsthours/resources/index.asp iii. Communicating in the First Hours / Terrorism Emergencies: http://www.bt.cdc.gov/firsthours/terrorist.asp 	
LHD Public Information Officers have completed NIMS training				<ul style="list-style-type: none"> • Public Information staff should complete the following National Incident Management System training: <ul style="list-style-type: none"> ○ Introduction to Incident Command System (IS-100.b) ○ Incident Command System for Single Resources and Initial Action 	

Objective	Activities	Person Responsible	Timeline	Benchmarks/ Evaluation Measures	Progress/Accomplishments
				<ul style="list-style-type: none"> Incidents (IS-200.b) ○ Emergency Support Function 15 External Affairs: A New Approach to Emergency Communication and Information Distribution (IS-250) ○ National Incident Management System, An Introduction (IS-700.a) ○ National Incident Management System Public Information Systems (IS-702.a) ○ National Response Framework, An Introduction (IS-800.b) 	

Program Grant Number: _____

Public Health Emergency Preparedness Program Plan

Initial Program Plan Midyear Program Report End of the Year Report

Capability: Medical Countermeasure Dispensing

Outcome: 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.

Objective	Activities	Person Responsible	Timeline	Benchmarks/ Evaluation Measures	Progress/Accomplishments
<p><i>The objectives are provided by ODH guidance.</i></p> <p><i>The applicant must address all of the objectives associated with each target capability.</i></p>	<p><i>List the specific Activities proposed that will be done to implement each Objective.</i></p>	<p><i>List the staff that will be responsible for implementing the specific Activities</i></p>	<p><i>Indicate the date the Activities will be completed or accomplished.</i></p> <p><i>It is not acceptable to list "ongoing" or "at end of grant period" for all Activities.</i></p>	<p><i>The Benchmarks/Evaluation Measures describe how the Objectives will be measured and evaluated.</i></p> <p><i>Each Objective has Benchmark/Evaluation Measures associated with it. All Benchmarks/ Evaluation Measures associated with an objective must be addressed.</i></p>	<p><i>The Progress/Accomplishments column on the program plan is not due at the time of the grant submission.</i></p> <p><i>A description of the Progress/Accomplishments is due with the mid-year and Annual Progress Reports.</i></p> <p><i>The reports should describe the overall progress, including results to date and comparison of actual accomplishments with proposed goals for the period, any current problems or favorable or unusual developments, and work to be performed during the succeeding period.</i></p> <p><i>It is not acceptable to state "in progress".</i></p>
Applicant completes this section					

Objective	Activities	Person Responsible	Timeline	Benchmarks/ Evaluation Measures	Progress/Accomplishments
LHD develops standard operating procedures to identify the medical countermeasures required for the incident or potential incident				<ul style="list-style-type: none"> • Written plans should include standard operating procedures that provide guidance to identify the medical countermeasures required for the incident or potential incident. Consideration should be given to the following elements: <ul style="list-style-type: none"> ○ Number and location of people affected by the incident, including a process to collect and analyze medical and social demographic information of the jurisdiction's population to plan for the types of medications, durable medical equipment, or consumable medical supplies that may need to be provided during an incident, including supplies needed for the functional needs of at-risk individuals. ○ Agent or cause of the incident <ul style="list-style-type: none"> i. (For additional or supporting detail, see Capability 12: Public Health Laboratory Testing) ○ Severity of the incident ○ Potential medical countermeasures <ul style="list-style-type: none"> i. (For additional or supporting detail, see Capability 13: Public Health Surveillance and Epidemiological Investigation) ○ Time line for establishing 	

Objective	Activities	Person Responsible	Timeline	Benchmarks/ Evaluation Measures	Progress/Accomplishments
				<ul style="list-style-type: none"> ○ medical countermeasure dispensing operations ○ Personnel and staffing mix ● Suggested resources <ul style="list-style-type: none"> ○ CDC Emergency Preparedness and Response: http://emergency.cdc.gov ○ Federal Emergency Management Agency National Response Framework Incident Annexes: http://www.fema.gov/emergency/nrf/incidentannexes.htm 	
LHD develops protocols to request additional medical countermeasures				<ul style="list-style-type: none"> ● Written plans should include protocols to request additional medical countermeasures, including memoranda of understanding or other letters of agreement with state/local partners. Consideration should be given to the following elements: <ul style="list-style-type: none"> ○ Assessment of local inventory/medical countermeasure caches ○ Identification of local pharmaceutical and medical-supply wholesalers ○ Identification of a decision matrix guiding the process of requesting additional medical countermeasures if local supplies are exhausted. Matrix should take into account the Stafford Act and U.S. Department of Health and Human Services Regional Emergency Coordinators. ○ If jurisdictions decide to purchase their own medical countermeasures, they are required 	

Objective	Activities	Person Responsible	Timeline	Benchmarks/ Evaluation Measures	Progress/Accomplishments
				<p>to meet regulatory standards (abide by U.S. Food and Drug Administration standards including current good manufacturing practices, have appropriate Drug Enforcement Administration registrations, and be responsible to fund and track medical countermeasures rotation)</p> <ul style="list-style-type: none"> • Suggested resource <ul style="list-style-type: none"> ○ U.S. Food and Drug Administration Current Good Manufacturing Practices/Compliance: http://www.fda.gov/Drugs/Guidance/ComplianceRegulatoryInformation/Guidances/ucm064971.htm 	
LHD develops written agreements (e.g., memoranda of agreement, memoranda of understanding, mutual aid agreements or other letters of agreement) to share resources, facilities, services, and other potential support				<ul style="list-style-type: none"> • Written plans should include written agreements (e.g., memoranda of agreement, memoranda of understanding, mutual aid agreements or other letters of agreement) to share resources, facilities, services, and other potential support required during the medical countermeasure dispensing activities. 	
LHD develops protocols to govern the activation of dispensing modalities				<ul style="list-style-type: none"> • Written plans should include processes and protocols to govern the activation of dispensing modalities. <ul style="list-style-type: none"> ○ Identify multiple dispensing modalities that would be activated depending on the incident characteristics (e.g., identified population and type of agent/exposure). Consideration should be given to the following 	

Objective	Activities	Person Responsible	Timeline	Benchmarks/ Evaluation Measures	Progress/Accomplishments
				<ul style="list-style-type: none"> elements: <ul style="list-style-type: none"> i. Traditional public health operated (e.g., open points of dispensing) ii. Private organizations (e.g., closed points of dispensing) iii. Pharmacies iv. Provider offices and clinics v. Military/tribal vi. Incarcerated population vii. Other jurisdictionally approved dispensing modalities ○ Initiate notification protocols with the dispensing locations. The following information should be determined for the sites: <ul style="list-style-type: none"> i. Dispensing site name/identifier ii. Demand estimate (number of people planning to visit the site) iii. Required throughput iv. Staff required to operate one shift v. Number of shifts of distinct staff vi. Staff availability vii. Total number of staff required to operate the dispensing location through the whole incident ○ Plan for functional needs of at-risk individuals (e.g., wheelchair access) 	

Objective	Activities	Person Responsible	Timeline	Benchmarks/ Evaluation Measures	Progress/Accomplishments
				<ul style="list-style-type: none"> for handicapped) ○ Identify, assess, prioritize, and communicate legal and liability dispensing barriers to those with the authority to address issues. Consideration should be given to the following elements: <ul style="list-style-type: none"> i. Clinical standards of care ii. Licensing iii. Civil liability for volunteers iv. Liability for private sector participants v. Property needed for dispensing medication ● Suggested resource <ul style="list-style-type: none"> ○ Receiving, Distributing, and Dispensing Strategic National Stockpile Assets: A Guide for Preparedness, Version 10.02, Chapter 12: Dispensing Oral Medications: https://ophcs.odh.ohio.gov/ophcs/Documents/SNS/LHD%20Collaboration/CDC%20SNS%20Guidance/ https://ophcs.odh.ohio.gov/ophcs/Documents/SNS/Preparedness%20for%20LHDs/Guidance/ 	
LHD develops protocols to govern the dispensing of medical countermeasures				<ul style="list-style-type: none"> ● Written plans should include processes and protocols to govern the dispensing of medical countermeasures to the target population. <ul style="list-style-type: none"> ○ Protocol for screening and triaging patients, taking into consideration an assessment of patient 	

Objective	Activities	Person Responsible	Timeline	Benchmarks/ Evaluation Measures	Progress/Accomplishments
				<p>characteristics (e.g., cultural and linguistic characteristics, age, weight, clinical manifestations, available medical history, and drug or food allergies, assessment of radiation exposure duration and time since exposure, presence of radioactive contamination on the body or clothing, intake of radioactive materials into the body, identification of the radioactive isotope, removal of external or internal contamination) to determine the medical countermeasure to dispense</p> <ul style="list-style-type: none"> o Ensure that the permanent medical record by using the statewide Name, Address, Personal History (NAPH) form for the recipient which includes the following information: <ul style="list-style-type: none"> i. The date the medical countermeasure was dispensed ii. Information on the medical countermeasure including, but not limited to, product name, national drug control number, and lot number iii. The name and address of the person dispensing the medical countermeasure. Federal dispensing law requires: name/address of dispenser, prescription number, date of 	

Objective	Activities	Person Responsible	Timeline	Benchmarks/ Evaluation Measures	Progress/Accomplishments
				<p>prescription, name of prescriber, name of patient (if stated on prescription), directions for use, and cautionary statements.</p> <ul style="list-style-type: none"> iv. The edition date of the information statement (e.g., pre-printed drug information sheets) distributed o Ensure medical countermeasure recipient receives the information sheet matching the medical countermeasure dispensed o Data recording protocols to report the data at an aggregate level to state/federal entities. Considerations should be given to population demographics (e.g., sex, race, age group, language and if an at-risk individual) and dispensing information (e.g., medical countermeasure name, location, and date) <ul style="list-style-type: none"> • Ohio Note - Suggested Resources: <ul style="list-style-type: none"> o https://ophcs.odh.ohio.gov/ophcs/Documents/SNS/Preparedness%20for%20LHDs/Guidance/ 	

Program Grant Number: _____

Public Health Emergency Preparedness Program Plan

Initial Program Plan Midyear Program Report End of the Year Report

Capability: Medical Materiel Management and Distribution

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

Objective	Activities	Person Responsible	Timeline	Benchmarks/ Evaluation Measures	Progress/Accomplishments
<p><i>The objectives are provided by ODH guidance.</i></p> <p><i>The applicant must address all of the objectives associated with each target capability.</i></p>	<p><i>List the specific Activities proposed that will be done to implement each Objective.</i></p>	<p><i>List the staff that will be responsible for implementing the specific Activities</i></p>	<p><i>Indicate the date the Activities will be completed or accomplished.</i></p> <p><i>It is not acceptable to list "ongoing" or "at end of grant period" for all Activities.</i></p>	<p><i>The Benchmarks/Evaluation Measures describe how the Objectives will be measured and evaluated.</i></p> <p><i>Each Objective has Benchmark/Evaluation Measures associated with it. All Benchmarks/ Evaluation Measures associated with an objective must be addressed.</i></p>	<p><i>The Progress/Accomplishments column on the program plan is not due at the time of the grant submission.</i></p> <p><i>A description of the Progress/Accomplishments is due with the mid-year and Annual Progress Reports.</i></p> <p><i>The reports should describe the overall progress, including results to date and comparison of actual accomplishments with proposed goals for the period, any current problems or favorable or unusual developments, and work to be performed during the succeeding period.</i></p> <p><i>It is not acceptable to state "in progress".</i></p>
Applicant completes this section					
LHD documents primary and backup receiving sites				<ul style="list-style-type: none"> Written plans should include documentation of primary and backup receiving sites that take into consideration federal Strategic National Stockpile recommendations. Written plans 	

Objective	Activities	Person Responsible	Timeline	Benchmarks/ Evaluation Measures	Progress/Accomplishments
				<p>should include the following elements:</p> <ul style="list-style-type: none"> ○ Type of site (commercial vs. government) ○ Physical location of site ○ 24-hour contact number ○ Hours of operation ○ Inventory of material-handling equipment on-site and list of minimum materials that need to be procured and/or delivered at the time of the incident ○ Inventory of office equipment on-site and list of minimum materials that need to be procured and/or delivered at the time of the incident ○ Inventory of storage equipment (e.g., refrigerators and freezers) on-site and list of minimum materials/supplies that need to be procured and/or delivered at the time of the incident <p>Ohio Note:</p> <ul style="list-style-type: none"> ● Update and confirm quarterly in Ohio Public Health Analysis Network (OPHAN) County Drop Site, Points of Dispensing (PODs), and Closed PODs 	
LHD develops a transportation strategy				<ul style="list-style-type: none"> ● Written plans should include transportation strategy. If public health will be transporting material using their own vehicles, plan should include processes for cold chain management, if necessary to the incident. If public health will be using outside vendors for transportation, there should be a written process for initiating transportation agreements (e.g., contracts, memoranda of understanding, formal written agreements, and/or other letters of agreement). Transportation agreements should include, at a minimum, the following elements: <ul style="list-style-type: none"> ○ Type of vendor (commercial vs. 	

Objective	Activities	Person Responsible	Timeline	Benchmarks/ Evaluation Measures	Progress/Accomplishments
				<ul style="list-style-type: none"> government) ○ Number and type of vehicles, including vehicle load capacity and configuration ○ Number and type of drivers, including certification of drivers ○ Number and type of support personnel ○ Vendor's response time ○ Vendor's ability to maintain cold chain, if necessary to the incident ● In addition to this process, public health should have written evidence of a relationship with outside transportation vendors. This relationship may be demonstrated by a signed transportation agreement or documentation of transportation planning meeting with the designated vendor. 	
LHD develops a protocol to report medical materiel levels to public health at least weekly,				<ul style="list-style-type: none"> ● Written plans should include protocols for medical and health-related agencies and organizations to report medical materiel levels to public health at least weekly, but potentially more frequently. (For additional or supporting detail, see Capability 6: Information Sharing) <p>Ohio Note:</p> <ul style="list-style-type: none"> ● Complete and submit the ODH Countermeasure Report through OPHAN ● Suggested Resources <p>https://ophcs.odh.ohio.gov/ophcs/Documents/SNS/Preparedness%20for%20LHDs/Guidance/</p>	
LHD develops a process to request medical materiel (initial request and re-supply requests)				<ul style="list-style-type: none"> ● Written plans should include a process to request medical materiel (initial request and re-supply requests), including memoranda of understanding and mutual aid agreements with state/local partners if applicable. These plans should consider the following elements: <ul style="list-style-type: none"> ○ Assessment of local inventory/medical countermeasure caches 	

Objective	Activities	Person Responsible	Timeline	Benchmarks/ Evaluation Measures	Progress/Accomplishments
				<ul style="list-style-type: none"> ○ Identification of local pharmaceutical and medical-supply wholesalers ○ Assessment of asset request trigger indicators, thresholds, and validation strategies to guide decision making ○ A process for requesting medical countermeasures through the Emergency Management Assistance Compact ○ A process for justifying medical countermeasure requests ○ If sites decide to purchase their own medical countermeasures, they are required to meet regulatory standards (i.e., abide by U.S. Food and Drug Administration standards including current good manufacturing practices (cGMP), have appropriate Drug Enforcement Administration registrations, and be responsible to fund and track medical countermeasures rotation) ● Suggested resources <ul style="list-style-type: none"> ○ U.S. Food and Drug Administration Current Good Manufacturing Practices/Compliance: http://www.fda.gov/Drugs/GuidanceComplianceRegulatoryInformation/Guidances/ucm064971.htm ○ (For additional or supporting detail, see Capability 1: Community Preparedness) <p>Ohio Note:</p> <ul style="list-style-type: none"> ● Suggested resources <ul style="list-style-type: none"> ○ https://ophcs.odh.ohio.gov/ophcs/Documents/SNS/LHD%20Collaboration/CD%20SNS%20Guidance/ ○ https://ophcs.odh.ohio.gov/ophcs/Documents/SNS/Preparedness%20for%20LHDs/Guidance/ 	

Objective	Activities	Person Responsible	Timeline	Benchmarks/ Evaluation Measures	Progress/Accomplishments
LHD develops protocols for reporting to jurisdictional, state, regional, and federal authorities				<ul style="list-style-type: none"> • Written plans should include protocols for reporting to jurisdictional, state, regional, and federal authorities. At a minimum, report should include the following elements: <ul style="list-style-type: none"> ○ Amount of materiel received (including receipt date/time and name of individual who accepted custody of materiel) ○ Amount of materiel distributed ○ Amount of materiel expired ○ Current available balance of materiel ○ <i>(For additional or supporting detail, see Capability 6: Information Sharing)</i> <p>Ohio Note:</p> <ul style="list-style-type: none"> • Complete and submit the ODH Countermeasure Report through OPHAN • Suggested Resources https://ophcs.odh.ohio.gov/ophcs/Documents/SNS/Preparedness%20for%20LHDs/Guidance/ 	
LHD develops protocols to maintain the physical security of medical countermeasures throughout acquisition, storage, and distribution				<ul style="list-style-type: none"> • Written plans should include processes and protocols that address the maintenance of physical security of medical countermeasures throughout acquisition, storage, and distribution, and include, at a minimum, the following elements: <ul style="list-style-type: none"> ○ Contact information for security coordinator ○ Coordination with law enforcement and security agencies to secure personnel and facility ○ Acquisition of physical security measures (e.g., cages, locks, and alarms) for materiel within the receiving site ○ Maintenance of security of medical materiel in transit <p>Ohio Note:</p> <ul style="list-style-type: none"> • Complete and submit the ODH Countermeasure Report through OPHAN • Suggested Resources 	

Objective	Activities	Person Responsible	Timeline	Benchmarks/ Evaluation Measures	Progress/Accomplishments
				<p>https://ophcs.odh.ohio.gov/ophcs/Document/s/SNS/Preparedness%20for%20LHDs/Guidance/ https://ophcs.odh.ohio.gov/ophcs/Document/s/SNS/LHD%20Collaboration/CDC%20SNS%20Guidance/</p> <p>Site Security Assessment can be found at https://ophcs.odh.ohio.gov/ophcs/Documents/</p>	
LHD develops protocols for allocation and distribution of medical materiel				<ul style="list-style-type: none"> • Written plans should include an allocation and distribution strategy including delivery locations, routes, and delivery schedule/frequency, and should take into consideration the transport of materials through restricted areas. The strategy should also consider whether recipients will be responsible for acquiring materiel from an intermediary distribution site or if the health department is responsible for delivering materiel. • Ohio Note: Suggested resources <ul style="list-style-type: none"> ○ Receiving, Distributing, and Dispensing Strategic National Stockpile Assets: A Guide for Preparedness, version 10.02, Chapter 9: Controlling Strategic National Stockpile Inventory: https://ophcs.odh.ohio.gov/ophcs/Document/s/SNS/LHD%20Collaboration/CDC%20SNS%20Guidance/ ○ Receiving, Distributing, and Dispensing Strategic National Stockpile Assets: A Guide for Preparedness, version 10.02, Chapter 11: Distributing Strategic National Stockpile Assets: https://ophcs.odh.ohio.gov/ophcs/Document/s/SNS/Preparedness%20for%20LHDs/Guidance/ ○ Receiving, Distributing, and Dispensing Strategic National Stockpile Assets: A Guide for Preparedness, version 10.02, Chapter 11: Distributing Strategic National Stockpile Assets: https://ophcs.odh.ohio.gov/ophcs/Document/s/SNS/LHD%20Collaboration/CDC%20SNS%20Guidance/ 	

Objective	Activities	Person Responsible	Timeline	Benchmarks/ Evaluation Measures	Progress/Accomplishments
				https://ophcs.odh.ohio.gov/ophcs/Documents/SNS/Preparedness%20for%20LHDs/Guidance/	
LHD develops protocols for the storage, distribution, disposal, or return of unused (unopened) medical materiel				<ul style="list-style-type: none"> Written plans should include protocols for the storage, distribution, disposal, or return of unused (unopened) medical materiel, unused pharmaceuticals, and durable items, including plans for maintaining integrity of medical materiel during storage and/or distribution within the jurisdictional health system. 	

Program Grant Number: _____

ATTACHMENT #10

Public Health Emergency Preparedness Program Plan

Initial Program Plan Midyear Program Report End of the Year Report

Capability: Medical Surge

Outcome: 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.

Objective	Activities	Person Responsible	Timeline	Benchmarks/ Evaluation Measures	Progress/Accomplishments
<p><i>The objectives are provided by ODH guidance.</i></p> <p><i>The applicant must address all of the objectives associated with each target capability.</i></p>	<p><i>List the specific Activities proposed that will be done to implement each Objective.</i></p>	<p><i>List the staff that will be responsible for implementing the specific Activities</i></p>	<p><i>Indicate the date the Activities will be completed or accomplished.</i></p> <p><i>It is not acceptable to list "ongoing" or "at end of grant period" for all Activities.</i></p>	<p><i>The Benchmarks/Evaluation Measures describe how the Objectives will be measured and evaluated.</i></p> <p><i>Each Objective has Benchmark/Evaluation Measures associated with it. All Benchmarks/Evaluation Measures associated with an objective must be addressed.</i></p>	<p><i>The Progress/Accomplishments column on the program plan is not due at the time of the grant submission.</i></p> <p><i>A description of the Progress/Accomplishments is due with the mid-year and Annual Progress Reports.</i></p> <p><i>The reports should describe the overall progress, including results to date and comparison of actual accomplishments with proposed goals for the period, any current problems or favorable or unusual developments, and work to be performed during the succeeding period.</i></p> <p><i>It is not acceptable to state "in progress".</i></p>

Objective	Activities	Person Responsible	Timeline	Benchmarks/ Evaluation Measures	Progress/Accomplishments
Applicant completes this section					
LHD develops or maintains plans which include documentation of how they will engage in healthcare coalitions.				<ul style="list-style-type: none"> • Written plans should include documentation of the process for how the public health agency will engage in healthcare coalitions and other response partners regarding the activation of alternate care systems. Documentation should also include the following elements: <ul style="list-style-type: none"> ○ Written list of healthcare organizations with alternate care system plans ○ Written list of home health networks and types of resources available that are able to assist in incident response ○ List of pre-identified site(s) that have undergone an initial assessment to determine their adequacy to serve as an alternate care facility (<i>For additional or supporting detail, see Capability 7: Mass Care</i>) • Suggested resource <ul style="list-style-type: none"> ○ Disaster Alternate Care Facility Selection Tool: http://www.ahrq.gov/prep/acfselection/index.html 	
LHD develops or maintains protocols to identify essential situation awareness.				<ul style="list-style-type: none"> • Written plans should include processes and protocols to identify essential situational awareness information for federal, state, local, and non-governmental agencies; private sector agencies; and other Emergency Support Function # 8 partners. Jurisdictional processes to identify essential situational awareness requirements should consider the following elements: <ul style="list-style-type: none"> ○ Identifying essential information ○ Defining required information 	

Objective	Activities	Person Responsible	Timeline	Benchmarks/ Evaluation Measures	Progress/Accomplishments
				<ul style="list-style-type: none"> ○ Establishing requirements ○ Determining common operational picture elements ○ Identifying data owners ○ Validating data with stakeholders <p><i>(For additional or supporting detail, see Capability 6: Information Sharing)</i></p>	
<p>LHD develops or maintains plans for at-risk individuals with the assistance of the healthcare coalition.</p>				<ul style="list-style-type: none"> • Written plans should include documentation that public health participates in the development and execution of healthcare coalition plans to address the functional needs of at-risk individuals. Plans should include a written list of healthcare organizations and community providers that are able to address the functional needs for at-risk individuals and a process to communicate with healthcare organizations and community providers to maintain a current list of available services that support the functional needs of at-risk individuals. <i>(For additional or supporting detail, see Capability 1: Community Preparedness)</i> 	

Program Grant Number: _____

ATTACHMENT #11

Regional Public Health Planning Program Plan

Initial Program Plan Midyear Program Report End of the Year Report

Target Capability: Regional Public Health Planning

Outcome: Ohio Homeland Security Planning Regions are prepared for, protected from and resilient in the face of public health threats and/or incidents.

Objective	Activities	Person Responsible	Timeline	Benchmarks/ Evaluation Measures	Progress/Accomplishments
<p><i>The objectives are provided by ODH guidance.</i></p> <p><i>The applicant must address all of the objectives associated with each target capability.</i></p>	<p><i>List the specific Activities proposed that will be done to implement each Objective.</i></p>	<p><i>List the staff that will be responsible for implementing the specific Activities</i></p>	<p><i>Indicate the date the Activities will be completed or accomplished.</i></p> <p><i>It is not acceptable to list "ongoing" or "at end of grant period" for all Activities.</i></p>	<p><i>The Benchmarks/Evaluation Measures describe how the Objectives will be measured and evaluated.</i></p> <p><i>Each Objective has Benchmark/Evaluation Measures associated with it. All Benchmarks/ Evaluation Measures associated with an objective must be addressed.</i></p>	<p><i>The Progress/Accomplishments column on the program plan is not due at the time of the grant submission.</i></p> <p><i>A description of the Progress/Accomplishments is due with the mid-year and Annual Progress Reports.</i></p> <p><i>The reports should describe the overall progress, including results to date and comparison of actual accomplishments with proposed goals for the period, any current problems or favorable or unusual developments, and work to be performed during the succeeding period.</i></p> <p><i>It is not acceptable to state "in progress".</i></p>
Applicant completes this section					

Objective	Activities	Person Responsible	Timeline	Benchmarks/ Evaluation Measures	Progress/Accomplishments
<p>A Regional Resource-Sharing Plan is developed to identify the procedures and protocols for sharing public health resources within and outside the region.</p>				<ul style="list-style-type: none"> • Maintain communications between State and local health depts.; provide situational awareness and management coordination. • Convene and facilitate regional meetings to assure coordination and collaboration. Compile meeting minutes and maintain documentation of strategies, activities and responsibilities. • Collaborate with Regional Hospital and EMA staff in regional planning. Review and identify gaps in regional response plans annually. Provide documentation that collaboration takes place. • Complete an objective evaluation survey of all jurisdictions in the region to assure accountability and value of regional public health coordination to local public health. Evaluation may include some subjective measures. • Includes a written MOU with all jurisdictions in the region • Provide accomplishments and evaluation results of regional coordination to each jurisdiction. 	
<p>A Continuity of Operations Plan template is developed and/or modified for use by each local health department.</p>				<p>Written plans should include the following elements (either as a stand-alone Public Health Continuity of Operations Plan or as a component of another plan):</p> <ul style="list-style-type: none"> • Definitions and identification of essential services needed to sustain agency mission and operations • Plans to sustain essential services regardless of the nature of the incident (e.g., all-hazards planning) • Scalable work force reduction • Limited access to facilities (social 	

Objective	Activities	Person Responsible	Timeline	Benchmarks/ Evaluation Measures	Progress/Accomplishments
				distancing, staffing or security concerns) <ul style="list-style-type: none"> • Broad-based implementation of social distancing policies if indicated • Positions, skills and personnel needed to continue essential services and functions (Human Capital Management) • Identification of agency vital records (legal documents, payroll, staff assignments) that support essential functions and/or that must be preserved in an incident • Alternate worksites • Devolution of uninterruptible services for scaled down operations • Reconstitution of uninterruptible services 	
A Stakeholder Role-Based Public Health Directory template is developed and/or modified for use by each local health department for alert messaging for OPHCS.				<ul style="list-style-type: none"> • Collect information and provide resource information to local health departments. • <i>A Stakeholder Information Exchange Process</i> template (including a protocol for public health alert messages) is developed and/or modified for use by each local health department for OPHCS. 	
A Regional Epidemiological Surveillance and Investigation Plan is developed and/or modified for use and updated annually.				The plan should include: <ul style="list-style-type: none"> • Documentation of the legal and procedural framework that supports information exchange • Protocols for assessing health information • Protocols to gather and analyze surveillance data • Procedures to ensure 24/7 local health department access • Protocols to notify CDC of cases on the NNID list • Tier 1 competencies and skills for applied epidemiologists • Access to health information infrastructure 	

Objective	Activities	Person Responsible	Timeline	Benchmarks/ Evaluation Measures	Progress/Accomplishments
				and surveillance systems <ul style="list-style-type: none"> • Investigation report templates • Staffing capacity to manage routine epidemiological investigation systems • Protocols for recommending and initiating containment and mitigation actions 	
An Emergency Public Information System Plan template (including common message templates that address jurisdictional vulnerabilities) is developed and/or modified for use by each local health department.				<ul style="list-style-type: none"> • Local health department public information staff have completed IS – 701a and Emergency Management Institute G291 training courses 	
A Medical Countermeasure Dispensing Plan template is developed and/or modified for use by each local health department.				The template should include: <ul style="list-style-type: none"> • SOPs to identify the medical countermeasures required • Protocols to request additional medical countermeasures • Written agreements to share resources, facilities, services, etc • Processes to govern the activation of dispensing modalities • Processes to govern the dispensing of medical countermeasures • Process to track medical countermeasure usage locally, and regionally serve as a central information collection point for resources • Attend ODH SNS Mass Antibiotic Dispensing (MAD) train the trainer course and conduct SNS MAD trainings throughout region • Conduct SNS Public Information Communication (PIC) trainings throughout region; 	

Objective	Activities	Person Responsible	Timeline	Benchmarks/ Evaluation Measures	Progress/Accomplishments
				<ul style="list-style-type: none"> Attend ODH SNS Local Technical Assistance (L-TAR) training and conduct L-TAR throughout region; 	
<p>A Medical Materiel Management and Distribution Plan template is developed and/or modified for use by each local health department.</p>				<p>The template should include:</p> <ul style="list-style-type: none"> Documentation of primary and backup POD's and County Drop sites Transportation strategy Protocols for reporting medical materiel levels Processes to request medical materiel Protocols for tracking and reporting to jurisdictional / state / regional/federal authorities Protocols to ensure physical security of medical materiel Allocation and distribution strategy for medical materiel Protocols for the storage, distribution, disposal and/or return of unused medical materiel 	
<p>A template to address community preparedness plan(s) is developed and/or modified for use by each local health department to build community partnerships to support health preparedness.</p>				<ul style="list-style-type: none"> The template should include a policy and process to participate in partnerships representing the following 11 community sectors: <ul style="list-style-type: none"> business; community leadership; cultural/faith-based organizations; emergency management; healthcare; social services; housing and sheltering; media; mental/behavioral health; Office of Aging or equivalent; education/childcare. Each local health department solicits 	

Objective	Activities	Person Responsible	Timeline	Benchmarks/ Evaluation Measures	Progress/Accomplishments
				public comment on emergency preparedness plans.	
Support the integration of public health and medical surge plans to ensure regional health preparedness.				<ul style="list-style-type: none"> • Documentation the process for local health departments to engage healthcare coalitions and other response partners regarding the activation of alternate care systems • Develop processes and protocols to identify essential situational awareness information for ESF #8 partners • Documentation that local health departments participate in healthcare coalition planning for functional needs support services (FNSS) for at-risk individuals 	

Program Grant Number: _____

ATTACHMENT #12

Public Health Emergency Preparedness Program Plan

Initial Program Plan Midyear Program Report End of the Year Report

Capability: Cities Readiness Initiative

Outcome: Ensure the capacity to deliver medicines and medical supplies during a large-scale public health emergency such as a bioterrorism attack or a nuclear accident within 48 hours

Objective	Activities	Person Responsible	Timeline	Benchmarks/ Evaluation Measures	Progress/Accomplishments
<p><i>The objectives are provided by ODH guidance.</i></p> <p><i>The applicant must address all of the objectives associated with each target capability.</i></p>	<p><i>List the specific Activities proposed that will be done to implement each Objective.</i></p>	<p><i>List the staff that will be responsible for implementing the specific Activities</i></p>	<p><i>Indicate the date the Activities will be completed or accomplished.</i></p> <p><i>It is not acceptable to list "ongoing" or "at end of grant period" for all Activities.</i></p>	<p><i>The Benchmarks/Evaluation Measures describe how the Objectives will be measured and evaluated.</i></p> <p><i>Each Objective has Benchmark/Evaluation Measures associated with it. All Benchmarks/ Evaluation Measures associated with an objective must be addressed.</i></p>	<p><i>The Progress/Accomplishments column on the program plan is not due at the time of the grant submission.</i></p> <p><i>A description of the Progress/Accomplishments is due with the mid-year and Annual Progress Reports.</i></p> <p><i>The reports should describe the overall progress, including results to date and comparison of actual accomplishments with proposed goals for the period, any current problems or favorable or unusual developments, and work to be performed during the succeeding period.</i></p> <p><i>It is not acceptable to state "in progress".</i></p>
<p>Applicant completes this section</p>					

Objective	Activities	Person Responsible	Timeline	Benchmarks/ Evaluation Measures	Progress/Accomplishments
Participate in annual CRI assessment.				<ul style="list-style-type: none"> Achieve a score of 79% on the current L-TAR review conducted by either CDC or ODH Ensure all CRI jurisdictions within the MSA achieve a score of 79% on the current L-TAR review conducted by either CDC or ODH Provide all LTAR self-assessment, and all supporting documentation, two weeks prior to the scheduled date of assessment 	
Conduct a minimum of 3 different CDC/SNS RAND drills.				<ul style="list-style-type: none"> Complete and submit the required drills, and all documentation, to your PHEP consultant prior to May 1, 2013 <ul style="list-style-type: none"> Personnel Call down Site Activation Facility Set-up Dispensing or modeling throughput Distribution tool for table top exercise Decision making evaluation tool Submit the CDC RAND drill data collection sheet, the Strategic National Stockpile Drill, Exercise and After Action Report (AAR) form (see attachment # 12), when submitting each of the three (3) different required RAND drills. 	
Complete documentation of the POD standards.				<ul style="list-style-type: none"> The data elements for the POD Standards, (listed in the CDC Medical Countermeasure Distribution and Dispensing (MCDD) Composite Measure Guide, are readily available in Microsoft Excel or Microsoft Word based electronic files. The POD Standards' data elements are submitted to your PHEP consultant, on the approved template spreadsheet, prior to May 1, 2013. 	

Objective	Activities	Person Responsible	Timeline	Benchmarks/ Evaluation Measures	Progress/Accomplishments
<p>Complete one full scale mass prophylaxis exercise (FSE) for each CRI MSA within the five year PHEP project period, 2011-2016. The FSE must test key components of mass dispensing/prophylaxis plan (Section 10 in L-TAR) and follow HSEEP methodology.</p>				<ul style="list-style-type: none"> • Complete, and submit documentation for the FSE prior to June 1, 2016. • The exercise must follow the MCDD and PHEP Cooperative Agreement requirements. • The exercise follows HSEEP methodology. https://hseep.dhs.gov • Notify ODH of the exercise, 90 days prior to the day of the exercise. • Submit exercise planning documents to ODH at least 60 days before the exercise. To include: <ul style="list-style-type: none"> ○ Mid-term planning conference ○ Master Scenario Events List (MSEL) ○ Exercise Evaluation Guides ○ Exercise Plan (ExPlan) • Notify ODH of all exercise planning, meetings including initial planning, mid-planning and final planning conferences. • All jurisdictions participate in the exercise as a player (not an observer or evaluator). • Each FSE must include all pertinent jurisdictional leadership, emergency support function leads, planning and operational staff and all applicable personnel. • Local planning jurisdiction staff participation must be demonstrated throughout the exercise planning cycle. Participation from representative staff from all the local planning jurisdictions must participate in the FSE planning and development cycle. • CRI subgrantee must participate with CRI local planning jurisdictions in the MSA. • Each CRI local planning jurisdiction in MSA is required to participate. 	

Objective	Activities	Person Responsible	Timeline	Benchmarks/ Evaluation Measures	Progress/Accomplishments
				<ul style="list-style-type: none"> • Submit AAR and IP to your PHEP consultant. The AAR/IP follows HSEEP methodology. https://hseep.dhs.gov • Submit performance metrics (observed data) for select performance measures indicated in the CDC MCDD Composite Measure Guide. • Exercise planning and after-action reports must be submitted as a single report of the jurisdiction's exercise activities and clearly identify all participating jurisdictions. 	

Public Health Emergency Preparedness (PHEP) Match Requirement

Background

Beginning in fiscal year 2010, each PHEP Subgrantee is required to contribute 7.7% of their PHEP award towards Matching Funds.

Administrative Requirement

Subgrantees must be able to separately account for stewardship of the PHEP funds and for any required matching; it is subject to monitoring, oversight, and audit.

Source of Matching Funds

- Nonfederal contributions required may be provided directly or through donations from public or private entities and may be in cash or in kind, fairly evaluated, including plant, equipment or services.
- Amounts provided by the federal government or services assisted or subsidized to any significant extent by the federal government, may not be included in determining the amount of such nonfederal contributions.
- Fully document, in the grant application, the specific costs or contributions proposed to meet the matching requirement, the source of funding or contribution, and how the valuation was determined.

S. 3678: Pandemic and All-Hazards Preparedness Act

(C) REQUIREMENT FOR STATE MATCHING FUNDS

Beginning in fiscal year 2009, in the case of any State or consortium of two or more States, the Secretary may not award a cooperative agreement under this section unless the State or consortium of States agree that, with respect to the amount of the cooperative agreement awarded by the Secretary, the State or consortium of States will make available (directly or through donations from public or private entities) non-Federal contributions in an amount equal to—

(i) for the first fiscal year of the cooperative agreement, not less than 5 percent of such costs (\$1 for each \$20 of Federal funds provided in the cooperative agreement); and

(ii) for any second fiscal year of the cooperative agreement, and for any subsequent fiscal year of such cooperative agreement, not less than 10 percent of such costs (\$1 for each \$10 of Federal funds provided in the cooperative agreement).

(D) DETERMINATION OF AMOUNT OF NON-FEDERAL CONTRIBUTIONS

As determined by the Secretary, non-Federal contributions required in subparagraph (C) may be provided directly or through donations from public or private entities and may be in cash or in kind, fairly evaluated, including plant, equipment or services. Amounts provided by the Federal government or services assisted, or subsidized to any significant extent by the Federal government, may not be included in determining the amount of such non-Federal contributions.

**Match Documentation Attachment
(To be submitted with the PHEP FY13 Application and with the
End of the Year Report)**

[Health Commissioner]
[Health Department]
[Address]
[City, State, Zipcode]

Dear Mr. Wagner:

Our agency is required to contribute a total of _____ Matching funds to the Public Health Emergency Preparedness (PHEP) grant for the period of August 10, 2012 – June 30, 2013. The table below outlines the source and amount of the funds.

These funds are not used for other Match requirements nor are they federal funds. The funds come from our general revenue from our health department and from _____. These Matching funds reflect work and activities that enhance and support our public health preparedness efforts in our jurisdiction. If you have any questions about this, please contact _____ of my staff.

Sincerely,

Health Commissioner (Must be signed)

Match Category	Match Description	Match Amount
TOTAL MATCH AMOUNT		

ATTACHMENT # 14

Public Health Emergency Preparedness (PHEP) Grant Budget Worksheet
*Each applicant * must submit this Budget Worksheet with their grant application*

Applicant Agency: _____

PHEP Core Component <i>Must address and budget for all 6 Capabilities</i>		
Capabilities	Description	Budget Proposal
Community Preparedness		\$
Community Recovery		\$
Information Sharing		\$
Public Health Surveillance & Epidemiological Response		\$
Emergency Public Information & Warning		\$
Medical Countermeasure Dispensing		\$
Medical Materiel Distribution		\$
Medical Surge		\$
Optional Resource Elements (List by Capability)		\$
Total Core Budget (must not exceed total for the core budget that is listed in Appendix)		

** Subgrantees applying for CRI, Liaison, or Regional Public Health Coordination do not need to complete this attachment.*

Ohio Strategic National Stockpile

Purpose: This document details the questions asked during the web-based submission of CDC DSNS Drill and Exercises. It also informs which After Action Reports (AARs) to upload. Be advised that additional data collection questions may be required and CDC may change data elements during the course of the grant year.

DSNS Web-Based Data Collection Questions

What is your contact information?

- o Name
- o State (select)
- o Email
- o Password (entry)

Select locality and drill that you would like to report. The drills with data entry are:

- o Staff Notification, Acknowledgement and Assembly
- o Site Activation
- o Facility Set-up
- o Pick List Generation
- o Dispensing Throughput

Which After Action Report (AAR) would you like to submit?

- o Public Health Decision Making Tool
- o RSS/RDS Supply Chain Management Game (Distribution, modules 1-3)
- o RSS/RDS Supply Chain Management Game (Resource Allocation, modules 4-5)
- o RealOpt© (substitutes for Dispensing Throughput)
- o Medical Countermeasure Dispensing Full Scale Exercise
- o Medical Supplies Management and Distribution Full Scale Exercise

Note: Clicking a link opens a new browser window on top of this one. When you are finished with the selected drill, close the window to get back to the home page. Click "Update" when you are done working with drills to view the status of all drills.

DSNS requires AARs for the following:

- RSS/RDS Supply Chain Management Game (Distribution, modules 1 3)
- RSS/RDS Supply Chain Management Game (Resource Allocation, modules 4-5)
- Public Health Decision Making Tool
- RealOpt© (substitutes for Dispensing Throughput)
- Medical Countermeasure Dispensing Full Scale Exercise
- Medical Supplies Management and Distribution Full Scale Exercise

You will be able to upload your file through the website

. Staff Notification, Acknowledgement, and Assembly (BP11)
1. What was the drill start date and time? <i>Note: Date entries (mm/dd/yyyy) must be between August 10th of the starting year and July 15th of the ending year, but not greater than the current date. Time entries are in the form of hh:MM AM/PM</i>
2. What was the drill end date and time?
3. Is this staff notification drill being performed as part of a larger HSEEP standard operational response exercise or a stand-alone drill? Select from: A larger HSEEP standard operational response exercise or a stand-alone drill
If larger exercise: What is the name, date, and operational category of the exercise? What date was this conducted? What exercise type? Select from: Functional (FE) or Full-Scale (FSE)
4. Was this a real world event? Yes/No
If yes: What kind of real event was it? Select from: Bioterrorism Event, NSSE (National Special Security Event), Natural Disaster (flood, hurricane, tornado, ice storm, earthquake, tsunami, fire, etc.), Outbreak of Disease, Pandemic or Seasonal Influenza, Other (please specify)
5. What was the extent of notice for this drill? Select from: No Notice, Partial Notice, Full Notice
6. What communication platforms were used for staff notification? Check all that apply: Phone, Email, Text, Pager
7. What calling process was used to notify sites? Automated, Manual, Hybrid (automated + manual)
8. What was the date and time the first person on the roster was notified? <i>Note: Dates and times must be between the drill date and times entered in questions 1 and 2</i>
9. What was the date and time when the last person on the roster was notified? <i>Note: Dates and times must be between the drill date and times entered in questions 1 and 2</i>
10. What date and time did the last person acknowledge emergency response notification? <i>Note: If personnel responded outside of your specified drill time, they should be considered to be non-responders for the purpose of this drill</i>
11. What was the total number of staff included in this staff notification?
12. How many staff were called on the following rosters: <input type="checkbox"/> Emergency Operations Center (EOC)? <input type="checkbox"/> Regional Distribution Sites (RDS)? <input type="checkbox"/> Points of Dispensing (PODs)? <input type="checkbox"/> Public Information and Communication (PIC)? <input type="checkbox"/> Security/Law Enforcement? Or select "Site not applicable"
13. For each type of staff list (EOC, RDS, POD, PIC, Security/Law) called, what is the: <input type="checkbox"/> Number of staff who acknowledged emergency response notification? <input type="checkbox"/> Target time for assembly (in minutes)? Or select "No established target time" <input type="checkbox"/> Number of staff able to assemble by target time?
<i>Please print the drill summary page for your records.</i>

Site Activation (BP11)

1. What was the drill start date and time? *Note: Date entries (mm/dd/yyyy) must be between August 10th of the starting year and July 15th of the ending year, but not greater than the current date. Time entries are in the form of hh:MM AM/PM*

2. What was the drill end date and time?

3. Is this site activation drill being performed as part of a larger HSEEP standard operational response exercise or a stand-alone drill? Select from: A larger HSEEP standard operational response exercise or a stand-alone drill

If larger exercise: What is the name, date, and operational category of the exercise? What date was this conducted? What exercise type? Select from: Functional (FE) or Full-Scale (FSE)

4. Was this a real world event? Yes/No

If yes: What kind of real event was it? Select from: Bioterrorism Event, NSSE (National Special Security Event), Natural Disaster (flood, hurricane, tornado, ice storm, earthquake, tsunami, fire, etc.), Outbreak of Disease, Pandemic or Seasonal Influenza, Other (please specify)

5. What was the extent of notice for this drill? Select from: No Notice, Partial Notice, Full Notice

6. What communication platforms were used for site activation? Check all that apply: Phone, Email, Text, Pager

7. What calling process was used to notify sites? Automated, Manual, Hybrid (automated + manual)

8. What date and time was the first site notified? *Note: Dates and times must be between the drill date and times entered in questions 1 and 2*

9. What date and time was the last site was notified? *Note: Dates and times must be between the drill date and times entered in questions 1 and 2*

10. What date and time did the last site acknowledge emergency response notification?

11. What was the total number of sites included in this call down? *Note: If you are initiating a call tree, please report all responses from each site on the calling tree.*

12. How many Emergency Operation Centers (EOCs), Regional Distribution Sites (RDS'), Points of Dispensing (PODs) were called? Or select "Site not applicable" *Note: Each category (e.g EOC) is asked separately*

13. How many EOCs/RDS'/PODs acknowledged the call? *Note: Each category (e.g EOC) is asked separately*
What was the target time for EOCs/RDS'/PODs activation (in minutes)? Or select "No established target time"
How many of the EOC/RDS'/POD sites can be available by the target time? *Note: This cannot exceed the number acknowledging sites for each category*

Please print the drill summary page for your records.

Facility Setup (BP11)

1. What was the drill start date and time? *Note: Date entries (mm/dd/yyyy) must be between August 10th of the starting year and July 15th of the ending year, but not greater than the current date. Time entries are in the form of hh:MM AM/PM*

2. What was the drill end date and time?

3. Is this facility set-up drill being performed as part of a larger HSEEP standard operational response exercise or a stand-alone drill? Select from: A larger HSEEP standard operational response exercise or a stand-alone drill

If larger exercise: What is the name, date, and operational category of the exercise? What date was this conducted? What exercise type? Select from: Functional (FE) or Full-Scale (FSE)

4. Was this a real world event? Yes/No

If yes: What kind of real event was it? Select from: Bioterrorism Event, NSSE (National Special Security Event), Natural Disaster (flood, hurricane, tornado, ice storm, earthquake, tsunami, fire, etc.), Outbreak of Disease, Pandemic or Seasonal Influenza, Other (please specify)

5. What was the extent of notice for this drill? Select from: No Notice, Partial Notice, Full Notice

6. What type of facility did you set up? Check all that apply: POD (Point of Dispensing), RDS (Regional Distribution Site), EOC (Emergency Operations Center) *include Department and State Operations Centers in this category*

7. What type of POD did you set up? Select from: General/Traditional/Open, Closed

8. Was this a Walk Through or Drive Through POD?

9. How many POD/RDS/EOC sites did you set up? *Note: Each facility type (e.g POD) is asked separately*

10. What is the name/identifier of each POD/RDS/EOC site that you set up? *Note: Ensure that the name/identifier is consistent with the name/identifier used in the POD standards template for your jurisdiction.*

11. What is the target time (in minutes) after notification that each POD/RDS/EOC should be set up? Or select "No established target time" *Note: Each facility type (e.g POD) is asked separately.*

12. What is the time (in minutes) that each POD/RDS/EOC was actually set up? E.g. Two pods were given names (POD_NAME1, POD_NAME2) and their individual times (106, 45) in minutes, would be entered for each.

Please print the drill summary page for your records.

Pick List Generation (BP11)

1. What was the drill start date and time? *Note: Date entries (mm/dd/yyyy) must be between August 10th of the starting year and July 15th of the ending year, but not greater than the current date. Time entries are in the form of hh:MM AM/PM*

2. What was the drill end date and time?

3. Is this pick list generation drill being performed as part of a larger HSEEP standard operational response exercise or a stand-alone drill? Select from: A larger HSEEP standard operational response exercise or a stand-alone drill

If larger exercise: What is the name, date, and operational category of the exercise? What date was this conducted? What exercise type? Select from: Functional (FE) or Full-Scale (FSE)

4. Was this a real world event? Yes/No

If yes: What kind of real event was it? Select from: Bioterrorism Event, NSSE (National Special Security Event), Natural Disaster (flood, hurricane, tornado, ice storm, earthquake, tsunami, fire, etc.), Outbreak of Disease, Pandemic or Seasonal Influenza, Other (please specify)

5. What was the extent of notice for this drill? Select from: No notice, partial notice, full notice

6. What is your primary type of inventory system? Select from: Spreadsheet (e.g MS Excel), Database (e.g MS Access), Commercial Off the Shelf System (COTs), Hard Copy/Written

7. What type(s) of inventory were you creating pick lists for? Check all that apply. 12-hour Push Package Test File 12-hour Training Push Package (Eagle Package) State or Local Inventory

8. Was physical management of inventory included in this event?

9. What is the total number of PODs/receiving sites in your jurisdiction?

10. How many of each type of POD/receiving site is in your jurisdiction? List numbers for: General Population PODS, Closed PODS, Hospitals, Non-acute care treatment centers, Other

11. What was the total time (in minutes) required to generate ALL pick lists to support initial supply for all identified PODs in the jurisdiction? *Note: This is the total from all POD types, not just one POD*

12. Please provide individual times (in minutes) to generate up to six pick lists. *Note: Select the POD type from drop-down; You do not need to have six entries for just one POD type; You may mix and match.*

13. What was the total time (in minutes) for picking all inventory? *Note: This question is optional. It should only be answered if you physically picked inventory in the warehouse. You are not required to provide a numerical answer. If you are not providing a numerical answer, please check 'no answer'*

Please print the drill summary page for your records.

Dispensing Throughput (BP11)

1. What was the drill start date and time? *Note: Date entries (mm/dd/yyyy) must be between August 10th of the starting year and July 15th of the ending year, but not greater than the current date. Time entries are in the form of hh:MM AM/PM*

2. What was the drill end date and time?

3. Is this dispensing throughput drill being performed as part of a larger HSEEP standard operational response exercise or a stand-alone drill? Select from: A larger HSEEP standard operational response exercise or a stand-alone drill

If larger exercise: What is the name, date, and operational category of the exercise? What date was this conducted? What exercise type? Select from: Functional (FE) or Full-Scale (FSE)

4. Was this drill part of a real event or exercise?

If yes: What kind of real event was it? Select from: Bioterrorism Event, NSSE (National Special Security Event), Natural Disaster (flood, hurricane, tornado, ice storm, earthquake, tsunami, fire, etc.), Outbreak of Disease, Pandemic or Seasonal Influenza, Other (please specify)

5. What was the extent of notice for this drill? Select from: No notice, partial notice, full notice

6. Was the POD fully staffed and functional to meet the needs of a real world event?

7. How many people/vehicles were processed through the POD? *Note: If people/vehicles are looping through during the exercise, count each time they enter the POD*

8. How many individuals did you collect throughput times for? *Note: If people/vehicles are looping through during the exercise, count each time they enter the POD.*

9. What type of POD was used in the drill? Select from: General/Traditional/Open or Closed

10. Is this a Walk Through or Drive Through POD?

11. Does this POD include Head of Household dispensing (picking up for multiple members in the household)?

If yes: What is the authorized number of multiple regimens dispensed to Head of Households? Or select "unlimited"

12. Does this POD use a medical or non-medical model for dispensing?

13. What type of medical countermeasure was dispensed at the POD? Please check all that apply from: Oral Medical Countermeasure, Injection

14. What type of dispensing occurred at your POD? Please check all that apply (you will be asked a series of questions for each type you check). Traditional/Assisted (>3 steps) or express (2-3 steps)

15. What type of dispensing data would you like to provide about your Traditional/Assisted, Express? Select from: Time at each step/station or Time to complete overall process POD.

16. For each step (*up to 9 enterable*), what function(s) were in the (first, second, etc) step of your POD? Select from: Greeting/Entry Forms Distribution Briefing Triage Mental Health Screening and Counseling Medical Evaluation Drug Triage Dispensing Form Collection and Exit None of these (select when none of the remaining stations apply to your drill) *Note: You must select at least 1 station (function) type. This page will repeat until either all stations have been selected or 'None of these' is selected by itself*

17. How many clients went through each step and how many stations were at each step? E.g Step 1 Greeting Forms/Distribution – How many clients? How many stations? Step 2 Dispensing/Forms Collection- How many clients? How many stations

18. How much time in minutes did it take for each person going through each step or from beginning to end?

Please print the drill summary page for your records.

Epidemiology Surveillance Performance Measures

Subgrantees are required to submit this document in GMIS by September 10, 2012. The report must be generated for the time period August 10, 2011 – August 9, 2012. Performance Measure specific information are found in this RFP Appendix E and Appendix F.

Subgrantee: _____

Subgrantee Response	Measure- Table 1.20. SURV – Disease Reporting
	Numerator: Number of reports of selected reportable disease received by a public health agency within the awardee-required timeframe
	Denominator: Number of reports of selected reportable disease received by a public health agency
Subgrantee Response	Reported Data Elements
	1. Do the subgrantees-required reporting timeframes differ for providers and laboratories for any of the selected diseases? [Y/N] If NO, please skip to Question 4.
	2. For each of the selected diseases, please indicate the awardee-required reporting timeframe for providers [select one] <input type="checkbox"/> Immediately <input type="checkbox"/> 24 hours <input type="checkbox"/> 48 hours <input type="checkbox"/> 72 hours <input type="checkbox"/> 7 days <input type="checkbox"/> Other – specify
	3. For each of the selected diseases, please indicate the subgrantee-required reporting timeframe for laboratories [select one] – Please skip to Question 5. <input type="checkbox"/> Immediately

	<input type="checkbox"/> 24 hours <input type="checkbox"/> 48 hours <input type="checkbox"/> 72 hours <input type="checkbox"/> 7 days <input type="checkbox"/> Other – specify
	<p>4. For each of the selected diseases, please indicate the subgrantee-required reporting timeframe [select one]</p> <input type="checkbox"/> Immediately <input type="checkbox"/> 24 hours <input type="checkbox"/> 48 hours <input type="checkbox"/> 72 hours <input type="checkbox"/> 7 days <input type="checkbox"/> Other – specify
	<p>5. Case event date type selected for each disease [select one]</p> <input type="checkbox"/> Date of diagnosis – lab-confirmed <input type="checkbox"/> Date of diagnosis – presumptive/clinical <input type="checkbox"/> Date of laboratory report <input type="checkbox"/> Date of laboratory result <input type="checkbox"/> Date of specimen collection
	<p>6. Total number of disease reports received within the subgrantee-required reporting timeframe [numerator]. Please aggregate reports received by the health department receiving reports in counties in the pre-selected sample; do not include reports from counties that were not included in the sample.</p> <input type="checkbox"/> By disease
	<p>7. Total number of disease reports received [denominator]. Please aggregate reports received by the subgrantee health department and receiving reports in counties in the pre-selected sample; do not include reports from counties that were not included in the sample.</p> <input type="checkbox"/> By disease
	<p>8. Does the health department have in place processes, procedures, etc., for periodic (e.g., annual) review of data related to timeliness of disease</p>

	reporting for the purposes of program improvement? [Y/N] – If NO, skip to Question 11.
	9. Please describe processes, procedures, etc., the health department has in place for periodic (e.g., annual) review of data related to timeliness of disease reporting for the purposes of program improvement.
	10. Total number of LHDs reporting data for this performance measure.
	11. Total number of LHDs (from the reporting sample) that has a process, procedure, etc., in place for periodic (e.g., annual) review of data related to timeliness of reporting for the purposes of program improvement.
	12. Please describe the key barriers to timely reporting of the select diseases for this performance measure by hospitals, providers and labs.

Subgrantee Response	Measure- Table 1.21. SURV – Disease Control
	Numerator: Number of reports of selected reportable diseases for which public health control measure(s) were initiated within an appropriate timeframe
	Denominator: Number of reports of selected reportable diseases received by a public health agency
Subgrantee Response	Reported Data Elements
	1. Total number of reports for which a control measure was initiated within the appropriate timeframe [numerator] <input type="checkbox"/> By disease a. By reporting LHDs (aggregated)
	2. Total number of disease reports received [denominator]. Please aggregate reports received by health department and by LHDs receiving reports in counties in the pre-selected sample; do not include reports from counties that were not included in the sample. <input type="checkbox"/> By disease

	3. Does the health department have in place processes, procedures, etc., for periodic (e.g., annual) review of data related to timely initiation of public health control measures for the purposes of program improvement? [Y/N] – If NO, skip to Question 5.
	4. Please describe processes, procedures, etc., the health department has in place for periodic (e.g., annual) review of data related to timely initiation of public health control measures for the purposes of program improvement.
	5. Total number of LHDs reporting data for this performance measure.
	6. Total number of reporting LHDs that has a process, procedure, etc., in place for periodic (e.g., annual) review of data related to timely initiation of public health control measures for the purposes of program improvement.
	7. Please describe the key barriers faced by health departments in the timely control or mitigation of the select diseases for this performance measure.

Subgrantee Response	Measure- Table 1.23. EI – Outbreak Investigation Reports
	Numerator: Number of infectious disease outbreak investigation reports containing all minimal elements
	Denominator: Number of infectious disease outbreak reports generated
Subgrantee Response	Reported Data Elements
	<p>1. The total number of infectious disease outbreak investigations for which a report was generated</p> <p>a. in which the subgrantee led the investigation [denominator for subgrantee metric]</p> <p>b. in which the subgrantee supported any LHD investigation and contributed to writing the investigation report (irrespective of whether LHD is in 74 reporting sample)</p> <p>c. in which the awardee supported any other type of joint investigation and contributed to writing the investigation report.</p>

	<p>2. Total number of infectious disease outbreak reports containing all minimal elements</p> <p>a. in which the subgrantee led the investigation [numerator for subgrantee metric]</p> <p>b. in which the subgrantee supported any LHD investigation and contributed to writing the investigation report (irrespective of whether the LHD is in reporting sample)</p> <p>c. in which the subgrantee supported any other type of joint investigation and contributed to writing the investigation report.</p>
	<p>3. For the reports identified above that do not contain all of the minimal elements, please identify the elements that were most frequently missing [Check all that apply]</p> <p><input type="checkbox"/> Context/background</p> <p><input type="checkbox"/> Initiation of investigation</p> <p><input type="checkbox"/> Investigation methods</p> <p><input type="checkbox"/> Investigation findings/results</p> <p><input type="checkbox"/> Discussion and/or conclusions</p> <p><input type="checkbox"/> Recommendations</p> <p><input type="checkbox"/> Key investigators and/or report authors</p>
	<p>4. Briefly explain why this element(s) was most frequently missing.</p>
	<p>5. The total number of infectious disease outbreak investigations for which a report was generated (LHD must have led the investigation) [denominator for local metric]</p>
	<p>6. The total number of infectious disease outbreak investigation reports containing all minimal elements [numerator for local metric]</p>
	<p>7. For the reports identified above that do not contain all of the minimal elements, please identify the elements that were most frequently missing. [Check all that apply]</p> <p><input type="checkbox"/> Context/background</p> <p><input type="checkbox"/> Initiation of investigation</p> <p><input type="checkbox"/> Investigation methods</p>

	<input type="checkbox"/> Investigation findings/results <input type="checkbox"/> Discussion and/or conclusions <input type="checkbox"/> Recommendations <input type="checkbox"/> Key investigators and/or report authors
	8. Briefly explain why this element(s) was most frequently missing.

Subgrantee Response	Measure- Table 1.25. EI – Exposure Investigation Reports
	Numerator: Number of EI reports of acute environmental exposures generated
	Denominator: Number of EIs of acute environmental exposures
Subgrantee Response	Reported Data Elements
	1. Is the health department responsible for conducting EIs of acute environmental exposure incidents of public health significance, in either a lead or a supporting role? [Y / N] – If YES, proceed to #2.
	2. Which agency (or agencies) outside the health department is responsible for conducting epidemiological investigations of acute environmental exposures?
	3. Is the subgrantee health department typically notified of epidemiological investigations of acute environmental exposures conducted by that agency? [Y / N]
	4. Does the subgrantee health department typically receive investigation reports documenting epidemiological investigations of acute environmental exposures conducted by that agency? [Y / N]
	5. What barriers, if any, does the subgrantee health department face in being notified of acute environmental exposure incidents of public health significance, epidemiological investigations of these exposures, and/or receiving investigation reports from that agency?
	6. What steps, if any, has the subgrantee health department taken to address these barriers?

	7. Total number of acute environmental exposure incidents of public health significance that occurred in the subgrantees' jurisdiction.
	8. Total number of EIs of acute environmental exposures in which a. the subgrantee led the investigation – solely or as part of a joint investigation [denominator] b. the subgrantee supported another agency's investigation [Proceed to #4, below] c. Another agency conducted the EI(s) of an acute environmental exposures, but reported the investigation to the subgrantee (for subgrantees with no role in these investigations)
	9. If the subgrantee assumes a supporting role in the epidemiological investigation of acute environmental exposure(s), please identify the types of organizations that the subgrantee health department supports. [Check all that apply] <input type="checkbox"/> LHD <input type="checkbox"/> State environmental health agency <input type="checkbox"/> State occupational safety and health agency <input type="checkbox"/> State department of natural resources <input type="checkbox"/> State law enforcement agency <input type="checkbox"/> Hazardous materials agency <input type="checkbox"/> Other – specify
	10. Total number of investigations for which a report was generated in which a. the subgrantee led the investigation – solely or as part of a joint investigation (numerator) b. the subgrantee supported another agency's investigation and contributed to writing the investigation report c. another agency conducted the epidemiological investigation(s) of an acute environmental exposures, but reported the investigation to the subgrantee (for subgrantees with no role in these investigations)
	11. (Note: applies only to subgrantees with a lead or supporting epidemiological investigation role for acute environmental exposures) Rank

	<p>the key factors that account for the subgrantee health department not conducting epidemiological investigations of acute environmental exposures (this question refers exclusively to acute environmental exposures for which it is the general policy and/or usual practice of the subgrantee to investigate). [Rank only those that apply]</p> <p><input type="checkbox"/> Interagency collaboration and coordination challenges (i.e., between a health department and another government agency or department)</p> <p><input type="checkbox"/> Intra-agency collaboration and coordination challenges (i.e., within the health department)</p> <p><input type="checkbox"/> Insufficient resources (e.g., funding, staffing, time)</p> <p><input type="checkbox"/> Major or unexpected shifts in priorities due to emergent events, changes in mission or organization, etc.</p> <p><input type="checkbox"/> Other – specify</p>
	<p>12. What type(s) of processes, procedures, etc., does the subgrantee health department have in place for review of its epidemiological investigations of acute environmental exposures for the purposes of program improvement? [check all that apply]</p> <p><input type="checkbox"/> Periodic or annual reviews</p> <p><input type="checkbox"/> Episodic reviews or hot washes</p> <p><input type="checkbox"/> After-action reports</p> <p><input type="checkbox"/> No procedure in place</p> <p><input type="checkbox"/> Other – specify</p>

Subgrantee Response	Measure- Table 1.27. EI – Exposure Reports with Minimal Elements
	Numerator: Number of EI reports of acute environmental exposures containing all minimal elements
	Denominator: Number of EI reports of acute environmental exposures generated
Subgrantee Response	Reported Data Elements
	1. Is the subgrantee health department responsible, in either a lead or

	<p>supporting role, for conducting EIs of the human health impact(s) of acute environmental exposures of public health significance? [Y / N] If YES, proceed to question #2. If NO, all following data elements are optional.</p>
	<p>2. The total number of EIs of acute environmental exposures for which a report was generated in which</p> <ol style="list-style-type: none"> the subgrantee led the investigation – solely or as part of a joint investigation [denominator] the subgrantee supported another agency’s investigation Another agency conducted the EI(s) of an acute environmental exposures, but reported the investigation to the subgrantee (for subgrantees with no role in these investigations) [optional reporting]
	<p>3. Total number of EI reports of acute environmental exposures containing all minimal elements in which</p> <ol style="list-style-type: none"> the subgrantee led the investigation [numerator] the subgrantee supported another agency’s investigation and contributed to writing the investigation report Another agency conducted the EI(s) of an acute environmental exposures, but reported the investigation to the subgrantee (for subgrantees with no role in these investigations) [optional reporting]
	<p>4. For the reports identified above that do not contain all of the minimal elements, please identify the minimal elements that were most frequently missing. [check all that apply]</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Context/background <input checked="" type="checkbox"/> Initiation of investigation <input checked="" type="checkbox"/> Investigation methods <input checked="" type="checkbox"/> Investigation findings/results <input checked="" type="checkbox"/> Discussion and/or conclusions <input checked="" type="checkbox"/> Recommendations <input checked="" type="checkbox"/> Key investigators and/or report authors
	<p>5. Briefly explain why this element(s) was most frequently missing.</p>

Program Grant Number: _____

ATTACHMENT #17

Public Health Emergency Preparedness Program Plan

Initial Program Plan Midyear Program Report End of the Year Report

OPTIONAL RESOURCE ELEMENTS:

Outcome: Complete the program plan indicating Optional Resource Elements addressed including an objective, activities, person responsible, timeline, and benchmarks/evaluation measures. The Optional Resource Elements can be found on the following pages.

Objective	Activities	Person Responsible	Timeline	Benchmarks/ Evaluation Measures	Progress/Accomplishments

Optional Resource Elements”

Community Preparedness

CP1 Plans include process for identifying high risk and vulnerable populations.

Written plans should include policies and procedures to identify populations with the following: Health vulnerabilities such as poor health status, limited access to neighborhood health resources (e.g., disabled, elderly, pregnant women and infants, individuals with other acute medical conditions, individuals with chronic diseases, underinsured persons, persons without health insurance), reduced ability to hear, speak, understand, or remember, reduced ability to move or walk independently or respond quickly to directions during an emergency, populations with health vulnerabilities that may be caused or exacerbated by chemical, biological, or radiological exposure.

These procedures and plans should include the identification of these groups through the following elements: Review/access to existing health department data sets; existing chronic disease programs/maternal child health programs, community profiles; utilizing the efforts of the jurisdiction strategic advisory council; community coalitions to assist in determining the community’s risks

CP2 Plans include a Jurisdictional risk assessment, utilizing an all-hazards approach.

Written plans should include a jurisdictional risk assessment, utilizing an all-hazards approach with the input and assistance of the following elements: Public health and non–public health subject matter experts (e.g., emergency management, state radiation control programs/radiological subject matter experts <http://www.crcpd.org/Map/RCPmap.htm> Existing inputs from emergency management risk assessment data, health department programs, community engagements, and other applicable sources, that identify and prioritize jurisdictional hazards and health vulnerabilities

This jurisdictional risk assessment should identify the following elements: Potential hazards, vulnerabilities, and risks in the community related to the public health, medical, and mental/ behavioral health systems; the relationship of these risks to human impact, interruption of public health, medical, and mental/behavioral health services; the impact of those risks on public health, medical, and mental/behavioral health infrastructure; Jurisdictional risk assessment must include at a minimum the following elements: A definition of risk; use of Geospatial Information System or other mechanism to map locations of at-risk populations; evidence of community involvement in determining areas for risk assessment or hazard mitigation; assessment of potential loss or disruption of essential services such as clean water, sanitation, or the interruption of healthcare services, public health agency infrastructure

CP3 Plans include protocol for MRC participation

Written plans should include a protocol to encourage or promote medical personnel (e.g., physicians, nurses, allied health professionals) from community and faith-based organizations and professional organizations to register and participate with community Medical Reserve Corps or state Emergency Systems for Advance Registration of Volunteer Health Professionals programs to support health services during and after an incident.*(For additional or supporting detail, see Capability 15: Volunteer Management)*

CP4 Plans include approaches to address children's needs

Written plans should include documentation that public health has participated in jurisdictional approaches to address how children's medical and mental/behavioral healthcare will be addressed in all-hazard situations, including but not limited to the following elements: Approaches to support family reunification; Care for children whose caregivers may be killed, ill, injured, missing, quarantined, or otherwise incapacitated for lengthy periods of time; Increasing parents' and caregivers' coping skills; Supporting positive mental/behavioral health outcomes in children affected by the incident; Providing the opportunity to understand the incident.

Suggested resources:

Kids Dealing with Disasters:

<http://www.oumedicine.com/body.cfm?id=3745>

National Commission on Children and Disasters: 2010 Report to the President and Congress:

<http://www.ahrq.gov/prep/nccdreport/nccdreport.pdf>

Post-Katrina Emergency Management Reform Act of 2006: http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=109_cong_bills&docid=f:s3721is.txt.pdf

CP5 Plans include opportunities for residents to participate in safety efforts

Written plans should include a process and procedures to build and sustain volunteer opportunities for residents to participate with local emergency responders and community safety efforts year round (e.g., Medical Reserve Corps). *(For additional or supporting detail, see Capability 15: Volunteer Management)*

Community Recovery

CR1 Plans include processes for community collaboration

Written plans should include processes for collaborating with community organizations, emergency management, and healthcare organizations to identify the public health, medical, and mental/behavioral health system recovery needs for the jurisdiction's identified hazards.

Suggested resource: National Disaster Recovery Framework (draft February 2010):

<http://disasterrecoveryworkinggroup.gov/ndrf.pdf>

CR2 Plans include procedure to conduct a community assessment

Written plans should include how the health agency and other partners will conduct a community assessment and follow-up monitoring of public health, medical, and mental/behavioral health system needs after an incident.

Suggested resource for environmental incidents:

Community Assessment for Public Health Emergency Response Toolkit:

http://www.emergency.cdc.gov/disasters/surveillance/pdf/CASPER_toolkit_508%20COMPLIANT.pdf

Suggested resource for radiation incidents:

State Radiation Control Programs:

<http://www.crcpd.org/Map/RCPmap.htm>

(For additional or supporting detail, see Capability 1: Community Preparedness)

CR3 Plans include Continuity of Operations

Written plans should include the following elements (either as a stand-alone Public Health Continuity of Operations Plan or as a component of another plan): Definitions and identification of essential services needed to sustain agency mission and operations; Plans to sustain essential services regardless of the nature of the incident (e.g., all-hazards planning); Scalable work force reduction; Limited access to facilities (social distancing, staffing or security concerns); Broad-based implementation of social distancing policies if indicated; Positions, skills and personnel needed to continue essential services and functions (Human Capital Management); Identification of agency vital records (legal documents, payroll, staff assignments) that support essential functions and/or that must be preserved in an incident; Alternate worksites; Devolution of uninterrupted services for scaled down operations; Reconstitution of uninterrupted services.

Emergency Operations Coordination

EOC1 Plans include SOPs for management, operation and staffing

Written plans should include standard operating procedures that provide guidance for the management, operation, and staffing of the public health emergency operations center or public health functions within another emergency operations center. The following should be considered for inclusion in the standard operating procedures: activation procedures and levels, including who is authorized to activate the plan and under what circumstances; notification procedures; procedures recalling and/or assembling required incident command/management personnel and for ensuring facilities are available and operationally ready for assembled staff

Suggested resource: Federal Emergency Management Agency Incident Command System Forms:
http://training.fema.gov/EMIWeb/IS/ICSResource/ICSResCntr_Forms.htm

EOC2 Staff training requirements

Staff involved in incident response should have competency in the incident command and emergency management responsibilities they may be called upon to fulfill in an emergency. A precursor to having competency is for staff to attain the applicable National Incident Management System (NIMS) Certification based on discipline, level and/or jurisdictional requirements. Additional information on NIMS is located at <http://www.fema.gov/emergency/nims/>. A suggested approach to establish your NIMS training needs based on CDC guidelines is outlined below.

Tier One: Personnel who, in the event of a public health emergency, will not be working within the emergency operations center/multiagency coordination system or will not be sent out to the field as responders. Applicable training courses are: National Incident Management System, An Introduction (IS-700a); National Response Framework, An Introduction (IS-800.b);

Tier Two: Personnel who, in a public health emergency, will be assigned to fill one of the functional seats in the emergency operations center during the response operation. Applicable training courses are listed below: Introduction to Incident Command System (IS-100.b); Incident Command System for Single Resources and Initial Action Incidents (IS-200.b); National Incident Management System: An Introduction (IS-700a); National Response Framework: An Introduction (IS-800.b)

Tier Three: Personnel who, in a public health emergency, have the potential to be deployed to the field to participate in the response, including personnel who are already assigned to a field location. Applicable training

courses are listed below: Introduction to Incident Command System (IS-100.b); Incident Command System for Single Resources and Initial Action Incidents (IS-200.b); Intermediate Incident Command System (ICS-300); National Incident Management System, An Introduction (IS-700a); National Response Framework, An Introduction (IS-800.b)

Tier Four: Personnel who, in a public health emergency, are activated to Incident Management System leadership and liaison roles and are deployed to the field in leadership positions. Applicable training courses are listed below: Introduction to Incident Command System (IS-100.b); Incident Command System for Single Resources and Initial Action Incidents (IS-200.b); Intermediate Incident Command System (ICS-300); Advanced Incident Command System (ICS-400); National Incident Management System, An Introduction (IS-700a); National Response Framework, An Introduction (IS-800.b)

EOC3 Plans have a template for Incident Action Plans.

Written plans should include a template for producing Incident Action Plans. The following should be considered for inclusion in Incident Action Plans as indicated by the scale of the incident: Incident goals; Operational period objectives (major areas that must be addressed in the specified operational period to achieve the goals or control objectives); Response strategies (priorities and the general approach to accomplish the objectives); Response tactics (methods developed by Operations to achieve the objectives); Organization list with Incident Command System chart showing primary roles and relationships; Assignment list with specific tasks: Critical situation updates and assessments; Composite resource status updates; Health and safety plan (to prevent responder injury or illness); Logistics plan (e.g., procedures to support Operations with equipment and supplies); Responder medical plan (providing direction for care to responders); Map of the incident or of ill/injured persons (e.g., map of incident scene); Additional component plans, as indicated by the incident. The use of the following Incident Command System forms or equivalent documentation is recommended: Form 202 – “Incident Objectives,” Form 203 – “Organization Assignment List,” and Form 204 – “Division/Group Assignment List.”

EOC4 Plans include protocols for essential function performance

Written plans should include processes and protocols to ensure the continued performance of pre-identified essential functions during a public health incident and during an incident that renders the primary location where the functions are performed inoperable. This can be a stand-alone plan or annex but at a minimum the plan must include these elements: Definitions and identification of essential services needed to sustain agency mission and operations; plans to sustain essential services regardless of the nature of the incident (e.g., all-hazards planning); scalable workforce reduction; limited access to facilities (e.g., social distancing and staffing or security concerns); broad-based implementation of social distancing policies if indicated; positions, skills, and personnel needed to continue essential services and functions (Human Capital Management); identification of agency vital records (e.g., legal documents, payroll, and staff assignments) that support essential functions and/or that must be preserved in an incident; alternate worksites; devolution of uninterruptible services for scaled-down operations; reconstitution of uninterruptible services. For guidance on developing a Continuity of Operations Plan, refer to the resources provided by the Federal Emergency Management Agency: <http://www.fema.gov/government/coop/index.shtm>

EOC5 Plans include demobilization procedures

Written plans should include demobilization procedures for public health operations. The following should be considered for inclusion: General information about the demobilization process; responsibilities/agreements for

reconditioning of equipment/resources; responsibilities for implementation of the Demobilization Plan; general release priorities (i.e., resource type such as staff or equipment to be released) and detailed steps and processes for releasing those resources; directories (e.g., maps and telephone listings). The use of Incident Command System Form 221 - “Demobilization Checkout” or equivalent documentation is recommended.

Emergency Public Information and Warning

PIO1 Plans include responsibilities of PIO

Written plans should include description of the roles and responsibilities for the Public Information Officer, support staff (depending on incident and subject matter expertise), and potential spokesperson(s) to convey information to the public.

PIO2 Training requirements for PIO’s

Deliver key messages using principles of crisis and emergency risk communication. To ensure this, the following training must be taken within six months of hire date and at least once every five years thereafter by public information staff within the jurisdiction: CDC Crisis and Emergency Risk Communication Basic; CDC Crisis and Emergency Risk Communication for Pandemic Influenza.

These courses may be taken in any of the following ways: Self-paced online training, which is available at all times; any CDC webinar course, which is offered four times per year; in-person training at CDC, which is offered four times per year; access to Crisis and Emergency Risk Communication courses at the Preparedness and Emergency Response Learning Centers

If for any reason staff is not able to attend these courses, completing training given by staff that has been CDC trained is acceptable (train the trainer model).

PIO3 Virtual JIC requirements

Minimum components of a Virtual Joint Information Center: equipment to exchange information electronically within the jurisdiction and CDC, in real-time, if possible; shared site or mechanism or system to store electronic files of joint information center products, e-mail group lists, incident information, and scheduling

Minimum components of a Virtual Joint Information Center for territory jurisdictions entail the following: electronic access to both the CDC public website and the World Health Organization shared information site.

Fatality Management

FM1 Plans should include MOU’s, MOA’s, MAA’s for activities and resources

Written plans should include memoranda of agreement, memoranda of understanding, mutual aid agreements, contracts, and/or letters of agreement with other agencies to support coordinated activities and with other jurisdictions to share resources, facilities, services, and other potential support required during the management of fatalities. Requests should be determined by the local authority and follow the jurisdictional escalation process (i.e., local to state to federal):

State and federal resources (to include Disaster Mortuary Operational Response Teams) are requested when anticipated resource needs exceed the local capacity. County/jurisdictional plans should address mass fatality planning and thresholds for requesting additional resources.

Federal resources should be engaged/notified through the U.S. Department of Health and Human Services

(HHS) Regional Emergency Coordinators

Resources available through mutual aid (e.g., Emergency Management Assistance Compact (EMAC), memoranda of understanding, and/or memoranda of agreement) should be engaged/notified through appropriate channels (EMAC Coordinator, emergency management)

Suggested resources: National Response Framework: <http://www.fema.gov/emergency/nrf/>

National Oil and Hazardous Substances Pollution Contingency Plan:

<http://www.epa.gov/oem/content/lawsregs/ncpover.htm>

FM2 Plans include procedure for antemortem data collection

Written plans should include a procedure for the collection of antemortem data. Consideration should be given to the inclusion of these elements: Data collection/dissemination methods; call center or 1-800 number; family reception center; family assistance center. Staff who can perform the following functions: administrative activities; interviews of families in order to acquire antemortem data; system data entry of antemortem data.

FM3 Plans should include services for survivors

Written plans should include processes and protocols developed in conjunction with jurisdictional mental/behavioral health partners to identify services to provide to survivors after an incident involving fatalities. Written plans should include a contact list of pre-identified resources that could provide mental/behavioral health support to responders and families according to the incident. Consideration should be given to the inclusion of the following elements: mental/behavioral health professionals; spiritual care providers; Hospices; translators; Embassy and Consulate representatives when international victims are involved.

FM4 Plan include staff list for fatality management

Written plans should include list of staff selected in advance of an incident that could potentially fill the fatality management roles adequate to a given response.

FM5 Plan includes protocol for fatality management coordination

Written plans should include protocols that ensure that the health department, through healthcare coalitions or other mechanisms, supports the coordination of healthcare organization fatality management plans with the jurisdictional fatality management plan.

Suggested resources: FY10 Hospital Preparedness Funding Opportunity Announcement, Section 1.5.6 Fatality Management: http://www.phe.gov/Preparedness/planning/hpp/Documents/fy10_hpp_guidance.pdf

Joint Commission Emergency Management Standard EM.02.02.11.7

Information Sharing

COM1 Plan includes engagement of stakeholders

Written plans should include processes to engage stakeholders that may include the following: Law enforcement; Fire; Emergency Medical Services; Private healthcare organizations (e.g., hospitals, clinics, large corporate medical provider organizations and urgent care centers); Fusion centers; For states: local health departments, tribes and territories; Individuals who have or may need a security clearance, based on functional role. Suggested resources: FBI-CDC Criminal and Epidemiological Investigation Handbook: <http://www2a.cdc.gov/phlp/docs/crimepihandbook2006.pdf>

Joint Public Health Law Enforcement Investigations: Model Memorandum of Understanding, created by Public Health and Law Enforcement Emergency Preparedness Workgroup, CDC and Bureau of Justice Assistance: <http://www.nasemso.org/Projects/DomesticPreparedness/documents/JIMOUFinal.pdf>

COM2 Plan includes data-exchange requirements

Written plans should include a listing of data-exchange requirements for each stakeholder (including the use of common terminology, definitions, and lexicon by all stakeholders) that adhere to available national standards for data elements to be sent and data elements to be received.

COM3 Plan includes protocol for health information exchange

Written plans should include health information exchange protocols for each stakeholder that identify determinants for exchange and which may include the following elements: unusual cluster(s) or illness that threaten closure of institutional settings (e.g., illness among healthcare workers or prisoners); high burden of illness or a cluster of illness confined to a specific population (e.g., racial or ethnic group, or vulnerable populations); illness burden that is expected to overwhelm local medical or public health resources; a public health laboratory finding of interest (e.g., a novel virus identified by lab) that is not picked up clinically or through other surveillance; large numbers of patients with similar and unusual symptoms; large number of unexplained deaths; higher than expected morbidity and mortality associated with common symptoms and/or failure of patients to respond to traditional therapy; simultaneous clusters of similar illness in noncontiguous areas; received threats or intelligence; incidents in other jurisdictions that raise possible risk in home jurisdiction (e.g., elevation of pandemic influenza alert level).

Mass Care

MC1 Plan includes assessment form for shelter inspection

Written plans should include an assessment form to be used in shelter environmental health inspections, including at a minimum the following elements: identification of barriers for disabled individuals; structural integrity; facility contamination (e.g., radiological, nuclear, or chemical); adequate sanitation (e.g., toilets, showers, and hand washing stations) and waste removal; potable water supply; adequate ventilation; clean and appropriate location for food preparation and storage.

Suggested resources: CDC Environmental Health Assessment Form for Shelters:

<http://www.bt.cdc.gov/shelterassessment/>

Federal Emergency Management Agency Shelter Operations Management Toolkit, “Opening a Shelter” section, p.3-4: <http://www.fema.gov/pdf/emergency/disasterhousing/dspg-MC-ShelteringHandbook.pdf>

CDC Disaster Surveillance Tools: <http://www.emergency.cdc.gov/disasters/surveillance>

MC2 Plan includes pre-identified congregate locations

Written plans should include a list of pre-identified site(s) that have undergone an initial assessment to determine their adequacy to serve as congregate locations (based on the size, scope, and nature of potential incidents and jurisdictional risk assessment).

MC3 Access to a health screening tool at shelter registration

Have or have access to a tool for health screening of individuals during shelter registration. The following are

suggested elements for inclusion: immediate medical needs; assistive device needs; mental health needs; sensory impairment or other disability; medication use; need for assistance with activities of daily living; substance abuse.

Suggested resources: Initial Intake and Assessment Tool (HHS/American Red Cross):

http://www.acf.hhs.gov/ohsepr/snp/docs/disaster_shelter_initial_intake_tool.pdf

CDC Field Triage Decision Scheme: <http://www.cdc.gov/fieldtriage/pdf/triage%20scheme-a.pdf>

<http://www.aap.org/disasters/pdf/Standards-Disaster-Shelter-Care.pdf>

MC4 Plan includes MOU's, MOA's, MAA's for activities and resources

Written plans should include memoranda of understanding, memoranda of agreement, or letters of agreement with medication providers, including but not limited to the following elements: requesting medication from providers; bringing medication to congregate locations; storing and distributing medication at congregate locations; referring and transporting individuals to pharmacies and other providers for medication. (*For additional or supporting detail, see Capability 8: Medical Countermeasure Dispensing, Capability 9: Medical Materiel Management and Distribution, and Capability 10: Medical Surge*)

MC5 Plan includes scalable staffing model for congregate locations

Written plans should include a scalable congregate location staffing model based on number of individuals, resources available, competing priorities, and time frame in which intervention should occur that is incident-driven and, at a minimum, includes the ability to provide the following elements: medical care services; management of mental/behavioral disorders; environmental health assessments (e.g., food, water, and sanitation); data collection, monitoring, and analysis; infection control practices and procedures.

Suggested resources: Memoranda of understanding, memoranda of agreement, or letters of agreement with mental/behavioral health specialists to provide mental/behavioral health services to individuals registering at congregate locations (either at congregate locations or through referral) (*For additional or supporting detail, see Capability 10: Medical Surge and Capability 15: Volunteer Management*)

MC6 Plan includes procedures for transfer of individuals with special needs

Written plans should include procedures to coordinate with partner agencies to transfer individuals from general shelters to specialized shelters or medical facilities if needed, including the following procedural elements: patient information transfer (e.g., current condition and medical equipment needs); physical transfer of patient. (*For additional or supporting detail, see Capability 10: Medical Surge*)

MC7 Plan includes process to coordinate population monitoring at congregate locations Written plans should include a process to coordinate with partner agencies to monitor populations at congregate locations, including but not limited to the following processes: establishing registries for exposed or potentially exposed individuals for long-term health monitoring; separate shelter facilities for monitoring individuals at congregate locations; identifying, stabilizing and referring individuals who need immediate medical care or decontamination; prioritization of at-risk populations at congregate locations that have specific needs after a radiation incident (e.g., children, elderly, and pregnant women).

Suggested resources: Population Monitoring in Radiation Emergencies:

<http://emergency.cdc.gov/radiation/pdf/population-monitoring-guide.pdf>

Radiation Emergency Medical Management: <http://www.remm.nlm.gov/>

Conference of Radiation Control Program Directors State Radiation Control Programs:
<http://www.crcpd.org/Map/RCPmap.htm>

MC8 Plan includes scalable staffing for population monitoring and decontamination with one back-up for congregate locations

Written plans should include a scalable congregate location staffing matrix identifying at least one back-up for each population monitoring and decontamination response role. Skill sets at a minimum should include the following elements: the ability to manage population monitoring operation; the ability to monitor arrivals for external contamination and assess exposure; the ability to assist with decontamination services; the ability to assess exposure and internal contamination.

Suggested resources: Report on Workshop on Operating Public Shelters During a Radiation Emergency :
<http://www.naccho.org/topics/environmental/radiation/index.cfm>

Virtual Community Reception Center: <http://www.emergency.cdc.gov/radiation/crc/vcrc.asp>

Population Monitoring in Radiation Emergencies: A Guide for State and Local Public Health Partners:
<http://www.emergency.cdc.gov/radiation/pdf/population-monitoring-guide.pdf>

Map of State Radiation Control Programs: <http://www.crcpd.org/Map/RCPmap.htm>

Radiation Emergency Assistance Center Training: <http://orise.orau.gov/reacts/>

MC9 Plan includes process to conduct ongoing shelter population health surveillance

Written plans should include a process to conduct ongoing shelter population health surveillance, including the following elements: identification or development of mass care surveillance forms and processes; determination of thresholds for when to start surveillance; coordination of health surveillance plan with partner agencies' (e.g., Red Cross) activities. (*For additional or supporting detail, see Capability 14: Public Health Surveillance and Epidemiological Investigation*)

MC10 Plan includes disaster-surveillance forms

Written plans should include templates for disaster-surveillance forms, including Active Surveillance and Facility 24-hour Report forms.

Suggested resources: CDC Public Health Assessment and Surveillance After a Disaster:
http://www.emergency.cdc.gov/disasters/surveillance/pdf/CASPER_toolkit_508%20COMPLIANT.pdf

Active Surveillance form, Natural Disaster Morbidity Surveillance Individual Form:

<http://www.emergency.cdc.gov/disasters/surveillance/pdf/NaturalDisasterMorbiditySurveillanceIndividualForm.pdf>

Facility 24-hour Report Forms, Natural Disaster Morbidity Surveillance Tally Sheet:

<http://www.emergency.cdc.gov/disasters/surveillance/pdf/NaturalDisasterMorbiditySurveillanceTallySheet.pdf>

Medical Countermeasure Dispensing

MCD1 Plan includes protocols for reporting adverse events

Written plans should include processes and protocols to govern reporting of adverse events. The following items should be considered in the plans: guidance and communications messages/campaign that articulates the importance of adverse reporting regardless of suspected cause; process to ensure individuals receive the information sheet about potential adverse events of the medical countermeasure dispensed and how to report

adverse events; triage protocols when receiving notifications of adverse events; protocols when receiving notifications of adverse events.

Information required to document adverse events includes the following: patient, provider, and reporter demographics; adverse event; relevant diagnostic tests/laboratory data; recovery status; vaccine(s)/pharmaceutical(s) received, including receipt location, date, vaccine/pharmaceutical type, lot number, and dose number; utilize existing federal and jurisdictional adverse event reporting system, processes and protocols.

MC12 Staff training for adverse event reporting

Public Health staff should be trained on federal as well as their jurisdiction's adverse event reporting system, processes and protocols.

Suggested systems for training include the following: MedWatch:

<https://www.accessdata.fda.gov/scripts/medwatch/medwatch-online.htm>

Vaccine Adverse Events Reporting System:

<https://vaers.hhs.gov>

Adverse Event Reporting System, U.S. Food and Drug Administration:

<http://www.fda.gov/Drugs/GuidanceComplianceRegulatoryInformation/Surveillance/AdverseDrugEffects/default.htm>

Drug Abuse Warning Network:

<https://dawninfo.samhsa.gov/default.asp>

Medical Materiel Management and Distribution

No additional Priority Resources Elements

Medical Surge

MS1 Plan includes processes for maintaining bed-tracking systems

Written plans should include process to ensure access into the jurisdiction's bed-tracking system to maintain visibility of bed availability across the jurisdiction.

Suggested resources: Hospital Preparedness Program, Office of the Assistant Secretary of Preparedness and Response:

<http://www.phe.gov/preparedness/planning/hpp>

Hospital Preparedness Program Guidance FY10:

http://www.phe.gov/preparedness/planning/hpp/Documents/fy10_hpp_guidance.pdf

MS2 Plans include documentation of ESAR-VHP

Written plans should include the following elements: Documentation of process or protocol for how the health agency will access volunteer resources through the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) and the Medical Reserve Corps program of credentialed personnel available for assistance during an incident.

Documentation of processes for coordinating with health professional volunteer entities (e.g., MRC) and other personnel resources from various levels. (ESAR-VHP Compliance Requirements). (*For additional or*

supporting detail, see Capability 15: Volunteer Management)

MS3 Plan includes documentation of pediatric provider participation

Written plans should include documentation of participation from jurisdictional and regional pediatric providers and leaders from a variety of settings (e.g., maternal and child health programs, clinic-based, hospital-based, home healthcare, and rehabilitation) in jurisdictional response planning. Plans should include but are not limited to the following elements: process to identify gaps in the provision of pediatric care; process to access pediatric providers or pediatric medical liaisons for consultation related to clinical care. In order to access the appropriate level of care or consultation, plans should include lists of healthcare organizations that can stabilize and/or manage pediatric traumatic and medical emergencies and that have written inter-facility transfer agreements that cover pediatric patients.

Suggested resources: Pediatric Hospital Surge Capacity in Public Health Emergencies:

<http://www.ahrq.gov/prep/pedhospital/>

Coordinating Pediatric Medical Care During an Influenza Pandemic:

http://emergency.cdc.gov/healthcare/pdf/hospital_workbook.pdf

Health Resources and Services Administration's Emergency Medical Services for Children:

<http://bolivia.hrsa.gov/emsc/>

MS4 Plan includes processes for family reunification

Written plans should include processes to support or implement family reunification. Considerations should include the following elements:

Capturing and transferring the following known identification information throughout the transport continuum: pickup location (e.g., cross streets, latitude & longitude, and/or facility/school); gender and name (if possible); for nonverbal or critically ill children, collect descriptive identifying information about the physical characteristics or other identifiers of the child; keep the primary caregiver (e.g., parents, guardians, and foster parents) with the patient to the extent possible.

MS5 Plan includes coordination for demobilization of transportation

Written plans should include a process for the jurisdiction to coordinate with state emergency medical services to demobilize transportation assets used in the incident.

MS6 Plan includes process for demobilization of staff

P2: (*Priority*) Written plans should include a process to demobilize surge staff to include other state (e.g., MRC) and federal medical resources (e.g., NDMS). Process should include identification of triggers that would identify the need for demobilization. (*For additional or supporting detail, see Capability 15: Volunteer Management*)

Non-Pharmaceutical Interventions

NPI1 Plan includes documentation for implementing non-pharmaceutical interventions

Written plans should include documentation of the applicable jurisdictional, legal, and regulatory authorities and policies for recommending and implementing non-pharmaceutical interventions in both routine and incident-specific situations. This includes but is not limited to authorities for restricting the following elements:

Individuals; Groups; Facilities; Animals (e.g., animals with infectious diseases and animals with exposure to environmental, chemical, radiological hazards); Consumer food products; Public works/utilities (e.g., water supply); Travel through ports of entry. Public health departments are strongly encouraged to consult with jurisdictional legal counsel or academic centers for assistance. If applicable by jurisdictional authority, develop written memoranda of understanding or other letters of agreement with law enforcement for enforcing mandatory restrictions on movement.

Suggested resources: CDC Public Health Law Program's Coordinated Implementation of Community Response Measures (Including Social Distancing) to Control the Spread of Pandemic Respiratory Disease: A Guide for Developing a MOU for Public Health, Law Enforcement, Corrections, and the Judiciary:

<http://www2a.cdc.gov/phlp/docs/crm%20mou%20Final.pdf>

CDC Public Health Law Program's Social Distancing Law Assessment Template, Appendix A:

<http://www2a.cdc.gov/phlp/SDLP/>

NPI2 Plan includes documentation of contact information, MOU's MAA's MOA's for activities and resources

Written plans should include documentation of the following elements:

Contact information of at least two representatives from each partner agency/organization: Suggested community partners: schools, community organizations (e.g., churches and homeless shelters), businesses, hospitals, and travel/transportation industry planners

Memoranda of understanding or other written acknowledgements/agreements with community partners outlining roles, responsibilities, and resources in non-pharmaceutical interventions

Agreements with healthcare providers which must include at a minimum: procedures to communicate case definitions determined by epidemiological surveillance; procedures for reporting identified cases of inclusion to the health department. (*For additional or supporting detail, see Capability 13: Public Health Surveillance and Epidemiological Investigation*)

Suggested partners: Conference of Radiation Control Program Directors:

<http://www.crcpd.org/Map/RCPmap.html>, other radiation subject matter experts, health physicists, state environmental protection agency, U.S. Department of Energy, and U.S. Department of Agriculture

Suggested resources

H1N1 Flu: A Guide for Community and Faith-Based Organizations, Sections F, H, I:

<http://www.flu.gov/professional/community/cfboguidance.pdf>

Pandemic Influenza Community Mitigation Interim Planning Guide for Businesses and Other Employers (Appendix 4): <http://www.flu.gov/professional/community/commitigation.html>

Doing Business During an Influenza Pandemic: Human Resource Policies, Protocols, Templates, Tools, & Tips: <http://www.cidrap.umn.edu/cidrap/files/33/cidrap-shrm-hr-pandemic-toolkit.pdf>

Coordinated Implementation of Community Response Measures (Including Social Distancing) to Control the Spread of Pandemic Respiratory Disease: A Guide for Developing a MOU for Public Health, Law Enforcement, Corrections, and the Judiciary: <http://www2a.cdc.gov/phlp/emergencyprep.asp>

– Flu Guidance, Checklists and Resources: <http://www.flu.gov/professional/index.html>

– Community Strategy for Pandemic Influenza Mitigation:

<http://pandemicflu.gov/professional/community/commitigation.html>

– Business Pandemic Influenza Planning Checklist:

<http://pandemicflu.gov/professional/business/businesschecklist.html>

NPI3 Plan includes recommendation and/or implementation for potential interventions

Written plans should include a jurisdictional non-pharmaceutical intervention “playbook” detailing plans for intervention recommendation and/or implementation, based on potential interventions identified from the jurisdictional risk assessment. Suggested categories of interventions include isolation, quarantine, school and child care closures, workplace and community organization/event closure, and restrictions on movement (e.g., port of entry screenings and public transportation).

Each plan should address the following items, at a minimum: Staff and subject matter expert roles and responsibilities; legal and public health authorities for the intervention actions; intervention actions; list of identified locations that have the specific equipment required for, or locations that are easily adaptable for the intervention; contact information/notification plan of community partners involved in intervention (e.g., those providing services or equipment); identification of any issues that may be associated with the implementation of individual community-mitigation measures or the net effect of the implementation of measures (secondary effects); intervention-specific methods for information dissemination to the public (e.g. information cards to be distributed at ports of entry during movement restrictions); processes for de-escalation of intervention once it is no longer needed; documentation of the intervention during an incident.

Suggested resources

U.S. Department of Health and Human Services Assistant Secretary for Preparedness and Response, Playbooks for Hurricanes, Aerosolized Anthrax, and Radiological Dispersal Devices:

<http://www.phe.gov/Preparedness/planning/playbooks/Pages/default.aspx>

Manual of Protective Action Guides and Protective Actions for Nuclear Incidents, EPA 400-R-92-001:

<http://www.epa.gov/rpdweb00/docs/er/400-r-92-001.pdf>

Implementation of Protective Actions for Radiological Incidents at Other Than Nuclear Power Reactors:

http://www.epa.gov/rpdweb00/docs/er/symposium_on_non-npp_incidents.pdf

National Council on Radiation Protection and Measurements, Report No. 161: Management of Persons

Contaminated with Radionuclides Handbook: <http://www.ncrponline.org/Publications/161press.html>

Community Strategy for Pandemic Influenza Mitigation-Appendix 8:

<http://www.flu.gov/professional/community/commitigation.html#I>

Faith-Based and Community Organizations Pandemic Influenza Preparedness Checklist:

<http://pandemicflu.gov/professional/community/faithcomchecklist.html>

A Framework for Improving Cross-Sector Coordination for Emergency Preparedness and Response: Action Steps for Public Health, Law Enforcement, the Judiciary and Corrections:

http://www2a.cdc.gov/phlp/docs/CDC_BJA_Framework.pdf

(For additional or supporting detail, see Capability 1: Community Preparedness and Capability 4: Emergency Public Information and Warning)

NPI4 Plan includes MOU’s, MAA’s, MOA’s for support services during isolation and quarantine

Written plans should include agreements with healthcare coalitions and other community partners to coordinate support services to individuals during isolation or quarantine scenarios. *(For additional or supporting detail, see Capability 10: Medical Surge)*

NPI5 Plan includes procedures for separation of exposed from general population at ports of entry

Written plans should include procedures to support the separation of cohorts of potentially exposed travelers from the general population at ports of entry. Plans should include but are not limited to the following elements:

identification of resources (e.g., staff, facilities, and equipment) at or near ports of entry to be used for separation of cohorts; scalable plans to accommodate cohorts of various sizes in identified facilities; local and state Communicable Disease Response Plan compatible with CDC's Division of Global Migration and Quarantine guidance; applicable state/local legal authorities for detention, quarantine, and conditional release of potentially exposed persons and isolation of ill persons; processes for transportation of cohorts to, and security at, pre-identified sites.

Suggested resource: Pandemic Influenza Federal Guidance 2008, Appendix B.2:
<http://www.pandemicflu.gov/news/guidance031108.pdf>

Public Health Surveillance and Epidemiological Investigation

EPI1 Epidemiological investigation staff train on HSEEP and AAR's

Public health staff participating in epidemiological investigations should receive awareness-level training with the Homeland Security Exercise and Evaluation After Action Report process.

EPI2 Plan includes IP and Corrective action communication to stakeholders

Written plans should include procedures to communicate the improvement plan to key stakeholders (including groups representing at-risk populations) and to implement corrective actions identified in the improvement plan.

Responder Safety and Health

RSH1 Plan includes scenarios for public health responder safety and risk

Written plans should include documentation of the safety and health risk scenarios likely to be faced by public health responders, based on pre-identified jurisdictional incident risks, which are developed in consultation with partner agencies (e.g., environmental health, occupational health and safety, jurisdictional Local Emergency Planning Committee, risk-specific subject matter experts). This documentation should include the following elements: limits of exposure or injury necessitating response; job-specific worker safety guides (e.g., radiation, heat, fire, and infrastructure damage resulting in other chemical release); potential for post-event medical and mental/behavioral health follow-up assessments.

Suggested resources:

State Occupational Safety and Health Plans: <http://www.osha.gov/dcsp/osp/index.html>

Environmental Protection Agency guidelines: <http://www.epa.gov/radiation/rert/pags.html>

Jurisdictional National Weather Service Office: <http://www.weather.gov/stormready/contact.htm>

Hybrid Single Particle Lagrangian Integrated Trajectory Model: http://www.arl.noaa.gov/HYSPLIT_info.php

Area Locations of Hazardous Atmospheres Predictive Model for Chemical Emergencies:

<http://response.restoration.noaa.gov/topic>

U.S. Department of Transportation, Emergency Response Guidebook (ERG2008):

<http://www.tc.gc.ca/media/documents/canutec-eng/erg2008eng.pdf>

World Health Organization, Manual for the Public Health Management of Chemical Incidents:

http://www.who.int/environmental_health_emergencies/publications/FINAL-PHM-Chemical-Incidents_web.pdf

Jurisdictional Association for Professionals in Infection Control and Epidemiology:

<http://www.apic.org/scriptcontent/custom/members/chapters/chaptermap.cfm?section=chapters>

RSH2 Plan includes documentation of public health roles for risks

Written plans should include documentation that identifies public health roles and responsibilities related to the jurisdiction's identified risks, that was developed in conjunction with partner agencies (e.g., state environmental health, state occupational health and safety, and hazard-specific subject matter experts) and emergency managers. This documentation should identify the protective equipment, protective actions, or other mechanisms that public health responders will need to have to execute potential roles. Roles for consideration may include the following elements: conducting environmental health assessments; potable water inspections; field surveillance interviews.

Recommend inclusion of the following groups, at a minimum: State versions of Environmental Protection Agency; State Radiation Control Programs: <http://www.crcpd.org/Map/RCPmap.htm>_ State Occupational Safety and Health Agency.

Suggested resources:

Federal Emergency Management Agency, Center for Domestic Preparedness Responder Handbook:

http://cdp.dhs.gov/pdfs/responder_handbook.pdf

Department of Homeland Security, Planning Guidance for Protection and Recovery Following RDD and IND Incidents: <http://ogcms.energy.gov/73fr45029.pdf>

CDC National Institute for Occupational Safety and Health, Pocket Guide to Chemical Hazards:

<http://www.cdc.gov/niosh/npg/npgsyn-c.html>

Jane's Chem-Bio Handbook

American Conference of Governmental Industrial Hygienists Threshold Limit Values and Biological Exposure Indices Guide

CDC, Population Monitoring in Radiation Emergencies: A Guide for State and Local Public Health Planners:

<http://emergency.cdc.gov/radiation/pdf/population-monitoring-guide.pdf>

CDC Radiological Terrorism: Just in Time Training for Hospital Clinicians:

<http://emergency.cdc.gov/radiation/justintime.asp>

CDC Radiological Terrorism: Tool Kit for Public Health Officials:

<http://emergency.cdc.gov/radiation/publichealthtoolkit.asp>

Federal Emergency Management Agency, Environmental Health Training in Emergency Response:

<https://cdp.dhs.gov/resident/ehtr.html>

Occupational Safety and Health Services Unit, Keeping Workers Safe During Clean Up and Recovery Operations Following Hurricanes, 2005: www.osha.gov/OshDoc/hurricaneRecovery.html

American Public Health Association (APHA) Policy Statement 20027: Protecting the Health and Safety of Workers Who Respond to Disasters. APHA Policy Statements, 1948 - present, cumulative:

http://www.apha.org/legislative/policy/policysearch/index.cfm?fuseaction=search_results&YearofPolicy=2002

American Public Health Association Policy Statement 20069: Response to Disasters: Protection of Rescue and Recovery Workers, Volunteers, and Residents Responding to Disasters:

<http://www.apha.org/advocacy/policy/policysearch/default.htm?id=1333>

RSH3 Plan includes PPE recommendations

P1: (Priority) Written plans should include recommendations for risk-related personal protective equipment for public health responders that have been developed in conjunction with partner agencies (e.g., state environmental health, state occupational health and safety, and risk-specific subject matter experts).

Suggested resources

CDC's National Institute for Occupational Safety and Health, Pocket Guide to Chemical Hazards:

<http://www.cdc.gov/niosh/npg/npgsyn-c.html>

U.S. Health and Human Services, Radiation Emergency Medical Management Guide PPE Guidance:

<http://www.remm.nlm.gov/onsite.htm>

Occupational Safety and Health Services Unit, general description and discussion of the levels of protection and protective gear:

http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=STANDARDS&p_id=9767

RSH4 Access to PPE for identified risks

Have or have access to personal protective equipment that is consistent with the identified risks in the jurisdiction and associated job functions of public health response personnel. This equipment should meet nationally recognized standards as defined by the InterAgency Board for Equipment Standardization and Interoperability <https://iab.gov/>

Note: If public health departments elect to purchase personal protective equipment for their responders, they must follow state, Occupational Safety and Health Services Unit, CDC's National Institute for Occupational Safety and Health, and other applicable regulations regarding the storage, dissemination, fit testing, and maintenance of such personal protective equipment.

Suggested resource:

General description and discussion of the levels of protection and protective gear, OSHA:

http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=STANDARDS&p_id=9767

RSH5 Staff training for N-95 or other respirators

Public health staff required to use N-95 or other respirators as part of their response role should undergo respiratory function testing.

Suggested resources:

Professional Training and Certification in Spirometry Testing and Respiratory Health Surveillance, a National Institute for Occupational Safety and Health-approved Program for Health Professionals

National Institute for Occupational Safety and Health Spirometry Initial Training and National Institute for Occupational Safety and Health Spirometry Refresher Course

American National Standards Institute/American Industrial Hygiene Association Z88 Accredited Standards Committee, Respiratory Protection: <http://www.aiha.org/insideaiha/standards/Pages/Z88.aspx>

RSH6 Responder training for public health staff

S2: (Priority) Public health staff that perform responder functions, as well as staff identified as surge-capacity personnel, should have documentation of training, with documentation updated a minimum of once per year. Documentation should include training date and manner of delivery (e.g., formal training or "train the trainer"). Formal training examples include CDC courses and CD or DVD-based courses, with completion verified by a formal demonstration.

RSH7 Plan includes protocols for surveillance activities between public health and lead agency

Written plans should include process and protocols for how the public health agency, in conjunction with lead partners (e.g., occupational health and safety) will participate in surveillance activities to monitor levels of

environmental exposure, environmental effects on the responders, and/or incident-related injuries. (*For additional or supporting detail, see Capability 13: Public Health Surveillance and Epidemiological Investigation*)

Suggested resources:

Physical Health Status of World Trade Center Rescue and Recovery Workers and Volunteers -New York City, July 2002 - August 2004. *Morbidity and Mortality Weekly Report* , 53(35): 807-812. September 10, 2005: www.cdc.gov/mmwr/preview/mmwrhtml/mm5335a1.htm

CDC, Chemical Exposure Assessment Considerations for Use in Evaluating Deepwater Horizon Response Workers and Volunteers: <http://www.cdc.gov/niosh/topics/oilspillresponse/assessment.html>

National Institute for Occupational Safety and Health (NIOSH) Deepwater Horizon Data Use and Disclosure: <http://www.cdc.gov/niosh/topics/oilspillresponse/pdfs/NIOSH-Disclosure-English-051110.pdf>

NIOSH Deepwater Horizon Initial Roster Form: <http://www.cdc.gov/niosh/topics/oilspillresponse/pdfs/NIOSH-Roster-Form-English-051210.pdf>

Procedures for Recruiting Volunteers for Investigative Studies from the NIOSH Deepwater Horizon Response: <http://www.cdc.gov/niosh/topics/oilspillresponse/recruiting.html>

RSH8 Access to database of responder exposure

Have or have access to a registry database of responders who were exposed and/or injured during an incident. This database should be updated at a frequency appropriate to the incident.

Volunteer Management

VM1 Plan includes anticipated volunteer needs

Written plans should address anticipated volunteer needs in response to incidents or situations identified in the jurisdictional risk assessment including the following elements: identification of functional roles; skills, knowledge, or abilities needed for each volunteer task or role; description of when the volunteer actions will happen; identification of jurisdictional authorities that govern volunteer liability issues and scope of practice

VM2 Plan includes MOU's, MAA's, MOA's with volunteer sources

Written plans should include memoranda of understanding or other letters of agreement with jurisdictional volunteer sources. Suggested partners include but are not limited to the following groups: Professional medical organizations (e.g., nursing and allied health); Professional guilds (e.g., behavioral health); Academic institutions; Faith-based organizations; Voluntary Organizations Active in Disasters; Medical Reserve Corps; Non-profit, private, and community-based volunteer groups; Partnership agreements should include plans for the following: Partner organizations' promotion of public health volunteer opportunities; Referral of all volunteers to register with jurisdictional Medical Reserve Corps and/or ESAR-VHP; Policies for protection of volunteer information, including destruction of information when it is no longer needed (e.g., Red Cross, Community Emergency Response Teams, and member organizations of the National and State Voluntary Organizations Active in Disasters); Liability protection for volunteers; Efforts to continually engage volunteers through routine community health activities; Documentation of the volunteers' affiliations (e.g., employers and volunteer organizations) at local, state, and federal levels (to assist in minimizing "double counting" of prospective volunteers), and provision for registered volunteer Identification cards denoting volunteers' area of expertise.

VM3 Plan includes volunteer briefing template

Written plans should include a template for briefing volunteers of current incident conditions, including the following elements: instructions on the current status of the emergency; volunteers' role (including how the volunteer is to operate within incident management); Just-in-time training; safety instructions; any applicable liability issues related to the incident and the volunteers' roles, psychological first aid, and/or volunteer stress management.

VM4 Plan includes spontaneous volunteers management process

Written plans should include a process to manage spontaneous volunteers. The process should include, at a minimum, the following elements: process to communicate to the public whether spontaneous volunteers should report, and, if so, where and to whom; method to inform spontaneous volunteers how to register for use in future emergency responses; method to refer spontaneous volunteers to other organization (e.g., non-profit or Medical Reserve Corps)

(For additional or supporting detail, see Capability 4: Emergency Public Information and Warning)

If spontaneous volunteers will be integrated into a response, the process should include the identification of duties spontaneous volunteers can perform.

Suggested resources:

Managing Spontaneous Volunteers in Times of Disaster: The Synergy of Structure and Good Intentions:

http://www.nvoad.org/index.php/rl/cat_view/46-volunteer-management-.html

CDC and Association of State and Territorial Health Officials, At-Risk Populations and Pandemic Influenza:

Planning Guidance for State, Territorial, Tribal, and Local Health Departments:

<http://www.astho.org/Display/AssetDisplay.aspx?id=401>

VM5 Plan includes volunteer release process

Written plans should include a process for releasing volunteers, to be used when the public health department has the lead role in volunteer coordination. The process should include steps to accomplish the following: demobilize volunteers in accordance with the incident action plan; assure all assigned activities are completed, and/or replacement volunteers are informed of the activities' status; determine whether additional volunteer assistance is needed from the volunteer; assure all equipment is returned by volunteer; confirm the volunteer's follow-up contact information. *(For additional or supporting detail, see Capability 4: Emergency Operations Coordination)*

VM6 Plan includes exit screening protocol

Written plans should include a protocol for conducting exit screening during out-processing, to include documentation of the following: any injuries and illnesses acquired during the response; mental/behavioral health needs due to participation in the response; when requested or indicated, referral of volunteer to medical and mental/behavioral health services.

Suggested resource:

Information on post-incident environmental or occupational exposure monitoring: National Institute of Occupational Safety and Health website <http://www.cdc.gov/niosh/>

(For additional or supporting detail, see Capability 14: Responder Safety and Health)

GMIS 2.0 USER ACCESS REQUESTS

Effective immediately, GMIS 2.0 User Access Requests will only be honored when requested by your Agency Head or Agency Financial Head. This procedure ensures that the integrity of the ODH Application Gateway – GMIS 2.0 System remains intact.

Requests for GMIS 2.0 new users are to include the following information:

- Salutation: Dr, Mr., Mrs., Miss or Ms
- User's Name (no nicknames, please)
- User's Job Title
- Phone Number
- Fax Number
- E-mail address
- Agency Name
- Listing of Grant(s) the individual is to have access to

Additional grant(s) access requests are to include the following information:

- User's Name
- Listing of additional Grant(s) the individual is to have access to

In addition, if a user leaves your agency, you are to notify ODH so that their account is rendered inactive.

Requests may be faxed or e-mailed to:

Evelyn Suarez, Training Coordinator	or Gail Byers, Grants Processing Team Manager
Grants Services Unit		Grants Services Unit
Office of Financial Affairs		Office of Financial Affairs
Ohio Department of Health		Ohio Department of Health
246 N High Street		246 N High Street
Columbus, Ohio 43215		Columbus, Ohio 43215
Phone: 614-644-7566		Phone: 614-644-5728
Fax: 614-752-9783		Fax: 614-752-9783
evelyn.suarez@odh.ohio.gov		gail.byers@odh.ohio.gov

The access process takes approximately one week. The user will receive their Username and password via e-mail once the request is processed.

If you need additional assistance please feel free to contact your Regional Grant Consultant.

Thank you.

Grants Services

Ohio Department of Health
GMIS 2.0 TRAINING

ALL INFORMATION REQUESTED MUST BE COMPLETED for EACH EMPLOYEE FROM YOUR AGENCY WHO WILL ATTEND A GMIS 2.0 TRAINING SESSION.

(Please Print Clearly or Type)

Grant Program _____ RFP due Date _____

County of Applicant Agency _____

Federal Tax Identification Number _____

NOTE: The applicant agency/organization name must be the same as that on the IRS letter. This is the legal name by which the tax identification number is assigned and as listed, if applicable, currently in GMIS.

Applicant Agency/Organization _____

Applicant Agency Address _____

Agency Employee to attend training _____

Telephone Number _____

E-mail Address _____

GMIS 2.0 Training Authorized by: _____

(Signature of Agency Head or Agency Fiscal Head) Required

Please Check One: _____ Yes – I ALREADY have access to the ODH GATEWAY (SPES, ODRS, LHIS, etc)

_____ No – I DO NOT have access to the ODH GATEWAY

Please indicate your training date choices: 1st choice _____, 2nd choice _____, 3rd choice _____

Mail, E-mail, or Fax To: **Evelyn Suarez**
Grants Services Unit
Ohio Department of Health
246 N. High Street
Columbus, Ohio 43215
E-mail: evelyn.suarez@odh.ohio.gov Fax: 614-752-9783

CONFIRMATION OF YOUR GMIS 2.0 TRAINING SESSION WILL BE E-MAILED TO YOU

APPENDIX B

**Ohio Department of Health Sub-Awardee
Federal Funding Accountability and Transparency Act (FFATA) Reporting Form
SAMPLE ONLY – COMPLETE FFATA IN GMIS 2.0**

Submission Date

____/____/____

Sub-Awardee Data

1	DUNS #	
2	DUNS # plus 4	
3	Name	
4	DBA Name	
5	Address - Street # 1	
6	Address - Street # 2	
7	Address - Street # 3	
8	City	
9	State	
10	County (select from list of Ohio counties)	
11	Zip plus 4	
12	Congressional District	
13	Sub-awardee - Parent DUNS #	
14	Amount of Sub-award/Contract	Completed by ODH
15	Sub-award Obligation/Action Date (i.e., date the NOA and/or Contract is signed/approved)	Completed by ODH
16	CFDA and Program Title	Completed by ODH
17	Federal Agency Name	Completed by ODH
18	Principal Place of Performance (PPP)- City (or County if as a whole)	
19	PPP - State	

20	PPP - County	
21	PPP - Zip + 4	
22	PPP - Congressional District	
23	Sub-award/Contract # (i.e., the project ID for sub-grants)	
24	Q1. In organization's previous FY did it receive 80% or more from federal contracts and \$25,000,000 or more from federal contracts? If yes, please see Q2.	
25	Q2. Does the public have access to compensation of senior executives via the section 6104 of the IRS Code of 1986? If "yes", then the project is not required to report the compensation information. If "no" please enter the compensation information.	
26	1 of 5 highest compensated officials - Name	
27	1 of 5 highest compensated officials - Amount	
28	2 of 5 highest compensated officials - Name	
29	2 of 5 highest compensated officials - Amount	
30	3 of 5 highest compensated officials - Name	
31	3 of 5 highest compensated officials - Amount	
32	4 of 5 highest compensated officials - Name	
33	4 of 5 highest compensated officials - Amount	
34	5 of 5 highest compensated officials - Name	
35	5 of 5 highest compensated officials - Amount	
36	Project Description	Completed by ODH
37	Agency Director/President	
38	Agency Program/Project Director	
39	Agency Phone Number	
40	Program Source/Treasury Account Symbol	Completed by ODH
41	CCR # (of Parent Agency if applicable)	

Complete section below if Agency is not in the State of Ohio

42	If 'Other' County Selected, name of county outside of Ohio	
43	If 'Out of State' Congressional District Selected, provide State and Congressional District	
44	If 'Out of State' PPP - County	
45	If 'Out of State' PPP - Congressional District	

APPLICATION REVIEW FORM

TOTAL POINTS APPLIED FOR: _____

TOTAL SCORE: _____

TOTAL PERCENTAGE: _____

**Bureau of Health Preparedness
Public Health Emergency Preparedness
Grant Application Review Form (FY 2013)**

AGENCY: _____ **COUNTY:** _____

FUNDING REQUESTED FOR FY2013: _____ **FUNDING ELIGIBILITY:** _____

PHEP CONSULTANT NAME: _____ **GSU CONSULTANT NAME:** _____

GMIS BUDGET INFORMATION (35 points total)	SCORE	COMMENTS
GMIS Budget: Personnel, Other Direct Costs, Equipment, Contracts and Confirmation of Contractual Agreement Forms: (10 points)		
Applicant provides a detailed narrative budget justification that: <ol style="list-style-type: none"> 1. An electronically submitted budget for the appropriate budget period has been proposed. (2 pts.) 2. Adequately describes each line item including total amount allocated. (2 pts.) 3. Includes a description of the specific functions (and associated costs) of all personnel involved with the grant. (2 pts.) 4. Discusses the necessity/appropriateness of each proposed cost, including justification of equipment, training and travel. (2 pts.) 5. A detailed description of what is to be accomplished via contracts and subsidies (paying special attention to deliverables) have been submitted. (2 pts.) 		

Past Performance (25 points)		
<ol style="list-style-type: none"> 1. All program reports submitted on time (or received an approved extension according to GAPP) for FY11 (3 pt.) 2. All special conditions are replied to on time for FY11 (2 pt.) 3. Any out of compliance (from site visits) issues are rectified within time period 4. (2 pt.) 5. Progress on mid-year progress report as reported to ODH in the March 2012 mid-year report (10 pts.) 6. All expenditure reports are submitted on time (or received an approved extension according to GAPP) (3 pt.) 7. All unspent funds are returned on time (as evidenced by not being certified to the Attorney General during the FY 10 and FY11 grant years) (5 pts.) 		
PROGRAM NARRATIVE: (22 points total)	SCORE	COMMENTS
Core Leadership and Grant Administration: (7 points)		
<p>CL1. For counties with multiple local health departments, describe the following: which local health departments participate in PHEP and how; PHEP funding is distributed including if any LHD in the county does not receive PHEP funding; how PHEP information and updates from ODH or PHEP sub-grantee are shared; how PHEP related activities are coordinated between health departments to ensure that the entire county population is served. (1 pts.)</p> <p>CL2. Provide one or two examples of success stories or promising practices your PHEP project has had in your county/region within the last grant year (e.g. collaboration among several LHDs or other local agencies in terms of planning efforts, volunteer recruitment and training, use of interoperable communications, staff training and development, etc.). (1 pts.)</p> <p>CL3. Describe how you will maintain Core Leadership (full-time health commissioner and/or administrator, full-time environmental health director, and full-time nursing director) during the course of this grant year. In the event of a vacancy, describe the steps you will take to meet the requirement, including official notification of ODH in writing. (1 pts.)</p> <p>CL4. Describe how you provide public health medical direction (including backup),</p>		

<p>24 hours a day, and seven days a week. (1 pts.)</p> <p>CL5. For Agencies that are the administering agent for other jurisdictions, describe your method of monitoring the use and administration of PHEP funds. (1 pts.)</p> <p>CL6. Provide a statement of assurance that the agencies Board of Health will provide preapproval to refund grant funds within 45 days of the end of the grant fiscal year. (1 pts.)</p> <p>CL7. Provide a statement of assurance that you will complete and submit Mid-Year Program Report by March 15, 2013 and End-of-Year Report by August 15, 2013. (1 pts.)</p>		
<p>Capabilities</p>		
<p>Community Preparedness (4 points)</p>		
<p>CP1. Provide the number of community sectors that you have identified as key organizations to participate in public health, medical, and/or mental/behavioral health-related emergency preparedness efforts. (1 pts.)</p> <p>CP2. Provide the number of community sectors that were utilized during the development of Hazard and Vulnerability Assessment (HVA) data to determine local hazards, vulnerabilities, and risks that may impact public health, medical, and/or mental/behavioral health systems and services. (1 pts.)</p> <p>CP3. Provide the number of key organizations that engaged in a significant public health emergency preparedness activity. (1 pts.)</p> <p>CP4. Provide the number of community sectors that engage in developing and/or reviewing a community recovery plan related to the restoration and recovery of public health, medical, and/or mental/behavioral health systems and services. (1 pts.)</p>		
<p>Information Sharing (1 point)</p>		

<p>IS1. Provide assurance that you will maintain 75% confirmation on monthly Multi-Agency Radio Communication System (MARCS) unannounced radio checks. (1 pt.)</p>		
<p>Public Health Surveillance & Epidemiological Investigation (7 points)</p>		
<p>EPI1. Provide assurance that you will comply with the Performance Measures reports that are listed in Appendix E. Sub-grantees will be responsible for the Performance Measures. (1 pt.)</p> <p>EPI2. Provide assurance that you will report summary data generated from real infectious disease outbreak investigations and investigation reports for the following diseases via ODRS.</p> <ul style="list-style-type: none"> ○ Botulism (Clostridium botulinum), all types excluding infant botulism (confirmed) ○ E. coli (STEC) (all reports) ○ Hepatitis A, Acute (confirmed) ○ Measles (confirmed and probable) ○ Meningococcal Disease (Neisseria meningitides) (confirmed) ○ Tularemia (Francisella tulanensis) (confirmed and probable) (1 pt.) <p>EPI3. Provide assurance that you will report selected reportable diseases for which initial public health control measures were initiated within the appropriate timeframe.</p> <ul style="list-style-type: none"> ○ Botulism (Clostridium botulinum), all types excluding infant botulism (confirmed) ○ E. coli (STEC) (all reports) ○ Hepatitis A, Acute (confirmed) ○ Measles (confirmed and probable) ○ Meningococcal Disease (Neisseria nemingitides) (confirmed) ○ Tularemia (Francisella tulanensis) (confirmed and probable) (1 pt.) <p>EPI4. Provide assurance that you will report summary data generated from real infectious disease outbreak investigations and investigation reports only. (1</p>		

<p>pt.)</p> <p>EPI5. Provide assurance that you will report summary data generated from real infectious disease outbreak investigations and investigation reports only that contain all minimal elements. Include the following elements:</p> <ul style="list-style-type: none"> ○ Context/Background ○ Initiation of Investigation, ○ Investigation methods ○ Investigation findings/results ○ Discussion and/or conclusion ○ Recommendations for controlling disease and/or preventing mitigating exposure ○ Key investigators and/or report authors (1 pt.) <p>EPI6. Provide assurance that you will report summary data generated from real environmental investigations and investigation reports only. (1 pt.)</p> <p>EPI7. Provide assurance that you will report summary data generated from real environmental investigations and investigation reports only that contain all minimal elements. Include the following elements:</p> <ul style="list-style-type: none"> ○ Context/Background ○ Initiation of Investigation, ○ Investigation methods ○ Investigation findings/results ○ Discussion and/or conclusion ○ Recommendations for controlling disease and/or preventing mitigating exposure ○ Key investigators and/or report authors (1 pt.) 		
<p>Medical Countermeasure Dispensing (3 points)</p>		
<p>CMD1. Submit via GMIS 2.0, a complete Local Technical Assistance Review (L-TAR) self-assessment with your application. Submit with your End-of-Year</p>		

<p>Report, an L-TAR self-assessment describing areas which show improvement from your initial self-assessment submitted with the application. (1 pts.)</p> <p>CMD2. Describe how you will address the identified gaps in the SNS L-TAR throughout the grant year in order to achieve a minimum score of 69%. Submit an Improvement Plan with your Mid-Year Report. Include in the Improvement Plan the action steps you will utilize to achieve a minimum score of 69% on the SNS L-TAR. (1 pts.)</p> <p>CMD3. Provide assurance that you will complete a DSNS Rand Drill with documentation submitted via email to your PHEP consultant by June 1, 2013. (1 pts.)</p>		
<p>Regional Coordination</p>		
<p>Regional Public Health Planning: (15 points total)</p>		
<p>RPH1. Provide an overview and update of your regional coordination decision making body, and any of its workgroups/sub-committees, including the Public Health Planning Committee (sometimes referred to as Public Health Executive Steering Committee) and any Additional committees. Describe how often the committees meet, their reporting structures, membership, and decision-making process that ensures full participation of membership. In addition, provide the dates the committee(s) will meet during this grant period. (5 pts.)</p> <p>RPH2. Describe how you will maintain and strengthen your collaboration with Regional Hospital Coordinators (RHC), LHDs, county Emergency Management Agencies (EMAs) and hospitals across the region to reinforce the objectives underlying regional planning. (5 pts.)</p> <p>RPH3. Describe how your region will facilitate the development and use of a consistent communication method and decision process for Public Health to request from the state, via county EMA, medical materiel for any regional assets, dispensing sites, hospitals, or other healthcare facilities. (5 pts.)</p>		

Cities Readiness Initiative (CRI)	(20 points total)	
<p>CRI1. Describe how CRI funding is allocated among the health departments in the MSA, ensuring a signoff by the leadership of all jurisdictions. (5 pts.)</p> <p>CRI2. Describe how the CRI subgrantee ensures that information is shared with the health departments in the MSA and how CRI activities are coordinated with the health departments in the MSA to ensure the CRI goals and objectives are met. (5 pts.)</p> <p>CRI3. Provide a statement of assurance indicating the subgrantee will facilitate a L-TAR self-assessment process with each CRI MSA in the region, and will submit the L-TAR self-assessment, and all supporting documentation, for each CRI MSA in the region, two weeks prior to the ODH or CDC assessments are completed. (5 pts.)</p> <p>CRI4. Provide a statement of assurance indicating the subgrantee will facilitate monthly meetings and/or conference calls with all CRI MSAs in the region to discuss collaboration, planning, and CRI goals/objectives/deliverables. Submit a schedule of the meeting dates no later than 30 days after receipt of the Notice of Award (NOA). (5 pts.)</p>		
Program Plans: Community Preparedness	(10 points total)	
Activities are listed addressing each benchmark for each objective below.		
<ul style="list-style-type: none"> LHD develop plans to participate in coalition with the 11 community sectors (5 pts.) LHD solicit public comment on plans (5 pts.) 		
Program Plans: Community Recovery	(5 points total)	
Activities are listed addressing each benchmark for each objective below.		
<ul style="list-style-type: none"> LHD maintains a written Public Health Continuity of Operations Plan (5 pts.) 		
Program Plans: Information Sharing	(10 points total)	
Activities are listed addressing each benchmark for each objective below.		
<ul style="list-style-type: none"> LHD maintain a written role-based public health directory for public health alert messaging (5 pts.) 		

<ul style="list-style-type: none"> LHD will develop public health alert messages (5 pts.) 		
<p>Program Plans: Public Health Surveillance & Epidemiological Investigation (41 points total)</p> <p>Activities are listed addressing each benchmark for each objective below</p>		
<ul style="list-style-type: none"> Develop or maintain documented legal and procedural framework for information exchange (5 pts.) Develop or maintain protocols for accessing health information that protects personal health information (4 pts.) LHD will develop or maintain protocols to gather and analyze surveillance data (4 pts.) LHD has procedures to ensure 24/7/365 health department access (4 pts.) LHD has protocols to notify CDC of cases on the Nationally Notifiable Infectious Disease List (4 pts.) LHD epidemiologist has at a minimum the Tier 1 Competencies and Skills for Applied Epidemiologists in Governmental Public Health Agencies (4 pts.) LHD have access to health information infrastructure and surveillance systems (4 pts.) LHD develops investigation report templates (4 pts.) LHD maintain staffing capacity to manage the routine and surge epidemiological investigations (4 pts.) LHD develop protocols for recommending and initiating, if indicated, containment and mitigation actions in response to public health incidents (4 pts.) 		
<p>Program Plans: Emergency Public Information and Warning (10 points total)</p> <p>Activities are listed addressing each benchmark for each objective below.</p>		
<ul style="list-style-type: none"> LHD will develop and maintain message templates that address jurisdictional vulnerabilities (5 pts.) LHD Public Information Officers have completed NIMS training (5 pts.) 		
<p>Program Plans: Medical Countermeasure Dispensing (25 points total)</p> <p>Activities are listed addressing each benchmark for each objective below.</p>		
<ul style="list-style-type: none"> LHD develop standard operating procedures to identify the medical countermeasures required for the incident or potential incident (5 pts.) LHD develop protocols to request additional medical countermeasures (5 pts.) LHD develop written agreements (e.g., memoranda of agreement, memoranda 		

<p>of understanding, mutual aid agreements or other letters of agreement) to share resources, facilities, services, and other potential support (5 pts.)</p> <ul style="list-style-type: none"> • LHD develop protocols to govern the activation of dispensing modalities (5 pts.) • LHD develop protocols to govern the dispensing of medical countermeasures (5 pts.) 		
<p>Program Plans: Medical Materiel Distribution (32 points total) Activities are listed addressing each benchmark for each objective below.</p>		
<ul style="list-style-type: none"> • LHD document primary and backup receiving sites (4 pts.) • LHD develop a transportation strategy (4 pts.) • LHD develop a protocol to report medical materiel levels to public health at least weekly (4 pts.) • LHD develop a process to request medical materiel (initial request and re-supply requests) (4 pts.) • LHD develop protocols for reporting to jurisdictional, state, regional, and federal authorities (4 pts.) • LHD develop protocols to maintain physical security of medical countermeasures throughout acquisition, storage and distribution (4 pts.) • LHD develop protocols for allocation and distribution of medical materiel (4 pts.) • LHD develop protocols for the storage, distribution, disposal or return of unused (unopened) medical materiel (4 pts.) 		
<p>Program Plans: Medical Surge (12 points total) Activities are listed addressing each benchmark for each objective below.</p>		
<ul style="list-style-type: none"> • LHD develop or maintain plans which include documentation of how they will engage in healthcare coalitions. (4 pts.) • LHD develop or maintain protocols to identify essential situation awareness. (4 pts.) • LHD develop or maintain plans for at-risk individuals with the assistance of the healthcare coalition. (4 pts.) 		
<p>Program Plans: Regional Public Health Planning (44 points total) Activities are listed addressing each benchmark for each objective below.</p>		
<ul style="list-style-type: none"> • A Regional Resource-Sharing Plan is developed to identify the procedures and protocols for sharing public health resources within and outside the region (4 pts.) 		

<ul style="list-style-type: none"> • A Continuity of Operations Plan template is developed and/or modified for use by each local health department (5 pts.) • A Stakeholder Role-Based Public Health Directory template is developed and/or modified for use by each local health department for alert messaging (5 pts.) • A Regional Epidemiological Surveillance and Investigation Plan is developed and/or modified for use and updated annually (5 pts.) • An Emergency Public Information System Plan template (including common message templates that address jurisdictional vulnerabilities) is developed and/or modified for use by each local health department (5 pts.) • A Medical Countermeasure Dispensing Plan template is developed and/or modified for use by each local health department (5 pts.) • A Medical Materiel Management and Distribution Plan template is developed and/or modified for use by each local health department (5 pts.) • A Community Preparedness Plan template is developed and/or modified for use by each local health department to build community partnerships to support health preparedness (5 pts.) • Support the integration of public health and medical surge plans to ensure regional health preparedness (5 pts.) 		
<p>Program Plans: Cities Readiness Initiative (19 points total) Activities are listed addressing each benchmark for each objective below.</p>		
<ul style="list-style-type: none"> • Participate in annual CRI assessment (4 pts.) • Conduct a minimum of 3 different CDC/SNS RAND drills (5 pts.) • Complete documentation of the POD standards (5 pts.) • Complete one full scale mass prophylaxis exercise (FSE) for each CRI MSA within the five year PHEP project period, 2011-2016. The FSE must test key components of mass dispensing/ prophylaxis plan (Section 10 in L-TAR) and follow HSEEP methodology (5 pts.) 		

AGENCY: _____

Strengths: _____

Weaknesses: _____

REVIEW RECOMMENDED ACTION:

Approval

Approval with Modifications: _____

Disapproval -The following criteria constitute grounds for disapproval of applications:

Incomplete grant proposal

Fraudulent presentation

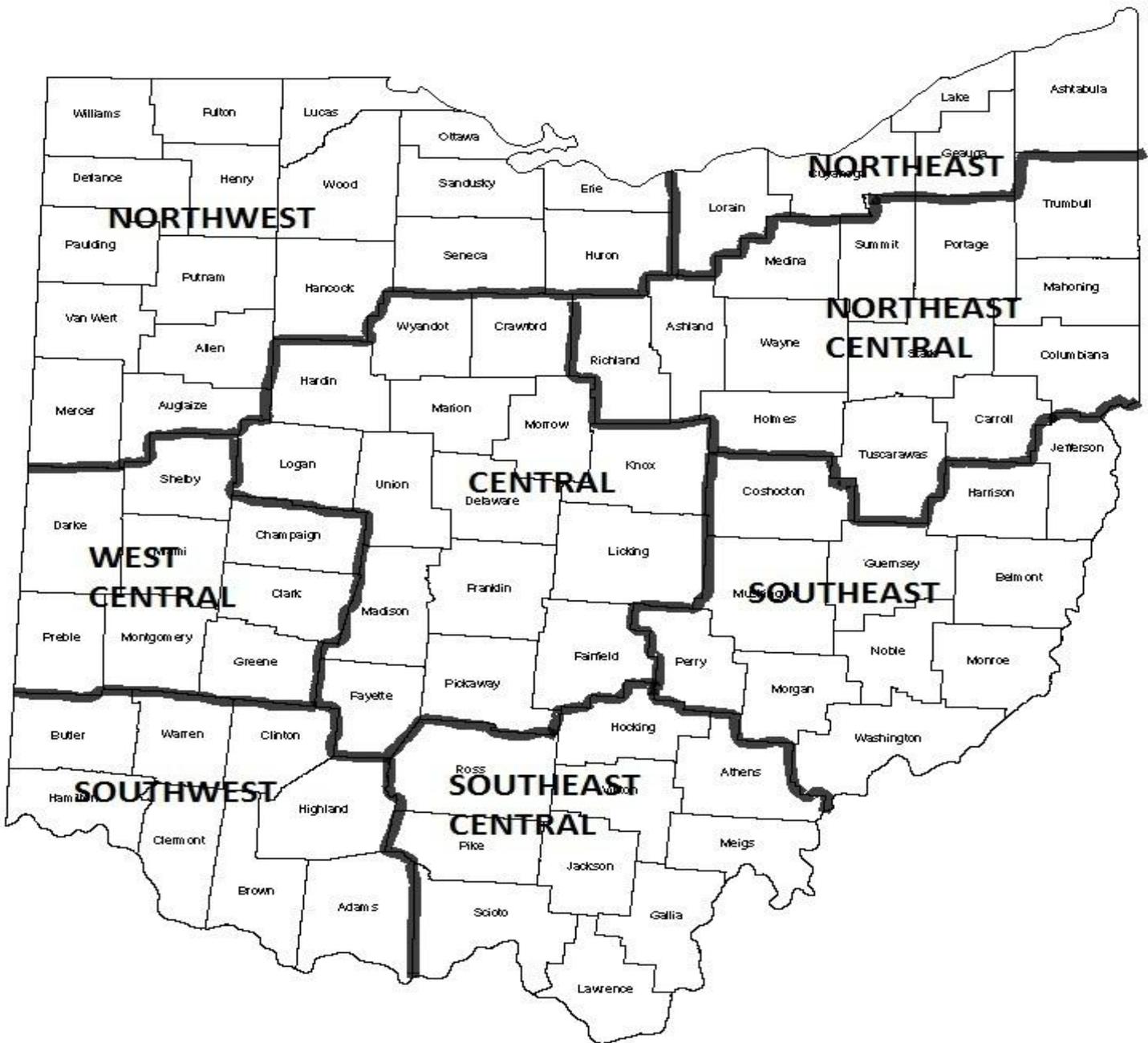
Failure to reach adequate score

Comments: _____

Signature: _____

Date: _____

OHIO PHEP PLANNING REGIONS



APPENDIX E

Public Health Surveillance and Epidemiological Investigation Performance Measures

All PHEP sub-grantees will be responsible for meeting the Surveillance and Epidemiological CDC PHEP performance measures. Full text of all CDC performance measures can be found at <http://www.cdc.gov/phpr/coopagreement.htm>

Introduction

The Public Health Surveillance (SURV) and Epidemiological Investigation (EI) capability represents a set of core public health activities related to the surveillance and detection of significant public health threats; conducting and documenting epidemiological investigations of infectious disease outbreaks and acute environmental exposures; and the recommendation or implementation of mitigation and public health control measures. Taken together, these activities form a key pillar for effective public health emergency response. Case reporting of reportable infectious diseases is a prerequisite for an effective public health system and is an essential component of effective public health emergency preparedness. Timely reporting permits public health agencies to initiate investigations and recommend meaningful interventions, thereby protecting the health of individuals as well as the broader community. Conducting and documenting EIs with complete reports enables public health agencies to improve the quality of these investigations by ensuring that the incident is appropriately characterized, and that results and recommendations are documented and shared with decision makers.

Capability Definition

The Public Health SURV and EI capability is defined as follows:

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 incidents³ of public health significance.

This capability consists of the ability to perform the following functions:

1. Conduct public health surveillance and detection
2. Conduct public health and epidemiological investigation
3. Recommend, monitor, and analyze mitigation actions
4. Improve public health surveillance and epidemiological investigation systems

The following table illustrates how the Public Health SURV and EI performance measures align with the defined public health preparedness capability and its associated functions.

Table 1.19. Public Health Surveillance and Epidemiological Investigation Functions and the Associated Performance Measures Capability	Function	Performance Measure(s)
Public Health SURV and EI	Conduct Public Health Surveillance and Detection	SURV – Disease Reporting
	Conduct Public Health and Epidemiological Investigation	EI – Outbreak Investigation Reports EI – Exposure Investigation Reports EI – Outbreak Investigation Reports with Minimal Elements EI – Exposure Investigation Reports with Minimal Elements
	Recommend, Monitor, and Analyze Mitigation Actions	SURV – Disease Control
	Improve Public Health Surveillance and Epidemiological Investigation Systems	None

³ The term —incident|| is used throughout this document. It is defined in the National Incident Management System Incident Command Structure as —an occurrence either human caused or by natural phenomena, that requires action to prevent or minimize loss of life or damage to property and/or natural resources.||

Reporting Requirements

All state PHEP awardees, Washington, D.C., and New York City are required to report data for the SURV performance measures. All awardees are required to report data for all EI performance measures.

Local Health Department Data – County Sampling

For most awardees, the Public Health SURV and EI performance measures require data collection from a pre-selected sample of counties within each awardee’s jurisdiction. **Specifically, performance measure data should be collected related to cases of select diseases (for SURV measures) and outbreaks/exposures (for EI measures) occurring in the pre-selected sample of counties.** Local health departments (LHDs) that take the case reports or do the investigations in those counties should report performance measure data to the awardee. The actual sample of counties for each state is provided separately from this performance measures guidance. The purpose of the sampling strategy is to ensure that awardees do **not** have to report performance measure data to CDC from all counties/LHDs. Although data from all counties/LHDs is not required, awardees are **strongly encouraged** to collect these data from all counties/LHDs for their own program improvement purposes – that is, to document areas for improvement and track progress related to system and organizational improvements over time. It is anticipated that the sample selected to report Public Health SURV and EI performance measures data for BP11 will remain the same in subsequent years. Awardees that do not have LHDs should report data at the awardee-level only, as applicable. The sampling strategy and related information are detailed in Appendix B.

Definition of Key Terms Related to the Public Health SURV and EI

Below is a list of terms and definitions that appear throughout the Public Health SURV and EI performance measures. Please use the provided definitions when interpreting the guidelines for data collection and reporting on these performance measures. Some terms below refer to a specific performance measure. The performance measure will be indicated in parentheses next to the term itself.

Acute environmental exposure (all EI measures): Discrete, sudden, and/or generally unexpected exposure to a **non-infectious** agent that could potentially cause adverse symptoms, conditions, illness, or disease in a human population within either an immediate or relatively short timeframe. Please see the Special Notes section below and Table 1.20 for further guidance on the types of exposures that these performance measures are designed to capture.

Appropriate timeframe (SURV – Disease Control): A timeframe for intervention(s) or control measures with meaningful public health relevance. Although individual cases may vary in practice, appropriate timeframes for each of the six selected diseases (described in the SURV – Disease Control performance measure above) have been standardized for the purpose of this performance measure. Please see the Special Notes section below and Table 1.21 for examples of control measures and the initiation timeframe for each of the six selected diseases included in the surveillance performance measures.

Awardee-required timeframe (SURV – Disease Reporting): State-mandated timeframe either by law or regulation for healthcare providers and, in some states, laboratories, to report cases (or positive test results) of specific reportable diseases.

Case (SURV – both measures): Awardees should provide aggregate data solely on cases that meet the classification criteria for each disease described below (e.g., meningococcal disease: confirmed cases only). These criteria meet CDC’s most recent Morbidity and Mortality Weekly Report (MMWR) print criteria for each disease. Due to the provisional nature of some case data and the likelihood of eventual rule-outs of some cases, it is understood that case counts may change following awardee reporting for this performance measure. Awardees are **not** required to reconcile this performance measure data to their final National

Notifiable Disease Surveillance System (NNDSS) data. Provisional case counts for this performance measure are acceptable.

Case event date types (SURV – Disease Reporting): Case events mark the occurrence of specific clinical or laboratory activities or milestones that, in the context of the SURV – Disease Reporting performance measure, serve as the —start time|| (measured via the —case event date||) against which timeliness of reporting for cases of disease can be calculated. There are five options for case event date types, all defined below. Awardees may utilize only one type of case event date for all cases of a given disease, but are free to use that same type for multiple diseases (e.g., Date of diagnosis-lab confirmed for Hepatitis A and *E. coli* (STEC)). Please see the Additional Guidance section of the SURV – Disease Reporting performance measure for further instructions and recommendations regarding *E. coli* and measles.

- Date of diagnosis – lab-confirmed: Date of medical determination of a disease state following confirmation of the presence of an organism or toxin (e.g., positive blood or stool culture, antigen test, botulinum toxin test, etc.) or physiological effects (e.g., presence or increase in antibodies associated with a disease, etc.) from laboratory testing. This refers to **definitive**, as opposed to preliminary, laboratory results.
- Date of diagnosis – presumptive/clinical: Date of medical determination indicating **suspected** presence of a particular disease for which initial interventions can be initiated and/or further testing undertaken. By definition, a presumptive diagnosis has not (yet) been confirmed. Instead, this type of diagnosis may be based on empirical observations by a clinician, patient histories, establishment of epidemiological linkages, preliminary laboratory findings (e.g. Gram’s stain), or special diagnostic procedures (e.g. using an EMG test on a person with suspected botulism).
- Date of laboratory report: Date that the first positive laboratory test result is either **posted** or **communicated** to an appropriate clinical or organizational entity (i.e., a provider, not the public health agency). The laboratory report date can refer to communication of **preliminary** (if applicable or necessary) or confirmed lab results.
- Date of laboratory result: Date that a laboratory test, assay or other procedure is **first** determined to be either positive for the existence of an organism or otherwise significantly indicative of a disease state relevant to this performance measure.
- Date of specimen collection: Date that a clinical specimen is collected for analysis and/or testing. Specimen collection generally refers to the collection of blood, feces, or cerebrospinal fluid.

Immediate reporting timeframe (SURV – Disease Reporting): Within 12 standard (i.e., not business) hours. If health departments do not capture dates **and** times of specific case events, they may consider cases as immediately reported if the selected case event date and date of first report to a health department occur on the same date.

Incident of public health significance (EI – both acute environmental exposure measures): A discrete, sudden, and/or generally unexpected real event marked by human exposure to a toxic, poisonous, or otherwise harmful **noninfectious** agent for which (a) acute and immediate adverse symptoms, conditions, illness, or disease can feasibly be expected, and (b) additional exposure beyond the initial exposure case can feasibly be anticipated.

Infectious disease outbreak (EI – both outbreak measures): An increase in the number of observed cases (over expected) of a given disease or illness of public health importance caused by a specific infectious agent. Please see the Additional Guidance sections of the EI – Outbreak Investigation Reports and EI – Outbreak Investigation Reports with Minimal Elements performance measures for more information regarding reported/nonreported outbreaks and food-borne outbreaks.

Initiation of a control measure (SURV – disease control): Initiation of a control measure refers to the first substantive activity by public health staff to prevent or control the spread of disease. Please see the Additional Guidance section of the SURV – Disease Control performance measure for more information regarding activities that constitute initiation and examples of control measures. Examples may also be found in Appendix B.

Investigation (all EI measures): The systematic collection and analysis of facts or data to determine the scope of an incident and the cause(s) of illness as well as identify a means of intervention or prevention strategy. In general, the term refers to systematic investigative activity **beyond** that required for routine follow-up and basic documentation (e.g., of single cases). It may (but is not required to) call for the allocation of additional organizational resources such as staff, funding, etc. Example activities include, but are not limited to, site visits, field assessments, case finding, record reviews, and lab testing. The term refers **explicitly** to epidemiological investigations in the context of the outbreak and acute environmental exposure EI performance measures. The term does **not** refer to an environmental health assessment or regulatory-related investigation. There is **no** expectation by CDC that *all* outbreaks or documented exposures shall lead to epidemiological investigations.

Investigation report (all EI measures): Written or electronic documentation describing the event, methods of investigation (e.g., lab, epidemiological, and statistical methods), findings, recommendations, etc., produced as a result of an epidemiological investigation of an infectious disease outbreak or acute environmental exposure(s). Although in practice elements of a report vary, generally all should contain each of seven main —minimal elements|| (see below). Further, while reports are often generated in traditional —report|| style, other formats can be included for the purpose of this performance measure. Examples include memoranda, e-mails, written correspondence, templates, forms, etc.

Joint investigation (all EI measures): Any investigation involving the awardee and at least one other agency. Awardees can lead or support joint investigations. Examples include investigations conducted by both the awardee and CDC or investigations conducted by multiple agencies (e.g., the awardee, CDC, and a LHD).

Minimal elements (EI – outbreak reports with minimal elements **and** exposure reports with minimal elements): A core set of elements that are necessary for an investigation report to be considered complete. Generally, all subbullets relevant to an infectious disease outbreak or acute environmental exposure investigation, below, must be part of a report for it to be considered complete. **Sub-bullets not relevant to a given type of investigation (infectious disease or acute environmental exposure) are not required.** Recognizing that investigation reports take various forms, and are presented in various ways, these elements do not have to be in the exact format laid out below. Please see the Additional Guidance sections of the EI – Outbreak Reports with Minimal Elements and EI – Exposure Reports with Minimal Elements performance measures for further information.

- **Context / background** – Information that helps to characterize the incident, including:
 - Population affected (e.g., estimated number of persons exposed and number of persons ill)
 - Location (e.g., setting or venue)
 - Geographical area(s) involved
 - Suspected or known etiology
- **Initiation of investigation** – Information regarding receipt of notification and initiation of the investigation, including:
 - Date and time initial notification was received by the agency
 - Date and time investigation was initiated by the agency
- **Investigation methods** – Epidemiological or other investigative methods employed, including:
 - Any initial investigative activity (e.g., verified laboratory results)
 - Data collection and analysis methods (e.g., case-finding, cohort/case-control studies, environmental investigation or testing, etc.)
 - Tools that were relevant to the investigation (e.g., epidemic curves, attack rate tables, questionnaires)
 - Case definitions (as applicable)

- Exposure assessments and classification (as applicable)
- Reviewing reports developed by first responders, lab testing of environmental media, reviews of environmental testing records, industrial hygiene assessments, questionnaires
- **Investigation findings/results** – All pertinent investigation results, including:
 - Epidemiological results
 - Laboratory results (as applicable)
 - Clinical findings (as applicable)
 - Other analytic findings (as applicable)
- **Discussion and/or conclusions** – Analysis and interpretation of the investigation results, and/or any conclusions drawn as a result of performing the investigation. In certain instances, a conclusions section without a discussion section may be sufficient (this is left to awardees’ discretion).
- **Recommendations for controlling disease and/or preventing/mitigating exposure** – Specific control measures or other interventions recommended for controlling the spread of disease or preventing future outbreaks and/or for preventing/mitigating the effects of an acute environmental exposure.
- **Key investigators and/or report authors** – Names and titles are critical to ensure that lines of communication with partners, clinicians and other stakeholders can be established.

Reporting of selected disease (SURV – disease reporting): An initial communication **by a hospital, lab, or provider** to report a suspected or confirmed case of disease, or positive test result, either to an awardee health department (including its local, regional or branch offices in centralized states) or autonomous LHDs participating in the data collection effort for this performance measure. Please note, by definition, awardees should **not** count cases of disease reported to the awardee (e.g., state health department) from a LHD.

Supporting role (in an investigation) (all EI measures): Technical assistance or consultation provided by the awardee health department to a LHD or other agency. The term generally does **not** refer to routine involvement by a state public health laboratory in support of a local investigation or to aid in establishing a diagnosis (e.g., to conduct rule-out or confirmation testing). In some awardee jurisdictions, support in an investigation occurs as a function of an outbreak crossing jurisdictional lines; in others, it may be initiated upon request from a single, typically local level agency. See above: Joint investigation (all EI measures)

Table 1.20. SURV – Disease Reporting

SURV – Disease Reporting Annual	Proportion of reports of selected reportable diseases received by a public health agency within the awardee-required timeframe
Measurement Specifications	Numerator: Number of reports of selected reportable disease received by a public health agency within the awardee-required timeframe Denominator: Number of reports of selected reportable disease received by a public health agency
Intent	<p>Case reporting of reportable infectious diseases is a prerequisite for an effective public health system. Timely reporting permits public health agencies to initiate investigations and recommend meaningful interventions, thereby protecting the health of individuals as well as the broader community.</p> <p>The immediate intent of this performance measure is to capture the extent to which specific diseases of local and national public health significance are first reported to any level of the public health system (e.g., local, state, regional, county) from reporting entities (e.g., hospitals, labs, providers) within awardee-required timeframes.</p> <p>The broader programmatic aim of this performance measure is to improve the timeliness of disease reporting by providers, hospitals, and laboratories to public health agencies as part of systematic program and process improvement for awardee and LHD surveillance programs.</p> <p>Note: The intent of this measure is not to capture the timeliness of disease “reporting” from LHDs to an awardee health department (or vice versa) or notification from an awardee to CDC.</p>
Reporting Criteria	<p>Reporting for this performance measure is required for the 50 awardee states, New York City and District of Columbia.</p> <p>This performance measure requires self-reported data.</p> <p>This performance measure requires data collection from a sample of counties in the awardee’s jurisdiction. LHDs that receive reports of select cases of disease in these counties should report all necessary data for this measure to the awardee.</p> <p>Awardees are required to report data on case reports with CDC notification dates between MMWR Week 33, 2011 and Week 31, 2012 (August 14, 2011, and August 4, 2012).</p> <p>Awardees are required to provide data on the following diseases according to the specified case classification criteria noted in parentheses:⁴</p> <ul style="list-style-type: none">▪ Diseases associated with the following Category A agents:<ul style="list-style-type: none">○ Botulism (<i>Clostridium botulinum</i>), all types excluding infant botulism⁵ (confirmed)

⁴ Source:

http://www.cdc.gov/osels/ph_surveillance/nndss/phs/files/NNDSS_event_code_list_February_2011_07_FINAL.pdf. Awardees must use the CDC/Council or State and Territorial Epidemiologists (CSTE) case definitions for these diseases. In addition: Reporting data for this performance measure is **separate from, and requires no change to**, notifiable disease reporting to CDC’s Nationally Notifiable Disease

-
- Tularemia (*Francisella tularensis*) (confirmed and probable)
 - *E. coli*, STEC⁶ (all reports)
 - Hepatitis A, acute (confirmed)
 - Measles (confirmed and unknown)
 - Meningococcal disease (*Neisseria meningitides*)⁷ (confirmed)

Awardees should calculate the numerator and denominator for this performance measure at the public health system level (i.e., to include reports first received by the awardee health department *and* reports first received by LHDs in pre-selected sample of counties). In other words, awardees should aggregate all reports first received by the awardee health department *and* by LHDs receiving case reports in the pre-selected sample of counties – excluding duplicate cases. **Reports occurring in counties not included in the sample should be excluded from the numerator and denominator** in reporting to CDC.

Awardees should ensure counts exclude duplicate cases.

Awardees should exclude cases of disease from the numerator that are missing pertinent data (e.g., dates), which preclude definitive calculation of timeliness. These cases must be included in the denominator.

Awardees may be asked to provide information on counties, or LHDs reporting data for this performance measure, to verify sample.

Reported Data Elements

The following information should be collected in support of the performance measure:

1. Do the awardee-required reporting timeframes differ for **providers** and **laboratories** for any of the selected diseases? [Y/N] If NO, please skip to Question 4.
2. For each of the selected diseases, please indicate the awardee-required reporting timeframe for **providers** [select one]
 - Immediately
 - 24 hours
 - 48 hours
 - 72 hours
 - 7 days
 - Other – specify [text box]
3. For each of the selected diseases, please indicate the awardee-required reporting timeframe for laboratories [select one] – Please skip to Question 5.
 - Immediately
 - 24 hours
 - 48 hours
 - 72 hours
 - 7 days
 - Other – specify [text box]

⁵ Awardees should aggregate all botulism cases (except infant botulism) into one numerator and denominator for this measure (i.e., sum food-borne plus wound plus other, etc.).

⁶ Awardees that only require reporting of *E. coli* O157:H7 (not all shiga-positive *E. coli*) may report on those data instead.

⁷ Isolated from a sterile site (e.g., blood or cerebrospinal fluid).

**Additional
Guidance**

Definitions and Discussions for SURV performance measures: below are terms and phrases that were first defined in the Key Definitions section above.

Case: [in Key Definitions]

Case event dates – assessing timeliness of disease reporting by providers and labs: Time requirements for disease reporting by providers and labs to public health agencies are typically determined at the awardee level through statute or regulation (e.g., Providers should report measles within 24 hours to their LHD). For the purpose of this measure, awardees will need to determine the length of time between two specific case event dates noted for each case to determine whether a report was received within the required timeframe. Awardees may choose the first case event date type. The second case event date (and type) is always the date of first report to a public health agency.

Note: for each disease, awardees are encouraged to select the **earliest** case event that is feasible to collect from a program standpoint and subtract that from the date of first report to a public health agency. The result is a period of time that falls either within or outside the awardee-required reporting timeframe for a given disease. **Once a case event date type is selected for a given disease, all cases of that disease must use that case event date type to calculate timeliness.** For example, if presumptive diagnosis date is selected for measles, timeliness calculations for all measles cases **must** subtract date presumptive diagnosis date from first report to public health agency.

Case event date types – Considerations for selection: With input from LHDs, awardees should select one case event date type for each disease **prior to the start** of the performance period. All health departments participating in data collection for this performance measures should then uniformly use the same case event date for that disease.

Note: awardees may select different case event date types for each of the six diseases included in this performance measure.

Awardees may also choose the same case event date type for multiple diseases. Although awardees have flexibility to determine which case event date type they will use for each disease, certain case event types may be less amenable for use for a given disease. Examples of questionable case event date types for specific diseases include date of presumptive diagnosis for hepatitis A or date of lab report, lab result, or lab-confirmed diagnosis for measles. Please see below for specific issues to consider regarding case event date types for *E. coli* and measles.

Category A agents: Category A agents can create situations that significantly impact community health. Most require broad public health preparedness efforts, such as enhanced surveillance and rapid public health response, particularly if used intentionally or found to be widespread. For this performance measure, awardees should report only for botulism and tularemia.

Date of diagnosis – presumptive/clinical: Selection of this case event date type presumes awardees (and LHDs) have or will have a standardized process and defined data field in place in their surveillance system(s) to capture this information. Awardees that have a generic date of diagnosis

field on their case report forms or in their electronic disease surveillance systems should be sure they have clearly defined whether this field refers to

presumptive/clinical or lab-confirmed diagnosis. Please see definitions section above for more information.

E. coli (STEC), Hemolytic Uremic Syndrome (HUS) and case event date types: A small percentage of STEC cases result in an extremely serious condition known as HUS. Although these cases differ clinically from other STEC (which suggests using different case event date types for each), awardees are requested to choose **only one** case event date type for STEC and calculate timeliness against only that type.

First report to a public health agency: Awardees should use the time that a public health agency was first alerted to a case of selected disease whether by phone, fax, online surveillance system, case report form, or another means of notification.

Low or zero incidence of disease: It is understood that in many jurisdictions (awardee and local), there may be few or no cases of certain diseases. Although there may be challenges in instituting program improvement processes on the basis of extremely low incidence diseases, the diseases selected for this performance measure are of significance nationally and require surveillance systems and processes for timely reporting irrespective of incidence rates. It should also be noted that reporting low or zero incidence of disease by awardees is not, in and of itself, a reflection of poor performance and will not be interpreted as such by CDC.

Measles – case event date type options: Due to the relative feasibility of recognizing and reporting suspected measles cases prior to lab confirmation, CDC recommends awardees select date of diagnosis – presumptive or Date of specimen collection for this disease.

Reporting timeframes – provider and lab differences: In some awardee jurisdictions, reporting timeframes for select diseases differ depending on whether reported by providers or labs. Awardees are requested to ensure that calculations of timeliness of reporting for each case of disease are compared against the appropriate required timeframe.

Note: for cases in which both a provider and a lab report the same case of disease, awardees should count the first instance of reporting the case for the purpose of this performance measure.

Sample of LHDs: [see Reporting Requirements]

Simultaneous reporting to state and LHDs: In some instances, disease reports may be submitted to, or populate, local and state health department surveillance systems simultaneously. This should not impact total counts for this performance measure if duplicate cases are not included.

Table 1.21. SURV – Disease Control

SURV – Disease Control	Proportion of reports of selected reportable diseases for which initial public health control measure(s) were initiated within the appropriate timeframe
Annual	
Measurement Specifications	<p>Numerator: Number of reports of selected reportable diseases for which public health control measure(s) were initiated within an appropriate timeframe</p> <p>Denominator: Number of reports of selected reportable diseases received by a public health agency</p>
Intent	<p>Effective control measures and mitigation strategies are fundamental to the health of communities and populations by limiting the spread of disease and, as feasible, eliminating or reducing sources of infection.</p> <p>The immediate intent of this performance measure is to capture the extent to which initial public health control measures are initiated within an appropriate timeframe following the first report of a selected disease (i.e., either probable or confirmed depending on what is appropriate in practice for that disease) received by a public health agency.</p> <p>The broader programmatic aim of this measure is to improve the timeliness of appropriate interventions to limit the spread of disease in human populations and communities.</p>
Reporting Criteria	<p>Reporting for this performance measure is required for the 50 states, New York City, and Washington, D.C..</p> <p>This performance measure requires self-reported data.</p> <p>Awardees are required to report data on case reports with CDC notification dates between MMWR Week 33, 2011 and Week 31, 2012 (August 14, 2011, and August 4, 2012).</p> <p>Awardees are required to provide data on the following diseases according to the specified case classification criteria noted in parentheses⁸:</p> <ul style="list-style-type: none"> ▪ Diseases associated with the following CDC Category A agents: <ul style="list-style-type: none"> o Botulism (<i>C. botulinum</i>), all types excluding infant botulism¹⁰ (confirmed) o Tularemia (<i>F. tularensis</i>) (confirmed and probable) ▪ <i>E. coli</i>, STEC¹¹ (all reports) ▪ Hepatitis A, acute (confirmed) <ul style="list-style-type: none"> o Measles (confirmed and unknown) o Meningococcal disease (<i>N. meningitides</i>)¹² (confirmed) <p>Awardees should calculate the numerator and denominator for this performance</p>

⁸ Awardees must use CDC/CSTE case definitions for these diseases.

⁹ Please note: Reporting data for this performance measure is **separate from, and requires no change to**, notifiable disease reporting to CDC’s Nationally Notifiable Disease Surveillance System (NNDSS).

¹⁰ Awardees should aggregate all botulism cases (except infant botulism) into one numerator and denominator for this measure (i.e., sum food-borne plus wound plus other, etc.).

¹¹ Awardees that only require reporting of *E. coli* O157:H7 (not all *E. coli* STEC) may report on those data instead.

¹² Isolated from a sterile site (e.g., blood or cerebrospinal fluid).

measure:

- By disease

Awardees should ensure counts exclude duplicate cases

Awardees should exclude cases of disease from the numerator that meet inclusion criteria but are missing pertinent data (i.e., dates), and include them in the denominator.

Awardees may be asked to provide information on LHDs reporting data for this measure (including name of department, county or population served, etc.)

Reported Data Elements

The following information should be collected in support of the performance measure:

1. Total number of reports for which a control measure was initiated within the appropriate timeframe [numerator]
 - By disease
 - o By awardee health department
 - o By reporting LHDs (aggregated)
2. Total number of disease reports received [denominator]. Please aggregate reports received by awardee health department **and** by LHDs receiving reports in counties in the pre-selected sample; do **not** include reports from counties that were not included in the sample.
 - By disease
3. Does the awardee health department have in place processes, procedures, etc., for periodic (e.g., annual) review of data related to timely initiation of public health control measures for the purposes of program improvement? [Y/N] – If NO, skip to Question 5.
4. Please describe processes, procedures, etc., the awardee health department has in place for periodic (e.g., annual) review of data related to timely initiation of public health control measures for the purposes of program improvement.
[text box]
5. Total number of LHDs reporting data for this performance measure.
6. Total number of reporting LHDs that has a process, procedure, etc., in place for periodic (e.g., annual) review of data related to timely initiation of public health control measures for the purposes of program improvement.
7. Please describe the key barriers faced by health departments in the timely control or mitigation of the select diseases for this performance measure.
[text box]

Additional Guidance

Assessing control measure timeliness: For a given case to count toward the numerator for the SURV – Disease Control performance measure, awardees will need to compare case data with the Public Health Control Measures Table (see Appendix B) to determine whether a control measure(s) was initiated within the appropriate timeframe. Awardees should use the time that the first report of a selected disease (i.e., either probable or confirmed depending on what is appropriate in practice for that disease) was received by a public health agency as the start time for this performance measure. Note that this time should be the same as the stop time used to calculate timeliness for the SURV - Disease

Reporting performance measures. For example, a case report for meningococcal disease documenting prophylaxis or recommendations for prophylaxis of indicated contacts within 24 hours of

receipt of the case **would count** toward the numerator for this performance measure.

Case: [See Key Definitions]

Category A agents: [see Additional Guidance for SURV – Disease Reporting (Table 3)]

First report to a public health agency: [see Additional Guidance for SURV – Disease Reporting (Table 3)]

Public health control measures and initiation: This performance measure focuses on the timely **initiation** of any one of a variety of public health control measures. Depending on the disease, measures range from identification (and removal, as feasible) of a source of infection, to immunization or prophylaxis of contacts, to exclusions from child care or food-handling. Awardees are given some latitude to determine which documented actions will count as an appropriate control measure, although in general the examples provided in the table of control measures (Appendix B) are meant to highlight the actions for each disease for which timeliness should be measured. Important points to note:

- This performance measure is meant to capture **initiation** of public health control measures, **not** completion.
- In general, the intent of this performance measure is **not** to capture the first phone call to a healthcare provider to discuss a case patient, unless that discussion entails recommendations and/or education regarding specific control measures (e.g., calling a parent and/or a day care center to exclude an infectious child from child care due to *E. coli* or hepatitis A would count).
- If a health department documents timely **initiation** of either (a) an appropriate control measure, (b) a **recommendation** for a control measure, (c) a decision **not** to initiate a control measure, or (c) **inability** to initiate a control measure despite an effort to do so, this will meet the intent of the measure and count toward the numerator.
- Awardees may wish to consider standardizing, with input from LHDs, an operational definition of initiation. Examples may include date of patient contact or date of interview, etc., as long as these explicitly entail implementation or recommendation of control measures in addition to routine fact-finding.

Sample of LHDs: [See Reporting Requirements]

Special Note regarding the performance measures SURV – disease control:

Table 1.22 outlines illustrative inclusion and exclusion criteria for determining which environmental exposures to include for the epidemiological investigation performance measures. **Meeting any one criterion is sufficient for inclusion/exclusion.** For incidents that are judged to meet both inclusion and exclusion criteria, inclusion will be at the discretion of the awardee.

To determine whether a public health control measure was initiated within an appropriate timeframe for any given case of the selected diseases (i.e., whether it should be included in the numerator of the SURV - Disease Control performance measure), awardees will need to compare case data with the table below.

Table 1.22. Examples of Public Health Control Measures for the selected six diseases

Disease agent	Example control measures	Initiation timeframe
Botulism	Identification of potentially exposed individuals Identification / recovery of suspected source of infection, as applicable	Within 24 hours of initial case identification
<i>E. coli</i> (STEC)	Contact tracing Education: contacts as applicable Exclusions: child care, food handling as applicable	Within 3 days of initial case identification
Hepatitis A, Acute	Contact tracing Education: contacts Immunization (active/passive) administered or recommended to contacts, as appropriate	Within 1 week of initial case identification
Measles	Contact tracing Education: contacts Immunization (active/passive) administered or recommended for susceptible individuals Isolation: confirmed cases	Within 24 hours of initial case identification
Meningococcal Disease	Contact tracing Education: contacts Prophylaxis administered or recommended for susceptible individuals	Within 24 hours of initial case identification
Tularemia	a) Identification of potentially exposed individuals b) identification of source of	a) Within 48 hours b) within 48 hours of initial case identification

Table 1.23. EI – Outbreak Investigation Reports

EI – Outbreak Investigation Reports	Percentage of infectious disease outbreak investigations that generate reports
Annual	
Measurement Specifications	Numerator: Number of infectious disease outbreak investigation reports generated Denominator: Number of infectious disease outbreaks investigated
Intent	The immediate intent of this measure is to capture the ability of awardees and LHDs to document EIs of infectious disease outbreaks. The broader programmatic aim of this measure is to improve the ability of health departments to conduct epidemiological investigations of infectious disease outbreaks by appropriately documenting and reporting on investigation activities and findings.
Reporting Criteria	Reporting for this performance measure is REQUIRED for all awardees. This performance measure requires self-reported data. Awardees are required to report summary data generated from real infectious disease outbreak investigations and investigation reports only (i.e., not drills or exercises). Draft reports are acceptable for inclusion in the numerator for this measure under select circumstances, including: <ul style="list-style-type: none"> ▪ The completion of an investigation near the end of the reporting period for this performance measure, with insufficient time to complete an investigation report ▪ Completed investigations for which a draft investigation report has not yet been finalized or approved. ▪ Long-term or ongoing investigations for which the timeline for completion of a final investigation report is unknown.
Reported Data Elements	The following information should be collected in support of the performance measure: Questions 1 through 7 refer to awardee-level investigation activities only (i.e., no data from LHDs reporting on outbreaks in the pre-selected sample of counties should be included in these responses). <ol style="list-style-type: none"> 1. Total number of infectious disease outbreaks reported to the awardee by all sources 2. Total number of infectious disease outbreak investigations in which the

-
- awardee
- a. **led** the investigation – solely or as part of a joint investigation [denominator for awardee metric]
 - b. **supported** any LHD investigation (irrespective of whether LHD is in reporting sample)
 - c. supported any other type of joint investigation (i.e., **not** supporting an LHD; this may include supporting CDC or another state)
3. The total number of infectious disease outbreak investigations for which **a report was generated**
- a. in which the **awardee led** the investigation [numerator for awardee metric]
 - b. in which the awardee supported **any LHD investigation** and contributed to the investigation report
 - c. in which the awardee supported **any other type** of joint investigation and contributed to the investigation report (i.e., **not** supporting a LHD; this may include supporting CDC or another state)
4. Rank the key factors that accounted for the awardee health department **not** conducting investigations of infectious disease outbreaks. [Rank only those that apply]
- **Interagency** collaboration and coordination challenges (i.e., **between** a health department and another government agency or department)
 - **Intraagency** collaboration and coordination challenges (i.e., **within** the health department)
 - Insufficient resources (e.g., funding, staffing, time): If selected, please describe, to extent feasible, how this impacted awardee’s ability to investigate outbreaks. (e.g., numbers or types of outbreaks not investigated, etc.) [text box]
 - Major or unexpected shifts in priorities due to emergent events, changes in mission or organization, etc.
 - Policy decision not to investigate certain types of infectious disease outbreaks (e.g., norovirus): please elaborate. [text box]
 - Other – specify [text box]
5. Does the awardee health department have in place processes, procedures, etc., for review of its EIs of infectious disease outbreaks for the purposes of program improvement? [Y/N]
6. What type(s) of processes, procedures, etc., does the awardee health department have in place for review of its EIs of infectious disease outbreaks for the purposes of program improvement? [Check all that apply]
- Periodic or annual reviews
 - Episodic reviews or hotwashes
 - After-action reports
 - No procedure in place
 - Other – specify [text box]

**The following questions (7-12) refer to the LHDs reporting data from the pre-selected sample of counties. Specifically, these questions concern outbreak investigations led by health departments within this sample, without any support from the awardee or federal agencies.

-
7. The total number of infectious disease outbreaks occurring within the sample of pre-selected counties.
 8. The total number of infectious disease outbreak investigations **led by LHDs reporting on outbreaks in the pre-selected sample of counties** [denominator for local metric]
 9. The total number of infectious disease outbreak investigations for which a report was generated (LHD must have **led** the investigation) [numerator for local metric]
 10. What were the key factors that accounted for **not** investigating infectious disease outbreaks among the sample of LHDs reporting data for this performance measure? [Check all that apply]
 - **Interagency** collaboration and coordination challenges (i.e., **between** a health department and another government agency or department)
 - **Intraagency** collaboration and coordination challenges (i.e., **within** a health department)
 - Insufficient resources (e.g., funding, staffing, time)
 - Major or unexpected shifts in priorities due to emergent events, changes in mission or organization, etc.
 - Policy decision not to investigate certain types of infectious disease outbreaks (e.g., norovirus): please elaborate. [text box]
 - Other – Specify [text box]
 11. Total number of LHDs reporting data for this measure.
 12. Please identify the total number of LHDs (from the reporting sample) that has a process, procedure, etc., in place for review of EIs of infectious disease outbreaks for the purposes of program improvement. Examples can include, but are not limited to, periodic or annual reviews, hotwashes, after-action reports, etc.

Additional Guidance

Infectious disease outbreak reporting: Only **reported** outbreaks, which should include notifiable disease cases and clusters – and might include other unusual cases – should be included in this performance measure. Food-borne outbreaks should be included here.

Note: HIV, STDs, and tuberculosis are **not** included in this definition. In addition, the EI performance measures refer to outbreaks of (usually) reportable diseases **as defined and operationalized by the health department**; the EI performance measures are **not** limited to the six selected diseases identified for the SURV performance measures.

Investigation: For the purpose of these performance measures, initial investigative activity of a more preliminary or exploratory character that results in either a decision not to investigate further or referral to another agency **without** further significant involvement by the health department, should **not** count as an investigation. Referrals to other agencies that **do** entail further significant involvement by the health department **should** count as an investigation. Investigations that take place **across reporting periods** for this performance measure may, at the awardees discretion, be included in the denominator for the following reporting period.

Sample of LHDs: [See Reporting Requirements]

Table 1.24. EI – Outbreak Reports with Minimal Elements

EI – Outbreak Reports with Minimal Elements	Percentage of infectious disease outbreak investigation reports that contain all minimal elements
Annual Measurement Specifications	Numerator: Number of infectious disease outbreak investigation reports containing all minimal elements
Intent	Denominator: Number of infectious disease outbreak reports generated The immediate intent of this measure is to capture the ability of awardees and LHDs to document EIs of infectious disease outbreaks with complete reports (i.e., reports that contain a set of minimal elements). The broader programmatic aim of this measure is to improve the quality of EIs reports by ensuring that awardee and LHDs appropriately characterize and investigate the incident, document results and recommendations, and share these data as appropriate with decision makers.
Reporting Criteria	Reporting for this performance measure is REQUIRED for all awardees. This performance measure requires self-reported data. Awardees are required to report summary data generated from real infectious disease outbreak investigations and investigation reports only (i.e., not drills or exercises). Draft investigation reports are acceptable for inclusion in the numerator for this measure under select circumstances, including: <ul style="list-style-type: none"> ▪ The completion of an investigation near the end of the reporting period for this performance measure, with insufficient time to complete an investigation report ▪ Completed investigations for which a draft investigation report has not yet been finalized or approved ▪ Long-term or ongoing investigations for which the timeline for completion of a final investigation report is unknown
Reported Data Elements	The following information should be collected in support of the performance measure: <ol style="list-style-type: none"> 1. The total number of infectious disease outbreak investigations for which a report was generated <ol style="list-style-type: none"> a. in which the awardee led the investigation [denominator for awardee metric] b. in which the awardee supported any LHD investigation and contributed to writing the investigation report (irrespective of whether LHD is in reporting sample) c. in which the awardee supported any other type of joint investigation and contributed to writing the investigation report (i.e., not supporting a LHD; this may include CDC or another state) 2. Total number of infectious disease outbreak reports containing all

minimal elements

- a. in which the awardee **led** the investigation [numerator for awardee metric]
- b. in which the awardee **supported** any LHD investigation and contributed to writing the investigation report (irrespective of whether the LHD is in reporting sample)
- c. in which the awardee supported **any other type** of joint investigation and contributed to writing the investigation report (i.e., not supporting a LHD; this may include CDC or another state)

3. For the reports identified above that do **not** contain all of the minimal elements, please identify the elements that were most frequently missing [Check all that apply]

- Context/background
- Initiation of investigation
- Investigation methods
- Investigation findings/results
- Discussion and/or conclusions
- Recommendations
- Key investigators and/or report authors

3a. Briefly explain why this element(s) was most frequently missing. [text box]

The following questions refer to the group of LHDs reporting data for this performance measure. Specifically, these questions concern outbreak investigations, **led** by an LHD, in counties from the pre-selected sample, **without** any support from the awardee or federal agencies.

4. The total number of infectious disease outbreak investigations for which **a report was generated** (LHD must have **led** the investigation) [denominator for local metric]

5. The total number of infectious disease outbreak investigation reports containing **all** minimal elements [numerator for local metric]

6. For the reports identified above that do **not** contain all of the minimal elements, please identify the elements that were most frequently missing. [Check all that apply]

- Context/background
- Initiation of investigation
- Investigation methods
- Investigation findings/results
- Discussion and/or conclusions
- Recommendations
- Key investigators and/or report authors

6a. Briefly explain why this element(s) was most frequently missing. [text box]

<p>Additional Guidance</p>	<p><u>Infectious disease outbreak reporting:</u> [See Additional Guidance in Table 5. EI – Outbreak Investigation Reports] Please note: HIV, STDs, and tuberculosis are not included in this definition. In addition, the EI performance measures refer to outbreaks of (usually) reportable diseases as defined and operationalized by the health department; the EI performance measures are not limited to the six selected diseases identified for the SURV performance measures.</p> <p><u>Minimal Elements:</u> [See Key Definitions for a detailed description of the seven Minimal Elements] Health departments reporting on this performance measure should determine whether investigation reports include all of the seven minimal elements. Report elements do not have to be labeled exactly as shown below but should, if applicable, contain all of the content (bullets) within each element, as described. In some instances, some content (bullets) may appear under another minimal element (e.g., population affected may be reported in the results section of the report and not in context/background). This is acceptable for the purpose of calculating a numerator for this measure.</p> <p>Sample of LHDs: [See Reporting Requirements]</p>
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Table 1.25. EI – Exposure Investigation Reports

EI – Exposure Investigation Reports Annual	Percentage of EIs of acute environmental exposures that generate reports
Measurement Specifications	Numerator: Number of EI reports of acute environmental exposures generated Denominator: Number of EIs of acute environmental exposures
Intent	<p>The immediate intent of this measure is to capture awardees’ ability to document epidemiological investigations of the human health impacts of acute environmental exposures of public health significance. For awardee health departments that do not conduct these investigations, the intent is to ensure the awardee is aware of these exposures, investigations, and investigation reports to be able to act upon, learn from, or refer to them as appropriate.</p> <p>The broader programmatic aim of this measure is to improve the ability of health departments to conduct epidemiological investigations of acute environmental exposures by appropriately documenting and reporting on investigation activities and findings.</p>
Reporting Criteria	<p>Reporting for this performance measure is REQUIRED for all awardees. This performance measure requires self-reported data. Awardees are required to report summary data generated from real EIs of acute environmental exposure and investigation reports only (i.e., not drills or exercises). Draft investigation reports are acceptable for inclusion in the numerator for this measure under select circumstances, including:</p> <ul style="list-style-type: none"> ▪ The completion of an investigation near the end of the reporting period for this performance measure, with insufficient time to complete an investigation report ▪ Completed investigations for which a draft investigation report has not yet been finalized or approved ▪ Long-term or ongoing investigations for which the timeline for completion of a final investigation report is unknown <p>Awardees that do not conduct EIs of acute environmental exposures of public health significance are expected to have access to information from other jurisdictional partners pertaining to these investigations and the reports generated from them for the purpose of reporting for this performance measure. Awardees that do not conduct EIs of acute environmental exposures of public health significance are not required to provide information for Reported Data Elements #6 or #7.</p>
Reported Data Elements	<p>The following information should be collected in support of the performance measure:</p> <ol style="list-style-type: none"> 1. Is the awardee health department responsible for conducting EIs of acute
	<p>environmental exposure incidents of public health significance, in either a lead or a supporting role?</p> <p>[Y / N] – If YES, proceed to #2. If NO, please answer Questions 1a. through 1e. in reference to your jurisdiction before continuing to #2.</p>

-
- a. Which agency (or agencies) outside the health department is responsible for conducting epidemiological investigations of acute environmental exposures? [text box]
 - b. Is the awardee health department typically notified of epidemiological investigations of acute environmental exposures conducted by that agency? [Y / N]
 - c. Does the awardee health department typically receive investigation reports documenting epidemiological investigations of acute environmental exposures conducted by that agency? [Y / N]
 - d. What barriers, if any, does the awardee health department face in being notified of acute environmental exposure incidents of public health significance, epidemiological investigations of these exposures, and/or receiving investigation reports from that agency? [text box]
 - e. What steps, if any, has the awardee health department taken to address these barriers? [text box]
2. Total number of acute environmental exposure incidents of public health significance that occurred in the awardees' jurisdiction.
 3. Total number of EIs of acute environmental exposures in which
 - a. the awardee **led** the investigation – solely or as part of a joint investigation [denominator]
 - b. the awardee **supported** another agency's investigation [Proceed to #4, below]
 - c. **Another agency** conducted the EI(s) of an acute environmental exposures, but reported the investigation to the awardee (for awardees with **no role** in these investigations)
 4. If the awardee assumes a supporting role in the epidemiological investigation of acute environmental exposure(s), please identify the types of organizations that the awardee health department supports. [Check all that apply]
 - LHD
 - State environmental health agency
 - State occupational safety and health agency
 - State department of natural resources
 - State law enforcement agency
 - Hazardous materials agency
 - Other – specify [text box]
 5. Total number of investigations for which **a report was generated** in which
 - a. the **awardee led** the investigation – solely or as part of a joint investigation (numerator)
 - b. the **awardee supported** another agency's investigation and contributed to writing the investigation report
 - c. **another agency** conducted the epidemiological investigation(s) of an acute environmental exposures, but reported the investigation to the awardee (for awardees with **no role** in these investigations)
 6. (**Note:** applies only to awardees with a lead or supporting epidemiological

investigation role for acute environmental exposures) Rank the key factors that account for the awardee health department **not** conducting epidemiological investigations of acute environmental exposures (this question refers exclusively to acute environmental exposures for which it is the general policy and/or usual practice of the awardee to

-
- investigate). [Rank only those that apply]
- **Interagency** collaboration and coordination challenges (i.e., **between** a health department and another government agency or department)
 - **Intraagency** collaboration and coordination challenges (i.e., **within** the health department)
 - Insufficient resources (e.g., funding, staffing, time)
 - Major or unexpected shifts in priorities due to emergent events, changes in mission or organization, etc.
 - Other – specify [text box]
7. What type(s) of processes, procedures, etc., does the awardee health department have in place for review of its epidemiological investigations of acute environmental exposures for the purposes of program improvement? [check all that apply]
- Periodic or annual reviews
 - Episodic reviews or hotwashes
 - After-action reports
 - No procedure in place
 - Other – specify [text box]
-

Additional Guidance	<p><u>Food-borne outbreaks:</u> Food-borne outbreaks should not be reported in this performance measure; these should be reported in the EI- Outbreak Investigation Reports performance measure.</p> <p><u>Investigation:</u> [See Additional Guidance in Table 1.25. Outbreak Investigation Reports]</p>
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Special Notes regarding the performance measures EI – exposure reports:

Table 1.26 outlines illustrative inclusion and exclusion criteria for determining which environmental exposures to include for the epidemiological investigation performance measures. **Meeting any one criterion is sufficient for inclusion/exclusion.** For incidents that are judged to meet both inclusion and exclusion criteria, inclusion will be at the discretion of the awardee.

Table 1.26: Inclusion and Exclusion Criteria for Acute Environmental Exposures

Inclusion criteria	Exclusion criteria
<p>Incidents that directly impact human health immediately or with a short latency period (< 1 week) in which the signs and symptoms of acute toxicity are present or anticipated. These could include respiratory (e.g., constricted airway, shortness of breath), dermatological (e.g., itching, burning, redness of the skin), gastrointestinal (e.g., nausea, vomiting), and neurologic (e.g., disorientation, seizures) effects. Incidents in which two or more persons are ill with signs/symptoms of acute toxicity, are exposed, or a combination of both. Examples could include:</p> <ul style="list-style-type: none"> ▪ Organophosphate exposures ▪ Substantial heavy metal exposure, such as children playing with mercury <p>Any poisoning that is considered nonmedicinal, unintentional, or to be of unknown etiology.</p>	<p>Exposures, including sustained or repeated low-level exposures, that result in diseases and conditions with long latencies such as:</p> <ul style="list-style-type: none"> ▪ Cancers ▪ Disorders of organ systems, or ▪ Long-term neurological, behavioral and/or developmental disabilities. (e.g., reports of abnormal blood levels of lead).
<p>Incidents necessitating contact tracing, such as for secondary exposures or for tracking the movement or spread of toxic substances away from the incident site. Examples include:</p> <ul style="list-style-type: none"> ▪ Persons exposed to pesticides in the field having residual amounts in their clothing, leading to exposure and illness to EMS and emergency department healthcare workers. ▪ A person with traces of mercury driving his vehicle back to his home resulting in the contamination of both vehicle and domicile. 	<p>Incidents related to occupational hazards involving only those in the workplace setting.² This can include incidents that occurred at a non-occupational setting (e.g. a hazardous waste spill on a public road) with either no direct impact on human health or impact only to persons directly working with the hazardous materials (e.g. workers).</p>
<p>Acute exposure incidents that lead to the activation of the public health agency’s department operations center (DOC) or the jurisdiction’s emergency operations center (EOC), the formation of a task force, or the assignment of personnel to another agency’s DOC or EOC.</p>	<p>Incidents that fall under the purview or jurisdiction of another state and/or federal agency for which the public health agency has no definable role.</p>
<p>Incidents that are suspected or proven to be intentional, malicious, or criminal.¹</p> <p>Any large-scale or disaster incident in which public health agencies have a defined or prominent role in</p>	<p>Exposures or injuries related to light, noise or transfers of energy other than radiation.</p> <p>Ongoing incidents with a low level of exposure. These can include issues surrounding air quality</p>
Inclusion criteria	Exclusion criteria

<p>the response. Examples include, but are not limited to:</p> <ul style="list-style-type: none"> ▪ Conflagrations ▪ Explosions leading to the release of hazardous or toxic substances ▪ "Natural disasters" including but not limited to hurricanes, earthquakes, tornadoes, etc. 	<p>and concerns about water quality such as taste and odor problems, presence of low levels of contaminants that can be chemical (e.g. nitrates), microbiological (e.g. coliforms), or biotoxic (e.g., decaying harmful algae), etc.</p>
<p>Any incident involving an acute illness or disease state that has either the significance or interest to the public health agency to initiate an investigation. The presumed cause(s) can be either identified substances known to have adverse health effects or unknown substances yet to be identified and linked to that incident.</p>	<p>Incidents for which an investigation is deemed neither warranted nor appropriate, or for which site visits are made only to assess a setting for regulatory violations, gaps in proper procedures, or for mitigation or educational purposes.</p>
	<p>Clusters of chronic diseases or exacerbated medical conditions (e.g., cancer or asthma, respectively).</p>

¹ A notable exception includes incidents involving the transport or delivery of an alleged biological agent or toxin (white powder) which are deemed **noncredible** (hoax). If such an incident occurs and noncredibility **cannot** be established (e.g., a false-positive preliminary test), leading to the initiation of a public health response, then such incidents should be included. An example of the latter is the evacuation of the New York governor's Manhattan offices in October 2001 due to a positive preliminary test for anthrax.

² Possible exception: incidents in an occupational setting that are large or widespread enough to affect populations outside the work setting.

Table 1.27. EI – Exposure Reports with Minimal Elements

EI – Exposure Reports with Minimal Elements	Percentage of EI Reports of acute environmental exposures that contain all Minimal Elements
Annual Measurement Specifications	Numerator: Number of EI reports of acute environmental exposures containing all minimal elements Denominator: Number of EI reports of acute environmental exposures generated
Intent	<p>The primary intent of this measure is to capture awardees’ ability to document epidemiological investigations of acute environmental exposures of public health significance with complete reports (i.e., reports that contain a complete set of minimal elements). For awardee health departments that do not conduct these epidemiological investigations, the intent is to ensure the awardee is aware of these acute environmental exposures, investigations and investigation reports in order to be able to act upon, learn from or refer to them as appropriate.</p> <p>The broader programmatic aim of this measure is to improve the quality of epidemiological investigation reports by ensuring that awardee health departments appropriately characterize and investigate the incident, document results and recommendations, and share these data as appropriate with decision makers.</p>
Reporting Criteria	<p>Reporting for this performance measure is REQUIRED for all awardees, EXCEPT FOR:</p> <ul style="list-style-type: none"> ▪ Awardee health departments that are not responsible for conducting EIs of the human health impact(s) of acute environmental exposures of public health significance <p>This performance measure requires self-reported data. Awardees are required to report summary data generated from real EIs of acute environmental exposures and investigation reports only (i.e., not drills or exercises). Draft investigation reports are acceptable for inclusion in the numerator for this measure under select circumstances, including:</p> <ul style="list-style-type: none"> ▪ The completion of an investigation near the end of the reporting period for this performance measure, with insufficient time to complete an investigation report ▪ Completed investigations for which a draft investigation report has not yet been finalized or approved ▪ Long-term or ongoing investigations for which the timeline for completion of a final investigation report is unknown
Reported Data Elements	<p>The following information will be collected in support of the performance measure:</p> <ol style="list-style-type: none"> 1. Is the awardee health department responsible, in either a lead or supporting role, for conducting EIs of the human health impact(s) of acute environmental

exposures of public health significance?

[Y / N] If YES, proceed to question #2. If NO, all following data elements are optional.

2. The total number of EIs of acute environmental exposures for which a **report was generated** in which

- a. the awardee **led** the investigation – solely or as part of a joint investigation [denominator]
- b. the awardee **supported** another agency’s investigation
- c. **Another agency** conducted the EI(s) of an acute environmental exposures, but reported the investigation to the awardee (for awardees with **no role** in these investigations) [optional reporting]

3. Total number of EI reports of acute environmental exposures containing **all** minimal elements in which

- a. the awardee **led** the investigation [numerator]
- b. the awardee **supported** another agency’s investigation and contributed to writing the investigation report
- c. **Another agency** conducted the EI(s) of an acute environmental exposures, but reported the investigation to the awardee (for awardees with **no role** in these investigations) [optional reporting]

4. For the reports identified above that do **not** contain all of the minimal elements, please identify the minimal elements that were most frequently missing. [check all that apply]

- Context/background
- Initiation of investigation
- Investigation methods
- Investigation findings/results
- Discussion and/or conclusions
- Recommendations
- Key investigators and/or report authors

4a. Briefly explain why this element(s) was most frequently missing.

**Additional
Guidance**

Food-borne outbreaks: Food-borne outbreaks should not be reported in this performance measure; these should be reported in the EI- Outbreak Reports with Minimal Elements performance measure.

Minimal Elements: [See Key Definitions for a detailed description of the seven Minimal Elements] Health departments reporting on this performance measure should determine whether investigation reports include all of the seven minimal elements. Report elements do not have to be labeled exactly as shown below, but should, if applicable, contain all of the content (bullets) within each element, as described. In some instances, some content (bullets) may appear under another minimal element, below (e.g., population affected may be reported in the results section of the report, and not in context/background). This is acceptable for the purpose of calculating a numerator for this measure.

All PHEP sub-grantees will be responsible for meeting the Surveillance and Epidemiological CDC PHEP performance measures. Full text of all CDC performance measures can be found at

Introduction

The Community Preparedness (CP) capability represents a set of core public health activities related to community resilience. Homeland Security Presidential Directive 21 (HSPD-21), released in 2007, defines community resilience as the following:

“Where local civic leaders, citizens and families are educated regarding threats and are empowered to mitigate their own risk, where they are practiced in responding to events, where they have social networks to fall back upon, and where they have familiarity with local public health and medical systems, there will be community resilience that will significantly attenuate the requirement for additional assistance.”¹³

The directive also identifies community resilience as one of the —four most critical components of public health and medical preparedness|| (in addition to biosurveillance, countermeasure distribution, and mass casualty care). In addition to this directive, the National Health Security Strategy (NHSS), released in 2009, indicates that community resilience relies upon the ability of public health, healthcare, and emergency response systems to meet the needs of communities in preventing or mitigating the effects of an outbreak, incident, or disaster.¹⁴

Capability Definition

CDC’s National Standards document defines community preparedness as —the ability of communities to prepare for, withstand, and recover—in both the short and long terms—from public health incidents. By engaging and coordinating with emergency management, health care organizations (private and community-based), mental/behavioral health providers, community and faith-based partners, state, local, and territorial public health’s role in community preparedness is to do the following:

- Support the development of public health, medical, and mental/behavioral health systems that support recovery
- Participate in awareness training with community and faith-based partners on how to prevent, respond to, and recover from public health incidents
- Promote awareness of and access to medical and mental/behavioral health¹⁵ resources that help protect the community’s health and address the functional needs (i.e., communication, medical care, independence, supervision, transportation) of at-risk individuals
- Engage public and private organizations in preparedness activities that represent the functional needs of at-risk individuals as well as the cultural and socio-economic, demographic components of the community
- Identify those populations that may be at higher risk for adverse health outcomes
- Receive and/or integrate the health needs of populations who have been displaced due to incidents that have occurred in their own or distant communities (e.g., improvised nuclear device or hurricane) || ¹⁶

This capability consists of the ability to perform the following functions:

1. Determine risks to the health of the jurisdiction
2. Build community partnerships to support health preparedness

¹³ The White House. (October 18, 2007). *Homeland Security Presidential Directive 21* (news release). Accessible at: <http://www.whitehouse.gov/news/releases/2007/10/20071018-10.html>.

¹⁴ Office of the Assistant Secretary for Preparedness and Response (ASPR). U.S. Department of Health & Human Services. *National Health Security Strategy of the United States of America 2009*. Accessible at: <http://www.phe.gov/Preparedness/planning/authority/nhss/Pages/default.aspx>.

¹⁵ Within the *National Standards* document, the term —Mental/Behavioral Health|| is used as an overarching term to encompass behavioral, psychosocial, substance abuse and psychological health.

¹⁶ CDC (2011)

3. Engage with community organizations to foster public health, medical, and mental/behavioral health social networks

4. Coordinate training or guidance to ensure community engagement in preparedness efforts

Reporting Requirements

Reporting on the community preparedness performance measures is REQUIRED for all awardees.

The community preparedness performance measures require self-reported data.

Data collected for the community preparedness measures must fall within PHEP BP11: August 10, 2011, through August 9, 2012.

Table 2.1 below illustrates how the performance measures align with the defined community preparedness capability, its associated functions, and denotes whether the measure is for the purpose of program accountability or program improvement.

Table 2.1. Community Preparedness Functions and Associated Performance Measures

Capability	Function	Performance Measure(s)	Purpose of Performance Measures
Community Preparedness	Determine risks to the health of the jurisdiction	Engagement in determining risk	Program accountability
	Build community partnerships to support health preparedness	Identification of key organizations Engagement in recovery planning	Program accountability Program accountability
	Coordinate training or guidance to ensure community engagement in preparedness efforts	Engagement in public health emergency preparedness	Program improvement

Detailed Description and Purpose of the CP Performance Measures

The four CP performance measures draw upon current literature in the field. ^{17,18,19,20}

¹⁷ Gurwitsch, R. H., Pfefferbaum, B., Montgomery, J. M., Klomp, R. W., & Reissman, D. B. (2007). *Building community resilience for children and families*. Oklahoma City: Terrorism and Disaster Center at the University of Oklahoma Health Sciences Center.

¹⁸ Norris, F. H., Stevens, S. P. Pfefferbaum, B., Wyche, K. F., & Pfefferbaum, R. L. (Published online December 2008). Community resilience as a metaphor, theory, set of capacities, and strategy for disaster readiness. *American Journal of Community Psychology*. 41, 127–150.

The first measure. The identification of key organizations is the first step toward building and maintaining a robust network. Organizations that have access or provide services to the community

are able to leverage their resources to help the community prepare for, respond to, and recover from a public health emergency. Vulnerable populations (e.g., the poor, disabled, immigrant communities, etc.) are often less successful in mobilizing economic resources and support despite being at greater risk for injury and death following an incident. LHDs must thus ensure that they identify key organizations that have access and provide services to these vulnerable populations. CP 1 is a program accountability measure to assess LHD identification of key organizations across all 11 community sectors. The intent of this measure is for LHDs to identify those key organizations with which they intend to work directly, or with which they may collaborate through an intermediary agency (e.g., local emergency management).

The second measure focuses on community sector representation in determining the hazards, vulnerabilities, and risks to local public health, medical, and/or mental/behavioral health systems. Identification of these hazards, vulnerabilities, and risks should serve as the foundation for developing local preparedness, response, and recovery plans. Participation in this process also helps to ensure that the key organizations acknowledge the identified hazards, vulnerabilities, and risks, which thus bolsters their commitment to preparedness and recovery efforts. **This measure does not require LHDs or their community sector partners to conduct a new jurisdictional hazards and vulnerabilities assessment (HVA)**, although this would certainly meet the measure's intent. Rather, the measure's intent involves the *use* of HVA data (regardless of who conducted the assessment). CP 2 is a program accountability measure.

The third measure assesses engagement with key organizations, as identified by LHDs in CP 1, in specific and significant public health emergency preparedness activities including development of emergency operations and response plans, jurisdictional exercises, and competency-based trainings. Key organizations increase their capacity to prepare for and mitigate the effects of a major incident through their engagement in these activities. Additionally, it helps to ensure that key organizations understand their roles and responsibilities for responding to and recovering from an incident. CP 3 is a program improvement measure to track the depth of LHD engagement in public health emergency preparedness activities with identified key organizations over time.

The fourth preparedness measure focuses on LHD engagement with these same key organizations in developing a community recovery plan related to the restoration and recovery of public health, medical, and/or mental/behavioral health systems and services. Communities must take deliberate steps to plan for recovering from a major incident to build resilience. The participation of key organizations in developing and/or reviewing a community recovery plan builds a better understanding of roles and responsibilities and steps to take toward rebuilding the community following a public health emergency. Key organizations can also make sure that the plan accounts for the needs of vulnerable populations. CP 4 is a program accountability measure.

Definition of Key Terms Related to CP Capability

Following is a list of terms and definitions that appear throughout the community preparedness performance measures. These terms, when they appear in the performance measure tables, are underlined. Please apply the following definitions when interpreting the guidelines for data collection and reporting on the community preparedness performance measures.

¹⁹ Pfefferbaum, R. L., Reissman, D. B., Pfefferbaum, B., Wyche, K. F., Norris, F. H., & Klomp, R. W. (2008). Factors in the development of community resilience to disasters. In M. Blumenfield & R. J. Ursano (Eds.) *Intervention and resilience after mass trauma*. (chap. 2, pp. 49–68). New York: Cambridge University Press.

²⁰ Schoch-Spana, M., Franco, C., Nuzzo, J. B., & Usenza, C. on behalf of the Working Group on Community Engagement in Health Emergency Preparedness (2007). Community engagement: Leadership toll for catastrophic events. *Biosecurity and Bioterrorism: Biodefense Strategy, Practice, and Science* 5(1): 8-25.

Community sectors:²¹ For the purposes of these performance measures, this refers to segments of a community within which different types of organizations operate. These organizations reach and/or provide a variety of critical services to members of the public, including vulnerable populations (e.g., the

elderly; pregnant women; children and infants; individuals with chronic diseases and/or other acute medical conditions; individuals with a reduced ability to hear, speak, understand, remember; individuals who are disabled mentally and/or physically).

The 11 sectors of interest, as specified in the National Standards²² are listed below. Suggested —leaders|| for LHDs to engage are additionally identified. Please note that the definitions and examples within each sector are not all-inclusive. Additionally, key organization membership in one category does not preclude membership in another (i.e. they are not mutually exclusive).

1. Businesses: For-profit organizations that engage in commerce. Examples include businesses that are actively involved in and are committed to improving their communities, as well as businesses with a significant presence or footprint in the community (e.g., large employers, key suppliers of goods, etc.). This sector also includes utility services such as electricity, water, and sanitation if they are for-profit organizations. Leaders engaged from this sector should be influential within their own organizations and communities.

2. Community leadership: Leaders in policy-making and decision-making, including elected officials (e.g., mayor, members of city councils, members of school boards), leaders of non-governmental organizations (e.g., American Red Cross, United Way, Salvation Army), and other community organizations (e.g., U.S. National Council on Disability, Lion's Club, Rotary Club, Kiwanis Club, and the Junior League). This sector also includes leaders or representatives of tribal groups.

3. Cultural and faith-based groups and organizations: Organizations that represent the various religious and cultural traditions of a community. Leaders of such cultural and faith-based groups and organizations may be directors of cultural centers, elected officials of cultural and faith-based groups (e.g., president of a congregation), and leaders of interfaith councils or similar entities (e.g., National Interfaith Alliance).

4. Education and childcare settings: Public and private educational organizations including universities and colleges, school systems, individual schools, institutions serving children with special needs, Head Start programs, and private childcare facilities for young children. Leaders from these organizations make decisions and set policy, such as university and college officials, school superintendents, principals, facility directors, and parent advocates.

5. Emergency management: Federal, state and non-governmental organizations in the area of emergency management, homeland security, and first responders. Examples include the local emergency management agency, relevant tribal entities involved in emergency services or emergency management, the state emergency management agency, federal entities such as Federal Emergency Management Agency (FEMA) and other components of the U.S. Department of Homeland Security, the Medical Reserve Corps (MRC), Citizen Corps groups, Community Emergency Response Teams (CERTs) and others. This sector also includes traditional first responder groups including fire, police, and emergency medical services, as well as local public works agencies and nonprofit utility companies (e.g., city/county utilities, energy, water, and sanitation) and tribal utility authorities that may respond to an incident and/or provide services critical for an effective response. Leaders from this sector may include emergency managers or their deputies; chiefs and assistant chiefs for divisions such as special operations, hazardous materials and fire suppression; state police, city police and county sheriffs involved in large-scale planning events; special weapons and tactics supervisors; directors and supervisors of emergency medical services; and senior-level public works administrators. Please note that to the extent that

²¹ Definitions of community sectors, including many of the examples, are adapted from Gurwitsch et al. (2007)

²² CDC (2011)

this sector covers public safety (e.g., police and sheriffs), it implies engagement to ensure incarcerated individuals are appropriately included in relevant public health preparedness efforts.

6. Health care: Organizations including private facilities, public hospitals and outpatient clinics, university/academic medical schools and programs, healthcare coalitions, Department of Veterans' Affairs (VA) hospitals and clinics, Indian Health Services facilities, community health centers, non-profit healthcare providers, and private practice settings. Leaders from this sector may include health care professionals, especially those experienced in trauma or disaster relief work; physicians, nurses, pharmacists, and senior-level health care administrators who have taken an active or leadership role in other health/public health campaigns; health care professionals who hold leadership positions in their professional society (e.g. state and/or local chapters of the American Academy of Pediatrics, the American College of Physicians, and other professional societies); and health care administrators who promote the work of building community resilience.

7. Housing and sheltering: Organizations that offer and/or provide references or referrals for temporary residence to individuals who are without permanent housing (e.g., state-level housing/shelter departments, homeless shelters, nonprofit housing providers, tribal housing authorities, American Red Cross, etc.). This sector may also include residential facilities for the elderly (e.g., nursing homes and assisted living centers), special needs individuals, and other vulnerable populations (e.g., domestic violence shelters, recovery or —halfway|| homes for substance abusers, etc.). Leaders in this sector may include senior-level administrators, executive directors, and other directors and managers.

8. Media: Organizations representing information channels and outlets such as print, radio, television, and the Internet. This sector also includes local means of communication (e.g., local and tribal newsletters and related publications, social networking sites, and listservs). Leadership of these organization include representatives with whom the community is familiar and to whom residents turn for important and accurate information.

9. Mental/behavioral health: Organizations in the public or private sector that provide services related to supporting or enhancing the emotional/mental/behavioral well-being of individuals, families, and communities including state and local mental health authorities, community mental health facilities, VA hospitals and clinics, and the mental/behavioral health units of organizations including hospitals, Indian Health Services facilities, and academic institutions. This sector also includes nonprofit service providers and private practice settings where professionals including psychologists, psychiatrists, social workers, and licensed counselors provide mental/behavioral health services. Leaders in this sector may serve on disaster planning and response committees within their local, state, or national professional organizations.

10. Social services: Organizations providing a range of services to vulnerable populations. Services may include, but not be limited to, medication assistance, assistance with accessing medical care and technology, transportation to needed services, nutrition/food assistance, and case management services. This sector also includes child welfare organizations and non-residential agencies, such as referral agencies and entities that serve individuals with developmental disabilities. Examples of these types of agencies include local nonprofit and faith-based social service providers (e.g. Meals on Wheels, Catholic Charities, The Salvation Army), state or local level departments of social services, VA, State Councils on Developmental Disabilities, and other related governmental and nongovernmental organizations that serve vulnerable populations. Leaders in this sector may include senior-level administrators, center officers in charge, executive directors, and other directors and managers.

11. Senior services: This sector may include nongovernmental service providers such as nursing homes, assisted living facilities, adult daycare programs targeting primarily seniors, offices of the AARP, and other nongovernmental organizations that have a focus on serving the aging. Additional governmental organizations may include entities such as any state government level office or department (e.g., State Office of Aging or its equivalent) as well as local area agencies on aging that administer various titles under the Federal Older Americans Act of 1965 and its amendments. Such offices may also administer a variety of state-funded programs, which serve the aging, particularly those with the greatest economic or social need, such as low-income minority elderly.

Leaders in this sector may include senior-level administrators, executive directors and other directors and managers.

Hazard and vulnerabilities assessment (HVA): An appraisal of hazards, vulnerabilities, and risks. For additional information regarding HVA, refer to the National Standards document, or for an example, refer to the UCLA Center for Public Health and Disaster Hazard Risk Assessment Instrument²³

Incident: Any natural or manmade occurrence that negatively affects or can potentially negatively affect public health. The incident does *not* need to be a declared emergency.

Key organization: An entity, group, agency, club, business, or professional association, as well as an individual service provider that the LHD deems critical in terms of one or more of the following criteria.

- The entity is expected to provide health and human services (e.g., food, shelter/housing, social services, mental/behavioral) to vulnerable or at-risk populations in the context of a significant disaster or public health emergency.
- The entity is an essential vehicle for community outreach, information dissemination, or other similar communications with vulnerable and hard-to-reach populations, as well as the general public, during response or recovery following an incident. Such key organizations may fit within one or more of the 11 community sectors (e.g. the media, community leaders, cultural and faith-based organizations, businesses).
- The entity is or would be an essential primary partner in a jurisdictional disaster or public health emergency response in terms of resource sharing, provision of goods or services, surge capacity, representation in the Incident Management Structure (e.g., the emergency operations center) or other type of formal integration into a LHD's response to a public health emergency.

Key organizations are often characterized as:

- Having a significant footprint or service area in a community (e.g., hospitals, TV/radio stations, food banks, or the local emergency management agency)
- High-volume or throughput in terms of goods or services provided [e.g., high-volume food providers and distributors (businesses); low-income or publicly funded housing organizations; shelters]
- Serving hard-to-reach, vulnerable, or at-risk populations (e.g., multi-service community-based organizations)
- Historically significant institutions, or key figures/icons, within a community, often with significant influence within one or more cultural or affinity groups (e.g., community leaders)
- Providers of narrow or unique, but critical, services to the community (e.g., media outlets, hospitals)

It is the specific intent of the CP performance measures that LHDs identify only those key organizations that they plan to engage in a significant public health emergency preparedness, response, or recovery context including, but not limited to, review of hazards, vulnerability, and risk data or other preparedness activities. It is not the intent of these measures to have LHDs identify (and subsequently engage with) all community organizations within their respective jurisdictions. Aspects to consider when collaborating with key organizations include the following:

²³ University of California, Los Angeles Center for Public Health and Disaster: *Hazard Risk Assessment Instrument Workbook*. Accessible at: <http://www.cphd.ucla.edu/hrai.html>.

- Key organizations do not need to be physically located in the LHD's area, but must be willing and able to engage in planning for and providing services to that area in the event of a public health emergency.

- Total numbers of key organizations are less important than the quality of organizations; a large key organization that is a leader within its sector or the community may suffice to represent that entire sector, whereas in other communities there may be several organizations, even dozens or more in large cities and in counties, deemed by the LHD to be key and an appropriate target for engagement in a public health emergency preparedness or response activity
- Key organizations may represent more than one sector. For example, the local chapter of the American Red Cross may represent both the housing and sheltering and social services sectors.
- Representatives of the key organizations should be leaders and hold influence within their own organizations and within the sectors that they represent. They should also be in a position to commit their organization and/or its resources to community preparedness and recovery efforts.

In local jurisdictions in which the emergency management agency is the primary liaison with community organizations and sectors, LHDs are encouraged to partner with emergency management to meet the intent of all four community preparedness performance measures.

Public health, medical, and mental/behavioral health: One or more systems of public and private agencies, and their associated programs, that function to provide services to ensure the overall physical and mental well-being of the community-at-large.

- **Public health** is concerned with the health of the community as a whole. The Institute of Medicine defines a public health system as executing the core functions of public health agencies at all levels of government: assessment, policy development, and assurance²⁴. The mission of public health is to “fulfill society’s interest in assuring conditions in which people can be healthy.” The three core public health functions are:

1. The assessment and monitoring of the health of communities and populations at risk to identify health problems and priorities;
2. The formulation of public policies designed to solve identified local and national health problems and priorities;
3. To assure that all populations have access to appropriate and cost-effective care, including health promotion and disease prevention services, and evaluation of the effectiveness of that care.²⁵

- **Medical** or health care is the diagnosis, treatment, and prevention of disease, illness, injury, and other physical and mental impairments in humans. Health care is delivered by practitioners in medicine, chiropractic, dentistry, nursing, pharmacy, allied health, and other relevant areas of care. It refers to the work done in providing primary care, secondary care, and tertiary care, as well as in public health.²⁶

- **Mental/behavioral health** refers to “a broad array of activities directly or indirectly related to the mental well-being. It is related to the promotion of well-being, the prevention of mental disorders, and the treatment and rehabilitation of people affected by mental disorders.”²⁷ In the National Standards, this is an overarching term used to encompass behavioral, psychosocial, substance abuse, and psychological health.²⁸

²⁴ Institute of Medicine (1988). *The Future of Public Health*. Washington, DC: National Academy Press.

²⁵ Public Health (n.d.). In *MedTerms Dictionary*. Accessible at: <http://www.medterms.com/script/main/art.asp?articlekey=5120>.

²⁶ —Medicine| (n.d.). Accessible at: http://en.wikipedia.org/wiki/Health_care

²⁷ WHO (n.d.). World Health Organization (n.d.). *Health Systems*. Retrieved July 8, 2011 from the WHO Web site:

http://www.who.int/topics/health_systems/en/

²⁸ CDC (2011)

Table 2.2. CP – Identification of Key Organizations

CP – Identification of key	<u>Median number of community sectors in which LHDs identified key organizations to participate in public health, medical, and/or</u>
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organizations	<u>mental/behavioral health-related emergency preparedness efforts.</u>
Annual	
Measurement Specifications	When the numbers of community sectors engaged by each participating LHD are arranged from highest to lowest [maximum is 11, minimum is zero], the median is the midpoint number where half of the LHDs engaged a number of sectors at or above the midpoint and the other half of the LHDs engaged a number of sectors at or below it.
Intent	<p>This process measure demonstrates awardee accountability in relation to <u>LHDs</u> identifying and prioritizing key organizations (across all 11 <u>community sectors</u> as identified in CDC’s National Standards document) with which they wish to engage in emergency preparedness efforts related to <u>public health, medical and/or mental/behavioral health</u>. These sectors encompass a range of constituents and services and should provide services to the general public as well as vulnerable populations within the community in order to prepare for and recover from an incident or disaster.</p> <p>The intent of this measure is for awardee health departments to capture data on the identification and prioritization of those organizations deemed, by <u>LHDs</u>, to be critically important (i.e., key) for inclusion and/or engagement in public health, medical and/or mental/behavioral emergency preparedness, response, and recovery efforts.</p>
Reporting Criteria	<p>Reporting on this performance measure is REQUIRED.</p> <p>All PHEP awardees are required to report.</p> <p>This performance measure requires self-reported data.</p> <p>Data collected for this measure must fall within PHEP BP11</p>
Reported Data Elements	<ol style="list-style-type: none"> 1. Number of LHDs reporting 2. Total number of <u>key organizations</u>, across all 11 community sectors, identified by <u>LHDs</u>. 3. Number of <u>key organizations</u>, by <u>community sector</u>, identified by <u>LHDs</u>. 4. Number of <u>key organizations</u> that represent multiple <u>community sectors</u>. 5. What additional <u>key organizations</u> did LHDs identify that do not fit within any of the 11 specified <u>community sectors</u>? <ol style="list-style-type: none"> a. Briefly describe the type of <u>key organizations</u> and the populations they serve. 6. Briefly describe the successes cited by <u>LHDs</u> in terms of <u>identifying key organizations</u>. 7. Briefly describe any barriers or challenges cited by <u>LHDs</u> in terms of identifying <u>key organizations</u>.

**Additional
Guidance**

Identified key organizations. In identifying key organizations, the following should be considered:

- Key organizations should have significant reach within the local community. The make-up of organizations within a community sector should have access to or provide services to one or more vulnerable populations.
- Key organizations may provide services for more than one community sector. Thus, the organization may represent or be counted for multiple sectors.

The intent of this measure is that LHDs identify only those key organizations that they believe are critical in providing services to at-risk populations, or acting as critical response partners, in a significant public health emergency. It is not the intent of this measure to have LHDs identify (and subsequently engage with) all community organizations within their jurisdictions. LHDs should reassess their list of key organizations annually.

Table 2.3. CP - Community Engagement in Risk Identification

CP - Community engagement in risk identification	<u>Median number of community sectors that LHDs engaged in using hazards and vulnerabilities assessment (HVA) data to determine local hazards, vulnerabilities, and risks that may impact public health, medical, and/or mental/behavioral health systems and services.</u>
Annual	
Measurement Specifications	When the numbers of community sectors that each LHD engaged to determine local hazards, vulnerabilities, and risks are arranged from highest to lowest [maximum is 11, minimum is zero], the median is the midpoint number where half of the LHDs engaged a number of sectors at or above the midpoint and the other half of the LHDs engaged a number of sectors at or below it.
Intent	<p>This is a process measure demonstrating awardee accountability by ensuring that LHDs engage key organizations, across all 11 sectors (as identified in CDC’s National Standards document) in using HVA data to determine local hazards, vulnerabilities, and risks that may impact public health, medical, and/or mental/behavioral health systems and services. A community’s understanding and acknowledgement of the identified hazards, vulnerabilities, and risks is critical to developing appropriate preparedness, response, and recovery plans. Engaging key organizations in these processes ensures their commitment and involvement in implementing these plans.</p> <p>The intent of this measure is for awardee health departments to capture information about LHD engagement of key organizations in identifying <u>hazards, vulnerabilities, and risks</u> that may impact <u>local public health, medical, and/or mental/behavioral health</u> systems and services. Awardee health departments should encourage and support LHDs to leverage findings, as applicable, from HVAs undertaken by themselves or other entities (e.g., local, state, or federal emergency management). Irrespective of which agency led the HVA, the findings must be discussed in relation to their potential impact on public health, medical, and/or mental/behavioral health systems and services. This helps to ensure that the community preparedness and recovery plan appropriately addresses the mitigation of risk and the restoration of these systems and services in as feasible a manner as possible.</p>
Reporting Criteria	<p>Reporting on this performance measure is REQUIRED.</p> <p>All PHEP awardees are required to report.</p> <p>This performance measure requires self-reported data.</p> <p>Data collected for this measure must fall within PHEP BP11</p>

Reported Data Elements	<ol style="list-style-type: none"> 1. Number of <u>LHDs</u> reporting 2. Total number of <u>key organizations</u>, across all 11 <u>community sectors</u>, engaged in determining the local hazards, vulnerabilities, and risks that may impact <u>public health, medical, and/or mental/behavioral health</u> systems and services. 3. Number of <u>key organizations</u>, by <u>community sector</u>, engaged in determining the local hazards, vulnerabilities, and risks that may impact <u>public health, medical and/or mental/behavioral health</u> systems and services. 4. Range of community sectors engaged by the sample of <u>LHDs</u> reporting data for this measure. 5. Number of <u>LHDs</u> that engaged all 11 community sectors <u>in using HVA data to determine local hazards, vulnerabilities, and risks</u> that may <u>impact public health, medical, and/or mental/behavioral health</u> systems and services. 6. Type of <u>HVA</u> data that <u>LHDs</u> used to determine local hazards, vulnerabilities, and risks that may impact <u>public health, medical, and/or mental/behavioral health</u> systems and services. <ol style="list-style-type: none"> a. Number of <u>LHDs</u> that conducted their own local <u>HVA</u>. b. Number of <u>LHDs</u> that reviewed <u>HVA</u> data conducted by the state health department. c. Number of <u>LHDs</u> that reviewed <u>HVA</u> data conducted by the local, state, or federal emergency management agency; d. Number of <u>LHDs</u> that reviewed <u>HVA</u> data from more than one source/agency (e.g. local emergency management and the state health department) 7. Briefly describe successes cited by <u>LHDs</u> in terms of engaging <u>key organizations</u> in using <u>HVA</u> data to determine local hazards, vulnerabilities, and risks. 8. Briefly describe any barriers or challenges cited by <u>LHDs</u> in terms of engaging <u>key organizations</u> in using <u>HVA</u> data to determine local hazards, vulnerabilities, and risks.
Additional Guidance	<p>This measure should only include those individuals and organizations (e.g., agency, club, business, or professional association) deemed sufficiently representative of a sector, and essential in providing input and feedback related to local hazards, vulnerabilities, and risks that may impact <u>public health, medical and/or mental/behavioral health</u> systems and services.</p> <p><u>LHDs</u> may either conduct their own <u>HVA</u> or review <u>HVA</u> data collected by other agencies (e.g., the state public health agency, state or local emergency management agency, and FEMA). Additionally, during a BP in which an <u>HVA</u> is not conducted for the local jurisdiction, the <u>LHD</u> should review the hazards, vulnerabilities, and risks previously identified (e.g., in a prior BP) to determine if they are still relevant, and update their local community preparedness and recovery plans as needed.</p> <p>Engaged in using <u>HVA</u> data to determine local hazards, vulnerabilities, and risks. <u>Key organizations</u>, representing all 11 <u>community sectors</u>, should provide verbal or written input to the LHD for determining the hazards, vulnerabilities, and risks relevant to <u>public health, medical, and/or mental/behavioral health</u> systems and services within their local jurisdiction. <u>LHDs</u> may engage their key organizations in a variety of ways depending on the source of the <u>HVA</u> data.</p> <ul style="list-style-type: none"> • If the <u>LHD</u> conducted its own local <u>HVA</u>, this may involve (but is not limited to) the following:

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- Providing information or input during the risk assessment process via meetings, interviews, or surveys.
 - Participating, as a member of a strategic advisory council (SAC), local emergency planning committee (LEPC), community consortia, or planning body to design a risk assessment, review risk assessment data, and/or identify hazards, vulnerabilities, and risks.
 - Participation in reviewing and discussing risk assessment data to identify hazards, vulnerabilities, and risks at in-person meetings, by phone, or via the Web or e-mail.
 - Voting to identify risks (or in support of identified risks); voting is sponsored by the local public health agency, SAC, community consortia, or planning body, and may occur at in-person meetings, or by paper, phone, Web, or e-mail.
 - Reviewing and acknowledging agreement with the identified hazards, vulnerabilities, and risks.
 - If the LHD reviewed HVA data conducted by one or more agency (e.g., state health department; local, state or federal emergency management agency), this may involve (but is not limited to) the following:
 - Participating, as a member of a SAC, LEPC, community consortium, or other type of planning body to secure and/or review risk assessment data and/or to identify hazards, vulnerabilities, and risks.
 - Providing information or input that informs the review of previously identified hazards, vulnerabilities, and risks for the current BP.
 - Participation in reviewing and discussing current or previously collected HVA data to identify hazards, vulnerabilities, and risks via in-person meetings, paper, phone, the Web or e-mail.
 - Voting to identify risks (or in support of identified risks)—currently or as identified in a previous BP. Voting is sponsored by the LHD, SAC, community consortia, or planning body, and may occur at in-person meetings, or by hard copy or electronic survey.
 - Reviewing and acknowledging agreement with the identified hazards, vulnerabilities, and risks (current or previously identified/reprioritized) for the BP.

This measure is meant to capture meaningful, bona fide participation by community sector representatives. Marginal or non-meaningful participation shall not count toward this performance measure. This measure excludes individuals that do not participate or those who participate marginally in a manner that is not meaningful, as well as those who do not provide explicit input or feedback on risks to public health, medical and/or mental/behavioral health systems or services (e.g., members of the media who show up to observe for the sole purpose of reporting).

Table 2.4. CP – Engagement in Public Health Emergency Preparedness

CP – Engagement in public health emergency preparedness	Proportion of <u>key organizations</u> that <u>LHDs engaged in a significant public health emergency preparedness activity</u>	
Annual		
Measurement Specifications	Numerator:	<p>Number of <u>key organizations</u> that <u>LHDs engaged in one or more of the following significant public health emergency preparedness activities</u>:</p> <ul style="list-style-type: none"> • Development of <u>key organizations’ emergency operations or response plans related to public health, medical, and/or mental/behavioral health</u> • Exercises containing objectives or challenges (e.g. injects) related to <u>public health, medical, and/or mental/behavioral health</u>. • Competency-based training related to <u>public health, medical, and/or mental/behavioral health emergency preparedness and response</u>
	Denominator:	Total number of <u>key organizations</u> identified by <u>LHDs</u> (as specified in data element 2 for CP 1)
Intent	<p>This process measure is intended, over time, to demonstrate program improvement at the local level by assessing the depth of key organizations (across the 11 community sectors identified in the National Standards document) engaged by <u>LHDs</u> in significant emergency preparedness activities related to <u>public health, medical, and/or mental/behavioral health</u>. The intent of this measure is for awardee health departments to capture information about <u>LHDs’ involvement with their key organizations in meaningful activities that build their overall capacity to plan for and/ or respond to incidents that impact their public health, medical, and/or mental/behavioral health systems and services</u>. These activities help the <u>LHD and key organizations</u> think through the ways in which they can restore the infrastructure and services as quickly as possible and identify potential gaps in their existing plans. These activities also help to ensure that <u>key organizations</u> understand their roles and responsibilities as well as protocols and procedures for responding to and recovering from an incident.</p>	
Reporting Criteria	<p>Reporting on this performance measure is REQUIRED. All PHEP awardees are required to report. This performance measure requires self-reported data. Data collected for this measure must fall within BP11:</p>	
Reported Data Elements	<ol style="list-style-type: none"> 1. Number of <u>LHDs</u> reporting 2. Total number of <u>key organizations</u>, across all 11 <u>community sectors</u>, that <u>LHDs engaged in at least one significant emergency preparedness activity related to public health, medical, and/or mental/behavioral health</u>. 3. Number of <u>key organizations</u>, by community sector, that participated in 	

more than one significant preparedness activity related to public health, medical, and/or mental/behavioral health.

4. Range of community sectors that participated in a significant preparedness activity related to public health, medical, and/or mental/behavioral health, across reporting LHD jurisdictions
 5. Number of LHDs for which all 11 community sectors participated in a significant preparedness activity related to public health, medical, and/or mental/behavioral health.
 6. Briefly describe successes cited by LHDs in terms of engaging key organizations in significant preparedness activity related to public health, medical, and/or mental/behavioral health.
 7. Briefly describe any barriers or challenges cited by LHDs in terms of engaging key organizations in significant preparedness activity related to public health, medical, and/or mental/behavioral health.
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Additional Guidance

Significant public health emergency preparedness activities. Endeavors that provide key organizations with the capacity to plan for and/or respond to an incident. For this performance measure, these activities are defined as:

- a. Development of key organizations' emergency operations or response plans related to public health, medical, and/or mental/behavioral health
- b. Exercises containing objectives or challenges (e.g. injects) related to public health, medical, and/or mental/behavioral health.
- c. Competency-based training related to public health, medical, and/or mental/behavioral health emergency preparedness and response

Emergency operations and response plans: Written plans that identify key organizations policies, procedures, and organizational structure for implementation during and following an incident. Continuity of operations plans (COOP) are also within scope for this element.

Exercises: An instrument to train for, assess, practice, and improve performance in prevention, protection, response, and recovery capabilities in a risk-free environment. Exercises can be used for testing and validating policies, plans, procedures, training, equipment, and interagency agreements; clarifying and training personnel in roles and responsibilities; improving interagency coordination and communications; identifying gaps in resources; improving individual performance; and identifying opportunities for improvement.

Additional information on exercise types is available from the Homeland Security Exercise and Evaluation Program²⁹ at <https://hseep.dhs.gov/support/VolumeI.pdf>

- **Discussion-based exercises** familiarize participants with current plans, policies, agreements, and procedures, or may be used to develop new plans, policies, agreements, and procedures. Types of discussion-based exercises include:
 - **Seminar:** A seminar is an informal discussion, designed to orient participants to new or updated plans, policies, or procedures (e.g., a seminar to review a new evacuation standard operating procedure).
 - **Workshop:** A workshop resembles a seminar but is employed to build specific products, such as a draft plan or policy (e.g., a training and exercise plan workshop is used to develop a multi-year training and exercise plan).
 - **Tabletop exercise (TTX):** A tabletop exercise involves key personnel discussing simulated scenarios in an informal setting. TTXs can be used to assess plans, policies, and procedures.
 - **Operations-based exercises** validate plans, policies, agreements, and procedures; clarifies roles and responsibilities; and identifies resource gaps in an operational environment. Types of operations-based exercises include:
 - **Drill:** A drill is a coordinated, supervised activity usually employed to test a single specific operation or function within a single entity (e.g., a fire department conducts a decontamination drill).
- **Functional exercise (FE):** A functional exercise examines and/or validates the coordination, command, and control between various multi-agency

²⁹Department of Homeland Security (DHS) (n.d.). *Homeland Security Exercise and Evaluation Program*. Accessible at : https://hseep.dhs.gov/pages/1001_Gloss.aspx

coordination centers (e.g., emergency operation center, joint field office, etc.). A functional exercise does not involve any boots on the ground (i.e., first responders or emergency officials responding to an incident in real time).

- **Full-Scale exercises (FSE):** A full-scale exercise is a multiagency, multijurisdictional, multidiscipline exercise involving functional (e.g., joint field office, emergency operation centers, etc.) and boots on the ground response (e.g., firefighters decontaminating mock victims).³⁰

Competency-based training entails the provision of standardized instructions/guidance related to disaster prevention, preparedness, response, and recovery role(s) in accordance with established national, state, and local health security and public health policies, laws, and systems. Examples of competency-based training programs include, but are not limited to, National Incident Management System (NIMS)³¹ and related training, Hospital Incident Command System (HICS) training³², the National Disaster Life Support Program³³; the American Academy of Pediatrics disaster medicine curriculum³⁴; and national and state Voluntary Organizations Active in Disaster planning documents.³⁵ Additional information on competency-based training is available through the Preparedness and Emergency Response Learning Centers from CDC³⁶ Information on the Public Health Preparedness and Response Core Competency Model is available through the Association of Schools of Public Health³⁷

³⁰ DHS (2011)

³¹ Department of Homeland Security. (n.d.). *NIMS Training*. Accessible at: <http://www.fema.gov/emergency/nims/NIMSTrainingCourses.shtm>

³² Hospital Incident Command System. *Center for HICS Education and Training*. Accessible at: <http://www.hicscenter.org/index.php>

³³ American Medical Association (AMA). (2003). *National Disaster Life Support™ Program*. Accessible at: <http://www.ama-assn.org/ama/pub/physician-resources/public-health/center-public-health-preparedness-disaster-response/national-disaster-life-support.page>

³⁴ American Academy of Pediatrics (AAP). (2008). *Pediatric Education in Disasters Manual: A Course of the "Helping the Children" Program*. Accessible at: <http://www.aap.org/disasters/peds.cfm>

³⁵ National Voluntary Organizations Active in Disaster (NOVAD). (n.d.). Accessible at: <http://www.nvoad.org/resource-library/documents>

³⁶ CDC. (n.d.). *Preparedness and Emergency Response Learning Centers*. Accessible at: <http://www.cdc.gov/phpr/perlc.htm>

³⁷ Association of Schools of Public Health (ASPH) & CDC. (December 2010). *Public Health Preparedness & Response Core Competency Model, v.1.0*. Accessible at: <http://www.asph.org/userfiles/PreparednessCompetencyModelWorkforce-Version1.0.pdf>

Table 2.5. CP – Engagement in Recovery Planning

CP – Engagement in recovery planning	<u>Median number of community sectors that LHDs engaged in developing and/or reviewing a community recovery plan related to the restoration and recovery of public health, medical, and/or mental/behavioral health systems and services.</u>
Measurement Specifications	When the numbers of <u>community sectors</u> that each <u>LHD engaged in developing and/or reviewing their community recovery plan</u> are arranged from highest to lowest [maximum is 11, minimum is zero], the median is the midpoint number where half of the LHDs engaged a number of sectors at or above the midpoint and the other half of the LHDs engaged a number of sectors at or below it.
Intent	<p>The purpose of this process measure is to demonstrate program accountability of cross-sector community engagement by LHDs in disaster recovery planning related to the restoration and recovery of <u>public health, medical, and/or mental/behavioral health</u> systems and services.</p> <p>The intent of this measure is for awardee health departments to capture information about LHDs engagement of community sector representatives in recovery planning for the restoration of services, providers, facilities, and infrastructure related to <u>public health, medical, and mental/behavioral health</u> systems. Additionally, this provides a mechanism to track improvements in these efforts over time. Building and maintaining community resilience requires deliberate action to plan for recovery from a major incident or disaster. The participation of <u>key organizations in developing and/or reviewing a community recovery plan</u> builds a better understanding of roles and responsibilities as well as steps to take toward rebuilding the community following an incident impacting <u>public health, medical and/or mental/behavioral health</u> systems and services.</p>
Reporting Criteria	<p>Reporting on this performance measure is REQUIRED.</p> <p>All PHEP awardees are required to report.</p> <p>This performance measure requires self-reported data.</p> <p>Data collected for this measure must fall within PHEP BP11:</p>
Reported Data Elements	<ol style="list-style-type: none"> 1. Number of LHDs reporting 2. Total number of <u>key organizations</u>, across the 11 <u>community sectors</u>, that LHDs engaged in developing and/or reviewing a <u>community recovery plan</u> related to the restoration and recovery of <u>public health, medical, and/or mental/behavioral health</u> systems and services.

Reported Data Elements	<ol style="list-style-type: none"> 3. Number of <u>key organizations</u>, by the 11 <u>community sectors</u>, that that <u>LHDs engaged in developing and/or reviewing a community recovery plan</u> related to the restoration and recovery of <u>public health, medical, and/or mental/behavioral health</u> systems and services. 4. Range of <u>community sectors</u> that were <u>engaged in developing and/or reviewing a community recovery plan</u>. 5. Number of <u>LHDs</u> for which all 11 <u>community sectors</u> were <u>engaged in developing and/or reviewing a community recovery plan</u>. 6. Briefly describe successes cited by <u>LHDs</u> in terms of engaging <u>key organizations</u> in <u>developing and/or reviewing a community recovery plan</u>. 7. Briefly describe any barriers or challenges cited by <u>LHDs</u> in terms of engaging <u>key organizations</u> in <u>developing and/or reviewing a community recovery plan</u>.
Additional Guidance	<p>Community recovery plan. A written, all-hazards or hazard-specific plan that documents objectives, actions, and other information to assist key community public and private sector entities during the recovery phase of a disaster or (typically) major incident of public health significance. For the purpose of this performance measure, the plan should include the roles and responsibilities of the LHD and <u>key organizations</u> in restoring <u>public health, medical, and/or mental/behavioral health</u> systems and services.</p> <p>The review of a community recovery plan should occur annually (if the plan was previously developed).</p> <p>Engaged in developing and/or reviewing a community recovery plan. <u>Key organizations</u>, across all 11 <u>community sectors</u> should be involved in developing and/or revisiting the <u>LHD's</u> (or local emergency management agency's) community recovery plan. Engagement in this activity may occur in various ways, including, but not limited to:</p> <ul style="list-style-type: none"> • Providing information or input to the <u>LHD</u> for the development or review of the community recovery plan. • Participating, as a member of a strategic advisory council (SAC), local emergency planning committee (LEPC), community consortia, or planning body to develop, review, and/or update the community recovery plan. • Participation in reviewing and discussing the community recovery plan at in-person meetings, by paper, phone, or via the Web or e-mail. • Voting in support of a community recovery plan; voting is sponsored by the local public health agency, SAC, community consortia, or planning body, and may occur at in-person meetings, by paper or phone, or via the Web or e-mail. • Reviewing and acknowledging agreement with a community recovery plan. <p>This measure is meant to capture meaningful, bona fide participation by <u>community sector</u> representatives. Marginal or non-meaningful participation does not count toward this performance measure. This measure excludes individuals that do not participate or those who participate marginally in a manner that is not meaningful, as well as those who do not provide explicit input or feedback on risks to <u>public health, medical and/or mental/behavioral health</u> systems or services (e.g., members of the media who show up to observe for the sole purpose of reporting).</p>

PHEP Subgrant Accountability Guidance Document

The Ohio Department of Health requires that successful applicants comply with administrative, fiscal, and programmatic requirements. Subgrantees must demonstrate adherence to all PHEP application and reporting deadlines. Failure to submit required PHEP program data and reports by ODH deadlines will constitute funding penalties. A failure to submit timely key program and fiscal data hinders ODH's ability to analyze data and submit accountability reports as required to the Centers for Disease Control and Prevention (CDC). This effects ODH's ability to accurately reflect Ohio PHEP program achievements and barriers to success. The CDC will impose fiscal penalties to Ohio if administrative, fiscal, and programmatic requirements are not met. These fiscal penalties will apply to all PHEP subgrantees. The ODH will withhold funding from entities that fail to achieve these requirements. This document provides additional clarification and specification that applies to the PHEP program.

Application Scoring

The 2012-2013 grant year application will be competitive. All eligible applications will be scored. Refer to Appendix C.

2012-2013 Grant Funding Withholding

Successful subgrantees are responsible for meeting all program and fiscal standards and deliverables. If a subgrantee does not meet program or fiscal requirements, funding withholding penalties will be applied. Funds withheld from a subgrantee may be awarded to other subgrantees and will not be released later to the subgrantee from whom the funds are withheld. The table in this attachment provides specific examples of penalties.

2013-2014 and Future Funding Withholding

Future funding awards (2013-2014 and beyond) will be based on performance during 2012-2013. Subgrantees that do not meet program standards, fiscal standards, administrative requirements, or performance measures will be subject to withholding of future grant dollars

- **Performance Measure Withholding Benchmarks:** Subgrantees will be required to submit Performance Measure data. The data will be used to determine minimum performance measure standards and benchmarks. Not meeting these performance measure benchmarks will jeopardize future funding. The Performance Measures are described in Appendix E & F. There are four categories of performance measures:
 - Epidemiology and Surveillance Performance Measures;
 - Community Preparedness Performance Measures;
 - Medical Material and Management Performance Measures; and
 - Overarching Performance Measures (i.e. OPHCS).
- **Fiscal Withholding Benchmarks:** Subgrantees are required to submit Fiscal reports on time and according to GAPP standards. Not meeting these benchmarks will jeopardize funding.

- Quarterly and Final Expenditure Reports not submitted by due date
- Quarterly and Final Expenditure Reports not submitted according to GAPP standards
- Late return of unspent funds
- **Program Withholding Benchmarks:** Subgrantees are required to submit Fiscal reports on time and according to GAPP standards. Not meeting these benchmarks will jeopardize funding.
 - Mid-Year Program Progress Reports not submitted by due date
 - Mid-Year Program Progress Reports not submitted according to program standards. The mid-year program reports will be used as part of the “application score” in future year funding decisions.

Funding Penalties

If a subgrantee demonstrates poor performance or lack of compliance with fiscal or program standards and reporting deadlines, the ODH will make the following decisions as detailed in the accountability grid:

- Hold quarterly payment until problem is remedied
- Reduce quarterly payment
- Cut subsequent year’s grant award by 1% (per infraction, can be cumulative up to 10%)
- Not fund subsequent year
- Identify subgrantee as ineligible for any supplemental funds
 - 5 pts: All unspent funds are returned on time (as evidenced by not being certified to the Attorney General during the FY 10 and FY11 grant years).

Application Scoring Results:

- 80-100 percent: No Risk: Subgrantees will be funded. Subgrantees will be required to comply with all special conditions; and comply with all programmatic and fiscal reporting requirements.
- 70-80 percent: At Risk: Subgrantees will be funded. Subgrantees will be required to submit an improvement plan to address low scored items. A corrective action plan will be developed in conjunction with the subgrantee. Subgrantee will need to remedy the concerns or quarterly payments will be held. A “high risk” monitoring visit will be conducted by ODH within the first half of the grant year.
- 0-70 percent: Subgrantees will not be funded.

Plan Regarding Unfunded County

If there is no successful applicant in a county – the ODH will consider these options:

- Re-bid or re-open the RFP so surrounding health jurisdictions or regional coordinating subgrantee can apply to address PHEP deliverables for that county. Unsuccessful applicants will be ineligible to participate in the re-bidding process.
- ODH contracts with local EMA to complete some of the planning activities
- ODH contracts with a vendor (at the state level) to provide some of the planning activities

2012-2013 Grant Funding Withholding

Successful subgrantees are responsible for meeting all program and fiscal standards and deliverables. If a subgrantee does not meet program or fiscal requirements, funding withholding penalties will be applied. The table in this attachment provides specific examples of penalties. Funds withheld from a subgrantee may be awarded to other subgrantees and will not be re-released to the subgrantee from whom the funds were withheld.

Withholding Penalties for 2012-2013

Withholding Penalty	Withholding Benchmark
1%	Not submitting Performance Measure Data on time to ODH. (due with EOY program report 9/17/12)
1%	Not submitting End of Year Progress Report on time to ODH (due 9/17/12)
1%	Not submitting the Fourth Quarter Expenditure Report on time to ODH (due 8/24/12)
1%	Not submitting the Final Expenditure Report on time to ODH (due 9/24/12)

** Withholding Penalties are cumulative; subgrantees may be subjected to a total 4% cut in their grant award*

** Subgrantees may request extensions (up to 10 days). Requests must be submitted before the report due date.*

Requests will be reviewed/approved on an individual basis.

2013-2014 and Future Funding Withholding

Future funding awards (2013-2014 and beyond) will be based on performance during 2012-2013. Subgrantees that do not meet program standards, fiscal standards, administrative requirements, or performance measures will be subject to withholding of future grant dollars

- **Performance Measure Withholding Benchmarks:** Subgrantees will be required to submit Performance Measure data with their end of year report in 2012. These data will be used to determine minimum performance measure standards and benchmarks. Not meeting these performance measure benchmarks will jeopardize future funding (TBA) when the CDC develops minimum benchmark requirements. The Performance Measures are described in Appendix E and F). There are four categories of performance measures:
 - Epidemiology and Surveillance Performance Measures;
 - Community Preparedness Performance Measures;
 - Medical Material and Management Performance Measures; and
 - Overarching Performance Measures (i.e. OPHCS).
- **Fiscal Withholding Benchmarks:** Subgrantees are required to submit Fiscal reports on time and according to GAPP standards. Not meeting these benchmarks will jeopardize funding.

- Quarterly and Final Expenditure Reports not submitted by due date
- Quarterly and Final Expenditure Reports not submitted according to GAPP standards
- Late return of unspent funds
- Program Withholding Benchmarks: Subgrantees are required to submit Fiscal reports on time and according to GAPP standards. Not meeting these benchmarks will jeopardize funding.
 - Mid-Year Program Progress Reports not submitted by due date
 - Mid-Year Program Progress Reports not submitted according to program standards. The mid-year program reports will be used as part of the “application score” in future year funding decisions.

Possible Funding Penalties

If a subgrantee demonstrates poor performance or lack of compliance with fiscal or program standards and reporting deadlines, the ODH will make the following decisions (Detailed in the accountability grid):

- Hold quarterly payment until problem is remedied
- Reduce quarterly payment
- Cut subsequent year’s grant award by 1% (per infraction, can be cumulative up to 10%)
- Not fund subsequent year
- Identify subgrantees ineligible for any supplemental funds

Subgrant Accountability Grid										
Issue	Courtesy Call from ODH Program Consultant	Technical Assistance Call from ODH Program Consultant	ODH documents conversation in GMIS	ODH Program Consultant sends email to subgrantee project director	ODH PHEP Supervisor sends email to subgrantee agency head	Special Condition is placed on subgrantee	Quarterly Payment is withheld	Supplemental (if applicable) is not received	Future funding is cut by 1%	Future funding is cut – no funding is awarded in subsequent year
Poor Program Performance (minor)	--	X	X	X	--	--	--	--	--	--
Poor Program Performance (major)	--	X	X	X	1 st	--	--	--	--	--
Not submitting Performance Measure data on time	X	X	X	X	X	--	1 st	--	--	--
Not meeting standards for Performance Measures (once established)	X	X	X	X	X	--	1 st	--	2 nd	3 rd
Not submitting program reports (special requests from ODH)	X	X	X	X		2 nd	--	--	--	--

Subgrant Accountability Grid										
Issue	Courtesy Call from ODH Program Consultant	Technical Assistance Call from ODH Program Consultant	ODH documents conversation in GMIS	ODH Program Consultant sends email to subgrantee project director	ODH PHEP Supervisor sends email to subgrantee agency head	Special Condition is placed on subgrantee	Quarterly Payment is withheld	Supplemental (if applicable) is not received	Future funding is cut by 1%	Future funding is cut – no funding is awarded in subsequent year
Not submitting required program reports (MY & EOY) on time	X	X	X	X	X	1 st	2 nd	--	--	--
Not submitting quarterly expenditure reports on time	X	--	X	X	X	--	1 st	--	--	--
Not submitting fiscal reports according to GAPP and ODH standards	X	--	X	X	X	--	1 st	--	2 nd	--
Not submitting final expenditure report on time	X	X	X	X	X	--	1 st	--	2 nd	3 rd

Subgrant Accountability Grid										
Issue	Courtesy Call from ODH Program Consultant	Technical Assistance Call from ODH Program Consultant	ODH documents conversation in GMIS	ODH Program Consultant sends email to subgrantee project director	ODH PHEP Supervisor sends email to subgrantee agency head	Special Condition is placed on subgrantee	Quarterly Payment is withheld	Supplemental (if applicable) is not received	Future funding is cut by 1%	Future funding is cut – no funding is awarded in subsequent year
Not returning unspent dollars by due date	X	X	X	X	X	--	1 st	--	1 st	2 nd
Not responding to Special Conditions timely	X	X	X	X	X	--	1 st	--	--	--
Not addressing Out of Compliance issues from the Field Activity Report	X	X	X	X	X	1 st	2 nd	--	3 rd	4 th

APPENDIX H

PUBLIC HEALTH EMERGENCY PREPAREDNESS GRANT FUNDING

FY13 Public Health Emergency Preparedness			
	\$	9,403,403	Total PHEP Allocation
	\$	4,873,360	Foundational Component A (Fixed Amount)
	\$	4,530,037	Foundational Component C (based on per capita)

THIS IS JUST AN ESTIMATE- FUNDING NOT FINAL

Sub-Grantee	Population by County	Foundational Component Pt. A	Foundational Component Pt. C	TOTAL PHEP AWARD	Subgrantee Match
Adams Co.	28,550	\$ 61,095	\$ 6,007	\$ 67,102	\$ 5,147
Allen Co.	109,667	\$ 53,095	\$ 41,967	\$ 95,062	\$ 7,292
Ashland Co.	53,193	\$ 55,095	\$ 16,931	\$ 72,026	\$ 5,525
Ashtabula Co.	101,497	\$ 53,095	\$ 38,345	\$ 91,440	\$ 7,014
Athens Co.	64,772	\$ 55,095	\$ 22,064	\$ 77,159	\$ 5,919
Auglaze Co.	45,949	\$ 61,095	\$ 13,720	\$ 74,815	\$ 5,739
Belmont Co.	69,899	\$ 55,095	\$ 24,337	\$ 79,432	\$ 6,093
Brown Co.	44,846	\$ 61,095	\$ 13,231	\$ 74,326	\$ 5,701
Butler Co.	368,396	\$ 52,095	\$ 156,663	\$ 208,758	\$ 16,013
Carroll Co.	26,794	\$ 61,095	\$ 5,228	\$ 66,323	\$ 5,087
Champaign Co.	40,097	\$ 61,095	\$ 11,126	\$ 72,221	\$ 5,540
Clark Co.	138,285	\$ 53,095	\$ 54,653	\$ 107,748	\$ 8,265
Clermont Co.	195,451	\$ 53,095	\$ 79,995	\$ 133,090	\$ 10,209
Clinton Co.	42,038	\$ 61,095	\$ 11,986	\$ 73,081	\$ 5,606
Columbiana Co.	108,857	\$ 53,095	\$ 41,607	\$ 94,702	\$ 7,264
Coshocton Co.	36,891	\$ 61,095	\$ 9,704	\$ 70,799	\$ 5,431
Crawford Co.	43,802	\$ 61,095	\$ 12,768	\$ 73,863	\$ 5,666
Cuyahoga Co.	1,280,238	\$ 5,095	\$ 560,889	\$ 565,984	\$ 43,414
Darke Co.	52,120	\$ 55,095	\$ 16,456	\$ 71,551	\$ 5,488
Defiance Co.	39,037	\$ 61,095	\$ 10,656	\$ 71,751	\$ 5,504
Delaware Co.	155,159	\$ 53,095	\$ 62,133	\$ 115,228	\$ 8,839
Erie Co.	83,292	\$ 55,095	\$ 30,274	\$ 85,369	\$ 6,548
Fairfield Co.	116,577	\$ 53,095	\$ 45,030	\$ 98,125	\$ 7,527

Sub-Grantee	Population by County	Foundational Component Pt. A	Foundational Component Pt. C	TOTAL PHEP AWARD	Subgrantee Match
Fayette Co.	28,919	\$ 61,095	\$ 6,170	\$ 67,265	\$ 5,160
Franklin Co	1,223,248	\$ 5,095	\$ 535,625	\$ 540,720	\$ 41,476
Fulton Co.	42,808	\$ 61,095	\$ 12,327	\$ 73,422	\$ 5,632
Gallia Co.	30,934	\$ 61,095	\$ 7,064	\$ 68,159	\$ 5,228
Geauga Co.	93,273	\$ 55,095	\$ 34,699	\$ 89,794	\$ 6,888
Greene Co.	161,152	\$ 53,095	\$ 64,790	\$ 117,885	\$ 9,042
Guemsey Co.	40,087	\$ 61,095	\$ 11,121	\$ 72,216	\$ 5,539
Hamilton Co.	807,441	\$ 15,095	\$ 351,295	\$ 366,390	\$ 28,104
Hancock Co.	71,677	\$ 55,095	\$ 25,125	\$ 80,220	\$ 6,153
Hardin Co.	32,170	\$ 61,095	\$ 7,612	\$ 68,707	\$ 5,270
Harrison Co.	15,741	\$ 62,095	\$ 328	\$ 62,423	\$ 4,788
Henry Co.	28,215	\$ 61,095	\$ 5,858	\$ 66,953	\$ 5,136
Highland Co.	43,591	\$ 61,095	\$ 12,675	\$ 73,770	\$ 5,659
Hocking Co.	29,365	\$ 61,095	\$ 6,368	\$ 67,463	\$ 5,175
Holmes Co.	42,186	\$ 61,095	\$ 12,044	\$ 73,139	\$ 5,610
Huron Co.	62,883	\$ 55,095	\$ 21,227	\$ 76,322	\$ 5,854
Jackson Co.	33,225	\$ 61,095	\$ 8,079	\$ 69,174	\$ 5,306
Jefferson Co.	70,296	\$ 55,095	\$ 24,513	\$ 79,608	\$ 6,106
Knox Co.	60,905	\$ 55,095	\$ 20,350	\$ 75,445	\$ 5,787
Lake Co.	230,041	\$ 53,095	\$ 95,329	\$ 148,424	\$ 11,385
Lawrence Co.	62,450	\$ 55,095	\$ 21,035	\$ 76,130	\$ 5,840
Licking Co.	157,762	\$ 53,095	\$ 63,287	\$ 116,382	\$ 8,927
Logan Co.	45,746	\$ 61,095	\$ 13,630	\$ 74,725	\$ 5,732
Lorain Co.	295,504	\$ 53,095	\$ 124,349	\$ 177,444	\$ 13,611
Lucas Co.	441,705	\$ 52,095	\$ 189,161	\$ 241,256	\$ 18,506
Madison Co.	44,263	\$ 61,095	\$ 12,972	\$ 74,067	\$ 5,681
Mahoning Co.	237,776	\$ 53,095	\$ 98,758	\$ 151,853	\$ 11,648
Marion Co.	66,501	\$ 55,095	\$ 22,831	\$ 77,926	\$ 5,977
Medina Co.	172,118	\$ 53,095	\$ 69,652	\$ 122,747	\$ 9,415
Meigs Co.	23,770	\$ 61,095	\$ 3,888	\$ 64,983	\$ 4,985

Sub-Grantee	Population by County	Foundational Component Pt. A	Foundational Component Pt. C	TOTAL PHEP AWARD	Subgrantee Match
Mercer Co.	40,888	\$ 61,095	\$ 11,476	\$ 72,571	\$ 5,567
Miami Co.	102,288	\$ 53,095	\$ 38,695	\$ 91,790	\$ 7,041
Monroe Co.	14,679	\$ 62,095	\$ -	\$ 62,095	\$ 4,763
Montgomery Co.	535,103	\$ 39,095	\$ 230,565	\$ 269,660	\$ 20,685
Morgan Co.	15,054	\$ 62,095	\$ 24	\$ 62,119	\$ 4,765
Morrow Co.	34,827	\$ 61,095	\$ 8,789	\$ 69,884	\$ 5,361
Muskingum Co.	85,231	\$ 55,095	\$ 31,134	\$ 86,229	\$ 6,614
Noble Co.	14,645	\$ 62,095	\$ -	\$ 62,095	\$ 4,763
Ottawa Co.	41,428	\$ 61,095	\$ 11,716	\$ 72,811	\$ 5,585
Paulding Co.	19,495	\$ 62,095	\$ 1,993	\$ 64,088	\$ 4,916
Perry Co.	36,813	\$ 61,095	\$ 9,670	\$ 70,765	\$ 5,428
Pickaway Co.	55,809	\$ 55,095	\$ 18,091	\$ 73,186	\$ 5,614
Pike Co.	28,709	\$ 61,095	\$ 6,077	\$ 67,172	\$ 5,153
Portage Co.	160,132	\$ 53,095	\$ 64,338	\$ 117,433	\$ 9,008
Preble Co.	42,540	\$ 61,095	\$ 12,209	\$ 73,304	\$ 5,623
Putnam Co.	34,499	\$ 61,095	\$ 8,644	\$ 69,739	\$ 5,349
Richland Co.	125,366	\$ 53,095	\$ 48,926	\$ 102,021	\$ 7,826
Ross Co.	78,064	\$ 55,095	\$ 27,957	\$ 83,052	\$ 6,371
Sandusky Co.	55,679	\$ 55,095	\$ 18,033	\$ 73,128	\$ 5,609
Scioto Co.	79,499	\$ 55,095	\$ 28,593	\$ 83,688	\$ 6,419
Seneca Co.	61,453	\$ 55,095	\$ 20,593	\$ 75,688	\$ 5,806
Shelby Co.	49,423	\$ 61,095	\$ 15,260	\$ 76,355	\$ 5,857
Stark Co.	377,670	\$ 52,095	\$ 160,774	\$ 212,869	\$ 16,328
Summit Co.	543,072	\$ 39,095	\$ 234,098	\$ 273,193	\$ 20,955
Trumbull Co.	210,301	\$ 53,095	\$ 86,578	\$ 139,673	\$ 10,714
Tuscarawas Co.	92,736	\$ 55,095	\$ 34,461	\$ 89,556	\$ 6,869
Union Co.	49,106	\$ 61,095	\$ 15,119	\$ 76,214	\$ 5,846
Van Wert Co.	25,700	\$ 61,095	\$ 4,743	\$ 65,838	\$ 5,050
Vinton Co.	13,435	\$ 62,095	\$ -	\$ 62,095	\$ 4,763
Warren Co.	210,504	\$ 53,095	\$ 86,668	\$ 139,763	\$ 10,721

Sub-Grantee	Population by County	Foundational Component Pt. A	Foundational Component Pt. C	TOTAL PHEP AWARD	Subgrantee Match
Washington Co.	61,778	\$ 55,095	\$ 20,737	\$ 75,832	\$ 5,817
Wayne Co.	114,730	\$ 53,095	\$ 44,211	\$ 97,306	\$ 7,464
Williams Co.	37,642	\$ 61,095	\$ 10,037	\$ 71,132	\$ 5,456
Wood Co.	124,450	\$ 53,095	\$ 48,520	\$ 101,615	\$ 7,794
Wyandot Co.	22,615	\$ 61,095	\$ 3,376	\$ 64,471	\$ 4,945
Totals	11,536,522	\$ 4,873,360	\$ 4,530,037	\$ 9,403,403	\$ 721,297
Regional Public Health Planning Subgrantees					
Central Region				\$ 79,950	\$ 6,133
Northeast Central Region				\$ 79,950	\$ 6,133
Northeast Region				\$ 79,950	\$ 6,133
Northwest Region				\$ 79,950	\$ 6,133
Southeast Region I				\$ 79,950	\$ 6,133
Southeast Region II				\$ 79,950	\$ 6,133
Southwest Region				\$ 79,950	\$ 6,133
West Central Region				\$ 79,950	\$ 6,133
Total Amount to be Awarded to Regional Public Health Planning Subgrantees				\$ 639,600	\$ 49,061
Cities Readiness Initiative (CRI)					
Cleveland MSA				\$ 562,368	\$ 43,137
Cincinnati MSA				\$ 448,698	\$ 34,418
Columbus MSA				\$ 484,594	\$ 37,171
Total Amount to be Awarded to CRI Subgrantees				\$ 1,495,660	\$ 114,726
				PHEP	\$ 9,403,403
				AOHC Liaison	\$ 46,800
				Regional Public Health Planning	\$ 639,600
				EWIDS	\$ 8,000
				CRI	\$ 1,495,660
Total Public Health Emergency Response Grant for FY 2013				\$ 11,593,463	\$ 885,082

APPENDIX I

**NOTICE OF INTENT TO APPLY FOR FUNDING
Ohio Department of Health
Division of Prevention and Health Promotion
Bureau of Health Preparedness**

ODH Program Title: Public Health Emergency Preparedness

**ALL INFORMATION REQUESTED MUST BE COMPLETED.
(Please Print Clearly or Type)**

County of Applicant Agency _____

Federal Tax Identification Number _____

NOTE: The applicant agency/organization name must be the same as that on the IRS letter. This is the legal name by which the tax identification number is assigned.

The following agency(s) will partner with the applicant: _____

Type of Applicant Agency (Check One) County Agency Hospital Local Schools
 City Agency Higher Education Not-for Profit

Applying for Areas of Funding (Check all that apply): PHEP RPHP Liaison CRI

Applicant Agency/Organization _____

Applicant Agency Address _____

Agency Contact Person/Title _____

Telephone Number _____

E-mail Address _____

Please Check One: _____ **Yes - Our agency will need GMIS training**
_____ **No - Our agency has already had GMIS training**

Mail, E-mail, or Fax To: **Ohio Department of Health**
ATTN: Sharon White
Public Health Emergency Preparedness
35 E. Chestnut St.
Columbus, Ohio 43215
E-mail: Sharon.White@odh.ohio.gov
Fax: 614-728-3556

**NOTICE OF INTENT TO APPLY FOR FUNDING MUST BE RECEIVED BY
MONDAY APRIL 2, 2012**