

# **EXHIBIT A**

## **PROJECT PERIOD PUBLIC HEALTH EMERGENCY PREPAREDNESS WORKPLAN FOR LOCAL HEALTH DEPARTMENTS**

**FY2011 (August 2010 through July 2011)**

## **DEFINITIONS**

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

**ENVIRONMENTAL HEALTH RESPONDER** - Included in the definition for Public Health Responder.

**FIRST RESPONDER** – Personnel who would be critical in the first phase of response efforts.

**IMPLEMENTATION** - includes all steps necessary to complete the tasks; installation, training, and technical assistance.

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

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

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

**PUBLIC HEALTH INFORMATION NETWORK (PHIN)** – Proposed to advance a fully capable and interoperable information system for public health. PHIN is a national initiative to implement a multi-organizational business and technical architecture for public health information systems which includes web-based and radio based communications with multiple levels of redundancy.

**PUBLIC HEALTH PREPAREDNESS** - Public health preparedness is the capacity of public health jurisdictions to respond to a public health emergency. The CDC Cooperative Agreement enables public health jurisdictions to upgrade their preparedness and response capacity.

**PUBLIC HEALTH FIRST RESPONDER (PHFR)** – Department of Health (DOH) personnel that are required to deploy in the wake of a public health emergency. Hospital personnel may be considered PHFRs if their activity is aligned to support public health response efforts. However, Emergency Medical Service (EMS) Responders are mostly covered through Department of Homeland Security (DHS).

**STANDARD OPERATING GUIDELINES (SOG)/STANDARD OPERATING PROCEDURES (SOP)** - Approved methods for accomplishing a task or set of tasks and are typically prepared at the department or agency level.

**CDC PREPAREDNESS GOAL 1: PREVENT**

**GOAL: Increase the use and development of interventions known to prevent human illness from chemical, biological, radiological agents, and naturally occurring health threats.**

<b>1A: Target Capability: Planning</b>	
<b>MEASURE</b>	
1) Public health agency has primary and secondary staff identified for core functional roles delineated in the Incident Command System (ICS) for public health. <b>Jurisdictional Target: For 100% of core public health ICS functional roles, public health agency has documented contact information for primary and secondary) backup) staff.</b>	
<b>REQUIRED CRITICAL TASKS DEFINED IN CDC GUIDANCE</b>	<b>PERFORMING AGENCY REQUIRED ACTIVITIES</b>
Critical Task (CT) 2: Support incident response operations according to all-hazards plan that includes identification and planning for populations with special needs.	CT 2: Review and revise annually as needed the health and medical component of the local emergency management plan and LHD all-hazards SOPs and/or SOGs (plans).  CT 2: Work with other entities to develop methods to identify and identify populations with special needs requirements and revise as necessary.
CT 3: Improve regional, jurisdictional, and state all-hazard plans (including those related to pandemic influenza) to support response operations in accordance with National Incident Management System (NIMS) and the National Response Plan (NRP).	CT 3: Work with local government and other health and medical agencies and entities to revise and revise annually as needed jurisdictional all-hazards health and medical plans, SOPs, and SOGs (including those related to pandemic influenza and mental health) as guidance/ requirements are issued from US Dept of Homeland Security regarding the National Incident Management System and the National Response Plan.
CT 3a: Increase participation in jurisdiction-wide self-assessment using the National Incident Management	CT 3a: Annually participate in the jurisdictional NIMCAST self-assessment, addressing the health and medical component of the

<p>System Compliance Assessment Support Tool (NIMCAST). Assure agency's Emergency Operations Center meets NIMS incident command structure requirements to perform core functions: coordination, communications, resource dispatch and tracking and information collection, analysis and dissemination.</p> <p>CT 4: Increase the number of public health responders who are protected through Personal Protective Equipment (PPE), vaccination or prophylaxis.</p> <p>CT 4a: Have or have access to a system that maintains and tracks vaccination or prophylaxis status of public health responders in compliance with PHIN Preparedness Functional Area Countermeasure and Response Administration.</p> <p>CT 5: Increase and improve mutual aid agreements, as needed, to support NIMS-compliant public health response</p>	<p>assessment.</p> <p>CT 3a: Work with local government and other health and medical entities to review and revise as needed all-hazards health and medical component of the local emergency management plan and LHD all-hazards SOPs and/or SOGs (plans) as necessary based upon the jurisdiction's annual self-assessment.</p> <p>CT 3a: Maintain a NIMS compliant Incident Command structure for public health response operations.</p> <p>CT 3a: Augment primary and secondary staff for core functional roles in ICS.</p> <p>CT 3a: Continue to implement SOPs and/or SOGs (plans) and training that is NIMS compliant.</p> <p>CT 4: Identify the number of public health responders who will require PPE, vaccination and/or prophylaxis.</p> <p>CT 4: Review adequacy of protection and maintain the level of protection for the number of public health responders who will require PPE.</p> <p>CT 4a: Implement and continue to track public health responders' vaccination or prophylaxis.</p> <p>CT 5: Establish, as needed with appropriate partners, Memorandums of Understanding (MOU) and/or Memorandums of Agreement (MOA)/</p>
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<p>(e.g. local, regional, and EMAC).</p> <p>CT 5a: Increase all-hazard incident management capability by conducting regional, jurisdictional and state level training for NIMS and the Incident Command System (ICS).</p>	<p>Mutual Aid Agreement (MAA)s that will support NIMS compliant public health responses.</p> <p>CT 5a: Identify all staff required to respond to an emergency and schedule training.</p> <p>CT 5a: Track staff training completion.</p>
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CT 1c: Have or have access to electronic applications in compliance with Public Health Information Network (PHIN) Preparedness Functional Area Early Event Detection to support: 1) Receipt of case or suspect case disease reports 24/7/365, 2) Reportable diseases surveillance, 3) Call triage of urgent reports to knowledgeable public health professionals, 4) Receipt of secondary use health-related data and monitoring of aberrations to normal data patterns.

CT 1d: Develop and maintain protocols for the utilization of early event detection devices located in your community (e.g., BioWatch).

CT 1e: Assess timeliness and completeness of disease surveillance systems annually.

CT 2: Increase sharing of health and intelligence information within and between regions and States with Federal and local and tribal agencies.

CT 2a: Improve information sharing on suspected or confirmed cases of immediately notifiable conditions, including foodborne illness, among public health epidemiologists, clinicians, laboratory personnel, environmental health specialists, public health nurses, and staff of food safety programs.

CT 1c: Continue to receive, evaluate and respond to urgent disease reports on a 24/7/365 basis by maintaining and revising as needed contact protocols, sharing updates with local, regional, and state partners, and assuring public access to reporting resources.

CT 1d: Develop and revise annually the protocols to use early event detection systems.

CT 1e: Develop and implement a quality assurance process based on standardized guidelines to assess annually the timeliness and completeness of disease surveillance systems.

CT 2: Initiate discussions to define *NEDSS* Base System (NBS) user roles and implement processes to facilitate data sharing between department regional staff, as needed.

CT 2: Share surveillance data with local health care providers through newsletters, meetings, conferences, etc.

CT 2a: Maintain and/or increase the ways information is shared and the number of persons receiving issued surveillance data.

<p>CT 3: Decrease the time needed to disseminate timely and accurate national strategic and health threat intelligence.</p> <p>CT 3a: Maintain continuous participation in CDC's Epidemic Information Exchange Program (Epi-X).</p> <p>CT 3b: Participate in the Electronic Foodborne Outbreak Reporting System (EFORS) by entering reports of foodborne outbreak investigations and monitor the quality and completeness of reports and time from onset of illnesses to report entry.</p> <p>CT 3c: Perform real-time subtyping of PulseNet tracked foodborne disease agents. Submit the subtyping data and associated critical information (isolate identification, source of isolate, phenotype characteristics of the isolate, serotype, etc) electronically to the national PulseNet database within 72 to 96 hours of receiving the isolate in the laboratory.</p> <p>CT 3d: Have or have access to a system for 24/7/365 notification/alerting of the public health emergency response system that can reach at least 90% of key stakeholders and is compliant with PHIN Preparedness Functional Area Partner Communications and Alerting.</p>	<p>CT 3: Continue to use Health Alert Network (HAN)/Public Health Information Network (PHIN) and other means to disseminate timely and accurate national strategic and health threat intelligence.</p> <p>CT 3a: Participate in Epi-X by having at least one staff registered.</p> <p>CT 3b: Submit the EFORS form to DSHS for foodborne outbreak investigations by local health departments per written guidance.</p> <p>CT 3c: Continue to participate in PulseNet activities supporting the tracking of foodborne disease causing bacteria.</p> <p>CT 3c: Increase capabilities to upload data to PulseNet database for <i>Listeria monocytogenes</i> and <i>E.coli</i> 0157:H7.</p> <p>CT 3d: Test and revise as necessary current notification procedures to achieve 90% notification of key stakeholders.</p>
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### CDC PREPAREDNESS GOAL 3: DETECT/REPORT

**Goal: Decrease the time needed to detect and report chemical, biological, radiological agents in tissue, food, or environmental samples that cause threats to the public's health.**

<b>TARGET CAPABILITY 3A: Public Health Laboratory Testing</b>	
<b>MEASURES:</b>	
<ol style="list-style-type: none"> <li>1) Percent of tested category A and B agents in specimens/samples for which the LRN reference lab(s) passes proficiency testing. <b>Jurisdictional Target: Reference labs has a passing rating for 100% of tested based on LRN-sponsored proficiency tests in which lab participated</b></li> <li>2) Percent of tested chemical agents in specimens/samples for which Level 1 and 2 LRN chemical lab(s) passes proficiency testing. <b>Jurisdictional Target - Level 1 and/or Level 2 chemical labs has a passing rating for 100% of tested chemical agents based on LRN-sponsored proficiency tests in which lab participated</b></li> <li>3) Time from shipment of clinical specimens to receipt at a LRN reference laboratory. <b>Jurisdictional Target - Mean = 6 hours</b></li> <li>4) Time from presumptive identification to confirmatory identification of select agents by LRN reference lab. <b>Jurisdictional Target - Targets from presumptive to confirmatory identification: Bacillus anthracis: &lt;4 days; Francisella tularensis: &lt; 7 days; Yersinia pestis: &lt; 6 days</b></li> <li>5) Time to have a knowledgeable LRN reference laboratorian answer a call during non-business hours. <b>Jurisdictional Target: Mean = 15 minutes</b></li> </ol>	
<b>CRITICAL TASKS DEFINED IN CDC GUIDANCE</b>	<b>PERFORMING AGENCY REQUIRED ACTIVITIES</b>
<p>CT 1a: Develop and maintain a database of all sentinel (biological)/Level Three (chemical) labs in the jurisdiction using the CDC-endorsed definition that includes: (Name, contact information, BioSafety Level, whether they are a health alert network partner, certification status, capability to rule-out Category A and B bioterrorism agents per State-developed proficiency testing or CAP bioterrorism module proficiency testing and names and contact information for in-state and out-of-state reference labs used by each of the jurisdiction's sentinel/Level Three labs).</p>	<p>CT 1a: Adapt DSHS protocols for local use.</p>

CT 1b: Test the competency of a chemical terrorism laboratory coordinator and bioterrorism laboratory coordinator to advise on proper collection, packaging, labeling, shipping, and chain of custody of blood, urine and other clinical specimens.

CT 1c: Test the ability of sentinel/Level Three labs to send specimens to a confirmatory Laboratory Response Network (LRN) laboratory on nights, weekends, and holidays.

CT 1d: Package, label, ship, and coordinate routing and maintain chain-of-custody of clinical, environmental, and food specimens/samples to laboratories that can test for agents used in biological and chemical terrorism.

CT 1e: Continue to develop or enhance operational plans and protocols that include: \* specimen/samples transport and handling, \*worker safety, \*appropriate Biosafety Level (BSL) working conditions for each threat agent, \*staffing and training of personnel, \*quality control and assurance, \*adherence to laboratory methods and protocols, \*proficiency testing to include routine practicing of Laboratory Response Network (LRN) validated assays as

CT 1b: Continue to update and maintain chain of custody protocols testing the competency of the chemical terrorism laboratory coordinator and bioterrorism laboratory coordinator.

CT 1c: Test the accurate and timely submission of diagnostic or infectious agent's submissions during a simulated or natural event.

CT 1d: Develop and review annually protocols for chain-of-custody.

CT 1d: Maintain chain-of-custody documentation.

CT 1d: Provide technical assistance to responders, law enforcement and Sentinel/Level 3 laboratories on maintaining chain-of-custody.

CT 1d: Develop and review annually protocols for specimen collection, packaging, labeling, and shipping.

CT 1d: Provide technical assistance to responders, law enforcement and Sentinel/Level 3 laboratories on specimen collection, packaging, labeling, and shipping.

CT 1e: Continue to develop laboratory-specific all-hazards operational SOP/SOGs to reduce response times to threat agents (biological, chemical, and radiological).

CT 1e: Assess training needs and implement training as necessary.

well as participation in the LRN's proficiency testing program electronically through the LRN website, \*threat assessment in collaboration with local law enforcement and Federal Bureau of Investigations (FBI) to include screening for radiological, explosive and chemical risk of specimens, \*intake and testing prioritization, \*secure storage of critical agents, \*appropriate levels of supplies and equipment needed to respond to bioterrorism events with a strong emphasis on surge capacities needed to effectively respond to a bioterrorism incident.

CT 1f: Ensure the availability of at least one operational Biosafety Level Three (BSL-3) facility in your jurisdiction for testing for biological agents. If not immediately possible, BSL-3 practices, as outlined in the CDC-NIH publication "Biosafety in Microbiological and Biomedical Laboratories, 4th Edition" (BMBL), should be used (see [www.cdc.gov/od/ohs](http://www.cdc.gov/od/ohs)) or formal arrangements (i.e., Memorandum of Understanding (MOU) should be established with a neighboring jurisdiction to provide this capacity.

CT 1f: Review and revise annually the written protocol coordinating specimen submission for laboratory analysis in response to an emergency situation or in support of an epidemiological investigation.

CT 1f: Adapt/review and revise annually written protocol for local use.







<p>CT 3: Coordinate and direct public health surveillance and testing, immunizations, prophylaxis, isolation or quarantine for biological, chemical, nuclear, radiological, agricultural, and food threats.</p> <p>CT 4: Have or have access to a system for an outbreak management system that captures data related to cases, contacts, investigation, exposures, relationships and other relevant parameters compliant with PHIN preparedness functional area Outbreak Management.</p>	<p>CT 2: Provide education/updates to stakeholders in epidemiological investigations and surveillance.</p> <p>CT 3: Continue to coordinate case investigations, laboratory testing, and implementation of control measures.</p> <p>CT 3: Develop, review and revise processes and protocols to manage and monitor surveillance data in NBS.</p> <p>CT 3: Initiate discussions to define NBS user roles and implement processes to facilitate data sharing between department regional staff, as needed.</p> <p>CT 3: Attend NBS reports training.</p> <p>CT 4: Enter data from outbreak investigations in the Outbreak Management System (OMS) or equivalent system that integrates with OMS.</p>
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## CDC PREPAREDNESS GOAL 6: CONTROL

**Goal: Decrease the time needed to provide countermeasures and health guidance to those affected by threats to the public's health**

<b>TARGET CAPABILITY 6A: Communications</b>	
<b>MEASURES:</b>	
<ol style="list-style-type: none"> <li>1) Time to distribute a health alert to key response partners of an event that may be of urgent public health consequence. <b>Jurisdictional Target: Mean = 6 hours from the time a decision is made to notify partners</b></li> <li>2) Percent of clinicians and public health response plan partners that receive public health emergency communication messages. <b>Jurisdictional Target: 70% of clinicians and public health partners receive messages within the specified time.</b></li> <li>3) Percent of key public health response partners who are notified/alerted via radio or satellite phone when electric grid power, telephones, cellular service and internet services are unavailable. <b>Jurisdictional Target: 75% of response partners acknowledge message within 5 minutes of communication being sent</b></li> <li>4) Time to notify/alert all primary staff (secondary or tertiary staff as needed) with public health agency ICS functional responsibilities that the public health agency's EOC is being activated. <b>Jurisdictional Target: Mean = 60 minutes</b></li> <li>5) Time for primary staff (secondary or tertiary staff as needed) with public health agency ICS functional responsibilities to report for duty at public health agency's Emergency Operation Center (EOC). <b>Jurisdictional Target: Mean = 2 1/2 hours from time that public health director or designated official received notification that the public health agency's EOC will be activated.</b></li> </ol>	
<b>CRITICAL TASKS DEFINED IN CDC GUIDANCE</b>	<b>PERFORMING AGENCY REQUIRED ACTIVITIES</b>
<p>CT 1: Decrease the time needed to communicate internal incident response information.</p> <p>CT 1a: Develop and maintain a system to collect, manage, and coordinate information about the event and response activities including assignment of tasks, resource allocation, status of task performance, and barriers to task completion.</p>	<p>CT 1: Use the PHIN/HAN web portal and Policies and Procedures for PHIN/HAN alerting.</p> <p>CT 1a: Use WebEOC through the PHIN/HAN web portal or an incident and response system interoperable with WebEOC or another system if city or county emergency management office provides access to an incident response system.</p>

<p>CT 4: Ensure communications capability using a redundant system that does not rely on the same communications infrastructure as the primary system.</p> <p>CT 5: Increase the number of public health experts to support Incident Command (IC) or Unified Command (UC).</p> <p>CT 6: Increase the use of tools to provide telecommunication and information technology to support public health response.</p> <p>CT 6a: Ensure that the public health agency's public information line can simultaneously handle calls from at least 1% of the jurisdiction's households (e.g. play a recorded message to callers, transfer callers to a voice mail box or answering service).</p> <p>CT 7: Have or have access to a system for 24/7/365 notification/alerting of the public health emergency response system that can reach at least 90% of key stakeholders and is compliant with PHIN Preparedness Functional Area Partner <i>Communications and Alerting</i>.</p>	<p>CT 4: Continue to maintain and update the PHIN/HAN system for all communications modalities.</p> <p>CT 5: Continue to train to increase number of ICS trained staff able to respond to emergency activation of public health EOC.</p> <p>CT 6: Continue to use, maintain and update the PHIN/HAN system for all communications modalities.</p> <p>CT 6a: Further develop and implement the agencies public information line process within the local Crisis and Emergency Risk Communication (CERC) plan. Local health departments should evaluate inbound call capability to accommodate 1% of local jurisdiction.</p> <p>CT 7: Continue to use and maintain PHIN/HAN portal system according to PHIN/HAN policies and procedures to enhance and improve response times.</p>
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**TARGET CAPABILITY 6B: Emergency Public Information and Warning**

**MEASURE:**

1) Time to issue critical health message to the public about an event that may be of urgent public health consequence

<b>CRITICAL TASKS DEFINED IN CDC GUIDANCE</b>	<b>CONTRACTOR REQUIRED ACTIVITIES</b>
<p>CT 1: Decrease time needed to provide specific incident information to the affected public, including populations with special needs such as non-English speaking persons, migrant workers, as well as those with disabilities, medical conditions, or other special health care needs, requiring attention.</p> <p>CT 1a: Advise public to be alert for clinical symptoms consistent with attack agent.</p> <p>CT 1b: Disseminate health and safety information to the public.</p>	<p>CT 1: Revise and expand local Crisis and Emergency Risk Communication (CERC) Guidelines to address the standard NIMS ICS structure, agency media policy and public information dissemination, translations (multiple languages), disaster mental health, work with special populations, agency Web site, and work with partners and stakeholders.</p> <p>CT 1a: Develop and/or revise pre-approved messages to include fact sheets, question-and-answer sheets, templates and key messages.</p> <p>CT 1a: Use pre-approved messages to address public health threats and emergencies.</p> <p>CT 1a: Develop and use messages specific to the local community as needed.</p> <p>CT 1b: Develop and/or revise pre-approved messages to include fact sheets, question-and-answer sheets, templates and key messages.</p> <p>CT 1b: Use pre-approved messages to address public health threats and emergencies.</p> <p>CT 1b: Develop and use messages specific to the local community as needed.</p>

<p>CT 1c: Ensure that the Agency's public information line can simultaneously handle calls from at least 1% of the jurisdiction's population.</p> <p>CT 2: Improve the coordination, management and dissemination of public information.</p> <p>CT 3: Decrease the time and increase the coordination between responders in issuing messages to those that are experiencing psychosocial consequences to an event.</p> <p>CT 4: Increase the frequency of emergency media briefings in conjunction with response partners via the jurisdiction's Joint Information Center (JIC), if applicable.</p> <p>CT 5: Decrease time needed to issue public warnings, instructions, and information updates in conjunction with response partners.</p> <p>CT 6: Decrease time needed to disseminate domestic and international travel advisories.</p>	<p>CT 1c: Update annually plan to have access and use public information line(s).</p> <p>CT 2: Develop and/or revise pre-approved messages to include fact sheets, question-and-answer sheets, templates and key messages.</p> <p>CT 2: Use pre-approved messages to address public health threats and emergencies.</p> <p>CT 2: Develop and use messages specific to the local community as needed.</p> <p>CT 3: Revise and expand local Crisis and Emergency Risk Communication (CERC) Guidelines to address messages to those that are experiencing psychosocial consequences to an event.</p> <p>CT 4: Include in the Crisis and Emergency Risk Communication Plan a process to address JIC participation.</p> <p>CT 5: Develop and/or revise pre-approved messages to include fact sheets, question-and-answer sheets, templates and key messages.</p> <p>CT 6: Disseminate via the PHIN/HAN messages domestic and international travel advisories received from the CDC and/or DSHS.</p>
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CT 7: Decrease the time needed to provide accurate and relevant public health and medical information to clinicians and other responders.

CT 7: Distribute via PHIN/HAN procedure accurate and relevant public health and medical information to clinicians and other responders.

<b>TARGET CAPABILITY 6C: Responder Safety and Health</b>	
<b>MEASURE:</b>	
<b>CRITICAL TASKS DEFINED IN CDC GUIDANCE</b>	<b>PERFORMING AGENCY REQUIRED ACTIVITIES</b>
<p>CT 1: Increase the availability of worker crisis counseling and mental health and substance abuse behavioral health support.</p> <p>CT 2: Increase compliance with public health personnel health and safety requirements.</p>	<p>CT 1: Establish and maintain an agreement (MOU/MOA/MAA) with local Community Mental health Center(s) or other community-based organization(s) to provide worker crises counseling as needed.</p> <p>CT 1: Identify appropriate staff member(s) and obtain Critical Incident Stress Management (CISM) training if community mental health services as not available.</p> <p>CT 1: Track staff training completion.</p> <p>CT 2: Review and update annually as needed LHD SOP/SOGs to include worker personnel health and safety requirements.</p>

<p>CT 2a: Provide Personal Protection Equipment (PPE) based upon hazard analysis and risk assessment.</p>	<p>CT 2a: Conduct staff hazard analysis and risk assessment to identify their level of occupational risk based on job description.</p> <p>CT 2a: Consult US Department of Labor Occupational Safety and Health Organization (OSHA) Website for guidance. OSHA.gov and search for standards. 1-800-321-OSHA (6742) {Toll Free U.S.}</p> <p>CT 2a: Purchase and have available appropriate PPE for staff according to their risk assessment.</p> <p>CT 2a: Provide access to training on PPE to staff based on OSHA hazard analysis and risk assessment.</p> <p>CT 2a: Track staff attendance at required training.</p>
<p>CT 2b: Develop management guidelines and incident health and safety plans for public health responders (e.g., heat stress, rest cycles, PPE).</p>	<p>CT 2b: Use the management guidelines to complete local plans which address worker safety issues.</p>
<p>CT 2c: Provide technical advice on worker health and safety for IC and UC.</p>	<p>CT 2c: Provide worker safety protocol within the IC/UC structure.</p>
<p>CT 3: Increase the number of public health responders that receive hazardous material training.</p>	<p>CT 3: Conduct staff hazard analysis and risk assessment to identify the level of occupational risk based on job description.</p> <p>CT 3: Provide access to training on hazardous materials to staff based on OSHA hazard analysis and risk assessment.</p>

**TARGET CAPABILITY 6D: Isolation and Quarantine**

**MEASURE:**  
 1) Time to issue an isolation or quarantine order. **Jurisdictional Target: Mean = 3 hours from the decision that an order is needed.**

CRITICAL TASKS DEFINED IN CDC GUIDANCE	PERFORMING AGENCY REQUIRED ACTIVITIES
<p>CT 1: Assure legal authority to isolate and/or quarantine individuals, groups, facilities, animals and food products.</p> <p>CT 2: Coordinate quarantine activation and enforcement with public safety and law enforcement.</p> <p>CT 3: Improve monitoring of adverse treatment reactions among those who have received medical countermeasures and have been isolated or quarantined.</p> <p>CT 4: Coordinate public health and medical services among those who have been isolated or quarantined.</p> <p>CT 5: Improve comprehensive stress management strategies, programs, and crisis response teams among those who have been isolated or quarantined.</p>	<p>CT 1: Maintain or have access to a professional epidemiologist regarding isolation and quarantine.</p> <p>CT 2: Plan, coordinate, and assist in the activation and enforcement of isolation and quarantine with public safety and law enforcement.</p> <p>CT 2: With local law enforcement, conduct functional exercise to determine time needed to issue an isolation or quarantine order.</p> <p>CT 3: Coordinate with CDC the planning of and implementation of OMS or implement an equivalent system.</p> <p>CT 4: Assist in the provision of medical services to those who are isolated or quarantined.</p> <p>CT 5: Assist in the provision of comprehensive stress management strategies, programs and crisis response teams.</p>

CT 6: Direct and control public information releases about those who have been isolated or quarantined.

CT 7: Decrease time needed to disseminate health and safety information to the public regarding risk and protective actions.

CT 6: Implement CERC plan.

CT 7: Develop and/or revise, make available and use pre-approved messages to include fact sheets, question-and-answer sheets, templates and key messages to address public health threats and emergencies.

CT 7: Implement CERC Plan.

**TARGET CAPABILITY 6E: Mass Prophylaxis**

**MEASURE:**  
 1) Adequacy of state and local plans to receive and dispense medical countermeasures as demonstrated through assessment by the Strategic National Stockpile(SNS)/Cities Readiness Initiative(CRI). **Jurisdictional Target: Agency has a passing rating on 100% of all elements and functions based on its most recent Strategic national Stockpile/Cities Readiness Initiative (CRI) assessment**

<b>CRITICAL TASKS DEFINED IN CDC GUIDANCE</b>	<b>PERFORMING AGENCY REQUIRED ACTIVITIES</b>
<p>CT 1: Decrease the time needed to dispense mass therapeutics and/or vaccines.</p>	<p>CT 1: Continue to develop and augment scalable SNS components of the local emergency management plan with supporting infrastructure to provide oral medications during an event to the entire population within 48 hours.</p> <p>CT 1: Develop and maintain SNS standard operating guidelines (SOG) for every major function in the scaleable SNS components of the local emergency management plan.</p> <p>CT 1: Participate in regional and local process to develop procedures for use of Chempack materials.</p> <p>CT 1: Initiate and maintain regular contact with regional and local stakeholders/partners regarding Chempack.</p> <p>CT 1: Participate in web-based Chempack training.</p>

<p>CT 1a: Implement local, (tribal, where appropriate), regional and State prophylaxis protocols and plans.</p> <p>CT 1b: Achieve and maintain the Strategic National Stockpile (SNS) preparedness functions described in the current version of the Strategic National Stockpile guide for planners.</p> <p>CT 1c: Ensure that smallpox vaccination can be administered to all known or suspected contacts of cases within 3 days and, if indicated, to the entire jurisdiction within 10 days.</p>	<p>CT 1a: Continue to develop and augment scalable SNS components of the local emergency management plan with supporting infrastructure.</p> <p>CT 1b: Assist in coordinating with local law enforcement for assessment of each POD site and the development of a comprehensive security plan.</p> <p>CT 1b: Develop and maintain contact list regarding receipt of SNS material in treatment centers.</p> <p>CT 1b: Identify, assess and secure Point of Dispensing (POD) sites.</p> <p>CT 1b: Recruit staff/volunteers to carry out all local SNS functions including POD operations.</p> <p>Ct 1b: Train staff/volunteers to carry out SNS functions including POD site functions.</p> <p>CT 1c: Maintain the database of individuals with capacity to provide smallpox vaccinations.</p> <p>CT 1c: Continue to develop and revise as needed the scalable SNS component of the local emergency management plan to include an integrated smallpox vaccination component.</p> <p>CT 1c: Develop and maintain smallpox components in the LHD all-</p>
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<p>CT 2: Decrease time to provide prophylactic protection and/or immunizations to all responders, including non-governmental personnel supporting relief efforts.</p> <p>CT 3: Decrease the time needed to release information to the public regarding dispensing of medical countermeasures via the jurisdiction's JIC (if JIC activation is needed).</p>	<p>hazards SOP/SOGs.</p> <p>CT 2: Develop and maintain first responder dispensing prophylaxis SOP/SOG.</p> <p>CT 3: Revise and expand local Crisis and Emergency Risk Communication (CERC) Guidelines to include pre-approved information regarding dispensing of medical countermeasures via the jurisdiction's JIC.</p>
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<b>TARGET CAPABILITY 6F: Medical Surge</b>	
<b>MEASURE:</b>	
<b>CRITICAL TASKS DEFINED IN CDC GUIDANCE</b>	<b>PERFORMING AGENCY REQUIRED ACTIVITIES</b>
<p>CT 1: Improve tracking of cases, exposures, adverse events, and patient disposition.</p> <p>CT 2: Decrease the time needed to execute medical and public health mutual aid agreements.</p> <p>CT 3: Improve coordination of public health and medical services.</p>	<p>CT 1: Use the NBS and PHIN/HAN to report Texas mandated notifiable diseases.</p> <p>CT 2: Establish and annually review MOU/MOAs as necessary and maintain relationships.</p> <p>CT 2: Assess the time from requesting public health mutual aid agreement to the time acknowledgement is received as either approved or disapproved.</p> <p>CT 3: Continue to develop/maintain relationships with infectious disease specialists, hospital infection control practitioners, laboratory directors, emergency department managers, medical examiners, and others to promote rapid disease reporting.</p> <p>CT 3: Provide training and information to local health care providers through newsletters, meetings, conferences, etc, to increase community awareness of the importance of early detection and rapid response.</p>



CT 5: Increase the number of physicians and other providers with experience and/or skills in the diagnosis and treatment of infectious, chemical, or radiological diseases or conditions possibly resulting from a terrorism-associated event who may serve as consultants during a public health emergency.

CT 5: Continue to identify and maintain a list of physicians and other providers with experience and/or skills in the diagnosis and treatment of conditions resulting from Chemical, Biological, Radiological, Nuclear, and Explosive (CPRNE) events.

CT 5: Continue to provide education to physicians and other providers on CBRNE topics.

<b>TARGET CAPABILITY 6G: Mass Care</b>	
<b>MEASURE:</b>	
<b>CRITICAL TASKS DEFINED IN CDC GUIDANCE</b>	<b>PERFORMING AGENCY REQUIRED ACTIVITIES</b>
<p>CT 2: Develop processes and criteria for conducting an assessment (cultural, dietary, medical) of the general population registering at the shelter to determine suitability for the shelter, identify issues to be addressed within the shelter, and the transference of individuals and caregivers/family members, to medical needs shelters if appropriate.</p> <p>CT 3: Develop plans, policies, and procedures to coordinate delivery of mass care services to medical shelters.</p>	<p>CT 2: Provide an assessment tool developed by DSHS to sheltering agencies and encourage the provision of feedback on the utility of the instrument.</p> <p>CT 3: Review and update annually as needed the health and medical component of the local emergency management plan to include the assignment of responsibility to improve the coordinated delivery of health, medical and mental health services to medical special needs shelters.</p> <p>CT 3: Review and update annually as needed the LHD SOP/SOGs to address operationalizing the expended roles and responsibilities.</p>

**TARGET CAPABILITY 6H: Citizen Evacuation and Shelter-In-Place**

**MEASURE:**

<b>CRITICAL TASKS DEFINED IN CDC GUIDANCE</b>	<b>PERFORMING AGENCY REQUIRED ACTIVITIES</b>
<p>CT 1: Develop plans and procedures to identify in advance populations requiring assistance during evacuation/shelter-in-place.</p> <p>CT 2: Develop plans and procedures for coordinating with other agencies to meet basic needs during evacuation.</p> <p>CT 3: Develop plans and procedures to get resources to those who have sheltered in place (Long term – 3 days or more).</p>	<p>CT 1: Participate in efforts with stakeholders who are already working to identify populations needing assistance for evacuation and shelter-in-place.</p> <p>CT 2: Support the local efforts to coordinate the provision of basic health and medical needs, to include the provision of mental health services for populations during evacuation operations.</p> <p>CT 2: Review and update annually as needed the health and medical component of the local emergency management plan and LHD all-hazards SOP/SOGs to include provisions for medical special needs population during evacuation operations.</p> <p>CT 3: Support the Office of Emergency Management (OEM) in coordinating the provision of health and medical resources, to include the provision of mental health services, for populations’ sheltering-in-place.</p> <p>CT 3: Review and annually as needed the health and medical component of the local emergency management plan and LHD all-hazards SOP/SOGs to include provisions for medical special needs populations’ sheltered-in-place.</p>

**CDC PREPAREDNESS GOAL 7: RECOVER**

**Goal: Decrease the time needed to restore health services and environmental safety to pre-event levels.**

<b>TARGET CAPABILITY 7A: Environmental Health</b>	
<b>MEASURE:</b> 1) Time to issue guidance to the public after an event. <b>Jurisdictional Target: Mean = 6 hours from the time a decision is made to provide recovery-related information to the public.</b>	
<b>CRITICAL TASKS DEFINED IN CDC GUIDANCE</b>	<b>PERFORMING AGENCY REQUIRED ACTIVITIES</b>
CT 1: Conduct post-event planning and operations to restore general public health services.	<p>CT 1: Begin to establish an MOU/MOA with environmental agency(ies) for reporting, notification and recommendation(s) for follow-up as needed.</p> <p>CT 1: Adapt/implement state written SOP/SOGs to local jurisdiction.</p> <p>CT 1: Develop written procedures to the extent possible to address restoration of services.</p>

<p>CT 2: Decrease the time needed to issue interim guidance on risk and protective actions by monitoring air, water, food, and soil quality, vector control, and environmental decontamination, in conjunction with response partners.</p>	<p>CT 2: If able, develop Global Information System (GIS)/mapping system data sets as identified in the environmental plan.</p> <p>CT 2: Develop and/or revise pre-approved messages to include fact sheets, question-and-answer sheets, templates and key messages.</p> <p>CT 2: Use pre-approved messages to address public health threats and emergencies.</p> <p>CT 2: Develop and use messages specific to the community at any time.</p> <p>CT 2: Assess time needed to issue guidance.</p> <p>CT 2: Continue environmental testing and monitoring (e.g., BioWatch, radiation control, food safety assessments, and large capacity water testing project in El Paso and Corpus Christi).</p> <p>CT 2: Obtain training in the use of PPE.</p>
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**CDC PREPAREDNESS GOAL 8: RECOVER**

Goal: Increase the long-term follow-up provided to those affected by threats to the public’s health

<b>TARGET CAPABILITY 8A: Economic and Community Recovery</b>	
<b>MEASURE:</b>	
<b>CRITICAL TASKS DEFINED IN CDC GUIDANCE</b>	<b>PERFORMING AGENCY REQUIRED ACTIVITIES</b>
<p>CT 1: Develop and coordinate plans for long-term tracking of those affected by the event.</p> <p>CT 2: Improve systems to track cases, exposures, and adverse event reports.</p> <p>CT 3: Increase the availability of information resources and messages to foster community’s return to self-sufficiency.</p>	<p>CT 1: Develop protocols to provide long term tracking of those affected by an event.</p> <p>CT 2: Coordinate with CDC the planning of and implementation of CDC's OMS or implement an equivalent system.</p> <p>CT 3: Use the pre-approved messages and adapt where necessary.</p> <p>CT 3: Provide appropriate messages to city/county jurisdictions.</p>

## CDC PREPAREDNESS GOAL 9: IMPROVE

**Goal: Decrease the time needed to implement recommendations from after-action reports following threats to the public’s health.**

<b>TARGET CAPABILITY 9A: Planning</b>	
<b>MEASURES:</b>	
1) Time to complete an After-Action Report (AAR) with corrective action plan(s). <b>Jurisdictional Target: Mean = 60 days from conclusion of an exercise or real event.</b>	
2) Time to re-evaluate area(s) requiring corrective action. <b>Jurisdictional Target: Mean = 180 days after AAR is completed</b>	
<b>CRITICAL TASKS DEFINED IN CDC GUIDANCE</b>	<b>PERFORMING AGENCY REQUIRED ACTIVITIES</b>
	<p>Exercises must focus on specific components of a plan although it is not necessary to exercise all components of the plan at one time. An Exercise Notification Form must be submitted to DSHS Central Office at least 60 days prior to any exercise. Exercises should test public health SOPs and/or SOGs and should address horizontal and vertical integration with appropriate response partners at the federal, state, tribal and local level. Response partners may include, but are not limited to: public health, emergency management, laboratory, emergency and clinical medical providers, pharmacy, public works, emergency services, elected officials, school districts, military, and private sector businesses/employers. Response partners may also include bi-national partners at the local, state or federal levels where appropriate. If components of a LHD’s all-hazards SOP and/or SOG are tested during a response to an actual event, then the incident may be credited as an exercise. An After Action Report (AAR) must be completed and submitted to DSHS Central Office after the event to receive credit.</p> <p>As much as possible, incorporate the exercise requirements into exercises being conducted at the regional level by Councils of Governments (COGs) and GDEM.</p>

CT 1: Exercise plans to test horizontal and vertical integration with response partners at the federal, state, tribal, and local level.

CT 1: Annually exercise hospital capacity including patient management, staffing and interoperability with local public health and emergency management as required by the Joint Commission on Accreditation of Healthcare Organizations standards on emergency management drills/exercises and hazard vulnerability analysis.

CT 1: Annually exercise components of the Strategic National Stockpile.

CT 1: Annually exercise capability to receive and respond to disease reports of urgent cases, outbreaks or other public health emergencies 24/7.

CT 1: Bi-annually exercise CERC plan.

CT 1: Annually exercise the laboratory readiness and capacity to receive and respond for chemical and biological agents (for those agencies with a laboratory response network (LRN)).

CT 1: Test PHIN/HAN notification system ability to receive and send critical health information.

CT 1: Test local redundant communication system ability to notify key stakeholders involved in public health response.

CT 1: Test every six-months the ability to notify clinicians and public health response plan partners to receive public health emergency communication messages.

CT 1: Test every six-months the ability to notify key public health response partners via radio or satellite phone.

CT 1: Test quarterly the time it takes the public health director or designated official to notify public health agency staff with response responsibilities.

<p>CT 2: Decrease the time needed to identify deficiencies in personnel, training, equipment, and organizational structure, for areas requiring corrective actions</p> <p>CT 3: Decrease the time needed to implement corrective actions</p> <p>CT 4: Decrease the time needed to re-test areas requiring corrective action.</p>	<p>CT 1: Test every six months the time it takes for public health agency staff with response responsibilities to report for duty.</p> <p>CT 2: Write and submit an after-action report and corrective action plan within 60 days of conclusion of exercise or real event.</p> <p>CT 3: Implement a plan to correct deficiencies and identify unresolved barriers.</p> <p>CT 4: Retest areas of deficiencies within 180 days of AAR.</p>
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