HAZARDS EXHIBIT A (WORK PLAN)

Organization Name:	Collin County		
Contract Number:	2014-001267-00	Program ID:	CPS/HAZARDS
Contract Term:	9/1/2013 - 8/31/2014	Program Name:	Public Health Emergency Preparedness (PHEP)

EXHIBIT A

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

Budget Period 2

Introduction

DSHS developed this work plan in support of the Public Health Emergency Preparedness Cooperative Agreement (Funding Opportunity Number CDC-RFA-TP12-120102-CONT13) from the Centers for Disease Control and Prevention (CDC). The funding opportunity announcement addresses alignment of the Public Health Emergency Preparedness (PHEP) Program and the Hospital Preparedness Program (HPP) through a five-year project period from FY 2012 to 2017.

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

The work plan consists of the following sections that describe the activities and deliverables for PHEP Budget Period 2:

I. Public Health Preparedness Capabilities
II. Annual Requirements
III. CDC-Defined Performance Measures
IV. PHEP Evidence-based Benchmarks

I. Public Health Emergency Preparedness (PHEP) Capabilities

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

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

During this project period, Texas Department of State Health Services (DSHS), with consultation from the CDC, intends to foster closer alignment between the PHEP Program and Hospital Preparedness Program (HPP). Grant alignment is a long-term initiative that will continue to evolve throughout the project period as PHEP and HPP seek additional opportunities to improve administrative and programmatic collaboration. DSHS recognizes the capabilities required to fulfill HPP and PHEP programmatic goals differ but increased collaboration will serve to strengthen both programs. When appropriate, PHEP funding should support collaborative work with HPP toward capability capacity.

In 2011, CDC released a Public Health Capabilities Planning Model (http://www.cdc.gov/phpr/capabilities/DSLR_capabilities_July.pdf (pg 6-9) that describes a high-level planning process public health departments may wish to follow as they address the 15 public health capabilities. The planning model allows local health departments to use the public health preparedness capabilities to a) determine preparedness priorities, b) plan appropriate preparedness activities, and c) demonstrate and evaluate achievement of capabilities through exercises, planned events, and real incidents. Contractors are encouraged to use routine activities and real incidents to demonstrate and evaluate the public health preparedness capabilities.

DSHS with consultation from the CDC strongly recommends that local health departments utilize a prioritization strategy to determine their work and the resulting investments regarding the 15 public health preparedness capabilities across the five-year project period based upon:

A. The assessment of current capabilities and gaps (using the TxPHRAT);
B. A jurisdictional risk assessment (using the TxPHRAT);

Activity 1 for Section I, PHEP Capabilities:

Using the CDC Capabilities Planning Guide, Contractors should conduct strategic mapping of their work plan for the remaining project period (through FY 2017) to include capability prioritization.

Deliverable 1 for Activity 2 for Section I, PHEP Capabilities

Contractors should submit a strategic map to DSHS by October 31, 2013 on a template provided by DSHS.

Activity 2 for Section I, PHEP Capabilities: Update Texas Public Health Jurisdictional Risk Assessment tool (TxPHRAT) with new Capabilities Planning Guide (CPG) data

Deliverable 1 for Activity 2 for Section I, PHEP Capabilities

Using new CPG data, Contractor will update the Texas Public Health Jurisdictional Risk Assessment Tool (TxPHRAT). An updated tool must be completed and uploaded to the Texas Public Health Information Network (TxPHIN) by June 30, 2014. The TXPHIN tool is available at: http://www.dshs.state.tx.us/layouts/contentpage.aspx?pageid=8589954779&id=8589957698&terms=PHEP

II. Annual Requirements

Contractors are required to submit plans, program data, progress reports, and financial data outlining progress in addressing annual requirements including evidence-based benchmarks, objective standards, and performance measures data. Reports will also include information on outcomes of preparedness exercises regarding strengths, weaknesses, and associated corrective actions; accomplishments highlighting the impact and value of the PHEP program in local jurisdictions to include enhanced capacity from previous budget years; and descriptions of incidents requiring activations of emergency operations centers. Reports must describe preparedness activities conducted with PHEP funds, the purposes for which PHEP funds were spent, and the extent to which Contractors met stated goals and objectives. To assist Contactors, DSHS will provide a reporting template consistent with information required by CDC to meet the following annual planning/reporting requirements for 2013 to 2014.

1) HPP and PHEP Program Alignment
Contractors must demonstrate progress in coordinating public health and healthcare preparedness program activities and leveraging funding to support those activities as well as tracking accomplishments highlighting the impact of the HPP and PHEP programs in contractors' jurisdictions.

2) Exercise Planning and Implementation

Contractors must revise current multi-year training and exercise plans or develop a new multi-year training and exercise plan for conducting training and exercises to develop and test public health and healthcare preparedness capabilities. . Training and exercise plans must demonstrate coordination with relevant entities and include methods to leverage resources to the maximum extent possible. Updated multi-year training and exercise plans must be submitted to DSHS annually. Plans must include training and exercise schedules and describe exercise goals and objectives, identified capabilities to be tested, inclusion of at-risk individuals, participating partner organizations, and previously identified improvement plan items from real incidents or previous exercises.

One Annual Preparedness Exercise
Contractors will conduct at least one (1) preparedness exercise annually according to the Contractor's exercise plan and developed in accordance with Homeland Security Exercise and Evaluation Program (HSEEP) standards. Contractor will submit to DSHS an exercise notification following the Concept and Objectives meeting but, no later than 90 days prior to the exercise and a final After Action Review/Improvement Plan within 60 days of the exercise.

These exercises can include a tabletop exercise, a functional exercise, or a full-scale exercise to test preparedness and response capabilities. Following such exercises, Contractors will report identified strengths, weaknesses, and corrective actions taken to address material weaknesses. See the DSHS Exercise Program Guidance document for detailed exercise requirements.

Contractors must conduct one, joint full-scale exercise within the five-year project period. Joint full-scale exercises should meet multiple program requirements including PHEP, HPP and Strategic National Stockpile requirements where possible to minimize the burden on exercise planners and participants.

3) Volunteer Recruitment and Management (Capability 15, Volunteer Management) If Contractors are using volunteers, such as Medical Reserve Corps or Strategic National Stockpile (SNS) point of dispensing volunteers), then Contractors must enter volunteers into the Texas Disaster Volunteer Registry, the Texas Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) system and utilize this system as their primary volunteer management tool. Data should be updated into the Texas Disaster Volunteer Registry by November 30, 2013 (mid-year) and July 31, 2014 (end-of-year).

4) Coordination among cross-cutting public health preparedness programs PHEP program components as a whole should complement and be coordinated with other public health and healthcare programs as applicable. For example, some functions within the Public Health Laboratory, Public Health Surveillance and Epidemiological Investigation and Information Sharing capabilities may mutually support activities as described in CDC's Epidemiology and Laboratory Capacity (ELC) for Infectious Diseases cooperative agreement. Contractors should work with immunization programs and partners on syndromic surveillance and other activities to assure preparedness for vaccine-preventable diseases, influenza pandemics, and other events requiring a response.

5) Stakeholder Engagement (Capability 1, Community Preparedness, Function 2 and Capability 2, Community Recovery, Function 1)
Contractors should identify the appropriate jurisdictional partner to address the emergency preparedness, response, and recovery needs of older adults regarding public health, medical and mental health behavioral needs and address processes and accomplishments to meet the needs of older adults.

6) Public Comment Solicitation on Emergency Preparedness Plans (Capability 1, Community Preparedness, Function 2)
Contractors should describe processes for solicitation of public comment on emergency preparedness plans and their implementation such as the establishment of an advisory committee or similar mechanism to ensure ongoing public comment on emergency preparedness and response plans.

7) National Incident Management System (NIMS) Compliance (Capability 3, Emergency Operations Coordination, Function 1)
Contractors should have plans, processes, and training in place to meet NIMS compliance requirements by June 30,

2014.

8) Public Health, Mental/Behavioral Health, and Medical Needs of At-risk Individuals (Capability 1, Community Preparedness; Capability 2, Community Recovery; Capability 4, Emergency Public Information and Warning; Capability 7, Mass Care; Capability 10, Medical Surge; and Capability 13, Public Health Surveillance and Epidemiological Investigation)

Strategic maps should describe plans to address the public health, mental/behavioral health, and medical needs of at-risk individuals in the event of a public health emergency.
The definition of at-risk individuals is available at:
http://www.phe.gov/Preparedness/planning/abc/Documents/at-risk-individuals.pdf

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

10) Fiscal and Programmatic Systems
Contractors will have in place fiscal and programmatic systems to document accountability and improvement.

11) One Annual Preparedness Exercise

One Annual Preparedness Exercise – due April 1, 2014
Contractors will conduct at least one (1) preparedness exercise annually according to the Contractor's exercise plan and developed in accordance with Homeland Security Exercise and Evaluation Program (HSEEP) standards. Contractor will submit to DSHS an exercise notification following the Concept and Objectives meeting but, no later than 90 days prior to the exercise and a final After Action Review/Improvement Plan within 60 days of the exercise.

The exercise can be a tabletop exercise, a functional exercise, or a full-scale exercise to test preparedness and response capabilities. Following such exercises, Contractors will report identified strengths, weaknesses, and corrective actions taken to address material weaknesses. See the DSHS Exercise Program Guidance document for detailed exercise requirements.

Activities for Section II, Annual Requirements

Local health departments have the flexibility to determine capability prioritization and jurisdiction-specific activities for annual requirements.

Deliverables for Section II, Annual Requirements 1 through 11

Progress reports, program data, plans, and financial data from local health departments are deliverables for annual requirements 1 through 11. DSHS will provide templates for reports that are consistent with information requests from CDC in order to meet reporting requirements within a timeframe necessary to complete consolidation of statewide reporting to CDC.

Deliverable 1 for Section II, Annual Requirement 3
(Exercise Planning and Implementation)

Contractors must submit a current Multi-Year Training & Exercise Plan (with 5-year exercise schedule) to DSHS by July 31, 2013.

Deliverable 1 for Section II, Annual Requirement 12
(One Annual Preparedness Exercise)

Submit a Notification of Exercise to DSHS following the Concept & Objectives meeting (HSEEP) or as soon as possible but no later than 90 days prior to the conduct of the exercise.

Deliverable 2 for Section II, Annual Requirement 12
(One Annual Preparedness Exercise)

Submit an HSEEP-compliant After Action Review/Improvement Plan to DSHS within 60 days of the exercise.

III. CDC-Defined Performance Measures

Performance measures are key tools to determine program effectiveness and may focus on any level of public health service delivery including local health departments, public health laboratories, healthcare coalitions, and healthcare organizations. DSHS with consultation from the CDC has determined the benefit of Contractors reporting on these capability-based performance measures. While Contractors may not have to report on all performance measures every year, Contractors will be required to collect and report select performance measure data for Budget Period 2 (2013 to 2014) based on guidance to be provided by the Centers for Disease Control and Prevention (CDC) at a later date.

CDC's PHEP Budget Period 1 Performance Measure Specifications and Implementation Guidance is available at: http://www.cdc.gov/phpr/documents/PHEP+BP1+PM+Specifications+and+Implementation+Guidance_v1_1.pdf.

IV. Evidence-based Benchmarks and Pandemic Influenza Plans
(PAHPA Benchmarks)

CDC identifies select program requirements as benchmarks as mandated by Section 319C-1 and 319C-2 of the PHS Act as amended by the Pandemic and All Hazards Preparedness Act (PAHPA). To substantially meet a benchmark, Contractors must provide complete and accurate information describing how the benchmark was met. DSHS and the CDC expect Contractors to achieve, maintain, and report on benchmarks throughout the five-year project period. CDC and DSHS reserve the right to modify benchmarks annually as needed and in accordance with CDC goals, objectives, and directives. Contractors shall maintain all documentation that substantiates achievement of benchmarks and make those documents available to DSHS staff as requested during site visits or through other requests.

DSHS has identified the following CDC benchmarks for BP 2.

1. Adherence to PHEP Reporting Deadlines

Deliverable 1 – Contractors will prepare and submit a PHEP Budget Period 2 mid-year progress report to DSHS using a template provided by DSHS that captures reporting information and data required by CDC. The report is due to DSHS December 20, 2013. More information on the report is found in the Work Plan Table attachment.

2. Receiving, Staging, Storing, Distributing, and Dispensing Medical Countermeasures:
As part of a response to public health emergencies, Contractor must be able to provide countermeasures to 100% of the identified population within 48 hours after the formal federal request. To achieve this standard, Contractor must maintain the capability to plan and execute the receipt, staging, storage, distribution, and dispensing of material during a public health emergency.

a. Complete self-assessments using the Technical Assistance Review (TAR) tool due 2 weeks before the documentation review with Central Office. The benchmark score is a 69.
b. Perform and submit metrics on three (3) Strategic National Stockpile (SNS) operational drills to SharePoint and submit After Action Reviews / Improvements Plans to the exercise team. Both are due no later than April 1, 2014.
c. Demonstrate compliance with current programmatic medical countermeasure guidance through submission of point of dispensing (POD) standards data by loading POD standards document to SharePoint no later than April 1, 2014.

d. Contractors within the three designated CRI/MSA Planning Areas must conduct one joint full-scale distribution/dispensing exercise that includes all pertinent jurisdictional leadership and emergency management support function leads, planning and operational staff, and all applicable personnel in the Metropolitan Statistical Area or Health Service Region within the 2011 to 2016 performance period.

Through these activities, contractors will meet the performance measures noted in Section II: Statement of Work Performance Measures of the Program Attachment associated with medical countermeasures.

Appendix 1

Definitions for the Public Health Capability Model

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

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

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

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

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

1) Planning: standard operating procedures or emergency operations guidance, including considerations for legal authorities and at-risk populations, for a Contractor's plans for delivering the capability.
2) Skills and Training: baseline competencies and skills personnel and teams should possess or have access to when delivering a capability.
3) Equipment and Technology: equipment Contractors should have or have access to in jurisdictionally defined quantities sufficient to achieve the capability.
4) Note: Certain resource elements have been identified as priority resource elements. Contractors may not require all resource elements to fully achieve all of the functions within a capability, but they must have or have access to the priority resource elements. Remaining resource elements are recommended for consideration by Contractors.

Appendix 2

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

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

Community Resilience
- Community Preparedness
- Community Recovery

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

Incident Management
- Emergency Operations Coordination

Information Management
- Emergency Public Information and Warning
- Information Sharing

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