



INTERGOVERNMENTAL AGREEMENT (IGA) AMENDMENT

ARIZONA DEPARTMENT OF HEALTH SERVICES  
1740 W Adams, Room 303  
Phoenix, Arizona 85007  
(602) 542-1040  
(602) 542-1741 Fax

Contract No: ADHS12-007886

Amendment No. 4

Sr. Procurement Specialist  
Gabriel Vigil

Emergency Preparedness Program

It is mutually agreed that the Intergovernmental Agreement referenced is amended as follows:

1. Effective July 1, 2013, replace Price Sheet, Page Two (2), of Amendment Three (3), with Price Sheet, Amendment Four (4). The Total Price Sheet is \$175,104 66
2. Effective July 1, 2013, Replace Attachment A, Amendment Three (3), Pages Three (3) through Fifteen (15), with Attachment A, Pages Four (4) through Twenty Four (24), of this Amendment Four (4).

All other provisions of this agreement remain unchanged.

CONTRACTOR SIGNATURE

Gila County Health Department

Contractor Name

5515 S. Apache Ave, Suite 400

Address

Globe

AZ

85501

City

State

Zip

Contractor Authorized Signature

Printed Name

Michael A. Pastor, Chairman, GC Board of Supervisors

Title

CONTRACTOR ATTORNEY SIGNATURE

Pursuant to A R S § 11-952, the undersigned public agency attorney has determined that this Intergovernmental Agreement is in proper form and is within the powers and authority granted under the laws of the State of Arizona. APPROVED AS TO FORM:

10-22-13  
Signature Date

Bryan B. Chambers, Deputy Attorney Principal

This Intergovernmental Agreement Amendment shall be effective the date indicated. The Public Agency is hereby cautioned not to commence any billable work or provide any material, service or construction under this IGA until the IGA has been executed by an authorized ADHS signatory

State of Arizona

Signed this 1<sup>st</sup> day of November 20 13

Procurement Officer

Attorney General Contract No. P0012012000033, which is an Agreement between public agencies, has been reviewed pursuant to A R S § 11-952 by the undersigned Assistant Attorney General, who has determined that it is in proper form and is within the powers and authority granted under the laws of the State of Arizona

10-22-13  
Signature Date

Assistant Attorney General

Printed Name: Laura Flores

RESERVED FOR USE BY THE SECRETARY OF STATE

Under House Bill 2011, A.R.S. § 11-952 was amended to remove the requirement that Intergovernmental Agreements be filed with the Secretary of State.



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3. Delete in its entirety, Terms and conditions, Provision Eighteen (18), Health Insurance Portability and Accountability Act of 1996 (HIPAA), and replace with the following:

**Health Insurance Portability and Accountability Act of 1996**

The Contractor warrants that it is familiar with the requirements of HIPAA, as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH Act) of 2009, and accompanying regulations and will comply with all applicable HIPAA requirements in the course of this Contract. Contractor warrants that it will cooperate with the Arizona Department of Health Services (ADHS) in the course of performance of the Contract so that both ADHS and Contractor will be in compliance with HIPAA, including cooperation and coordination with the Arizona Strategic Enterprise Technology (ASET) Office, Statewide Information Security and Privacy Office (SISPO) Chief Privacy Officer and HIPAA Coordinator and other compliance officials required by HIPAA and its regulations. Contractor will sign any documents that are reasonably necessary to keep ADHS and Contractor in compliance with HIPAA, including, but not limited to, business associate agreements.

If requested by the ADHS Procurement Office, Contractor agrees to sign a "Pledge To Protect Confidential Information" and to abide by the statements addressing the creation, use and disclosure of confidential information, including information designated as protected health information and all other confidential or sensitive information as defined in policy. In addition, if requested, Contractor agrees to attend or participate in HIPAA training offered by ADHS or to provide written verification that the Contractor has attended or participated in job related HIPAA training that is: (1) intended to make the Contractor proficient in HIPAA for purposes of performing the services required and (2) presented by a HIPAA Privacy Officer or other person or program knowledgeable and experienced in HIPAA and who has been approved by the ASET/SISPO Chief Privacy Officer and HIPAA Coordinator.

4. Delete in its entirety, Terms and Conditions, Provision Four (4), Contract Administration and Operation, Section 4.13, Scrutinized Businesses.



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**PRICE SHEET**

Fixed Price

Description	Quantity	Unit Rate	Extended Price
CDC Deliverables for Public Health Emergency Preparedness - PHEP	1	\$175,104.66	\$175,104.66
<b>Total</b>			<b>\$175,104.66</b>

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Arizona Department of Health Services  
Bureau of Public Health Emergency Preparedness  
PHEP Cooperative Agreement Grant

# Public Health Emergency Preparedness Deliverables

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BP2  
Budget Year 2013-2014



**REGIONS**

**CENTRAL NORTHERN**

**SOUTHEASTERN**

**WESTERN**

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**1. PROGRAM REQUIREMENTS:**

1.1 Arizona follows the established Emergency Medical Services boundaries to identify regions. The four identified regions are Northern, Central, Southeastern, and Western Regions. See Appendix 3 for reference.

1.1.1 Central Region PHEP partners include: Gila County, Maricopa County, Pinal County, and Gila River Indian Community.

1.1.2 Northern Region PHEP partners include: Apache County, Coconino County, Navajo County, Yavapai County, Hopi Tribe, Navajo Nation, and White Mountain Apache Tribe.

1.1.3 Southeastern Region PHEP partners include: Cochise County, Graham County, Greenlee County, Pima County, Santa Cruz County, Pascua Yaqui Tribe, San Carlos Apache Tribe, and Tohono O'Odham Nation.

1.1.4 Western Region PHEP partners include: La Paz County, Mohave County, Yuma County, Cocopah Tribe, Colorado River Indian Tribes, Fort Mohave Indian Tribe, Kaibab – Paiute Tribe, and Quechan Tribe.

**1.2 Partnership/Coalition Meetings (*Central, Northern, Southeastern, and Western Regions*)**

The designated Public Health Emergency Coordinator or representative will attend ADHS Healthcare Coalition meetings within their region. These meetings will provide an opportunity for collaboration with healthcare facilities, county, state, tribal, and other response partners. Partnerships/coalitions shall continue to plan and develop memoranda of understanding (MOU) to share assets, personnel and information. Coalition members shall maintain plans to unify ESF-8 management of healthcare during a public health emergency, and integrate communication with jurisdictional command in the area.

**1.3 Reporting**

Progress on these deliverables, performance measures, and activities conducted with funds from this grant will be reported in a timely manner for the Mid-Year and end of year report. These documents will be submitted to ADHS.

**1.4 Financial Requirements**

**1.4.1 Performance**

Failure to meet the deliverables and performance measures described in the Scope of Work may result in withholding from a portion of subsequent awards.

**1.4.2 Match Requirement**

The PHEP award requires a 10% "in-kind" or "soft" match from all the grant participants. Each recipient must include in their budget submission the format they will use to cover the match and method of documentation. Failure to include the match formula will preclude funding.

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- 1.4.3 Inventory
  - Provide by mid-year, a completed Inventory List to include all capital equipment (dollar amount above \$5000). Inventory list will be provided to ADHS.
  
- 1.4.4 Budget Spend Plan
  - Budget spend plans will be completed and submitted to ADHS after contractor signature. Your budget spend plan needs to be reviewed and approved by ADHS before funding is released.
  
- 1.4.5 Grant Activity Oversight
  - Maintain a full-time, part-time, or appointed public health emergency preparedness coordinator to have responsibility for oversight of all grant related activities. Preparedness coordinator to have responsibility for oversight of all grant related activities. Cooperate and coordinate with ADHS in completing on- site visits pursuant to, and in compliance with Standard Operating Procedures for Sub-Recipient Monitoring.
  
- 1.4.6 Employee Certifications
  - PHEP Recipients are required to adhere to all applicable federal laws and regulations, including OMB Circular A-87 and semiannual certification of employees who work solely on a single federal award. These certification forms must be prepared at least semiannually signed by the employee or a supervisory official having firsthand knowledge of the work performed by the employee. Employees that are split funded are required to maintain Labor Activity Reports (to be provided as requested). These certification forms must be retained in accordance with 45 Code of Federal Regulation, Part 92.42
  
- 1.4.7 Activities and Purchases
  - Activities conducted under and purchases made with this award will be kept specific to the deliverables outlined in this document. Other activities and purchases, in line with the CDC grant guidance for BP 2 or previous budget period deliverables may be allowed if assurances are made that all assigned deliverables for BP1 will be completed. Approval for this will be on a case by case basis and conducted by ADHS.

**1.5 Exercises**

- 1.5.1 Participate in the 2013-2014 ADHS Training and Exercise Planning Workshop. Provide the agency specific HSEEP compliant Training and Exercise Plan (TEP) to ADHS no later than September 6, 2013.
  
- 1.5.2 Support and participate in at least one ADHS sponsored HPP and PHEP/SNS exercises. Exercise participation and support activities may include exercise play, simulation, participation in communication pathways, partial or full activation of emergency operation centers, and participation in exercise design and evaluation meetings. Submit the After Action Reports (AARs) and Improvement Plans (IP) for each exercise to ADHS by June 10, 2014.

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**1.6 Corrective Actions**

Track and manage corrective actions identified in responses and exercises. Ensure after action reports (AAR) and improvement plans (IP) are generated for any public health emergency exercise or real world event in which the public health entity participates and has a role. After a standalone, DSNS drill an executive summary and an IP must be provided to the ADHS SNS Coordinator.

**1.7 Emergency Notification System**

Provide ADHS with an updated "County/Tribal Public Health Emergency Contact Information Sheet. This should include contact information for the primary, secondary, and tertiary individual for the Public Health Incident Management System (e.g. Incident Commander, Operations, etc.) The contact information for each individual shall include: ICS title, individual's name, non-emergency position title, office telephone number, mobile telephone number, home telephone number, and email address loaded into ADHS Health Service Portal by September 30.

**2. CAPABILITIES:**

**2.1 Capability 1: Community Preparedness**

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

- 2.1.1 Support the development of public health, medical and mental/behavioral health systems that support recovery
- 2.1.2 Participate in awareness training with community and faith-based partners on how to prevent, respond to, and recover from public health incidents
- 2.1.3 Promote awareness of and access to medical and mental/behavioral health 2 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
- 2.1.4 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
- 2.1.5 Identify those populations that may be at higher risk for adverse health outcomes
- 2.1.6 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)

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**2.1.7 Budget Period Short Term Goal:**

2.1.7.1 Goal 1. The State in collaboration with emergency management and homeland security will disseminate the Jurisdictional risk assessment for evaluation and analysis regarding risks to the public health. Local and Tribal health will develop a regional approach to address planning gaps.

2.1.7.2 Goal 2. Review written plans to ensure that they 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: 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.

**2.2 Capability 2: Community Recovery**

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

2.2.2 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.

**2.2.3 Budget Period Short Term Goal:**

Goal 1: Establish a statewide baseline for post-incident recovery and make recommendations for systemic improvement for the state of Arizona PHEP stakeholders by developing an assessment tool in order to evaluate healthcare system recovery, behavioral health care, and human services recovery needs, along with resource availability.

**2.3 Capability 3: Emergency Operations Coordination**

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

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**2.3.2 Budget Period Short Term Goal:**

2.3.2.1 **Goal 1:** ADHS will acquire situational awareness information in order to determine if and to what extent Health Emergency Operations Center (HEOC) activation is necessary in order to provide a statewide public health common operating picture. This short-term goal will demonstrate the ability of the HEOC to collect the essential elements of information from the Local Health Departments.

2.3.2.2 **Goal 2:** WebEOC access and the application will be extended to the 15 local Health Departments and any Tribes who request access to the application. This short-term goal will be measured by the execution of the WebEOC application with statewide partners.

2.3.2.3 **Goal 3:** Sustain the Health Emergency Operating Center (HEOC) functionality by ensuring competency in staff assembly times, training, and job specific functions.

**2.4 Capability 4: Emergency Public Information and Warning**

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

**2.4.2 Budget Period Short Term Goal:**

2.4.2.1 **Goal 1:** Leverage existing technologies to communicate with and inform the response partners and the general public during operational exercises, on-going drills, and responses. This short term goal will be measured and tracked through the documentation of drills and through the qualitative and quantitative evaluation of exercises and responses in After Action Reports and Improvement Plans (AAR/IPs).

2.4.2.2 **Goal 2:** Sustain the ability of state, local, and healthcare facility public information officers to coordinate, develop, and disseminate public information through the conducting of and evaluation of at least one operational exercise. The ability of public information officers to determine the need for public information systems establish and participate in information systems, and establish avenues for public interaction and exchange will be quantitatively and qualitatively evaluated in the context of an AAR/IP.

**2.5 Capability 5: Fatality Management**

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

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**2.5.2 Budget Period Short Term Goal:**

- 2.5.2.1 **Goal 1.** Identify specific roles and support functions between Arizona Department of Health, county Public Health, law enforcement, medical examiners, and private sector partners during a Fatality Management response.
- 2.5.2.2 **Goal 2.** Coordinate between internal and external partners to facilitate access to resources when demand on local jurisdiction exceeds capacity to support fatalities from an incident. Ensure resource request are in accordance with public health jurisdictional standards and practices and as requested by lead jurisdictional authority. This will result in the development and implementation of resource request process.
- 2.5.2.3 **Goal 3.** Survey county and tribal partners to identify training in support of Fatality Management operations to include: mental/behavioral health services, death notification, relief to families, and spiritual care. Utilization of a survey prior to and post training will measure increased knowledge.

**2.6 Capability 6: Information Sharing**

- 2.6.1 **Definition:** Information sharing is the ability to conduct multijurisdictional, multidisciplinary exchange of health-related information and situational awareness data among federal, state, local, territorial, and tribal levels of government, and the private sector.
- 2.6.2 **Maintain or Have Access to a Notification System**  
Jurisdictions shall maintain or have access to a notification system to share health updates and alerts, including epidemiological, clinical, and situational awareness data, with key healthcare partners.
- 2.6.3 **Provide Emergency Notification System Contact Information and Participate in Bimonthly Communications Drills.**  
Jurisdictions shall provide ADHS with emergency contact information sheets semi-annually and participate in Bimonthly Communication Drills. Drill results will be provided to ADHS after each drill.
- 2.6.4 **Budget Period Short Term Goal:**
  - 2.6.4.1 **Goal 1.** Conduct multi-jurisdictional and multi-disciplinary exchange of health related information and situational awareness with all County and Tribal and local ESF-8 partners statewide. This short-term goal will be measured by 8% increased membership to the interoperable communication systems such as the Health Alert Network.
  - 2.6.4.2 **Goal 2.** Disseminate accurate and appropriate information to the County and Tribal and local ESF-8 partners statewide. This goal will be measured by the development of an information generation/sharing protocol.

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**2.7 Capability 7: Mass Care**

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

**2.7.2 Budget Period Short Term Goal:**

2.7.2.1 **Goal 1.** Determine the jurisdictional public health roles and responsibilities in conjunction with Emergency Support Function 6, 8, and 11 partners. Consolidation of information will result in the completion of a statewide plan that will support Mass care operations.

2.7.2.2 **Goal 2.** In conjunction with state and local partners, including emergency management and Red Cross collaborate to identify a tool for health screening of individuals during shelter operations. Some elements of the tool may be, immediate medical needs, mental health needs, sensory impairment or other disability, medication use, need for assistance with activities of daily living, and substance abuse. The outcome will be a recommendation to the Emergency Preparedness Task Force for inclusion in a standard operating procedure for the intake process during shelter operations and the clarification of the request process for needed supplies in support of shelter operations for access and functional needs.

**2.8 Capability 8: Medical Countermeasure Dispensing**

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

**2.8.2 Budget Period Short Term Goal:**

2.8.2.1 **Goal 1.** ADHS, County, and Tribal partners will meet quarterly to share best practices and lessons learned from Exercises for the rapid dispensing of medical countermeasures during a public health emergency. Collaborative review will occur during the Arizona Local Public Health Emergency Response Association (ALPHERA) and Regional Coalition meetings. By the end of BP2, all County, State, and Tribal plans will have been reviewed in their entirety.

2.8.2.2 **Goal 2.** Coordination between SNS Coordinator and epidemiological staff will streamline the incorporation of investigation data into the SNS request process.

2.8.2.2.1 **Develop or Update Medical Countermeasure Dispensing Plans**  
Written plans should include: standard operating procedures that provide guidance to identify the medical countermeasures required for the incident or potential incident; protocols to request, receive, distribute,

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dispense, and manage medical countermeasures within 48 hours of request. Planning should include all memoranda of understandings or other letters of agreement with state/local/tribal partners; and 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. Update/ revise SNS Plans based upon training improvements, quarterly meeting notes, identified threats and regional risk assessments, partner involvement and post plans onto ADHS Health Service Portal.

**2.9 Capability 9: Medical Materiel Management & Distribution**

**2.9.1 Definition:** 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.

**2.9.2 Budget Period Short Term Goal:**

**2.9.2.1 Goal 1:** ADHS, County, and Tribal partners will meet quarterly to share best practices and lessons learned from Exercises for Medical Materiel Management and Distribution of medical countermeasures during a public health emergency. Collaborative review will occur during the Arizona Local Public Health Emergency Response Association (ALPHERA) and Regional Coalition meetings. By the end of BP2, all County, State, and Tribal plans will have been reviewed in their entirety.

**2.9.2.2 Goal 2:** Collaborate with the Arizona Board of Pharmacy (AZBP) to develop a query protocol of pharmacies during a public health emergency. The protocol will support ADHS in determining the current standard inventory of medical countermeasures and will allow for streamlined request of medical countermeasures. By the end of BP2, the protocol will be an annex to ADHS SNS Plan.

Participate in Inventory Management System quarterly drills in support of medical material management and distribution of medical countermeasures

**2.9.3 Drill Requirement**

Each County will conduct at least two different SNS drills utilizing the Target Metric template provided by DSNS/ADHS. An executive summary and improvement plan must be submitted for each drill. Jurisdictions shall provide ADHS with the Target Metrics by January 10, 2014 and April 25, 2014 respectively.

2.9.3.1 Staff notification, acknowledgement and assembly

2.9.3.2 Site activation: notification, acknowledgement and assembly

2.9.3.3 Facility Setup

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2.9.3.4 Pick List Generation

2.9.3.5 Dispensing Throughput

**2.9.4 Cities Readiness Initiative (CRI) Drill Requirement**

Each CRI will conduct at least three different SNS drills utilizing the Target Metric template provided by DSNS/ADHS. An executive summary and improvement plan must be submitted for each drill. Jurisdictions shall provide ADHS with the Target Metrics by January, 10, 2014, and April 25, 2014 respectively.

2.9.4.1 Staff notification, acknowledgement and assembly

2.9.4.2 Site activation: notification, acknowledgement and assembly

2.9.4.3 Facility Setup

2.9.4.4 Pick List Generation

2.9.4.5 Dispensing Throughput

2.9.4.6 Public Health Decision Making Tool

**2.10 Capability 10: Medical Surge**

2.10.1 **Definition:** Medical surge is the ability to provide adequate medical evaluation and care during events that exceed the limits of the normal medical infrastructure of an affected community. It encompasses the ability of the healthcare system to survive a hazard impact and maintain or rapidly recover operations that were compromised.

**2.10.2 Budget Period Short Term Goal:**

2.10.2.1 **Goal 1.** Coordinate jurisdiction's healthcare response through the collection and analysis of health data to define the needs of the incident and available healthcare staffing and resources. This will be measured by the results of monthly communication drills, and expansion of data being requested during Medical Surge exercises/operations.

2.10.2.2 **Goal 2.** As part of the regional Health Care Coalitions, help define public health role and the processes to obtain information relating to situational awareness in support of medical surge operations. This process will be tested in exercises during BP2.

**2.11 Capability 11: Non-Pharmaceutical Interventions**

2.11.1 **Definition:** Non-pharmaceutical interventions are the ability to recommend to the applicable lead agency (if not public health) and implement, if applicable, strategies for disease, injury, and exposure control. Strategies include the following:

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2.11.1.1 Isolation and quarantine

2.11.1.2 Restrictions on movement and travel advisory/warnings

2.11.1.3 Social distancing

2.11.1.4 External decontamination

2.11.1.5 Hygiene

2.11.1.6 Precautionary protective behaviors

**2.11.2 Budget Period Short Term Goal:**

2.11.2.1 **Goal 1.** Maintain and enhance existing plans to address NPIs for multiple incidents. Communication plans will be updated and/or maintained to share intervention activities with partners and the public. Plans will also include processes to address vulnerable populations as well as procedures to enable the scalable implementation of the intervention

**2.12 Capability 13: Public Health Surveillance and Epidemiological Investigation**

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

Local public health partners should maintain the capacity for surveillance, investigation, and control of infectious diseases and public health incidents. Partners should work with ADHS to accomplish these functions if capacity is limited at the local level.

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

Written plans should include processes and protocols to gather and analyze data from 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.

**2.12.2 Participate in State Testing of the Communicable Disease On-call System**

Jurisdictions shall participate in tests of the communicable disease on-call system, and shall ensure that sufficient staff are identified and trained to participate in all system tests.

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- 2.12.3 Provide ADHS Staff with Contact Information for MEDSIS Liaison Semi-annually**  
Jurisdictions shall provide ADHS staff with contact information for the MEDSIS liaison on a semi-annual (every 6 months) basis. MEDSIS liaison responsibilities include requesting/approving new users and notifying ADHS when users no longer require access. The MEDSIS liaison shall also participate in the MEDSIS quarterly meetings. Arizona utilizes MEDSIS to conduct reportable disease surveillance.
- 2.12.4 Conduct Outreach to Delayed Reporters**  
Jurisdictions shall conduct outreach to delayed reporters (entities reporting cases of disease later than timeframes allowed by Arizona Administrative Code). Delayed reporters can be identified through quarterly timeliness reports generated by ADHS or county-specific surveillance systems. Report on the percentage of delayed reporters educated about timeliness of reporting.
- 2.12.5 Participate in Epidemiology Trainings and Exercises**  
Jurisdictions shall participate in the Epidemiology Surveillance and Capacity (ESC) meetings (at least 10 out of 12), "How to" Presentations (at least 80%) and the Arizona Infectious Disease Training and Exercise. Attendance will be monitored by ADHS for use in grant reporting.
- 2.12.6 Conduct Investigations of Reported Urgent Diseases and Public Health Incidents**  
Investigation actions should include the following as necessary: case identification, specimen collection, case investigation/characterization, and control measure implementation.
- 2.12.7 Report All Identified Outbreaks Within 24 Hours**  
Jurisdictions shall Report all of identified outbreaks to ADHS within 24 hours; include documentation on outbreak investigation activities as part of your mid-year and end-of-year reports to ADHS. At a minimum, include the information identified in Appendix 1.
- 2.12.8 Submit Outbreak Summaries to ADHS**  
Outbreak summaries must be submitted to ADHS within 30 days of outbreak closure for all outbreaks investigated.
- 2.12.9 Initiate Control Measures within the Appropriate Timeframe**  
Indicate time of control measure initiation in the case management screen of MEDSIS. If MEDSIS case management screen is unavailable, document control measure timeliness in a data collection tool. See Appendix 2 for details related to control measure initiation and selected diseases.
- 2.12.10 Develop a plan to address and/or identify non-reporters**  
Local jurisdictions shall develop a brief plan to identify non-reporters and provide outreach to these reporters. (i.e., review all healthcare facilities in the jurisdiction and cross-check with cases reported in MEDSIS to identify non-reporters.)
- 2.12.11 Complete monthly performance measure report form**  
Jurisdictions shall complete the monthly PHEP performance measure report form distributed by ADHS for use in identifying gaps in timeliness of reporting and monitoring outbreaks in

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the jurisdiction. Performance measure report information will be utilized for mid-year and end-of-year grant reporting.

**2.12.12 Budget Period Short Term Goal:**

2.12.12.1 **Goal 1.** Maintain and enhance public health informatics infrastructure, including the state-wide electronic disease reporting system (MEDSIS), electronic laboratory reporting and syndromic surveillance systems to allow state and local-level epidemiologists to better collect data, track health events and analyze disease trends. This goal will be measured by the number of reports generated using the various surveillance systems, the integration of a new outbreak module into MEDSIS and the increase in the number of laboratories reporting electronically to ADHS.

2.12.12.2 **Goal 2.** Create and maintain protocols for investigation and communication and provide monthly trainings to improve the ability of health departments in Arizona to identify outbreaks and determine the source of infection or exposure. Goal measured by the number of trainings held throughout the grant period, the number of investigations initiated and by the percent of epidemiologists meeting CSTE Epidemiology Tier 1 core competencies.

**2.13 Capability 14: Responder Safety and Health**

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

**2.13.2 Budget Period Short Term Goal:**

2.13.2.1 **Goal:** Conduct gap assessment to determine the percent of healthcare coalitions that have systems and processes in place to preserve healthcare system functions to protect the coalition member employees (including non-healthcare).

**2.14 Capability 15: Volunteer Management**

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

**2.14.2 Budget Period Short Term Goal:**

2.14.2.1 **Goal:** Enhance the Volunteer Response Program for the members of the Healthcare Coalitions and volunteer organizations by developing updated plans, guidelines, forms and training as well as promote the utilization of the State Volunteer Management System (ESAR-VHP) at the local level to increase the credentialed volunteer database by 8%. The outcome will be measured by

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increased revised/updated plans, new standard operating procedures, and forms for healthcare coalitions, ESF 8 partners, and local volunteer organizations for volunteer management and increased utilization of the AZ ESAR-VHP database for all volunteer organizations in Arizona.

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**Table 1- Deliverables "At a Glance"**

<b>PROGRAM REQUIREMENTS APPLICABLE TO ALL PARTNERS</b>	
1	<b>Partnership/Coalition Meetings Attendance:</b> Designated PHEP Coordinator or representative will attend meetings within their region
2	<b>Reporting:</b> Mid-Year and End of Year Reports
3	<b>Financial Requirements:</b> Performance, Match Requirement, Inventory, Budget Spend Plan, Grant Activity Oversight, Employee Certifications, Activities and Purchases
4	<b>Exercises:</b> Participate in the 2013-2014 ADHS Training and Exercise Plan Workshop, Provide ADHS agency specific HSEEP TEP no later than September 6, 2013
5	<b>Exercises:</b> Conduct and Participate in at least one ADHS Sponsored HPP and PHEP/SNS Program Exercises and Public Health.
6	<b>Exercises:</b> Submit at Least One After Action Report from HSEEP Compliant Exercise or Real Event to ADHS by June 10, 2014
7	<b>Corrective Actions:</b> Develop and maintain Tracking Tool for AAR/IPs
<b>GOALS/OBJECTIVES</b>	
1	<b>Community Preparedness:</b> Local and Tribal health will develop a regional approach to address planning gaps identified
	<b>Community Preparedness:</b> Review/update written plans to ensure they include policy and process to participate in partnerships representing at least the 11 identified community sectors
2	<b>Community Recovery:</b> Evaluate healthcare system, behavioral health care and human services recovery needs, along with resource availability.
3	<b>Emergency Operations Coordination:</b> Local Health Departments gain access to WebEOC for their identified key staff
4	<b>Emergency Public Information:</b> Conduct regularly scheduled, ongoing communications drills with ADHS to ensure equipment and staff are ready for real-world responses
5	<b>Fatality Management:</b> Identify specific roles and functions during a Fatality Management response
6	<b>Information Sharing:</b> Provide Emergency Notification System Contact Information and Participate in System Tests
7	<b>Mass Care:</b> Identify Local Health roles and responsibilities to provide health services, and shelter services during a mass care incident

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8	<b>Medical Countermeasure Dispensing:</b> Meet with ADHS SNS Coordinator quarterly to review Medical Countermeasure Dispensing Plans for the alignment of State and Local deployment of medical countermeasures
	<b>Medical Countermeasure Dispensing Drills Non-CRI:</b> Each County conduct at least two different SNS drills provide ADHS the target metrics by January 10, 2114 and April 25, 2014
	<b>Medical Countermeasure Dispensing CRI:</b> Cities Readiness Initiative (CRI) Drill requirement, Each County conduct at least three different SNS drills provide ADHS the target metrics by January 10, 2114 and April 25, 2014
9	<b>Medical Materiel Management &amp; Distribution:</b> Participate in ADHS quarterly inventory Management System drills
10	<b>Medical Surge:</b> Participate in ADHS monthly communication drills with healthcare system partners
10	<b>Medical Surge:</b> Assist Coalition in developing processes for obtaining coalition-level situational awareness
11	<b>Non-Pharmaceutical Interventions:</b> Review plans to ensure the address NPIs for multiple incidents, updated plans as required to share intervention activities with partners and the public
13	<b>Public Health Surveillance and Epidemiological Investigation:</b> Participate in State testing of the communicable disease on-call system- Counties Only
	<b>Public Health Surveillance and Epidemiological Investigation:</b> Provide ADHS Staff with Contact Information for MEDSIS Liaison Semi-annually
	<b>Public Health Surveillance and Epidemiological Investigation:</b> Conduct outreach to delayed reporters (entities reporting cases of disease later than timeframes allowed by Arizona Administrative Code)- Counties Only
	<b>Public Health Surveillance and Epidemiological Investigation:</b> Participate in at least 80% of the Ep Surveillance and Capacity meetings
	<b>Public Health Surveillance and Epidemiological Investigation:</b> Conduct investigations of reported urgent diseases and public health incidents.
	<b>Public Health Surveillance and Epidemiological Investigation:</b> Report All Identified Outbreaks within 24 Hours (see Appendix 1)

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	<b>Public Health Surveillance and Epidemiological Investigation:</b> Submit Outbreak Summaries to ADHS (within 30 Days of Outbreak Closure for all Outbreaks Investigated)
	<b>Public Health Surveillance and Epidemiological Investigation - Mitigation Actions:</b> Initiate Control Measures within the Appropriate Timeframe (see Appendix 2)
14	<b>Responder Safety and Health:</b> Complete a gap assessment survey to identify system and processes in place to preserve and maintain healthcare system functions and provide an inventory of Personal Protective Equipment
15	<b>Volunteer Management:</b> Complete a volunteer needs assessment provided by ADHS which will include identification of situations that would necessitate the need for volunteers in healthcare organizations, estimations of the anticipated volunteers, resource needs, identification of the health professional roles and known liability issues

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APPENDIX 1

Outbreaks include all notifiable cases and clusters, but should exclude: conjunctivitis, strep throat/group A streptococcal infection, influenza-like illness, RSV, lice, scabies, HIV, STD, and TB.

**Outbreak Reporting Table – July 1, 2013-June 30, 2014:**

# of outbreak reports received	# of outbreaks investigated	# of outbreaks with specimens collected (human or animal)	# of outbreak investigations with reports generated	# of outbreak investigations with complete reports or summary forms submitted to ADHS

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APPENDIX 2

1. Initiation of control measures can include:
  - 1.1 Initiation of an appropriate control measure
  - 1.2 A recommendation for initiation of a control measure
  - 1.3 A decision not to initiate or recommend a control measure
  - 1.4 Documented inability to initiate a control measure despite an effort to do so
  
2. Selected reportable diseases include: Botulism, Shiga toxin-producing *E. coli*, Hepatitis A, Measles, Meningitis, Tularemia: reference appendix 2 for table of control measures and initiation timeframes requirements.

**Public Health Control Measures and Timeframes:**

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

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APPENDIX 3

<b>CENTRAL REGION</b>
County
GILA
MARICOPA
PINAL
Tribal
GILA RIVER INDIAN COMMUNITY
<b>NORTHERN REGION</b>
County
APACHE
COCONINO
NAVAJO
YAVAPAI
Tribal
HOPI TRIBE
NAVAJO NATION
WHITE MOUNTIAN APACHE TRIBE
<b>SOUTHERN REGION</b>
County
COCHISE
GRAHAM
GREENLEE
PIMA
SANTA CRUZ
Tribal
PASCUA YAQUI TRIBE
SAN CARLOS APACHE TRIBE
TOHONO O'ODHAM NATION

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<b>WESTERN REGION</b>
<b>County</b>
<b>LA PAZ</b>
<b>MOHAVE</b>
<b>YUMA</b>
<b>Tribal</b>
<b>COCOPAH TRIBE</b>
<b>COLORADO RIVER INDIAN TRIBES</b>
<b>FORT MOJAVE INDIAN TRIBE</b>
<b>KAIBAB - PAIUTE TRIBE</b>
<b>QUECHAN TRIBE</b>



**INTERGOVERNMENTAL AGREEMENT (IGA) AMENDMENT**

**ARIZONA DEPARTMENT OF HEALTH SERVICES**  
1740 W. Adams, Room 303  
Phoenix, Arizona 85007  
(602) 542-1040  
(602) 542-1741 Fax

Contract No: **ADHS12-007886**

Amendment No. 4

Sr. Procurement Specialist  
Gabriel Vigil

**Emergency Preparedness Program**

- 3. Delete in its entirety, Terms and conditions, Provision Eighteen (18), Health Insurance Portability and Accountability Act of 1996 (HIPAA), and replace with the following:

**Health Insurance Portability and Accountability Act of 1996**

The Contractor warrants that it is familiar with the requirements of HIPAA, as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH Act) of 2009, and accompanying regulations and will comply with all applicable HIPAA requirements in the course of this Contract. Contractor warrants that it will cooperate with the Arizona Department of Health Services (ADHS) in the course of performance of the Contract so that both ADHS and Contractor will be in compliance with HIPAA, including cooperation and coordination with the Arizona Strategic Enterprise Technology (ASET) Office, Statewide Information Security and Privacy Office (SISPO) Chief Privacy Officer and HIPAA Coordinator and other compliance officials required by HIPAA and its regulations. Contractor will sign any documents that are reasonably necessary to keep ADHS and Contractor in compliance with HIPAA, including, but not limited to, business associate agreements.

If requested by the ADHS Procurement Office, Contractor agrees to sign a "Pledge To Protect Confidential Information" and to abide by the statements addressing the creation, use and disclosure of confidential information, including information designated as protected health information and all other confidential or sensitive information as defined in policy. In addition, if requested, Contractor agrees to attend or participate in HIPAA training offered by ADHS or to provide written verification that the Contractor has attended or participated in job related HIPAA training that is: (1) intended to make the Contractor proficient in HIPAA for purposes of performing the services required and (2) presented by a HIPAA Privacy Officer or other person or program knowledgeable and experienced in HIPAA and who has been approved by the ASET/SISPO Chief Privacy Officer and HIPAA Coordinator.

- 4. Delete in its entirety, Terms and Conditions, Provision Four (4), Contract Administration and Operation, Section 4.13, Scrutinized Businesses.



**INTERGOVERNMENTAL AGREEMENT (IGA) AMENDMENT**

**ARIZONA DEPARTMENT OF  
HEALTH SERVICES**  
1740 W. Adams, Room 303  
Phoenix, Arizona 85007  
(602) 542-1040  
(602) 542-1741 Fax

Contract No: **ADHS12-007886**

Amendment No. 4

Sr. Procurement Specialist  
Gabriel Vigil

**PRICE SHEET**

Fixed Price

Description	Quantity	Unit Rate	Extended Price
CDC Deliverables for Public Health Emergency Preparedness - PHEP	1	\$175,104.66	\$175,104.66
<b>Total</b>			<b>\$175,104.66</b>

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Arizona Department of Health Services  
Bureau of Public Health Emergency Preparedness  
PHEP Cooperative Agreement Grant

# Public Health Emergency Preparedness Deliverables

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**BP2**  
**Budget Year 2013-2014**



**REGIONS**

**CENTRAL NORTHERN**

**SOUTHEASTERN**

**WESTERN**

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**1. PROGRAM REQUIREMENTS:**

1.1 Arizona follows the established Emergency Medical Services boundaries to identify regions. The four identified regions are Northern, Central, Southeastern, and Western Regions. See Appendix 3 for reference.

1.1.1 Central Region PHEP partners include: Gila County, Maricopa County, Pinal County, and Gila River Indian Community.

1.1.2 Northern Region PHEP partners include: Apache County, Coconino County, Navajo County, Yavapai County, Hopi Tribe, Navajo Nation, and White Mountain Apache Tribe.

1.1.3 Southeastern Region PHEP partners include: Cochise County, Graham County Greenlee County, Pima County, Santa Cruz County, Pascua Yaqui Tribe, San Carlos Apache Tribe, and Tohono O’Odham Nation.

1.1.4 Western Region PHEP partners include: La Paz County, Mohave County, Yuma County, Cocopah Tribe, Colorado River Indian Tribes, Fort Mohave Indian Tribe, Kaibab – Paiute Tribe, and Quechan Tribe.

**1.2 Partnership/Coalition Meetings (*Central, Northern, Southeastern, and Western Regions*)**

The designated Public Health Emergency Coordinator or representative will attend ADHS Healthcare Coalition meetings within their region. These meetings will provide an opportunity for collaboration with healthcare facilities, county, state, tribal, and other response partners. Partnerships/coalitions shall continue to plan and develop memoranda of understanding (MOU) to share assets, personnel and information. Coalition members shall maintain plans to unify ESF-8 management of healthcare during a public health emergency, and integrate communication with jurisdictional command in the area.

**1.3 Reporting**

Progress on these deliverables, performance measures, and activities conducted with funds from this grant will be reported in a timely manner for the Mid-Year and end of year report. These documents will be submitted to ADHS.

**1.4 Financial Requirements**

1.4.1 Performance

Failure to meet the deliverables and performance measures described in the Scope of Work may result in withholding from a portion of subsequent awards.

1.4.2 Match Requirement

The PHEP award requires a 10% “in-kind” or “soft” match from all the grant participants. Each recipient must include in their budget submission the format they will use to cover the match and method of documentation. Failure to include the match formula will preclude funding.

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1.4.3 Inventory

Provide by mid-year, a completed Inventory List to include all capital equipment (dollar amount above \$5000). Inventory list will be provided to ADHS.

1.4.4 Budget Spend Plan

Budget spend plans will be completed and submitted to ADHS after contractor signature. Your budget spend plan needs to be reviewed and approved by ADHS before funding is released.

1.4.5 Grant Activity Oversight

Maintain a full-time, part-time, or appointed public health emergency preparedness coordinator to have responsibility for oversight of all grant related activities. Preparedness coordinator to have responsibility for oversight of all grant related activities. Cooperate and coordinate with ADHS in completing on- site visits pursuant to, and in compliance with Standard Operating Procedures for Sub-Recipient Monitoring.

1.4.6 Employee Certifications

PHEP Recipients are required to adhere to all applicable federal laws and regulations, including OMB Circular A-87 and semiannual certification of employees who work solely on a single federal award. These certification forms must be prepared at least semiannually signed by the employee or a supervisory official having firsthand knowledge of the work performed by the employee. Employees that are split funded are required to maintain Labor Activity Reports (to be provided as requested). These certification forms must be retained in accordance with 45 Code of Federal Regulation, Part 92.42

1.4.7 Activities and Purchases

Activities conducted under and purchases made with this award will be kept specific to the deliverables outlined in this document. Other activities and purchases, in line with the CDC grant guidance for BP 2 or previous budget period deliverables may be allowed if assurances are made that all assigned deliverables for BP1 will be completed. Approval for this will be on a case by case basis and conducted by ADHS.

**1.5 Exercises**

1.5.1 Participate in the 2013-2014 ADHS Training and Exercise Planning Workshop. Provide the agency specific HSEEP compliant Training and Exercise Plan (TEP) to ADHS no later than September 6, 2013.

1.5.2 Support and participate in at least one ADHS sponsored HPP and PHEP/SNS exercises. Exercise participation and support activities may include exercise play, simulation, participation in communication pathways, partial or full activation of emergency operation centers, and participation in exercise design and evaluation meetings. Submit the After Action Reports (AARs) and Improvement Plans (IP) for each exercise to ADHS by June 10, 2014.

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## 1.6 Corrective Actions

Track and manage corrective actions identified in responses and exercises. Ensure after action reports (AAR) and improvement plans (IP) are generated for any public health emergency exercise or real world event in which the public health entity participates and has a role. After a standalone, DSNS drill an executive summary and an IP must be provided to the ADHS SNS Coordinator.

## 1.7 Emergency Notification System

Provide ADHS with an updated "County/Tribal Public Health Emergency Contact Information Sheet. This should include contact information for the primary, secondary, and tertiary individual for the Public Health Incident Management System (e.g. Incident Commander, Operations, etc.) The contact information for each individual shall include: ICS title, individual's name, non-emergency position title, office telephone number, mobile telephone number, home telephone number, and email address loaded into ADHS Health Service Portal by September 30.

## 2. CAPABILITIES:

### 2.1 Capability 1: Community Preparedness

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

- 2.1.1 Support the development of public health, medical and mental/behavioral health systems that support recovery
- 2.1.2 Participate in awareness training with community and faith-based partners on how to prevent, respond to, and recover from public health incidents
- 2.1.3 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
- 2.1.4 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
- 2.1.5 Identify those populations that may be at higher risk for adverse health outcomes
- 2.1.6 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)

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**2.1.7 Budget Period Short Term Goal:**

2.1.7.1 Goal 1. The State in collaboration with emergency management and homeland security will disseminate the Jurisdictional risk assessment for evaluation and analysis regarding risks to the public health. Local and Tribal health will develop a regional approach to address planning gaps.

2.1.7.2 Goal 2. Review written plans to ensure that they 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: 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.

**2.2 Capability 2: Community Recovery**

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

2.2.2 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.

**2.2.3 Budget Period Short Term Goal:**

Goal 1: Establish a statewide baseline for post-incident recovery and make recommendations for systemic improvement for the state of Arizona PHEP stakeholders by developing an assessment tool in order to evaluate healthcare system recovery, behavioral health care, and human services recovery needs, along with resource availability.

**2.3 Capability 3: Emergency Operations Coordination**

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

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**2.3.2 Budget Period Short Term Goal:**

2.3.2.1 **Goal 1:** ADHS will acquire situational awareness information in order to determine if and to what extent Health Emergency Operations Center (HEOC) activation is necessary in order to provide a statewide public health common operating picture. This short-term goal will demonstrate the ability of the HEOC to collect the essential elements of information from the Local Health Departments.

2.3.2.2 **Goal 2:** WebEOC access and the application will be extended to the 15 local Health Departments and any Tribes who request access to the application. This short-term goal will be measured by the execution of the WebEOC application with statewide partners.

2.3.2.3 **Goal 3:** Sustain the Health Emergency Operating Center (HEOC) functionality by ensuring competency in staff assembly times, training, and job specific functions.

**2.4 Capability 4: Emergency Public Information and Warning**

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

**2.4.2 Budget Period Short Term Goal:**

2.4.2.1 **Goal 1:** Leverage existing technologies to communicate with and inform the response partners and the general public during operational exercises, on-going drills, and responses. This short term goal will be measured and tracked through the documentation of drills and through the qualitative and quantitative evaluation of exercises and responses in After Action Reports and Improvement Plans (AAR/IPs).

2.4.2.2 **Goal 2:** Sustain the ability of state, local, and healthcare facility public information officers to coordinate, develop, and disseminate public information through the conducting of and evaluation of at least one operational exercise. The ability of public information officers to determine the need for public information systems establish and participate in information systems, and establish avenues for public interaction and exchange will be quantitatively and qualitatively evaluated in the context of an AAR/IP.

**2.5 Capability 5: Fatality Management**

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

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**2.5.2 Budget Period Short Term Goal:**

- 2.5.2.1 **Goal 1.** Identify specific roles and support functions between Arizona Department of Health, county Public Health, law enforcement, medical examiners, and private sector partners during a Fatality Management response.
- 2.5.2.2 **Goal 2.** Coordinate between internal and external partners to facilitate access to resources when demand on local jurisdiction exceeds capacity to support fatalities from an incident. Ensure resource request are in accordance with public health jurisdictional standards and practices and as requested by lead jurisdictional authority. This will result in the development and implementation of resource request process.
- 2.5.2.3 **Goal 3.** Survey county and tribal partners to identify training in support of Fatality Management operations to include: mental/behavioral health services, death notification, relief to families, and spiritual care. Utilization of a survey prior to and post training will measure increased knowledge.

**2.6 Capability 6: Information Sharing**

- 2.6.1 **Definition:** Information sharing is the ability to conduct multijurisdictional, multidisciplinary exchange of health-related information and situational awareness data among federal, state, local, territorial, and tribal levels of government, and the private sector.
- 2.6.2 **Maintain or Have Access to a Notification System**  
Jurisdictions shall maintain or have access to a notification system to share health updates and alerts, including epidemiological, clinical, and situational awareness data, with key healthcare partners.
- 2.6.3 **Provide Emergency Notification System Contact Information and Participate in Bimonthly Communications Drills.**  
Jurisdictions shall provide ADHS with emergency contact information sheets semi-annually and participate in Bimonthly Communication Drills. Drill results will be provided to ADHS after each drill.
- 2.6.4 **Budget Period Short Term Goal:**
  - 2.6.4.1 **Goal 1.** Conduct multi-jurisdictional and multi-disciplinary exchange of health related information and situational awareness with all County and Tribal and local ESF-8 partners statewide. This short-term goal will be measured by 8% increased membership to the interoperable communication systems such as the Health Alert Network.
  - 2.6.4.2 **Goal 2.** Disseminate accurate and appropriate information to the County and Tribal and local ESF-8 partners statewide. This goal will be measured by the development of an information generation/sharing protocol.

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## 2.7 Capability 7: Mass Care

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

### 2.7.2 Budget Period Short Term Goal:

2.7.2.1 **Goal 1.** Determine the jurisdictional public health roles and responsibilities in conjunction with Emergency Support Function 6, 8, and 11 partners. . Consolidation of information will result in the completion of a statewide plan that will support Mass care operations.

2.7.2.2 **Goal 2.** In conjunction with state and local partners, including emergency management and Red Cross collaborate to identify a tool for health screening of individuals during shelter operations. Some elements of the tool may be, immediate medical needs, mental health needs, sensory impairment or other disability, medication use, need for assistance with activities of daily living, and substance abuse. The outcome will be a recommendation to the Emergency Preparedness Task Force for inclusion in a standard operating procedure for the intake process during shelter operations and the clarification of the request process for needed supplies in support of shelter operations for access and functional needs..

## 2.8 Capability 8: Medical Countermeasure Dispensing

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

### 2.8.2 Budget Period Short Term Goal:

2.8.2.1 **Goal 1.** ADHS, County, and Tribal partners will meet quarterly to share best practices and lessons learned from Exercises for the rapid dispensing of medical countermeasures during a public health emergency. Collaborative review will occur during the Arizona Local Public Health Emergency Response Association (ALPHERA) and Regional Coalition meetings. By the end of BP2, all County, State, and Tribal plans will have been reviewed in their entirety.

2.8.2.2 **Goal 2.** Coordination between SNS Coordinator and epidemiological staff will streamline the incorporation of investigation data into the SNS request process.

#### 2.8.2.2.1 Develop or Update Medical Countermeasure Dispensing Plans

Written plans should include: standard operating procedures that provide guidance to identify the medical countermeasures required for the incident or potential incident; protocols to request, receive, distribute,

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dispense, and manage medical countermeasures within 48 hours of request. Planning should include all memoranda of understandings or other letters of agreement with state/local/tribal partners; and 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. Update/ revise SNS Plans based upon training improvements, quarterly meeting notes, identified threats and regional risk assessments, partner involvement and post plans onto ADHS Health Service Portal.

**2.9 Capability 9: Medical Materiel Management & Distribution**

2.9.1 **Definition:** 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.

**2.9.2 Budget Period Short Term Goal:**

2.9.2.1 **Goal 1:** ADHS, County, and Tribal partners will meet quarterly to share best practices and lessons learned from Exercises for Medical Materiel Management and Distribution of medical countermeasures during a public health emergency. Collaborative review will occur during the Arizona Local Public Health Emergency Response Association (ALPHERA) and Regional Coalition meetings. By the end of BP2, all County, State, and Tribal plans will have been reviewed in their entirety.

2.9.2.2 **Goal 2:** Collaborate with the Arizona Board of Pharmacy (AZBP) to develop a query protocol of pharmacies during a public health emergency. The protocol will support ADHS in determining the current standard inventory of medical countermeasures and will allow for streamlined request of medical countermeasures. By the end of BP2, the protocol will be an annex to ADHS SNS Plan.

Participate in Inventory Management System quarterly drills in support of medical material management and distribution of medical countermeasures.

**2.9.3 Drill Requirement**

Each County will conduct at least two different SNS drills utilizing the Target Metric template provided by DSNS/ADHS. An executive summary and improvement plan must be submitted for each drill. Jurisdictions shall provide ADHS with the Target Metrics by January 10, 2014 and April 25, 2014 respectively.

2.9.3.1 Staff notification, acknowledgement and assembly

2.9.3.2 Site activation: notification, acknowledgement and assembly

2.9.3.3 Facility Setup

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2.9.3.4 Pick List Generation

2.9.3.5 Dispensing Throughput

**2.9.4 Cities Readiness Initiative (CRI) Drill Requirement**

Each CRI will conduct at least three different SNS drills utilizing the Target Metric template provided by DSNS/ADHS. An executive summary and improvement plan must be submitted for each drill. Jurisdictions shall provide ADHS with the Target Metrics by January, 10, 2014, and April 25, 2014 respectively.

2.9.4.1 Staff notification, acknowledgement and assembly

2.9.4.2 Site activation: notification, acknowledgement and assembly

2.9.4.3 Facility Setup

2.9.4.4 Pick List Generation

2.9.4.5 Dispensing Throughput

2.9.4.6 Public Health Decision Making Tool

**2.10 Capability 10: Medical Surge**

2.10.1 **Definition:** Medical surge is the ability to provide adequate medical evaluation and care during events that exceed the limits of the normal medical infrastructure of an affected community. It encompasses the ability of the healthcare system to survive a hazard impact and maintain or rapidly recover operations that were compromised.

**2.10.2 Budget Period Short Term Goal:**

2.10.2.1 **Goal 1.** Coordinate jurisdiction's healthcare response through the collection and analysis of health data to define the needs of the incident and available healthcare staffing and resources. This will be measured by the results of monthly communication drills, and expansion of data being requested during Medical Surge exercises/operations.

2.10.2.2 **Goal 2.** As part of the regional Health Care Coalitions, help define public health role and the processes to obtain information relating to situational awareness in support of medical surge operations. This process will be tested in exercises during BP2.

**2.11 Capability 11: Non-Pharmaceutical Interventions**

2.11.1 **Definition:** Non-pharmaceutical interventions are the ability to recommend to the applicable lead agency (if not public health) and implement, if applicable, strategies for disease, injury, and exposure control. Strategies include the following:

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2.11.1.1 Isolation and quarantine

2.11.1.2 Restrictions on movement and travel advisory/warnings

2.11.1.3 Social distancing

2.11.1.4 External decontamination

2.11.1.5 Hygiene

2.11.1.6 Precautionary protective behaviors

**2.11.2 Budget Period Short Term Goal:**

2.11.2.1 **Goal 1.** Maintain and enhance existing plans to address NPIs for multiple incidents. Communication plans will be updated and/or maintained to share intervention activities with partners and the public. Plans will also include processes to address vulnerable populations as well as procedures to enable the scalable implementation of the intervention

**2.12 Capability 13: Public Health Surveillance and Epidemiological Investigation**

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

Local public health partners should maintain the capacity for surveillance, investigation, and control of infectious diseases and public health incidents. Partners should work with ADHS to accomplish these functions if capacity is limited at the local level.

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

Written plans should include processes and protocols to gather and analyze data from 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.

**2.12.2 Participate in State Testing of the Communicable Disease On-call System**

Jurisdictions shall participate in tests of the communicable disease on-call system, and shall ensure that sufficient staff are identified and trained to participate in all system tests.

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- 2.12.3 Provide ADHS Staff with Contact Information for MEDSIS Liaison Semi-annually**  
Jurisdictions shall provide ADHS staff with contact information for the MEDSIS liaison on a semi-annual (every 6 months) basis. MEDSIS liaison responsibilities include requesting/approving new users and notifying ADHS when users no longer require access. The MEDSIS liaison shall also participate in the MEDSIS quarterly meetings. Arizona utilizes MEDSIS to conduct reportable disease surveillance.
- 2.12.4 Conduct Outreach to Delayed Reporters**  
Jurisdictions shall conduct outreach to delayed reporters (entities reporting cases of disease later than timeframes allowed by Arizona Administrative Code). Delayed reporters can be identified through quarterly timeliness reports generated by ADHS or county-specific surveillance systems. Report on the percentage of delayed reporters educated about timeliness of reporting.
- 2.12.5 Participate in Epidemiology Trainings and Exercises**  
Jurisdictions shall participate in the Epidemiology Surveillance and Capacity (ESC) meetings (at least 10 out of 12), "How to" Presentations (at least 80%) and the Arizona Infectious Disease Training and Exercise. Attendance will be monitored by ADHS for use in grant reporting.
- 2.12.6 Conduct Investigations of Reported Urgent Diseases and Public Health Incidents**  
Investigation actions should include the following as necessary: case identification, specimen collection, case investigation/characterization, and control measure implementation.
- 2.12.7 Report All Identified Outbreaks Within 24 Hours**  
Jurisdictions shall Report all of identified outbreaks to ADHS within 24 hours; include documentation on outbreak investigation activities as part of your mid-year and end-of-year reports to ADHS. At a minimum, include the information identified in Appendix 1.
- 2.12.8 Submit Outbreak Summaries to ADHS**  
Outbreak summaries must be submitted to ADHS within 30 days of outbreak closure for all outbreaks investigated.
- 2.12.9 Initiate Control Measures within the Appropriate Timeframe**  
Indicate time of control measure initiation in the case management screen of MEDSIS. If MEDSIS case management screen is unavailable, document control measure timeliness in a data collection tool. See Appendix 2 for details related to control measure initiation and selected diseases.
- 2.12.10 Develop a plan to address and/or identify non-reporters**  
Local jurisdictions shall develop a brief plan to identify non-reporters and provide outreach to these reporters. (i.e., review all healthcare facilities in the jurisdiction and cross-check with cases reported in MEDSIS to identify non-reporters.)
- 2.12.11 Complete monthly performance measure report form**  
Jurisdictions shall complete the monthly PHEP performance measure report form distributed by ADHS for use in identifying gaps in timeliness of reporting and monitoring outbreaks in

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the jurisdiction. Performance measure report information will be utilized for mid-year and end-of-year grant reporting.

**2.12.12 Budget Period Short Term Goal:**

2.12.12.1 **Goal 1.** Maintain and enhance public health informatics infrastructure, including the state- wide electronic disease reporting system (MEDSIS), electronic laboratory reporting and syndromic surveillance systems to allow state and local-level epidemiologists to better collect data, track health events and analyze disease trends. This goal will be measured by the number of reports generated using the various surveillance systems, the integration of a new outbreak module into MEDSIS and the increase in the number of laboratories reporting electronically to ADHS.

2.12.12.2 **Goal 2.** Create and maintain protocols for investigation and communication and provide monthly trainings to improve the ability of health departments in Arizona to identify outbreaks and determine the source of infection or exposure. Goal measured by the number of trainings held throughout the grant period, the number of investigations initiated and by the percent of epidemiologists meeting CSTE Epidemiology Tier 1 core competencies.

**2.13 Capability 14: Responder Safety and Health**

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

**2.13.2 Budget Period Short Term Goal:**

2.13.2.1 **Goal:** Conduct gap assessment to determine the percent of healthcare coalitions that have systems and processes in place to preserve healthcare system functions to protect the coalition member employees (including non-healthcare).

**2.14 Capability 15: Volunteer Management**

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

**2.14.2 Budget Period Short Term Goal:**

2.14.2.1 **Goal:** Enhance the Volunteer Response Program for the members of the Healthcare Coalitions and volunteer organizations by developing updated plans, guidelines, forms and training as well as promote the utilization of the State Volunteer Management System (ESAR-VHP) at the local level to increase the credentialed volunteer database by 8%. The outcome will be measured by

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increased revised/updated plans, new standard operating procedures, and forms for healthcare coalitions, ESF 8 partners, and local volunteer organizations for volunteer management and increased utilization of the AZ ESAR-VHP database for all volunteer organizations in Arizona.

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**Table 1- Deliverables “At a Glance”**

PROGRAM REQUIREMENTS APPLICABLE TO ALL PARTNERS	
1	<b>Partnership/Coalition Meetings Attendance:</b> Designated PHEP Coordinator or representative will attend meetings within their region
2	<b>Reporting:</b> Mid-Year and End of Year Reports
3	<b>Financial Requirements:</b> Performance, Match Requirement, Inventory, Budget Spend Plan, Grant Activity Oversight, Employee Certifications, Activities and Purchases
4	<b>Exercises:</b> Participate in the 2013-2014 ADHS Training and Exercise Plan Workshop, Provide ADHS agency specific HSEEP TEP no later than September 6, 2013
5	<b>Exercises:</b> Conduct and Participate in at least one ADHS Sponsored HPP and PHEP/SNS Program Exercises and Public Health.
6	<b>Exercises:</b> Submit at Least One After Action Report from HSEEP Compliant Exercise or Real Event to ADHS by June 10, 2014
7	<b>Corrective Actions:</b> Develop and maintain Tracking Tool for AAR/IPs
GOALS/OBJECTIVES	
1	<b>Community Preparedness:</b> Local and Tribal health will develop a regional approach to address planning gaps identified
	<b>Community Preparedness:</b> Review/update written plans to ensure they include policy and process to participate in partnerships representing at least the 11 identified community sectors
2	<b>Community Recovery:</b> Evaluate healthcare system, behavioral health care and human services recovery needs, along with resource availability.
3	<b>Emergency Operations Coordination:</b> Local Health Departments gain access to WebEOC for their identified key staff
4	<b>Emergency Public Information:</b> Conduct regularly scheduled, ongoing communications drills with ADHS to ensure equipment and staff are ready for real-world responses
5	<b>Fatality Management:</b> Identify specific roles and functions during a Fatality Management response
6	<b>Information Sharing:</b> Provide Emergency Notification System Contact Information and Participate in System Tests
7	<b>Mass Care:</b> Identify Local Health roles and responsibilities to provide health services, and shelter services during a mass care incident

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8	<b>Medical Countermeasure Dispensing:</b> Meet with ADHS SNS Coordinator quarterly to review Medical Countermeasure Dispensing Plans for the alignment of State and Local deployment of medical countermeasures
	<b>Medical Countermeasure Dispensing Drills Non-CRI:</b> Each County conduct at least two different SNS drills provide ADHS the target metrics by January 10, 2014 and April 25, 2014
	<b>Medical Countermeasure Dispensing CRI:</b> Cities Readiness Initiative (CRI) Drill requirement, Each County conduct at least three different SNS drills provide ADHS the target metrics by January 10, 2014 and April 25, 2014
9	<b>Medical Materiel Management &amp; Distribution:</b> Participate in ADHS quarterly inventory Management System drills
10	<b>Medical Surge:</b> Participate in ADHS monthly communication drills with healthcare system partners
10	<b>Medical Surge:</b> Assist Coalition in developing processes for obtaining coalition-level situational awareness
11	<b>Non-Pharmaceutical Interventions:</b> Review plans to ensure the address NPIs for multiple incidents, updated plans as required to share intervention activities with partners and the public
13	<b>Public Health Surveillance and Epidemiological Investigation:</b> Participate in State testing of the communicable disease on-call system- Counties Only
	<b>Public Health Surveillance and Epidemiological Investigation:</b> Provide ADHS Staff with Contact Information for MEDSIS Liaison Semi-annually
	<b>Public Health Surveillance and Epidemiological Investigation:</b> Conduct outreach to delayed reporters (entities reporting cases of disease later than timeframes allowed by Arizona Administrative Code)- Counties Only
	<b>Public Health Surveillance and Epidemiological Investigation:</b> Participate in at least 80% of the Epidemiological Surveillance and Capacity meetings
	<b>Public Health Surveillance and Epidemiological Investigation:</b> Conduct investigations of reported urgent diseases and public health incidents.
	<b>Public Health Surveillance and Epidemiological Investigation:</b> Report All Identified Outbreaks within 24 Hours (see Appendix 1)

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	<b>Public Health Surveillance and Epidemiological Investigation:</b> Submit Outbreak Summaries to ADHS (within 30 Days of Outbreak Closure for all Outbreaks Investigated)
	<b>Public Health Surveillance and Epidemiological Investigation - Mitigation Actions:</b> Initiate Control Measures within the Appropriate Timeframe (see Appendix 2)
14	<b>Responder Safety and Health:</b> Complete a gap assessment survey to identify system and processes in place to preserve and maintain healthcare system functions and provide an inventory of Personal Protective Equipment.
15	<b>Volunteer Management:</b> Complete a volunteer needs assessment provided by ADHS which will include, identification of situations that would necessitate the need for volunteers in healthcare organizations, estimations of the anticipated volunteers, resource needs, identification of the health professional roles and known liability issues.

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APPENDIX 1

Outbreaks include all notifiable cases and clusters, but should exclude: conjunctivitis, strep throat/group A streptococcal infection, influenza-like illness, RSV, lice, scabies, HIV, STD, and TB.

**Outbreak Reporting Table – July 1, 2013-June 30, 2014:**

# of outbreak reports received	# of outbreaks investigated	# of outbreaks with specimens collected (human or animal)	# of outbreak investigations with reports generated	# of outbreak investigations with complete reports or summary forms submitted to ADHS

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APPENDIX 2

1. Initiation of control measures can include:
  - 1.1 Initiation of an appropriate control measure
  - 1.2 A recommendation for initiation of a control measure
  - 1.3 A decision not to initiate or recommend a control measure
  - 1.4 Documented inability to initiate a control measure despite an effort to do so
  
2. Selected reportable diseases include: Botulism, Shiga toxin-producing *E. coli*, Hepatitis A, Measles, Meningitis, Tularemia: reference appendix 2 for table of control measures and initiation timeframes requirements.

**Public Health Control Measures and Timeframes:**

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

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APPENDIX 3

<b>CENTRAL REGION</b>
<b>County</b>
<b>GILA</b>
<b>MARICOPA</b>
<b>PINAL</b>
<b>Tribal</b>
<b>GILA RIVER INDIAN COMMUNITY</b>
<b>NORTHERN REGION</b>
<b>County</b>
<b>APACHE</b>
<b>COCONINO</b>
<b>NAVAJO</b>
<b>YAVAPAI</b>
<b>Tribal</b>
<b>HOPI TRIBE</b>
<b>NAVAJO NATION</b>
<b>WHITE MOUNTIAN APACHE TRIBE</b>
<b>SOUTHERN REGION</b>
<b>County</b>
<b>COCHISE</b>
<b>GRAHAM</b>
<b>GREENLEE</b>
<b>PIMA</b>
<b>SANTA CRUZ</b>
<b>Tribal</b>
<b>PASCUA YAQUI TRIBE</b>
<b>SAN CARLOS APACHE TRIBE</b>
<b>TOHONO O'ODHAM NATION</b>

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**WESTERN REGION**

**County**

**LA PAZ**

**MOHAVE**

**YUMA**

**Tribal**

**COCOPAH TRIBE**

**COLORADO RIVER INDIAN TRIBES**

**FORT MOJAVE INDIAN TRIBE**

**KAIBAB - PAIUTE TRIBE**

**QUECHAN TRIBE**