	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. **3**	Procurement Specialist Cindy Sullivan

Emergency Preparedness Program

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

1. Effective July 1, 2012, replace the Price Sheet, Page Two (2), of Amendment Two (2), with the Price Sheet, of this Amendment Three (3), Page Two (2). The total Price Sheet, effective with this Amendment Three (3), is $166,738.00.

2. Effective July 1, 2012, replace Attachment A, of the original Contract, Pages Fifteen (15) through Twenty (20), with Attachment A, Pages Three (3) through Fifteen (15), of this Amendment Three (3).

All other provisions of this agreement remain unchanged.

Gila County Health and Emergency Services
Contractor Name

5515 S. Apache Ave, Suite 400
Address

Globe AZ 85501
City State Zip

CONTRACTOR SIGNATURE

Tommie C. Martin
Contractor Authorized Signature

Tommie C. Martin
Printed Name

Chairman, Board of Supervisors
Title

10/9/12

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.

10/9/2012
Signature Date

Bryan B. Chambers
Printed Name

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 25th **day of** October **20** 12

Christine Ruth
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.

Laura Flores 10-22-12
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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PRICE SHEET
Gila County

Cost Reimbursement

Description	Quantity	Unit Rate	Extended Price
CDC Deliverables for Public Health Emergency Preparedness - PHEP	1	$166,738.00	$ 166,738.00
Total			**$ 166,738.00**

FY 12-13

Public Health Emergency Preparedness Deliverables

BP1
Budget Year 2012-2013

Tier Definitions[1]

Tier I:
Allocation of
$300,000.00 and up

Tier II:
Allocation of
$150,000.00 to $299,999.99

Tier III:
Allocation of
$50,000.00 to $149,999.99

Tier IV:
Allocation of
$0.01 to $49,999.99

A. PROGRAM REQUIREMENTS:

1. Partnership/Coalition Meetings *(Northern, Central, Western, and Southern Regions)*:
The designated Public Health Emergency Coordinator or representative shall attend ADHS Healthcare Coalition meetings within their region. These meetings shall 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.

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

3. Financial Requirements

   3.1 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;

   3.2 Match Requirement: The PHEP award requires a 10% "in-kind" or "soft" match from all the Grant participants. Each recipient shall include in their budget submission the format they shall use to cover the match and method of documentation. Failure to include the match formula shall preclude funding;

   3.3 Inventory: Provide by mid-year, a completed Inventory List to include all capital equipment (dollar amount above $5,000). Inventory list shall be provided to ADHS;

   3.4 Budget Spend Plan: Budget spend plans shall 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;

   3.5 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;

   3.6 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 shall 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 shall be retained in accordance with 45 Code of Federal Regulation, Part 92.42; and

   3.7 Alignment of Activities and Purchases: Activities conducted under and purchases made with this award shall be kept specific to the deliverables outlined in this document. Other activities and purchases, in line with the CDC grant guidance for BP 1 or previous budget period deliverables may be allowed if assurances are made that all assigned deliverables for BP1 shall be completed. Approval for this shall be on a case by case basis and conducted by ADHS.

4. Exercises

   4.1 Participate in the 2012-2013 ADHS Training and Exercise Planning Workshop. Provide the agency specific HSEEP compliant Training and Exercise Plan (TEP) to ADHS no later than October 14, 2012; and

4.2 Support and participate in at least two (2) 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, 2013.

5. Corrective Actions:
Track and manage corrective actions identified in responses and exercises. Ensure after action reports AAR and 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 shall be provided to the ADHS SNS Coordinator.

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

B. CAPABILITY REQUIREMENTS:

1. Capability 1: Community Preparedness

1.1 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:

1.1.1 Conduct a Jurisdictional Risk Assessment: The jurisdictional risk assessment, at a minimum, shall address:

1.1.1.1 Organization objectives and priorities for response based on the Hazard Vulnerability Assessment and Risk assessment,

1.1.1.2 Include the needs of at-risk and vulnerable individuals,

1.1.1.3 Identify priority healthcare assets and essential services,

1.1.1.4 Estimates of anticipated number of casualties that contribute to surge and fatality management planning,

1.1.1.5 Existing inputs from emergency management risk assessment data, health department programs, community engagements, and other applicable sources, that identify and prioritize jurisdictional hazards and health vulnerabilities,

1.1.1.6 Potential hazards, vulnerabilities, and risks in the community related to the public health, medical, and mental/behavioral health systems,

1.1.1.7 The relationship of these risks to human impact, interruption of public health, medical, and mental/behavioral health services, and

1.1.1.8 The impact of those risks on public health, medical, and mental/behavioral health infrastructure.

2. Capability 5: Fatality Management

2.1 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; and

2.2 Develop/Update Written Plans to Include: Processes and protocols developed in conjunction with jurisdictional mental/behavioral health partners to identify services to provide to survivors after an incident involving fatalities. Written plans shall include a contact list of pre-identified resources that shall provide mental/behavioral health support to responders and families according to the incident. Consideration shall be given to the inclusion of the following elements:

2.2.1 Mental/behavioral health professionals,

2.2.2 Spiritual care providers,

2.2.3 Hospices,

2.2.4 Translators, and

2.2.5 Embassy and Consulate representatives when international victims are involved.

3. Capability 6: Information Sharing

3.1 Definition: Information sharing is the ability to conduct multijurisdictional, multidisciplinary exchange of health-related information and situational awareness data among federal, State, County, local, territorial, and tribal levels of government, and the private sector;

3.2 Written plans shall include a protocol for the development of public health alert messages that include the following elements:

3.2.1 Time sensitivity of the information,

3.2.2 Relevance to public health,

3.2.3 Target audience,

3.2.4 Security level or sensitivity,

3.2.5 The need for action may include:

3.2.5.1 Awareness,

3.2.5.2 Request a response back, and

3.2.5.3 Request that specific actions be taken.

3.3 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

3.4 Provide Emergency Notification System Contact Information and Participate in System Tests
Jurisdictions shall provide ADHS with emergency contact information sheets semi-annually and participate in system tests twice a year. Test results shall be provided to ADHS.

4. Capability 8: Medical Countermeasure Dispensing

4.1 Definition: Medical countermeasure dispensing is the ability to provide medical countermeasures including, but not limited to, vaccines, antiviral drugs, antibiotics, and antitoxin in support of treatment or prophylaxis (oral or vaccination) to the identified population in accordance with public health guidelines and/or recommendations.

4.2 Develop or Update Medical Countermeasure Dispensing Plans
Written plans shall include: Standard operating procedures that provide guidance to identify the medical countermeasures required for the incident or potential incident; protocols to request additional medical countermeasures, including memoranda of understanding or other letters of agreement with State/local partners; and written agreements, for example, 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.

4.3 Cities Readiness Initiative (CRI) Drill Requirement
Conduct at least three (3) different SNS drills utilizing the Target Metric template provided by DSNS/ADHS. An executive summary and improvement plan shall be submitted for each drill. One (1) of the three (3) drills shall be the ADHS Sponsored DSNS Inventory Resource Management System drill. Jurisdictions shall provide ADHS with the Target Metrics by January 13, 2013 and June 15 2013 respectively. The remaining two (2) drills, which shall be completed by June 30, 2013, can be selected from the listing below:

4.3.1 Dispensing through-put data collection from exercise with specified CDC-identified metrics or virtual practice using CDC Real Opt Data Collection Program,

4.3.2 Timed Point of Dispensing (POD) set up per County Plan (Facility Set-up): to receive credit from the CDC a completed Excel-based spreadsheet (provided by the SNS Coordinator) shall be submitted to ADHS,

4.3.3 Staff Notification, Acknowledgement and Assembly, and

4.3.4 Resource Allocation game.

4.4 Drill Requirement
Tier I and Tier II jurisdictions are required to participate in the ADHS Sponsored DSNS Inventory Resource Management System Drill. These public health jurisdictions shall also conduct at least one (1) DSNS drill utilizing the Target Metric template provided by DSNS/ADHS. This drill may be conducted in conjunction with a larger exercise or on its own. The associated data tool shall be completed and provided to ADHS by June 30 2013, selected from the listing below:

4.4.1 Dispensing through-put data collection from exercise with specified CDC-identified metrics or virtual practice using CDC Real Opt Data Collection Program,

4.4.2 Timed Point of Dispensing (POD) set up per County Plan (Facility Set-up): to receive credit from the CDC a completed Excel-based spreadsheet (provided by the SNS Coordinator) shall be submitted to ADHS,

4.4.3 Staff Notification, Acknowledgement and Assembly, or

4.4.4 Resource Allocation game.

4.5 Drill Requirement
Tier III partners that plan to establish point(s) of dispensing in an emergency, shall conduct one (1) DSNS drill utilizing the Target Metric template provided by DSNS/ADHS by October 9, 2012. One (1) of the following drills shall be performed:

4.5.1 Dispensing through-put data collection,

4.5.2 Decision Making Assessment Tool,

4.5.3 Facility Set Up, or

4.5.4 Pick List Generation.

5. Capability 10: Medical Surge

5.1 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; and

5.2 Written Plans in Support of Medical Surge will be Developed or Updated
Plans shall include: documentation of staff assigned (and training in advance) to fill public health incident management roles as applicable to a given response; process to engage in healthcare coalitions and understand the role that each coalition partner shall play, to obtain situational awareness; documentation of process or protocol for how the health agency shall access volunteer resources through the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) and the Medical Reserve Corps program of credentialed personnel available for assistance during an incident.

6. Capability 13: Public Health Surveillance and Epidemiological Investigation

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

Electronic exchange of personal health information shall 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 shall include processes and protocols to gather and analyze data from reportable condition surveillance including, but not limited to, conditions for which jurisdictional law mandates name-based case reporting to public health agencies. Jurisdictions shall plan to receive Electronic Laboratory Reporting for reportable conditions from healthcare providers using national Meaningful Use standards.

6.2 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;

6.3 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. Arizona utilizes MEDSIS to conduct reportable disease surveillance;

6.4 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;

6.5 Validate Communicable Disease Reporting
Jurisdictions shall validate communicable disease reporting using hospital discharge and mortality surveillance databases. Jurisdictions shall follow up with non-reporters identified and develop educational plans to address any reporting gaps identified;

6.6 Conduct Investigations of Reported Urgent Diseases and Public Health Incidents
Investigation actions shall include the following as necessary: case identification, specimen collection, case investigation/characterization, and control measure implementation;

6.7 Report All Identified Outbreaks Within 24 Hours
Jurisdictions shall Report all identified outbreaks to ADHS within twenty-four (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 of Attachment A;

6.8 Submit Outbreak Summaries to ADHS
Outbreak summaries shall be submitted to ADHS within thirty (30) days of outbreak closure for all outbreaks investigated; and

6.9 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 of Attachment A for details related to control measure initiation and selected diseases.

7. Capability 15: Volunteer Management

7.1 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;

7.2 Develop/Update Volunteer Management Plans
Written plans shall address anticipated volunteer needs in response to incidents, situations identified in the jurisdictional risk assessment including the following elements:

7.2.1 Identification of functional roles,

7.2.2 Skills, knowledge, or abilities needed for each volunteer task or role,

7.2.3 Description of when the volunteer actions shall happen,

7.2.4 Identification of jurisdictional authorities that govern volunteer liability issues and scope of practice,

7.2.5 Written plans shall include Memoranda of understanding or other letters of agreement with jurisdictional volunteer sources

7.2.6 Partnership agreements shall include plans for the following:

7.2.6.1 Partner organizations' promotion of public health volunteer opportunities,

7.2.6.2 Referral of all volunteers to register with jurisdictional Medical Reserve Corps and/or ESAR-VHP,

7.2.6.3 Policies for protection of volunteer information, including destruction of information when it is no longer needed,

7.2.6.4 Liability protection for volunteers,

7.2.6.5 Efforts to continually engage volunteers through routine community health activities, and

7.2.6.6 Documentation of the volunteer's affiliations at local, State, and federal levels, and provision for registered volunteer identification cards denoting volunteers' area of expertise.

Table 1- Deliverables "At a Glance"

	PROGRAM REQUIREMENTS for BP1	Tier 1	Tier 2	Tier 3	Tier 4
1	**Partnership/Coalition Meetings Attendance**	X	X	X	X
2	**Reporting:** Mid-Year and End of Year Reports	X	X	X	X
3	**Financial Requirements:** Performance, Match Requirement, Inventory, Budget Spend Plan, Grant Activity Oversight, Employee Certifications, Alignment of Activities and Purchases	X	X	X	X
4	**Exercises:** Participate in the 2012-2013 ADHS Training and Exercise Plan Workshop	X	X	X	X
5	**Exercises:** Conduct and Participate in ADHS Sponsored HPP and PHEP/SNS Program Exercises and Public Health for a Minimum of Two (2) Exercises.	X	X	X	X
6	**Exercises:** Submit at Least One (1) After Action Report from HSEEP Compliant Exercise or Real Event	X	X	X	
7	**Corrective Actions:** Develop and maintain Tracking Tool for AAR/IPs	X	X	X	X
	CAPABILITY REQUIREMENTS	**Tier 1**	**Tier 2**	**Tier 3**	**Tier 4**
8	**Community Preparedness:** Submit Jurisdictional Risk Assessment	X	X	X	X
9	**Fatality Management:** Develop/Update Written Plans	X	X	X	X
10	**Information Sharing:** Develop/Update Written Plans to Exchange Information to Determine a Common Operating Picture	X	X	X	X
11	**Information Sharing:** Maintain or Have Access to a Notification System	X	X	X	X
12	**Information Sharing:** Provide Emergency Notification System Contact Information and Participate in System Tests.	X	X	X	
13	**Medical Countermeasure Dispensing:** Develop or Update Medical Countermeasure Dispensing Plans	X	X	X	X
14	**Medical Countermeasure Dispensing:** Cities Readiness Initiative (CRI) Drill requirement	X			

15	**Medical Countermeasure Dispensing:** Drill Requirement	X	X	X	
16	**Medical Surge:** Written Plans in support of Medical Surge shall be developed or updated	X	X		
17	**Public Health Surveillance and Epidemiological Investigation:** Participate in State testing of the communicable disease on-call system- Counties Only	X	X	X	
18	**Public Health Surveillance and Epidemiological Investigation:** Provide ADHS Staff with Contact Information for MEDSIS Liaison Semi-annually	X	X	X	
19	**Public Health Surveillance and Epidemiological Investigation:** Conduct outreach to delayed reporters (entities reporting cases of disease later than timeframes allowed by Arizona Administrative Code)- Counties Only	X			
20	**Public Health Surveillance and Epidemiological Investigation:** Validate Communicable Disease Reporting using Hospital Discharge and Mortality Databases- Counties Only	X	X		
21	**Public Health Surveillance and Epidemiological Investigation:** Conduct investigations of reported urgent diseases and public health incidents.	X	X	X	X
22	**Public Health Surveillance and Epidemiological Investigation** : Report All Identified Outbreaks within twenty-four (24) Hours (see Appendix 1)	X	X	X	
23	**Public Health Surveillance and Epidemiological Investigation:** Submit Outbreak Summaries to ADHS (within thirty (30) Days of Outbreak Closure for all Outbreaks Investigated)	X	X	X	

24	**Public Health Surveillance and Epidemiological Investigation - Mitigation Actions:** Initiate Control Measures within the Appropriate Timeframe (see Appendix 2)	X	X	X	
25	**Volunteer Management:** Develop/Update Volunteer Management Plan	X	X	X	X

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, 2012-June 30, 2013:

# 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

APPENDIX 2

- Initiation of control measures can include:
  - Initiation of an appropriate control measure
  - A recommendation for initiation of a control measure
  - A decision not to initiate or recommend a control measure
  - Documented inability to initiate a control measure despite an effort to do so

- 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:

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