	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. **8**	Procurement Officer Ana Shoshtarikj

Emergency Preparedness Program

Effective July 1, 2015, it is mutually agreed that the Intergovernmental Agreement referenced is amended as follows:

1. Replace Amendment Six (6) Price Sheet, with Price Sheet of this Amendment Eight (8). The Total Price Sheet amount for FY16 is **$200,419.00**

2. Replace Amendment Six (6) Attachment A with Attachment A, Budget Period Four (4), County Requirements and Deliverables Document of this Amendment Eight (8).

All other provisions of this agreement remain unchanged.

Gila County Health Department Contractor Name	**CONTRACTOR SIGNATURE** Contractor Authorized Signature
5515 S Apache Ave, Suite 400 Address	Michael A. Pastor Printed Name
Globe AZ 85501 City State Zip	Chairman, 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. Signature Date Jefferson R. Dalton, Deputy Gila County Attorney, Civil Bureau Chief 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 _____ day of _____ 20_____ Procurement Officer
Attorney General Contract No. P00120143000078**,** 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. Signature Date Assistant Attorney General Printed Name:	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.**

PRICE SHEET

Budget Period Four (4)

July 1, 2015 – June 30, 2016

Fixed Price

Description	Quantity	Unit Rate	Total Amount
CDC Deliverables for Public Health Emergency Preparedness - PHEP	1	$200,419.00	**$200,419.00**

ATTACHMENT A

PUBLIC HEALTH EMERGENCY PREPAREDNESS (PHEP)

COUNTY REQUIREMENTS & DELIVERABLES DOCUMENT

Budget Period Four (BP4)

Period of Performance:
(July 1, 2015 – June 30, 2016)

1. **INTRODUCTION**

1.1 Approaching Budget Period Four (BP4), July 1st, 2015 through June 30th, 2016, continuous efforts are made to expand the preparedness capabilities based on the Five (5) Year Plan and the Capability Planning Guide (CPG) data. Based on the above, and the guidance set forth by the Center for Disease Control (CDC), Arizona Department of Health Services (ADHS) has developed the Requirement and Deliverable Document for the Counties.

1.2 The first section of this document outlines the requirements set forth by CDC and ADHS that all County partners will need to address to ensure they are met during BP4. The County Deliverables section covers the expected goals, objectives and outcomes for each capability within BP4. Progress on these goals and objectives will be measured throughout the year, through frequent communication and mid-year reporting.

1.3 Deliverables Table and Appendix One (1) incorporated herein, provide additional information for the County partners.

2. **PROGRAM REQUIREMENTS**

As a recipient of PHEP funds from the Arizona Department of Health Services (ADHS), you are required to adhere to Federal and State grant requirements. Below you will find a list of the program requirements for the PHEP grant.

3. **GRANT MEETINGS**

3.1 Grantee shall attend the following ADHS Sponsored Grant Meetings (two (2) events annually):

3.1.1 Attend semi-annual ADHS sponsored All-Partners Workshop;

3.1.2 Attend Regional ADHS sponsored Business Meeting

3.2 ADHS will hold one (1) business meeting in each of the four (4) Healthcare Coalition Regions within the State.

4. **HEALTHCARE COALITION MEETING**

4.1 Grantee shall participate in quarterly Healthcare Coalition meetings in the appropriate region. Regions are divided as follows:

4.1.1 **Northern Region**

4.1.1.1 County Representatives: Apache County, Coconino County and Navajo County;

4.1.1.2 Tribal Representatives: Hopi Tribe, Kaibab-Paiute Tribe and Navajo Nation.

4.1.2 **Western Region**

4.1.2.1 County Representatives: La Paz County, Mohave County and Yavapai County;

4.1.2.2 Tribal Representatives: Colorado River Indian Tribe and Fort Mojave Indian Tribe.

4.1.3 **Central Region**

4.1.3.1 County Representatives: Gila County, Maricopa County and Pinal County;

4.1.3.2 Tribal Representatives: Gila River Indian Community, San Carlos Apache Tribe and White Mountain Apache Tribe.

4.1.4 **Southern Region**

4.1.4.1 County Representatives: Cochise County, Graham County, Greenlee County, Pima County, Santa Cruz County and Yuma County;

4.1.4.2 Tribal Representatives: Cocopah Tribe, Pascua Yaqui Tribe, Tohono O'odham Nation and Fort Yuma Quechan Tribe.

5. FINANCIAL REQUIREMENTS

5.1 Match Requirement

The PHEP award requires a ten percent (10%) "in-kind" or "soft" match from all the grant participants. Each recipient shall 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.

5.2 Inventory

Inventory list shall be provided to ADHS, as part of the midyear report. Inventory List shall include all capital equipment (items over five thousand dollars ($5,000.00) each).

5.3 Budget Allocation

5.3.1 Budget tool developed by ADHS shall be completed and returned to ADHS for review and approval. ADHS will not release funding to the County prior to budget being approved.

5.3.2 All activities and procurements funded through the PHEP grant shall be aligned with the budget/spend and work plan, what shall help in reaching the goals and objectives outlined in this document. Any items and activities that are not specifically tied to the PHEP program capabilities shall be approved by ADHS before PHEP funds can be utilized on those activities/items.

5.3.3 Counties shall follow the applicable Office of Management and Budget (OMB) Circulars and Cost Principles when developing the budget and throughout the period of performance.

5.4 Grant Activity Oversight

Each County must maintain a full-time, part-time, or appointed PHEP Coordinator who shall have the responsibility for oversight of all grant related activities. The PHEP Coordinator shall be the main point of contact for ADHS in regards to the PHEP grant. The PHEP Coordinator shall work closely with ADHS to ensure all deliverables and requirements are met. The individual shall also coordinate all activities surrounding any onsite monitoring visits conducted by ADHS.

5.5 Employee Certifications

PHEP Recipients are required to adhere to all applicable federal laws and regulations, including applicable OMB Circulars and semiannual certification of employees who work solely on a single federal award. The certification forms shall be prepared at least semiannually and 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.

5.6 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.

6. EXERCISE REQUIREMENTS

6.1 Emergency Operation Coordination

6.1.1 Maintain documentation of all collaborative efforts with local and State emergency management

6.1.2 The County PHEP program must establish and maintain a collaborative working relationship with emergency management. This must include but not be limited to; Emergency communication plan, strategies for addressing emergency events, including the management of the consequences of power failures, natural disasters and other events that would affect public health.

6.1.3 Jointly participate with emergency management in an ADHS sponsored table top, functional exercise or other activity

6.2 Multi-Year Training and Exercise Workshop (MYTEP)

6.2.1 Each County shall participate in the annual ADHS Training and Exercise Planning Workshop.

6.2.1.1 Workshop date: TBD.

7. EXERCISE IMPLEMENTATION CRITERIA

7.1 Homeland Security Exercise and Evaluation Program

Sub-awardees shall conduct preparedness exercises in accordance with the HSEEP fundamentals including:

7.1.1 Exercise Design and Development;

7.1.2 Exercise Conduct;

7.1.3 Exercise Evaluation; and

7.1.4 Improvement Planning.

More information on the April 2013 HSEEP guidelines and exercise policy is available at https://hseep.preptoolkit.org/

7.2 At-Risk Individuals

Grantee shall include provisions for the needs of at-risk individuals within each exercise. HPP-PHEP sub-awardees shall report on the strengths and areas for improvement identified though the coalition based exercise After Action Report and Improvement Plan (AAR/IP). Information about the U.S. Department of Health and Human Services' definition of "at-risk" population may be obtained from the following website: http://www.phe.gov/Preparedness/planning/abc/Pages/at-risk.aspx

7.3 Sub-awardees conducting joint exercises shall include participation from healthcare coalitions (including at a minimum, hospitals, public health departments, emergency management agencies, and emergency medical services) and public health jurisdictions. Joint exercises shall meet multiple program requirements, including HPP, PHEP, and Strategic National Stockpile/Cities Readiness Initiative requirement to help minimize the burden on exercise planners and participants.

7.4 Exercises conducted with funding from other preparedness grant programs with similar exercise requirements may be used to fulfill the joint HPP-PHEP exercise requirements if HHS preparedness capabilities are tested and evaluated.

7.5 Exemption

County response and recovery operations supporting real incidents could meet the criteria for this annual exercise requirement, if the response was sufficient in scope and the AAR/IPs adequately detail which public health emergency preparedness (PHEP) capabilities were tested and evaluated. This shall be addressed on an as-requested basis.

8. **EXERCISE EVALUATION CRITERIA**

8.1 PHEP exercises shall address Public Health Preparedness (PHP) Capabilities in all qualifying exercises. If using FEMA Core Capabilities, a cross-walk shall be produced mapping PHP capabilities with core capabilities.

8.2 At a minimum, each County shall demonstrate and validate Public Health's ability to gain situational awareness of their hospital network through participation in resource and information management as outlined in the HPP-PHEP aligned capabilities.

8.2.1 These capabilities are:

8.2.1.1 Capability 3: Emergency Operations Coordination; and

8.2.1.2 Capability 6: Information Sharing.

9. **INFORMATION SYSTEMS REQUIREMENT**

The County shall:

9.1 Have access to a secure alerting system, that at a minimum has the ability to send email, faxes, and phone/ text alerts;

9.2 Participate in the Communication Pathway scenarios developed and sent out by ADHS Information Services Group; and

9.3 Utilize communication systems, which may include: HSP, EMResource, EMTrack, ESAR-VHP, AZHAN, IRMS, 800 radios or WebEOC.

9.3.1 ADHS will provide training on the systems and platforms as needed.

10. **REPORTING DELIVERABLES**

Progress on the deliverables, performance measures, and activities funded through the PHEP grant shall be reported on in a timely manner, to ensure ADHS has adequate time to compile the information and submit to CDC.

10.1 Mid-Year Report

10.1.1 ADHS shall send out the Mid-Year report templates in advance of the Due Date.

10.1.1.1 Due Date: TBD

10.1.2 ADHS shall provide the CDC Performance Measures templates (if applicable) in advance of the Due Date.

10.1.2.1 Due Date: TBD

10.1.3 Each County shall provide ADHS with updated Public Health Emergency Contact list, template to be provided by ADHS. The list should include contact information for the primary, secondary, and tertiary individuals for the Public Health Incident Management System (e.g. Incident Commander, Operations, etc.) and posted on the HSP.

10.1.3.1 Due Date: At time of midyear reporting.

10.2 Annual Report

10.2.1 ADHS shall send out the Annual Report template in advance of the Due Date.

10.2.1.1 Due Date: TBD

10.3 After Action Report/Improvement Plan

10.3.1 Each County shall submit an AAR/IP for any public health emergency exercise or real world event in which the public health entity participates and has a role.

10.3.2 AARs shall be submitted to ADHS within sixty (60) days after the exercise.

11. CAPABILITY DELIVERABLES

11.1 CAPABILITY 1: COMMUNITY PREPAREDNESS

11.1.1 ***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:

11.1.1.1 Support the development of public health, medical and mental/behavioral health systems which support recovery;

11.1.1.2 Participate in awareness training with community and faith-based partners on how to prevent, respond to and recover from public health incidents;

11.1.1.3 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;

11.1.1.4 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; and

11.1.1.5 Identify populations that may be at higher risk for adverse health outcomes.

11.1.2 **COUNTY OUTPUT REQUIREMENTS:**

11.1.2.1 Participate in review of HVAs, JRA and THIRAs and development of consolidated regional report. Consolidated report shall review process and procedures in place to mitigate the impact of an incident during a response and shall be integrated into preparedness processes and planning; and

11.1.2.2 Identify Geographic Information (GIS) resources utilized to assist in the identification of at-risk populations to include access and functional needs in support of planning activities, as part of the end of year report.

11.2 **CAPABILITY 2: COMMUNITY RECOVERY**

11.2.1 ***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.

11.2.2 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.

11.2.3 **COUNTY OUTPUT REQUIREMENTS:**

11.2.3.1 Ensure written plans include processes for collaborating with community organizations, emergency management, and health care organizations to identify public health, medical, and mental/behavioral health system recovery needs for the counties identified hazards. Written plans should include the following elements (either as a standalone Public Health Continuity of Operations plan or as a component of another plan):

11.2.3.1.1 Definitions and identification of essential services needed to sustain agency mission and operations;

11.2.3.1.2 Plans to sustain essential services regardless of the nature of the incident; and

11.2.3.1.3 Scalable work force reduction.

11.3 **CAPABILITY 3: EMERGENCY OPERATIONS COORDINATION**

11.3.1 ***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.

11.3.2 **COUNTY OUTPUT REQUIREMENTS:**

11.3.2.1 Participate in a functional exercise conducted within the respective region. Recommend participation in at least one (1) functional exercise to test the ability to stand up and operate an HEOC during a public health incident;

11.3.2.2 Maintain documentation of all collaborative efforts with local and State emergency management;

11.3.2.3 County/Tribal PHEP program shall establish and maintain a collaborative working relationship with emergency management. The relationship shall include, but not be limited to: Emergency communication plan, strategies for addressing emergency events, including the management of the consequences of power failures, natural disasters and other events that would affect public health; and

11.3.2.4 Jointly participate with emergency management in an ADHS sponsored table top, functional exercise or other activity.

11.4 **CAPABILITY 4: EMERGENCY PUBLIC INFORMATION AND WARNING**

11.4.1 ***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.

11.4.2 **COUNTY OUTPUT REQUIREMENTS:**

11.4.2.1 Provide ADHS a list of the top hazards identified within your jurisdictional risk assessment, as part of the midyear report.

11.4.2.2 Information provided will be utilized by ADHS to develop new message maps for inclusion in the CERC plan and for use by local health departments.

11.5 **CAPABILITY 5: FATALITY MANAGEMENT**

11.5.1 ***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.

11.5.2 **COUNTY OUTPUT REQUIREMENTS:**

11.5.2.1 Ensure Fatality Management plan identifies roles and responsibilities for county health department and thresholds indicating when to activate public health fatality management operations.

11.5.2.2 Fatality Management plan shall be submitted to HSP as part of the end of year report.

11.6 **CAPABILITY 6: INFORMATION SHARING**

11.6.1 ***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.

11.6.2 **COUNTY OUTPUT REQUIREMENTS:**

11.6.2.1 Participate in communication testing scenarios developed and administered by ADHS. Each County shall ensure communication systems and platforms are capable of receiving and disseminating information from multiple platforms.

11.6.2.2 Each County shall provide to ADHS a list of the system(s) that are utilized in EOC operations and for information sharing during their midyear report.

11.7 **CAPABILITY 7: MASS CARE**

11.7.1 ***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.

11.7.2 **COUNTY OUTPUT REQUIREMENTS:**

11.7.2.1 Review and update County's sheltering plan. County should review and update their plan to support shelter operations in coordination with local Emergency Management. Sheltering plans shall incorporate the needs for At-Risk Individuals and Functional and Access Needs Individuals.

11.7.2.2 Review and update plans to address functional needs of at risk individuals to include: medical caregivers, social services, utilization of universal design principals in signage and accessibility, and language and sign language interpreters.

11.8 **CAPABILITY 8: MEDICAL COUNTERMEASURE DISPENSING**

11.8.1 ***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.

11.8.2 **COUNTY OUTPUT REQUIREMENTS (CRI Counties):**

11.8.2.1 Cities Readiness Initiative (CRI) Drill Requirement Maricopa County and Pinal County shall conduct at least three (3) different SNS drills utilizing the templates provided by DSNS/ADHS. An executive summary and an improvement plan shall be submitted for each drill.

11.8.2.1.1 Provide ADHS with the drill results by March 30, 2016;

11.8.2.1.2 List of Drills that can be conducted: Staff notification, acknowledgement and assembly;

11.8.2.1.3 Site activation: notification, acknowledgement and assembly;

11.8.2.1.4 Facility Setup;

11.8.2.1.5 Pick List Generation;

11.8.2.1.6 Dispensing Throughput; and

11.8.2.1.7 Public Health Decision Making Tool.

11.8.2.2 CRI jurisdictions not conducting an ORR in BP4 shall complete Jurisdictional Worksheet as part of the midyear report.

11.8.3 **COUNTY OUTPUT REQUIREMENTS (Non-CRI Counties):**

11.8.3.1 Complete the POD Standards Worksheet (provided by ADHS) as part of the midyear report;

11.8.3.2 Conduct at least two (2) different SNS drills utilizing the templates provided by DSNS/ADHS.

11.8.3.2.1 Provide ADHS with the drill results as part of the end of year report.

11.8.3.2.2 List of Drills that can be conducted to meet the two (2) different drill requirements include:

11.8.3.2.2.1 Staff notification, acknowledgement and assembly;

11.8.3.2.2.2 Site activation: notification, acknowledgement and assembly;

11.8.3.2.2.3 Facility Setup;

11.8.3.2.2.4 Pick List Generation;

11.8.3.2.2.5 Dispensing Throughput; and

11.8.3.2.2.6 Public Health Decision Making Tool.

11.9 **CAPABILTY 9: MEDICAL MATERIEL MANAGEMENT & DISTRIBUTION**

11.9.1 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.

11.9.2 **COUNTY OUTPUT REQUIREMENTS (CRI and Non-CRI Counties):**

11.9.2.1 Participate in at least two (2) Inventory Management System drills conducted by ADHS; and

11.9.2.2 Demonstrate the ability to accept, manage, and return medical materiel electronically in coordination with ADHS.

11.10 **CAPABILITY 10: MEDICAL SURGE**

11.10.1 ***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.

11.10.2 **COUNTY OUTPUT REQUIREMENTS:**

11.10.2.1 Each County shall participate in Crisis Standards of Care/Medical Surge on-line training. Training shall be facilitated by ADHS and shall focus on the integration of federal and state planning guidelines for medical surge and CSC.

11.11 **CAPABILITY 11: NON-PHARMACEUTICAL INTERVENTIONS**

11.11.1 ***Definition:*** Non-pharmaceutical interventions (NPI) 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:

11.11.1.1 Isolation and quarantine;

11.11.1.2 Restrictions on movement and travel advisory/warnings;

11.11.1.3 Social distancing;

11.11.1.4 External decontamination;

11.11.1.5 Hygiene; and

11.11.1.6 Precautionary protective behaviors.

11.11.2 **COUNTY OUTPUT REQUIREMENTS:**

11.11.2.1 Local health shall develop and/or review local NPI plans. Written plans should include documentation which identifies public health roles and responsibilities related to the jurisdiction's identified risks, that was developed in conjunction with partner agencies (e.g., state environmental health, state occupational health and safety, and hazard-specific subject matter experts) and emergency managers. This documentation should identify the protective equipment, protective actions, or other mechanisms that public health responders shall have to execute potential roles. Roles for consideration may include the following elements:

11.11.2.1.1 Conducting environmental health assessments;

11.11.2.1.2 Potable water inspections; and

11.11.2.1.3 Field surveillance interviews.

11.11.2.2 Local Health Department shall complete the biannual performance measure report form distributed by ADHS for use in identifying gaps in planning and implementation of interventions in the jurisdiction.

11.12 **CAPABILITY 13: PUBLIC HEALTH SURVEILLANCE AND EPIDEMIOLOGICAL INVESTIGATION**

11.12.1 ***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.

11.12.2 **COUNTY OUTPUT REQUIREMENTS:**

11.12.2.1 **Participate in State Testing of the Communicable Disease On-Call System**. Local Department of Health 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. Jurisdictions shall complete the disease scenario evaluation form and return to ADHS.

11.12.2.2 **Enter Information into MEDSIS as Required and Provide ADHS Staff with Current Contact Information for MEDSIS Liaisons**. Jurisdictions shall maintain a primary and backup MEDSIS liaison; notify ADHS of any changes to the liaison roles or their contact information at the time of the change. MEDSIS liaison responsibilities include requesting/approving new users and notifying ADHS when users no longer require access. The MEDSIS liaison shall participate in the MEDSIS quarterly meetings.

11.12.2.3 **Participate in Epidemiology Trainings and Exercises**. Local Health Department shall participate in the Epidemiology Surveillance and Capacity (ESC) meetings (at least ten (10) out of twelve (12)), "How to" Presentations (at least eighty percent (80%)) and the Arizona Infectious Disease Training and Exercise.

11.12.2.4 **Conduct Investigations of Reported Infectious Diseases and Public Health Incidents**. Local Health Departments shall investigate and report cases of infectious disease as required by Arizona rules and statutes and MEDSIS policies and procedures. Investigation actions should be documented and include the following as necessary: case identification, specimen collection, case investigation / characterization, and control measure implementation. Outbreak investigations should begin within twenty four (24) hours of receipt of report. For

outbreak cases with a focused questionnaire, interview shall be conducted within forty-eight (48) hours.

11.12.2.5 **Report All Identified Outbreaks Within twenty-four (24) Hours**. Local Health Departments shall report all identified outbreaks to ADHS within twenty-four (24) hours utilizing the MEDSIS Outbreak Module; include documentation on outbreak investigation activities as part of jurisdictional mid-year and end-of-year reports to ADHS. At a minimum, include the following information: Outbreak Name, Date Reported to Local Health, Morbidity, Type of Setting, and County of Outbreak Exposure.

11.12.2.6 **Submit Outbreak Summaries to ADHS**. Outbreak summaries shall be submitted to ADHS utilizing the MEDSIS Outbreak Module within thirty (30) days of outbreak closure for all outbreaks investigated. Summary forms shall contain all required minimal elements. **(See Appendix 1)*

11.12.2.7 **Complete the Monthly Performance Measure Report Form**. Local Health Departments shall complete the monthly performance measure report form distributed by ADHS for use in identifying gaps in timeliness of reporting, completeness of interviews and monitoring outbreaks in the jurisdiction. Performance measure report information will be utilized for mid-year and end-of-year grant reporting for both PHEP and ELC grant deliverables.

11.12.3 **CAPABILITY 14: RESPONDER SAFETY AND HEALTH**

11.12.3.1 ***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.

11.12.3.2 **COUNTY OUTPUT REQUIREMENTS:**

Review/update plans to include documentation of the safety and health risk scenarios likely to be faced by public health responders, based on pre-identified jurisdictional incident risks, which are developed in consultation with partner agencies. Plans should include documentation that identifies public health roles and responsibilities related to the jurisdiction's identified risks developed in conjunction with partner agencies and emergency managers. This documentation should identify the protective equipment, protective actions, or other mechanisms that public health responders will need to have to execute potential roles.

11.12.4 **CAPABILITY 15: VOLUNTEER MANAGEMENT**

11.12.4.1 ***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.

11.12.4.2 **COUNTY OUTPUT REQUIREMENTS**

Review Volunteer Management plans to ensure processes are identified to manage spontaneous volunteers to include communication pathways, and a method to refer spontaneous volunteers to other organizations.

DELIVERABLES TABLE	
1	Participate in the All Partners Meeting
2	Attend ADHS Business Meeting
3	Participate in Region Healthcare Coalition Meetings
4	Submit Budget, Work Plan, and comply with PGO financial requirements
5	Participate in Multi-Year Training and Exercise Workshop (MYTEP)
6	Have or have access to an Alert System
7	Provide ADHS a list of systems utilized in your EOC and for information sharing
8	Participate in Communication Pathway testing scenarios on a regular basis
9	Submit PHEP Contact List, Mid-Year
10	Submit timely AAR/IPs to ADHS
11	Participate in Functional Exercise to test ability to stand up and operate EOC
12	Include a Top Hazards list in the Mid-Year Report to ADHS
13	Include a Fatality Management plan in the End of Year Report
14	Participate in ADHS administered communication testing
15	Review and update Mass Care/Sheltering Plans to incorporate additional measures to address At-Risk and Functional & Access Needs
16	Submit executive summaries and improvement plans for three separate SNS drills conducted (CRI counties)
17	Complete SNS Jurisdictional Worksheet if ORR is not conducted (CRI counties)
18	Complete POD Standards Worksheet (Non-CRI counties)
19	Conduct two SNS drills and submit results (Non-CRI counties)
20	Participate in inventory Management System drills
21	Participate in Crisis Standards of Care/Medical Surge training
22	Complete w/ADHS on NPI plan reviews and to complete bi-annual performance measure report
23	Participate in Epidemiology Trainings and Exercises
24	Conduct investigations, report outbreaks, conduct outreach to delayed reporters, submit summaries of outbreaks, complete monthly performance measure report, and enter information into MEDSIS
25	Review Responder Safety Plans and update to include jurisdictional risks
26	Validate that Volunteer Managements plans address spontaneous volunteers

APPENDIX ONE (1)

OUTBREAK SUMMARY FORM MINIMAL ELEMENTS

For the minimal elements to be considered complete on the ADHS Outbreak Summary Report Form the following elements need to be completed:

1. For CONTEXT:

1.1 County of Exposure

1.2 Case Information: # primary ill; # susceptible

1.3 Primary setting of exposure

1.4 Could etiology be determined

2. For INITIATION of INVESTIGATION:

2.1 Date LHD 1st notified

2.2 Date ADHS 1st notified

2.3 Date Investigation Started

3. For INVESTIGATION METHODS:

3.1 Case Definition: Confirmed case; Probable Case; Suspect case (at least one should be filled out)

3.2 Other Actions & Investigation methods: Interviewed cases; Interviewed controls; epi studies; traceback; case/pt samples; environmental samples, environmental health assessment; facility/establishment investigation (at least one should be filled out)

3.3 Were specimens collected

3.4 If yes, what is the confirmed etiology

4. For INVESTIGATION FINDINGS:

4.1 Were specimens collected

4.2 If yes, what is the confirmed etiology

4.3 Signs & Symptoms (at least one filled out)

4.4 Was a specific contaminated food, water or environmental vehicle/source identified?

5. For DISCUSSION and/or CONCLUSIONS:

5.1 Factors Contributing to an Outbreak: Foodborne; Waterborne; Nosocomial; Person to Person; Zoonotic or Vector (at least one filled out)

6. For RECOMMENDATIONS for CONTROLLING DISEASE:

6.1 Outbreak Control section (at least one filled out)

7. For KEY INVESTIGATORS:

7.1 Key Investigator section