Kansas Public Health Emergency Program

Local Public Health Guidance

Project Period Length: 5 Years
# Table of Contents

## SECTION 1 – SUPPORTING INFORMATION
- Mission ............................................................................................................................. 3
- PHEP Cooperative Agreement Priorities .......................................................................... 3
- PHEP Funding At a Glance ................................................................................................ 3
- Funding Methodology ....................................................................................................... 4

## SECTION 2 – SUBMISSION REQUIREMENTS
- Signed Agreements and Line Item Budgets ..................................................................... 4
- Affidavits of Expenditure and Work Plan Progress Reports ............................................. 4
- Resources .......................................................................................................................... 5
- Contact Information .......................................................................................................... 5

## SECTION 3 - PHEP CAPABILITIES
- Overview of CDC Capabilities ........................................................................................ 6
- CDC Tiered Strategy ......................................................................................................... 7
- Kansas Prioritization Strategy .......................................................................................... 7
- PHEP vs HPP Priorities .................................................................................................... 7
- Organization of Capabilities ............................................................................................. 7
- Kansas Capabilities Overview .......................................................................................... 8

## SECTION 4 – Attachments
- Attachment 1: Local Work Plan Deliverables .................................................................. 20
- Attachment 2: Regional Work Plan Deliverables ............................................................... 20
- Attachment 3: Rush County Work Plan Deliverables (Non-Regionalized) ....................... 20
- Attachment 4: CRI Work Plan Deliverables ..................................................................... 20
SECTION 1 – SUPPORTING INFORMATION

Mission
The Kansas Department of Health and Environment (KDHE) Bureau of Community Health Systems (BCHS) promotes all-hazards planning, defined as planning in the absence of a specific threat for capabilities that would be required to respond to any emergency regardless of the causative factor. BCHS receives Public Health Emergency Program (PHEP) funding from the Centers for Disease Control and Prevention (CDC) to be used to maintain, refine, and to the extent achievable, enhance the health and medical systems in Kansas, including exercising and improving preparedness plans for all-hazards. In addition, building public health preparedness response capabilities through associated planning, personnel, equipment, training and exercise capabilities at the state, regional and local levels remains a high priority. The PHEP supports capabilities based-planning by setting priorities that must be met by the end of the grant cycle.

PHEP Cooperative Agreement Priorities
Public health threats are always present. Whether caused by natural, unintentional, or intentional means, these threats can rapidly overwhelm routine public health systems. Being prepared to prevent, respond to, and rapidly recover from public health threats is critical for protecting and securing our nation’s public health.

The 2009 H1N1 influenza pandemic underscored the importance of communities being prepared for potential threats. Because of its unique abilities to respond to infectious, occupational, or environmental outbreaks and events, the Centers for Disease Control and Prevention (CDC) plays a pivotal role in ensuring that state and local public health systems are prepared for these and other public health incidents. CDC provides funding and technical assistance to public health departments nationwide through the Public Health Emergency Preparedness (PHEP) cooperative agreement to build and strengthen their abilities to respond effectively to public health threats. PHEP awardees include 50 states, four directly funded localities, and eight territories and freely associated states.

This ongoing support of public health departments has forged a strong partnership that helps to protect the nation’s communities from public health threats. This shared investment has been evident during numerous recent responses, ranging from routine food-borne outbreaks to the 2009-2010 H1N1 influenza pandemic response, which demonstrated that prepared public health systems are the cornerstone of an effective public health response during national public health emergencies.

While it is evident that public health departments have made significant progress in preparing for emergencies, the CDC’s new five-year PHEP cooperative agreement seeks to advance public health preparedness by:

• Establishing a prioritized and consistent set of public health preparedness capabilities,
• Encouraging public health departments to measure their ability to achieve the public health preparedness capabilities and report how PHEP funds are used to achieve these capabilities,
• Addressing lessons learned during the recent H1N1 influenza pandemic response regarding the administrative preparedness necessary at the state and local levels for effective response as well as provide an improved mechanism for awarding response funding,
• Developing all-hazards public health risk reduction strategies targeting 10 higher population metropolitan statistical areas, and
• Quantifying the return on investment of public funds used for preparedness.

PHEP Funding At a Glance

- Federal Funding Opportunity Number: CDC-RFA-TP11-1101
- Project Period Length: 5 years
- Current Budget Period Length: 12 months
- Current Performance Period: August 10, 2011, to August 9, 2012 (Year 1)
- Current Budget Period Funding for Kansas: (estimated funding based on CDC provided 2011 budget) (August 9, 2011 – August 10, 2012)
  - State of Kansas $6,178,453
    - Current State Allocation: $3,089,227
    - Aid to Local Allocation: $3,089,227
  - Cities Readiness Initiative (CRI): $416,567
    - Current State Allocation: $104,142
Aid to Local Allocation: $315,425
- Eligible Awardee: Kansas Department of Health and Environment (KDHE)
- Anticipated Award Date: August 9, 2011

Funding Methodology
Funding for the PHEP comes from federal funds granted by the CDC. The BCHS, within the KDHE, receives the preparedness grant award for the state. KDHE uses the money to improve preparedness across the state and to meet federal performance measures and requirements associated with the grant funds. KDHE works closely with the Kansas Association of Local Health Departments (KALHD) to distribute the grant funds to community and regional local health departments across Kansas. Award amounts are allocated to local health departments and public health preparedness regions based on population.

The contract will begin **August 10, 2011** and will end **August 9, 2012** with the following target period dates:
- Quarter one: August 10, 2011 – October 31, 2011
- Quarter three: February 1, 2012 – April 30, 2012
- Quarter four: May 1, 2012 – August 9, 2012 (CRI deliverables due July 15, 2012)

KDHE contracts directly with local health departments and public health preparedness regions. Local and regional deliverables and funding are outlined and tracked through quarterly submission of work plans, other applicable documentation and affidavits of expenditures. All activities funded by the contract agreement must take place between **August 10, 2011** and **August 9, 2012**. Activities performed before or after this period are not eligible for reimbursement.

**SECTION 2 – SUBMISSION REQUIREMENTS**

Signed Agreements and Line Item Budgets Due: **September 14, 2011**
Local health departments will receive an agreement outlining the work plan items and the expectations of the PHEP Program. This agreement must be signed by the local health department Administrator, be accompanied by a line item budget detailing expected expenditures, and be submitted to KDHE via standard mail by **September 14, 2011** to the following address:

KDHE – BCHS  
Attn: Sarah Beery  
1000 SW Jackson Street, Suite 340  
Topeka, KS 66612

These signed and submitted agreements confirm participation in the PHEP program during the 2011 – 2012 funding cycle.

Affidavits of Expenditures and Work Plan Progress Reports Due:  
- **Period 3** (February 1, 2012 – April 30, 2012) – due May 15, 2012  
- **Period 4** (May 1, 2012 – August 9, 2012) – due September 15, 2012

Local health departments are asked to submit an affidavit of expenditure and work plan progress report following the end of each reporting period. KDHE will process the affidavits, ensure allowable items are being purchased and that the correct amount of funding is being used. Payments will be made by either electronic deposit or a check will be submitted and sent via standard mail.

If funding has been exhausted before the fourth reporting period, local health departments must still submit affidavits of expenditure each reporting period, even if the fields are zero or if they are purchasing items over their funding amount.

The KDHE-KALHD preparedness team has provided a work plan containing deliverables for local and regional preparedness programs which is available at: [http://www.kdheks.gov/cphp/lhd_resources.htm](http://www.kdheks.gov/cphp/lhd_resources.htm). Each task requires a response to serve as an evaluation of the work completed. In some cases the task
is something that must be completed and submitted, therefore the task requires a simple check of a box (SUBMITTED or NOT SUBMITTED, YES or NO, COMPLETE or INCOMPLETE), or the task may ask for the DATE of completion or NAME of who completed this task. The deliverables listed in the work plan must be completed by the target date listed (unless otherwise stated). The work plan also serves as a quarterly report and must be completed and submitted electronically to KDHE at BTGrantReports@kdheks.gov at the end of each reporting period.

KDHE strongly encourages awardees to submit all required documentation to the BTGrantReports@kdheks.gov email account. If assistance is needed in completing any forms, please contact KDHE at (785) 296-8605. All documentation, including this guidance, the budget, and work plan, can be found on the KDHE BCHS website http://www.kdheks.gov/cphp/lhd_grant_apps_2011-2012.htm.

ALL PHEP SUBMISSIONS SHOULD BE SENT TO:
KDHE – BCHS
BTGrantReports@kdheks.gov

Resources
PHEP Grant Documents can be found at: http://www.kdheks.gov/cphp/lhd_resources.htm.

Contact Information
Additional questions related to this guidance, the budget, the work plan, or any other preparedness resources can also be directed to the contacts listed below. A map showing KDHE BCHS Planner county assignments for additional technical assistance can be found on the KDHE BCHS website http://www.kdheks.gov/cphp/lhd_resources.htm.

All preparedness program staff contact information is listed at: http://www.kdheks.gov/olrh/staff.htm.

SECTION 3 – PHEP Capabilities

Overview of CDC Capabilities
The CDC has released Public Health Preparedness Capabilities: National Standards for State and Local Planning as a guide to ensure that federal preparedness funds are directed to priority areas within jurisdictions. The CDC has identified the following fifteen (15) public health preparedness capabilities as the basis for state and local public health preparedness.

1. Community Preparedness
2. Community Recovery
3. Emergency Operations Coordination
4. Emergency Public Information and Warning
5. Fatality Management
6. Information Sharing
7. Mass Care
8. Medical Countermeasure Dispensing
9. Medical Materiel Management and Distribution
10. Medical Surge
11. Non-pharmaceutical Interventions
12. Public Health Laboratory Testing
13. Public Health Surveillance and Epidemiological Investigation
14. Responder Safety and Health
15. Volunteer Management

Important cross-cutting preparedness topics such as legal preparedness, vulnerable or at-risk populations, and radiological/nuclear preparedness are addressed in several of the 15 capabilities. In addition, the CDC has identified performance measures that must be demonstrated for the PHEP grant. KDHE has integrated these performance measures to be met through the work plan deliverables.

Kansas Prioritization Strategy:
Since the release of the Public Health Preparedness Capabilities, KDHE has worked with identified state and local preparedness partners in order to obtain a better understanding and awareness of public health preparedness at the state, regional and local levels. This process has incorporated the strong relationship with local health departments through KALHD. Using the capabilities as a framework, KDHE and KALHD
worked together to identify Kansas’ areas of strength, areas in need of improvement, and gaps within the public health infrastructure. The analysis set the foundation for the PHEP Cooperative Agreement application and, by extension, the state, regional and local deliverables for the upcoming budget period.

At the onset of the PHEP grant application process, the KDHE-KALHD Preparedness Team, which includes representatives from the KDHE preparedness and epidemiology sections and local health departments, identified which capabilities would be a priority for the upcoming budget period. To select the priorities in a logical manner, the team took advantage of the Public Health Preparedness Capabilities gap analyses at state and local levels and took into account the needs and wishes of local health department preparedness personnel. This led the team to unanimously agree that the following capabilities would be the priorities for the upcoming budget period:

- Capability #8: Medical Countermeasure Dispensing
- Capability #9: Medical Material Management and Distribution
- Capability #13: Public Health Surveillance and Epidemiological Investigation

The team identified three (3) of the fifteen (15) priorities to be the focus for funding during the current performance and budget period (Year 1), with the goal of addressing all fifteen (15) priorities by the end of the project period (Year 5).

**PHEP vs HPP Priorities**

The CDC Public Health Emergency Preparedness (PHEP) and the Assistant Secretary for Preparedness and Response (ASPR) Hospital Preparedness Program (HPP) priorities currently differ. For example, the HPP grant priorities include items in the list below:

- Available Bed Tracking and Reporting (HAVBED)
- Advance Registration and Credentialing of Volunteers (ESAR-VHP)
- Fatality Management
- Medical Evacuation/Shelter In Place
- Medical Surge/Alternate Care Sites and Mobile Medical Assets
- Medical Reserve Corps (MRC)

**Organization of Capabilities**

According to the CDC released *Public Health Preparedness Capabilities: National Standards for State and Local Planning* guide each capability includes a definition and a list of the associated functions, performance measures, tasks, and resource considerations.

- The Capability Definition defines the capability as it applies to state, local, tribal, and territorial public health.
- The Function describes the critical elements that need to occur to achieve the capability.
- The Performance Measure(s) lists the CDC-defined performance measures (if any) associated with a function.
- The Tasks describes the steps that need to occur to complete the functions.
- The Resource Elements section lists the resources a jurisdiction needs to have or have access to (via an arrangement with a partner organization, memoranda of understanding, etc.) to successfully perform a function and the associated tasks. The CDC categorizes the Resources into three categories:
  - Planning: standard operating procedures or emergency operations guidance, including considerations for legal authorities and at-risk populations, for a jurisdiction or entity’s plans for delivering the capability.
  - Skills and Training: baseline competencies and skills personnel and teams should possess or have access to when delivering a capability, and
  - Equipment and Technology: equipment jurisdictions should have or have access to in jurisdictionally defined quantities sufficient to achieve the capability.

The CDC further defines some Resources Elements as “Priority.” Priority elements are considered to be the most critical of the Resource Elements and as “minimum standards” for state and local preparedness. The remaining Resource Elements are recommended or suggested activities for consideration by jurisdictions.

Local health departments are not expected to perform each task and resource element as some of these capabilities are performed by the state and some are performed by local health departments or public health partners.
Kansas Capabilities Overview
For the three Public Health Preparedness Capabilities that are the focus for Budget Period 11, additional information has been provided such as the functions, associated tasks, performance measures and the priority resource elements, are for your information only. These have been appropriately integrated into your local work plan. Only the items that are noted below are priorities for the Kansas PHEP BP 11 application. Resource elements are broken down into planning, skills and training, and equipment and technology resources.

Additional resource elements that are not priority in nature can be found in the Public Health Preparedness Capabilities: National Standards for State and Local Planning guide from the CDC. This document can be found at: http://www.cdc.gov/phpr/capabilities/.

Note: In some of the Performance Measures it lists the composite performance indicator from the Division of Strategic National Stockpile (DSNS) in CDC’s Office of Public Health Preparedness. This indicator can be found on the DSNS extranet:

http://emergency.cdc.gov/stockpile/extranet
Username: Stockpile
Password: Str*teg!c

Capability 8: Medical Countermeasure Dispensing
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.

This capability consists of the ability to perform the following functions:
  Function 1: Identify and initiate medical countermeasure dispensing strategies
  Function 2: Receive medical countermeasures
  Function 3: Activate dispensing modalities
  Function 4: Dispense medical countermeasures to identified population
  Function 5: Report adverse events

Function 1: Identify and initiate medical countermeasure dispensing strategies
Notify and coordinate with partners to identify roles and responsibilities consistent with the identified agent or exposure and within a time frame appropriate to the incident.

Tasks
Task 1: Prior to an incident, and if applicable during an incident, engage subject matter experts (e.g. epidemiology, laboratory, radiological, chemical, and biological) including federal partners, to determine what medical countermeasures are best suited and available for the incidents most likely to occur based on jurisdictional risk assessment.

Task 2: Prior to an incident, and if applicable during an incident, engage private sector, local, state, regional, and federal partners, as appropriate to the incident, to identify and fill required response roles.

Performance Measure
N/A

Resource Elements
Priority 1: Written plans should include standard operating procedures that provide guidance to identify the medical countermeasures required for the incident or potential incident. Consideration should be given to the following elements:
  • Number and location of people affected by the incident, including a process to collect and analyze medical and social demographic information of the jurisdiction’s population to plan for the types of medications, durable medical equipment, or consumable medical supplies that may need to be provided during an incident, including supplies needed for the functional needs of at-risk individuals.
• Agent or cause of the incident
• Severity of the incident
• Potential medical countermeasures
• Time line for establishing medical countermeasure dispensing operations
• Personnel and staffing mix

Suggested resources
• CDC Emergency Preparedness and Response: http://emergency.cdc.gov
• CDC Radiation Emergency website (medical countermeasures): http://emergency.cdc.gov/radiation/countermeasures.asp
• Conference of Radiation Control Program Directors: www.crcpd.org

Function 2: Receive medical countermeasures

Identify dispersing sites and/or intermediary distribution sites and prepare these modalities to receive medical countermeasures in a time frame applicable to the agent or exposure.

Tasks
Task 1: Assess the extent to which current jurisdictional medical countermeasure inventories can meet incident needs. *(Targeted at state and local jurisdictions)*

Task 2: Request additional medical countermeasures from private, jurisdictional, and/or federal partners using established procedures, according to incident needs.

Task 3: Identify and notify any intermediary distribution sites based on the needs of the incident, if applicable.

Performance Measure
N/A

Resource Elements
Priority 1: Written plans should include protocols to request additional medical countermeasures, including memoranda of understanding or other letters of agreement with state/local partners. Consideration should be given to the following elements:
• Assessment of local inventory/medical countermeasure caches
• Identification of local pharmaceutical and medical-supply wholesalers
• Identification of a decision matrix guiding the process of requesting additional medical countermeasures if local supplies are exhausted. Matrix should take into account the Stafford Act and U.S. Department of Health and Human Services Regional Emergency Coordinators.
• If jurisdictions decide to purchase their own medical countermeasures, they are required to meet regulatory standards (abide by U.S. Food and Drug Administration standards including current good manufacturing practices, have appropriate Drug Enforcement Administration registrations, and be responsible to fund and track medical countermeasures rotation)

Suggested resource

Function 3: Activate dispensing modalities

Tasks
Task 1: Activate dispensing strategies, dispensing sites, dispensing modalities and other approaches, as necessary, to achieve dispensing goals commensurate with the targeted population.

Task 2: Activate staff that will support the dispensing modality in numbers necessary to achieve dispensing goals commensurate with the targeted population.

Task 3: If indicated by the incident, implement mechanisms for providing medical countermeasures for public health responders, critical infrastructure personnel and their families, if applicable.

Task 4: Initiate site-specific security measures for dispensing locations, if applicable.

Task 5: Inform public of dispensing operations including locations, time period of availability, and method of delivery.

Performance Measure
Measure 1: Composite performance indicator from the Division of Strategic National Stockpile (DSNS) in CDC’s Office of Public Health Preparedness and Response.

Resource Elements
Priority 1: Written plans should include 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.

Priority 2: Written plans should include processes and protocols to govern the activation of dispensing modalities.

• Identify multiple dispensing modalities that would be activated depending on the incident characteristics (e.g., identified population and type of agent/exposure). Consideration should be given to the following elements:
  o Traditional public health operated (e.g., open points of dispensing)
  o Private organizations (e.g., closed points of dispensing)
  o Pharmacies
  o Provider offices and clinics
  o Military/tribal
  o Incarcerated population
  o Other jurisdictionally approved dispensing modalities

• Initiate notification protocols with the dispensing locations. The following information should be determined for the sites:
  o Dispensing site name/identifier
  o Demand estimate (number of people planning to visit the site)
  o Required throughput
  o Staff required to operate one shift
  o Number of shifts of distinct staff
  o Staff availability
  o Total number of staff required to operate the dispensing location through the whole incident

• Plan for functional needs of at-risk individuals (e.g., wheelchair access for handicapped)

• Identify, assess, prioritize, and communicate legal and liability dispensing barriers to those with the authority to address issues. Consideration should be given to the following elements:
  o Clinical standards of care
  o Licensing
  o Civil liability for volunteers
  o Liability for private sector participants
  o Property needed for dispensing medication

Suggested resource
• CDC Strategic National Stockpile Technical Assistance Review, Section 6: https://www.orau.gov/snsnet/guidance.htm

Function 4: Dispense medical countermeasures to identified population
Provide medical countermeasures to individuals in the target population, in accordance with public health guidelines and/or recommendations for the suspected or identified agent or exposure.

**Tasks**

**Task 1:** Maintain dispensing site inventory management system to track quantity and type of medical countermeasures present at the dispensing site.

**Task 2:** Screen and triage individuals to determine which medical countermeasure is appropriate to dispense to individuals if more than one type or subset of medical countermeasure is being provided at the site.

**Task 3:** Distribute pre-printed drug/vaccine information sheets that include instructions on how to report adverse events.

**Task 4:** Monitor dispensing site throughput and adjust staffing and supplies as needed in order to achieve dispensing goals commensurate with the targeted population.

**Task 5:** Document doses of medical countermeasures dispensed, including but not limited to: product name and lot number, date of dispensing, and location of dispensing (e.g., address and zip code).

**Task 6:** Report aggregate inventory and dispensing information to jurisdictional authorities at least weekly during an incident, but potentially more frequently based on incident needs.

**Task 7:** Determine the disposition of unused medical countermeasures within the jurisdictional health system according to jurisdictional policies.

*Note: State jurisdictions are expected to ensure attainment of Tasks 1 through 7 by their local communities.*

**Performance Measure**

**Measure 1:** Composite performance indicator from the Division of Strategic National Stockpile (DSNS) in CDC’s Office of Public Health Preparedness and Response.

**Resource Elements**

**Priority 1:** Written plans should include processes and protocols to govern the dispensing of medical countermeasures to the target population.

- Protocol for screening and triaging patients, taking into consideration an assessment of patient characteristics (e.g., age, weight, clinical manifestations, available medical history, and drug or food allergies, assessment of radiation exposure duration and time since exposure, presence of radioactive contamination on the body or clothing, intake of radioactive materials into the body, identification of the radioactive isotope, removal of external or internal contamination) to determine the medical countermeasure to dispense
- Ensure that the permanent medical record (or log/file) of the recipient indicates the following information as deemed necessary:
  - The date the medical countermeasure was dispensed
  - Information on the medical countermeasure including, but not limited to, product name, national drug control number, and lot number
  - The name and address of the person dispensing the medical countermeasure. Federal dispensing law requires: name/address of dispenser, prescription number, date of prescription, name of prescriber, name of patient (if stated on prescription), directions for use, and cautionary statements.
  - The edition date of the information statement (e.g., pre-printed drug information sheets) distributed
- Ensure medical countermeasure recipient receives the information sheet matching the medical countermeasure dispensed
- Data recording protocols to report the data at an aggregate level to state/federal entities. Considerations should be given to population demographics (e.g., sex, age group, and if an at-risk individual) and dispensing information (e.g., medical countermeasure name, location, and date)
**Function 5: Report adverse events**

Report adverse event notifications (e.g., negative medical countermeasure side effects) received from an individual, healthcare provider, or other source.

**Tasks**

**Task 1:** Activate mechanism(s) for individuals and healthcare providers to notify health departments about adverse events.

**Task 2:** Report adverse event data to jurisdictional and federal entities according to jurisdictional protocols.

Note: Tasks 1 and 2 apply to all jurisdictions; states are expected to ensure attainment of Tasks 1 and 2 by their local communities.

**Performance Measure**

N/A

**Resource Elements**

**Priority 1:** Written plans should include processes and protocols to govern reporting of adverse events. The following items should be considered in the plans:

- Guidance and communications messages/campaign that articulates the importance of adverse reporting regardless of suspected cause
- Process to ensure individuals receive the information sheet about potential adverse events of the medical countermeasure dispensed and how to report adverse events
- Triage protocols when receiving notifications of adverse events
- Protocols when receiving notifications of adverse events. Information required to document adverse events includes the following:
  - Patient, provider, and reporter demographics
  - Adverse event
  - Relevant diagnostic tests/laboratory data
  - Recovery status
  - Vaccine(s)/pharmaceutical(s) received, including receipt location, date, vaccine/pharmaceutical type, lot number, and dose number
- Utilize existing federal and jurisdictional adverse event reporting system, processes and protocols

**Priority 2:** Public Health staff should be trained on federal as well as their jurisdiction’s adverse event reporting system, processes and protocols.

Suggested systems for training include the following:

- MedWatch: [https://www.accessdata.fda.gov/scripts/medwatch/medwatch-online.htm](https://www.accessdata.fda.gov/scripts/medwatch/medwatch-online.htm)
- Vaccine Adverse Events Reporting System: [https://vaers.hhs.gov](https://vaers.hhs.gov)
- Drug Abuse Warning Network: [https://dawninfo.samhsa.gov/default.asp](https://dawninfo.samhsa.gov/default.asp)

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

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.

This capability consists of the ability to perform the following functions:

- Function 1: Direct and activate medical materiel management and distribution
- Function 2: Acquire medical materiel
- Function 3: Maintain updated inventory management and reporting system
- Function 4: Establish and maintain security
Function 1: Direct and activate medical materiel management and distribution

Coordinate logistical operations and medical materiel requests when an incident exceeds the capacity of the jurisdiction’s normal supply chain, including the support and activation of staging operations to receive and/or transport additional medical materiel. This should be accomplished at the request of the incident commander and in coordination with jurisdictional emergency management.

Tasks

Task 1: Prior to an incident, identify receiving sites for responses of varying sizes and durations.

Task 2: Prior to an incident, identify transportation assets from commercial and/or government sources and create a transportation asset list.

Task 3: Prior to and when applicable during an incident, identify and coordinate with medical materiel suppliers and distributors within the jurisdiction to assess resource availability and potential distribution challenges (e.g., transport of materiel through restricted areas).

Task 4: Prior to and when applicable during an incident, identify staffing needs for receiving sites (e.g., numbers and skills of personnel).

Task 5: During an incident, monitor medical materiel levels at supporting medical and health-related agencies and organizations by collecting data on materiel availability at least once per week, but potentially more frequently as determined by incident needs.

Task 6: During an incident at the request of the incident commander, activate receiving sites dependent on incident needs.

Task 7: During an incident at the request of the incident commander, select transportation assets from pre-identified asset list, dependent on incident needs.

Performance Measure

Measure 1: Composite performance indicator from the Division of Strategic National Stockpile (DSNS) in CDC’s Office of Public Health Preparedness and Response.

Resource Elements

Priority 1: Written plans should include documentation of primary and backup receiving sites that take into consideration federal Strategic National Stockpile recommendations. Written plans should include the following elements:

• Type of site (commercial vs. government)
• Physical location of site
• 24-hour contact number
• Hours of operation
• Inventory of material-handling equipment on-site and list of minimum materials that need to be procured and/or delivered at the time of the incident
• Inventory of office equipment on-site and list of minimum materials that need to be procured and/or delivered at the time of the incident
• Inventory of storage equipment (e.g., refrigerators and freezers) on-site and list of minimum materials/supplies that need to be procured and/or delivered at the time of the incident

Priority 2: Written plans should include transportation strategy. If public health will be transporting material using their own vehicles, plan should include processes for cold chain management, if necessary to the incident. If public health will be using outside vendors for transportation, there should be a written process for initiating transportation agreements (e.g., contracts, memoranda of understanding, formal written agreements, and/or other letters of agreement). Transportation agreements should include, at a minimum, the following elements:

• Type of vendor (commercial vs. government)
• Number and type of vehicles, including vehicle load capacity and configuration
• Number and type of drivers, including certification of drivers
• Number and type of support personnel
• Vendor’s response time
• Vendor’s ability to maintain cold chain, if necessary to the incident

In addition to this process, public health should have written evidence of a relationship with outside transportation vendors. This relationship may be demonstrated by a signed transportation agreement or documentation of transportation planning meeting with the designated vendor.

Priority 3: Written plans should include protocols for medical and health related agencies and organizations to report medical materiel levels to public health at least weekly, but potentially more frequently.

Function 2: Acquire medical materiel

Obtain medical materiel from jurisdictional caches and request materiel from jurisdictional, private, regional, or federal partners, as necessary.

Tasks
Task 1: Request and accept medical materiel from jurisdictional, private, regional, or federal partners in alignment with National Incident Management System standards and incident needs.

Task 2: Maintain integrity of medical materiel in accordance with manufacturer specifications during acquisition and storage.

Performance Measure
Measure 1: Composite performance indicator from the Division of Strategic National Stockpile (DSNS) in CDC’s Office of Public Health Preparedness and Response.

Resource Elements
Priority 1: Written plans should include a process to request medical materiel (initial request and re-supply requests), including memoranda of understanding and mutual aid agreements with state/local partners if applicable. These plans should consider the following elements:
• Assessment of local inventory/medical countermeasure caches
• Identification of local pharmaceutical and medical-supply wholesalers
• Assessment of asset request trigger indicators, thresholds, and validation strategies to guide decision-making
• A process for requesting medical countermeasures through the Emergency Management Assistance Compact
• A process for requesting medical countermeasures from the federal level, which takes into account
  o Stafford Act vs. non-Stafford Act declarations
  o National Emergencies Act
  o Coordination between federal and state resources, including memoranda of understanding between CDC and the state
  o Role of U.S. Department of Health and Human Services Regional Emergency Coordinators, if necessary to the incident:

http://www.phe.gov/Preparedness/responders/rec/Pages/contacts.aspx

• A process for justifying medical countermeasure requests
• If sites decide to purchase their own medical countermeasures, they are required to meet regulatory standards (i.e., abide by U.S. Food and Drug Administration standards including current good manufacturing practices (cGMP), have appropriate Drug Enforcement Administration registrations, and be responsible to fund and track medical countermeasures rotation).

Suggested resources
• Requesting Strategic National Stockpile Assets:
  https://www.orau.gov/snsnet/functions/requesting.htm
• Sample Memorandum of Agreement. Receiving, Distributing, and Dispensing Strategic National Stockpile Assets: A Guide for Preparedness, Version 10.02, Appendix I:
Function 3: Maintain updated inventory management and reporting system

Maintain inventory system for the jurisdiction’s medical materiel for the life of the materiel, including acquisition, receipt, storage, transport, recovery, disposal, and return or loss.

Tasks

Task 1: Conduct initial inventory and update inventory management system with incoming and outgoing medical materiel, and materiel that is recovered, returned, or disposed of.

Task 2: Provide inventory status reports to jurisdictional, state, regional, and federal authorities at least weekly during an incident, but potentially more frequently.

Task 3: Track re-supply requests for medical materiel.

Performance Measure

Measure 1: Composite performance indicator from the Division of Strategic National Stockpile (DSNS) in CDC’s Office of Public Health Preparedness and Response.

Resource Elements

Priority 1: Written plans should include protocols for reporting to jurisdictional, state, regional, and federal authorities. At a minimum, report should include the following elements:

- Amount of materiel received (including receipt date/time and name of individual who accepted custody of materiel)
- Amount of materiel distributed
- Amount of materiel expired
- Current available balance of materiel

Function 4: Establish and maintain security

In coordination with emergency management and jurisdictional law enforcement, secure personnel and medical materiel during all phases of transport and ensure security for receiving site and distribution personnel.

Tasks

Task 1: Identify receiving sites from pre-identified locations and determine which sites may require increased security (such as controlled-substance storage areas).

Task 2: At the time of the incident, if necessary, identify additional receiving sites and determine which sites may require increased security (such as controlled-substance storage areas).

Task 3: Identify, acquire, and maintain security measures at receiving sites and during transportation to points of dispensing, if applicable to the incident.

Performance Measure

Measure 1: Composite performance indicator from the Division of Strategic National Stockpile (DSNS) in CDC’s Office of Public Health Preparedness and Response.

Resource Elements

Priority 1: Written plans should include processes and protocols that address the maintenance of physical security of medical countermeasures throughout acquisition, storage, and distribution and include, at a minimum, the following elements:

- Contact information for security coordinator
- Coordination with law enforcement and security agencies to secure personnel and facility
- Acquisition of physical security measures (e.g., cages, locks, and alarms) for materiel within the receiving site
- Maintenance of security of medical materiel in transit
Function 5: Distribute medical materiel

Distribute medical materiel to modalities (e.g., dispensing sites, treatment locations, intermediary distribution sites, and/or closed sites).

Tasks

Task 1: Determine allocation and distribution strategy, including delivery locations, routes, and delivery schedule/frequency, based on incident needs.

Task 2: Maintain integrity of medical materiel in accordance with established safety and manufacturer specifications during all phases of transport and distribution.

Performance Measure

Measure 1: Composite performance indicator from the Division of Strategic National Stockpile (DSNS) in CDC’s Office of Public Health Preparedness and Response.

Resource Elements

Priority 1: Written plans should include an allocation and distribution strategy including delivery locations, routes, and delivery schedule/frequency, and should take into consideration the transport of materials through restricted areas. The strategy should also consider whether recipients will be responsible for acquiring materiel from an intermediary distribution site or if the health department is responsible for delivering materiel.

Suggested resources


Function 6: Recover medical materiel and demobilize distribution operations

Tasks

Task 1: Recover materiel and equipment according to jurisdictional policies and federal regulations.

Task 2: Determine the disposition of unused (unopened) medical materiel, unused pharmaceuticals, and durable items within the jurisdictional health system according to jurisdictional policies.

Task 3: Dispose of biomedical waste materials generated by medical materiel management operations according to jurisdictional policies.

Task 4: Scale down distribution operations by deactivating receiving sites and releasing personnel as appropriate to evolving incident needs and in accordance with National Incident Management System protocol.

Task 5: Document incident findings as part of after action report process.

Performance Measure

Measure 1: Composite performance indicator from the Division of Strategic National Stockpile (DSNS) in CDC’s Office of Public Health Preparedness and Response.

Resource Elements

Priority 1: Written plans should include protocols for the storage, distribution, disposal, or return of unused (unopened) medical materiel, unused pharmaceuticals, and durable items, including plans for maintaining integrity of medical materiel during storage and/or distribution within the jurisdictional health system.

Capability 13: Public Health Surveillance & Epidemiological Investigation
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.

This capability consists of the ability to perform the following functions:

- Function 1: Conduct public health surveillance and detection
- Function 2: Conduct public health and epidemiological investigations
- Function 3: Recommend, monitor, and analyze mitigation actions
- Function 4: Improve public health surveillance and epidemiological investigation systems

**Function 1: Conduct public health surveillance and detection**

Conduct ongoing systematic collection, analysis, interpretation, and management of public health-related data to verify a threat or incident of public health concern, and to characterize and manage it effectively through all phases of the incident.

**Tasks**

**Task 1:** Engage and retain stakeholders, which are defined by the jurisdiction, who can provide health data to support routine surveillance, including daily activities outside of an incident, and to support response to an identified public health threat or incident.

**Task 2:** Conduct routine and incident-specific morbidity and mortality surveillance as indicated by the situation (e.g., complications of chronic disease, injury, or pregnancy) using inputs such as reportable disease surveillance, vital statistics, syndromic surveillance, hospital discharge abstracts, population-based surveys, disease registries, and active case-finding.

**Task 3:** Provide statistical data and reports to public health and other applicable jurisdictional leadership in order to identify potential populations at-risk for adverse health outcomes during a natural or man-made threat or incident.

**Task 4:** Maintain surveillance systems that can identify health problems, threats, and environmental hazards and receive and respond to (or investigate) reports 24/7.

**Performance Measure**

**Measure 1:** Proportion of reports of selected reportable diseases received by a public health agency within the jurisdiction-required time frame.

- **Numerator:** Number of reports of selected reportable disease received by a public health agency within the jurisdiction-required time frame
- **Denominator:** Number of reports of selected reportable disease received by a public health agency

**Resource Elements**

**Priority 1:** Written plans should document the legal and procedural framework that supports mandated and voluntary information exchange with a wide variety of community partners, including those serving communities of color and tribes.

**Priority 2:** Written plans should include processes and protocols for accessing health information that follow jurisdictional and federal laws and that protect personal health information via instituting security and confidentiality policies.

**Priority 3:** Written plans should include processes and protocols to gather and analyze data from the following:

- 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.
- Syndromic surveillance systems. Jurisdictions are encouraged to establish or participate in such systems to monitor trends of illness or injury, and to provide situational awareness of healthcare utilization.
  - Participation in the CDC BioSense data-sharing program is encouraged
• Surveillance of major causes of mortality, including the use of vital statistics as a data source
• Written plans should be able to adapt to include novel and/or emerging public health threats.

Gathering and analyzing data from the following sources should also be taken into consideration:
• Environmental conditions
• Hospital discharge abstracts
• Information from mental/behavioral health agencies
• Population-based surveys
• Disease registries
• Immunization registries/Immunization information systems
• Active case finding (e.g., by healthcare logs and record reviews)

Priority 4: Written plans should include procedures to ensure 24/7 health department access (e.g., designated phone line or contact person in place to receive reports) to collect, review, and respond to reports of potential health threats.

Priority 5: Written plans should include processes and protocols to notify CDC of cases on the Nationally Notifiable Infectious Disease List within the time frame identified on the list, including immediate notification when indicated. 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. Plans should include procedures to move to electronic case notification using CDC’s Public Health Information Network Case Notification Message Mapping Guides. Suggested resource – Case Notification Message Mapping Guides: http://www.cdc.gov/phin/resources/guides/mmghomepagetasenotification.html.

Priority 6: Public health staff conducting data collection, analysis, and reporting in support of surveillance and epidemiologic investigations should achieve, at a minimum, the Tier 1 Competencies and Skills for Applied Epidemiologists in Governmental Public Health Agencies.
• When creating new surveillance systems, consideration should be given to securing assistance (e.g., from academic institutions or state-level staff) from individuals with Tier 2 Competencies and Skills for Applied Epidemiologists in Governmental Public Health Agencies.
• Note: Formal educational degree requirement and masters' degree supervision requirement is suggested but not required.

Suggested resources:
• Tier 1 Competencies and Skills for Applied Epidemiologists in Governmental Public Health Agencies: http://www.cste.org/dnn/Portals/0/AEC_Summary_Tier1.pdf
• Tier 2 Competencies and Skills for Applied Epidemiologists in Governmental Public Health Agencies: http://www.cste.org/dnn/Portals/0/AEC_Summary_Tier2.pdf

Priority 7: Have or have access to health information infrastructure and surveillance systems that are able to accept, process, analyze and share data for surveillance and epidemiological investigation activities.
• 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.

Function 2: Conduct public health and epidemiological investigations
Identify the source of a case or outbreak of disease, injury, or exposure and its determinants in a population (e.g., time, place, person, disability status, living status, or other indices) to coordinate and report the summary results of the analysis to jurisdictional and federal partners, as appropriate.

Tasks

Task 1: Conduct investigations of disease, injury or exposure in response to natural or man-made threats or incidents and ensure coordination of investigation with jurisdictional partner agencies. Partners include law enforcement, environmental health practitioners, public health nurses, maternal and child health, and other regulatory agencies if illegal activity is suspected.

Task 2: Provide epidemiological and environmental public health consultation, technical assistance, and information to local health departments regarding disease, injury, or exposure and methods of surveillance, investigation, and response.

Task 3: Report investigation results to jurisdictional and federal partners, as appropriate.

Performance Measure

Measure 1: Percentage of infectious disease outbreak investigations that generate reports
- **Numerator**: Number of infectious disease outbreak investigation reports generated
- **Denominator**: Number of infectious disease outbreak investigation reports investigated

Measure 2: Percentage of infectious disease outbreak investigation reports that contain all minimal elements
- **Numerator**: Number of infectious disease outbreak investigation reports generated containing all minimal elements
- **Denominator**: Total number of infectious disease outbreak investigation reports generated

Measure 3: Percentage of acute environmental exposure investigations that generate reports
- **Numerator**: Number of acute environmental exposure investigation reports generated
- **Denominator**: Number of acute environmental exposures investigated

Measure 4: Percentage of acute environmental exposure reports that contain all minimal elements
- **Numerator**: Number of acute environmental exposure reports generated containing all minimal elements
- **Denominator**: Number of acute environmental exposure investigation reports generated

Resource Elements

Priority 1: Written plans should include investigation report templates that contain the following minimal elements:
- **Context / Background** – Information that helps to characterize the incident, including the following:
  - Population affected (e.g., estimated number of persons exposed and number of persons ill)
  - Location (e.g., setting or venue)
  - Geographical area(s) involved
  - Suspected or known etiology
- **Initiation of Investigation** – Information regarding receipt of notification and initiation of the investigation, including the following:
  - Date and time initial notification was received by the agency
  - Date and time investigation was initiated by the agency
- **Investigation Methods** - Epidemiological or other investigative methods employed, including the following:
  - Any initial investigative activity (e.g., verified laboratory results)
  - Data collection and analysis methods (e.g., case-finding, cohort/case-control studies, environmental)
  - Tools that were relevant to the investigation (e.g., epidemic curves, attack rate tables, and questionnaires)
  - Case definitions (as applicable)
  - Exposure assessments and classification
  - Review of reports developed by first responders, lab testing of environmental media, reviews of environmental testing records, industrial hygiene assessments, questionnaires

- **Investigation Findings/Results** - all pertinent investigation results, including the following:
Epidemiological results
Laboratory results (as applicable)
Clinical results (as applicable)
Other analytic findings (as applicable)

- Discussion and/or Conclusions – analysis and interpretation of the investigation results, and/or any conclusions drawn as a result of performing the investigation. In certain instances, a Conclusions section without a Discussion section may be sufficient.
- Recommendations for Controlling Disease and/or Preventing/Mitigating Exposure – specific control measures or other interventions recommended for controlling the spread of disease or preventing future outbreaks and/or for preventing/mitigating the effects of an acute environmental exposure.
- Key investigators and/or report authors – names and titles are critical to ensure that lines of communication with partners, clinicians and other stakeholders can be established.

Priority 2: Maintain staffing capacity to manage the routine epidemiological investigation systems at the jurisdictional level as well as to support surge epidemiological investigations in response to natural or intentional threats or incidents. This is accomplished through the following:

- Surge staff should be competent in Tier 1 Competencies and Skills for Applied Epidemiologists in Governmental Public Health Agencies.
- Consideration should be given to securing assistance (e.g., academic institutions or state-level staff) from an individual with Tier 2 Competencies and Skills for Applied Epidemiologists in Governmental Public Health Agencies.
- Note: Formal educational degree requirement and masters’ degree supervision requirement is suggested but not required.

Suggested resources

- Tier 1 Competencies and Skills for Applied Epidemiologists in Governmental Public Health Agencies: [http://www.cste.org/dnn/Portals/0/AEC_Summary_Tier1.pdf](http://www.cste.org/dnn/Portals/0/AEC_Summary_Tier1.pdf)
- Tier 2 Competencies and Skills for Applied Epidemiologists in Governmental Public Health Agencies: [http://www.cste.org/dnn/Portals/0/AEC_Summary_Tier2.pdf](http://www.cste.org/dnn/Portals/0/AEC_Summary_Tier2.pdf)

Function 3: Recommend, monitor and analyze mitigation actions

Recommend, implement, or support public health interventions that contribute to the mitigation of a threat or incident as well as monitor the effectiveness of the interventions.

Tasks

**Task 1:** Determine public health mitigation, including clinical and epidemiological management and actions to be recommended for the mitigation of the threat or incident based upon data collected in the investigation and on applicable science-based standards outlined by *Morbidity and Mortality Weekly Report*, control of Communicable Diseases Manual, Red Book of Infectious Diseases or, as available, a state or CDC incident annex.

**Task 2:** Provide information to public health officials to support them in decision making related to mitigation actions.

**Task 3:** Monitor and analyze mitigation actions throughout the duration of the public health threat or incident.

**Task 4:** Recommend additional mitigation activities, based upon mitigation monitoring and analysis, throughout the duration of the incident, as appropriate.

Performance Measure

**Measure 1:** Proportion of reports of selected reportable diseases for which initial public health control measure(s) were initiated within the appropriate time frame.

- **Numerator:** Number of reports of selected reportable diseases for which public health control measure(s) were initiated within an appropriate time frame.
- **Denominator:** Number of reports of selected reportable diseases received by a public health agency.
Resource Elements

Priority 1: Written plans should include protocols for recommending and initiating, if indicated, containment and mitigation actions in response to public health incidents. Protocols include case and contact definitions, clinical management of potential or actual cases, the provision of medical countermeasures, and the process for exercising legal authority for disease, injury, or exposure control. Protocols should include consultation with the state or territorial epidemiologist when warranted.

Priority 2: Public health staff participating in epidemiological investigations should receive awareness-level training with the Homeland Security Exercise and Evaluation After Action Report process.

Function 4: Improve public health surveillance and epidemiological investigation systems

Assess internal agency surveillance and epidemiologic investigation both during and after an incident and implement quality improvement measures that are within jurisdictional public health agency control.

Tasks

Task 1: Identify issues and outcomes during and after the incident.

Task 2: Conduct post-incident/post-exercise agency evaluation meeting(s) including all active participants (e.g., law enforcement, volunteer agencies, clinical partners or environmental regulatory agency) to identify internal protocols and deficiencies that require corrective actions in areas such as programs, personnel, training, equipment, and organizational structure.


Task 4: Communicate recommended After Action Report Improvement Plan corrective actions to public health leadership.

Performance Measure

N/A

Resource Elements

Priority 1: Written plans should include procedures to communicate the improvement plan to key stakeholders (including groups representing at-risk populations) and to implement corrective actions identified in the improvement plan.

SECTION 4 – Attachments

Attachments have been created for each work plan separate from the guidance document. You can find these attachments along with the PHEP Grant Documents at: http://www.kdheks.gov/chp/cphp/lhd_resources.htm

Attachment 1: Local Work Plan Deliverables
Attachment 2: Regional Work Plan Deliverables
Attachment 3: Rush County Work Plan Deliverables (Non-Regionalized)
Attachment 4: CRI Work Plan Deliverables