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