

# **PREPAREDNESS PROGRAM**

Program Boundary Statements

Program Quality Criteria

Program Objectives

## **2010 Program Boundary Statement Public Health Preparedness Program And Cities Readiness Initiative Program**

For each performance-based contract program, the Wisconsin Division of Public Health (DPH) has identified a boundary statement. The boundary statement sets the parameters of the program with which the local public health agency (LPHA), Tribal Health Center, Public Health Preparedness Consortium, or other agency will set its objectives. The boundaries are intentionally as broad as federal and state law permits to provide maximum flexibility. However, if there are objectives or program directions that the program is not willing to consider, those are included in the boundary statement.

### **Program Boundary Statement:**

Public Health Preparedness funds must be utilized to develop state, regional and local emergency-ready public health agencies and Tribes (hereafter referred to as LPHA) by upgrading, integrating and evaluating preparedness for and response to public health emergencies. This will be done through coordination with federal, state, local, and tribal governments, the private sector, and non-governmental organizations. These emergency preparedness efforts are intended to support the National Response Framework, and comply with the National Incident Management System (NIMS), Homeland Security Exercise and Evaluation Program (HSEEP), and utilize the Incident Command System (ICS).

Planning for infrastructure development must be done in the areas of emergency response and recovery, resource management, medical asset distribution, communicable disease surveillance, epidemiological interventions, environmental health investigations, communication and notification, laboratory specimen transfer and testing, training and education.

The Centers for Disease Control and Prevention (CDC) has developed preparedness goals and associated measures that are directly linked to the protection of the health of the public. CDC's Preparedness Goals are intended to frame, plan, and prepare for urgent public health system response concepts for terrorism and non-terrorism events, including infectious disease, environmental and occupation-related emergencies. The Public Health Emergency Preparedness (PHEP) fund allocations are not intended for response efforts unless specifically approved by the CDC PHEP Project Officer. "Response" indicates non-routine public health system reaction to limit possible mortality, morbidity, loss of quality of life, or economic damage.

**THE CDC'S PREPAREDNESS GOALS ARE - PREVENT:** (1) Increase the use and development of interventions known to prevent human illness from chemical, biological, radiological agents, and naturally occurring health threats. **DETECT AND REPORT:** (2) Decrease the time needed to classify health events as terrorism or naturally occurring in partnership with other agencies. (3) Decrease the time needed to detect and report chemical, biological, radiological agents in tissue, food or environmental samples that cause threats to the public's health. (4) Improve the timeliness and accuracy of

communications regarding threats to the public's health. **INVESTIGATE:** (5) Decrease the time to identify causes, risk factors, and appropriate interventions for those affected by threats to the public's health. **CONTROL:** (6) Decrease the time needed to provide countermeasures and health guidance to those affected by threats to the public's health. **RECOVER:** (7) Decrease the time needed to restore health services and environmental safety to pre-event levels. (8) Improve the long-term follow-up provided to those affected by threats to the public's health. **IMPROVE:** (9) Decrease the time needed to implement recommendations from after-action reports following threats to the public's health. (*See the Centers for Disease Control and Prevention Public Health Emergency Preparedness Grant Guidance for specific details.*)

**Relationship to State Health Plan: *Healthiest Wisconsin 2010***

Public Health Preparedness outcomes have been mapped to the following Healthiest Wisconsin 2010 Health and System Priorities and Essential Public Health Services.

*State Plan System Priorities:*

- Community Health Improvement Processes and Plans
- Coordination of State and Local Public Health System Partnerships
- Sufficient, Competent Workforce
- Equitable, Adequate, and Stable Financing

*State Plan Health Priorities:*

- Access to Primary and Preventive Health Services
- Adequate and Appropriate Nutrition
- Alcohol and Other Substance Use and Addiction
- Environmental and Occupational Health Hazards
- Existing, Emerging and Re-emerging Communicable Disease
- Intentional and Unintentional Injuries and Violence
- Mental Health and Mental Disorders
- Social and Economic Factors that Influence Health
- Integrated Electronic Data and Information Systems

*Essential Public Health Services:*

- Monitor health problems to identify community health problems
- Identify, investigate, control and prevent health problems and environmental health hazards in the community
- Educate the public about current and emerging health issues
- Promote community partnerships to identify and solve health problems
- Create policies and plans that support individual and community health efforts
- Enforce laws and regulations that protect health and insure safety
- Link people to needed health services
- Assure access to primary health
- Foster the understanding and promotion of social and economic conditions that support good health

**Unacceptable Proposals:**

There are several actions that are not allowable uses of CDC's PHEP Cooperative Agreement funding for both the Public Health Emergency Preparedness Program and the Cities Readiness Initiative Program.

Funds may not be used for:

- Research
- Reimbursement of pre-award costs
- Purchase vehicles of any kind
- Purchase incentive items
- Supplant any current state or local expenditures
- CRI funding may not be used to purchase inventory tracking software, vehicles, medications and medical supplies for use on the general population. Prophylaxis for health department first responders and their families is acceptable with the approval of the Division of State and Local Response – Project Officer in collaboration with the Division of Strategic National Stockpile – Subject Matter Expert.

All expenses charged to the PHEP funding must be directly related to the program objectives.

**Supplantation:**

Supplantation means using Federal funds to replace State or local funds. The Public Health Service Act, Title 1, Section 319(c) specifically states: “SUPPLEMENT NOT SUPPLANT. ~ Funds appropriated under this section shall be used to supplement and not supplant other Federal, State, and local public funds provided for activities under this section.”

**Resources:**

The DPH Preparedness Program has adopted and recommends use of the guidelines for preparedness activities as contained in Project Public Health Ready, nationally recognized competency and training standards, Wisconsin Preparedness Leadership Group and the Senior Advisory Committee recommendations.

**References:**

- Wisconsin Public Health Emergency Plan
- Centers for Disease Control and Prevention Public Health Emergency Preparedness Grant Guidance
- Pandemic and All-Hazards Preparedness Act
- National Response Framework
- National Incident Management System
- Homeland Security Exercise and Evaluation Program
- Strategic National Stockpile Program
- Pandemic Influenza Program
- Cities Readiness Initiative Program
- Homeland Security Presidential Directive 21

## **2010 Program Quality Criteria Public Health Preparedness Program And Cities Readiness Initiative Program**

The quality criteria focus on program development and implementation that result in cost-effective and consistent programs and policies throughout the state. They are required for an agency to be eligible to receive a public health preparedness contract. Contractees will implement policies and procedures that will assure each criterion is met for this program. Those criteria include:

### **1. Assessment and surveillance:**

- Contractees will identify community needs and support systematic competent program planning and sound policy development with activities focused at both the individual and community levels.
- Contractees will periodically assess public health preparedness within their agency or consortium by completing the required Wisconsin Division of Public Health (DPH) identified assessments, reports, and surveys, including annual completion of the SNS Technical Assistance Review (TAR).
- Contractees will annually conduct public health preparedness exercises and drills, and update the Public Health Emergency Plan (PHEP) and other associated plans based on the results of exercises and drills. Evaluation of the exercise will be completed using the After Action Report/Improvement Plan (AAR/IP) for each real event and exercise where the contractee leads or participates in a major role.
  - All public health exercises and drills that are conducted will be reported and evaluated in accordance with the Homeland Security Exercise and Evaluation Program (HSEEP) and NIMS all-hazards incident response compliance guidelines, using the HSEEP AAR/IP form. A notice prior to each event or exercise is to be posted on the National Exercise Schedule (NEXS).
  - A copy of the actual AAR/IP, or a message indicating the exercise/event was done including the date, lead agency, name and type of event, person to contact to review the exercise report content will be posted on the HAN no later than 60 days after the event.
  - Annual drills include testing and recording results of 24/7 off-hour response times conducted at the state, regional and local levels as detailed in the DPH and Local Performance Measures.
  - Contractees will annually demonstrate the corrective actions implemented by the agency to improve their public health emergency response capacity.

- Contractees will assess and train public health staff in accordance with nationally recognized competency standards as indicated by the Division of Public Health. Trainings, to the extent possible, will be planned and implemented based on needs identified through assessments and/or evaluations of performance and coordinated to ensure the most effective and efficient use of PHP funding.
- Contractees will assess Personal Protective Equipment (PPE) needs for their agency, purchase PPE, and train staff in PPE use for public health emergencies.

## **2. Delivery of public health services:**

- Contractees' qualified health professionals will provide public health services in a manner that is family centered, culturally competent and consistent with best practices for improvement of the community health status.
- Contractees must have a plan/system for appropriately addressing the public health needs for at-risk/vulnerable/special populations.
- Contractees agree to adopt, implement and demonstrate compliance with NIMS, ICS, and HSEEP. This includes the development and maintenance of a Local Public Health Agency (LPHA) ICS command structure that is at least three persons deep. Each LPHA will also use HSEEP for public health exercise design, implementation, evaluation and reporting.
  - Contractees are encouraged to direct funding towards activities necessary to advance implementation of NIMS requirements in accordance with the guidelines within their agency and with their partners that have designated roles and responsibilities in the agency's Incident Command System (ICS) and Emergency Operations Center (EOC).
- Contractees will assure the ability for the general public to be able to contact the LPHA 24 hours a day, 7 days a week.

## **3. Record keeping:**

- Contractees will assure documentation and tracking of individual focused services, respond to known health care problems on a timely basis, and keep client information confidential.

#### **4. Information educational outreach:**

- Contractees will regularly present to the media, partners and other stakeholders on their agency or consortium and the Public Health Preparedness Program in coordination with DPH program staff.
- Contractees are encouraged to affect policy and environmental changes at the community level.

#### **5. Coordination:**

- Contractees will assure that identified public health needs are addressed in a comprehensive, cost-effective manner across programs throughout the state. Public health partners may include human/social services agencies, hospitals, clinics, law and fire departments, schools, businesses, emergency government, neighboring LPHA, Public Health Preparedness Consortia, Wisconsin Emergency Management, DPH, and other state agencies.
- Contractees will be trained and utilize the following systems as appropriate and available: Public Health Information Network (PHIN), Analysis, Visualization and Reporting (AVR) system, Wisconsin Electronic Disease Surveillance System (WEDSS), Partner Communication and Alert (PCA) system, the Health Alert Network (HAN), TRAIN (TrainingFinder Real-time Affiliate Integrated Network), and other systems provided by DPH. Training to include at minimum the Health Officer/Tribal Health Director, or their designee.
- Contractees will coordinate with other preparedness programs by participating in state, regional, tribal, and local preparedness meetings.
- Contractees will contribute to the development of a statewide system for public health emergency response that is coordinated, consistent and efficient.
- Contractees will provide documentation for Pandemic Influenza preparedness as directed by CDC grant guidance and DPH contract requirements.
- Contractees will demonstrate involvement in setting statewide goals, strategic direction, and priorities for the public health preparedness program.
- Contractees will contribute to the development and sharing of tools, work plans, products, projects, templates, and other resources in a collaborative effort with DPH, LPHA, Public Health Preparedness Consortia, and other partners.

- Contractees will implement strategies and actions as directed by the goals and objectives of their regional and local work plans.
- Contractees will assist state and local SNS planners and healthcare administrators to coordinate activities in a public health emergency in which SNS assets are deployed.
- Contractees will maintain at least four tiers of redundant communication: Landline/Cellular Telephones, Two-Way Radio (UHF/VHF/800mhz), Satellite Telephone, Amateur (HAM) Radio.

**6, Provision of guidance to staff:**

- Contractees, through program and policy manuals and other means, will assure quality health care and cost-effective program administration. Provision of guidance should stem from, but is not limited to, the local Public Health Emergency Plan (PHEP).

**7. Financial management practices:**

- Contractees will maintain sufficient financial management practices to assure accurate eligibility determination, appropriate use of state and federal funds, prompt and accurate billing and payment for services provided and purchased, accurate expenditure reporting. Financial management includes ensuring that all PHEP grant spending is auditable by an outside agency.

**8. Data collection, analysis, and reporting:**

- Contractees will assure program outcome goals are met and will identify program management problems that need to be addressed.

## Year 2010 Local Template Objectives for Public Health Preparedness

### Legend

**A Objective Statement  
Your Information**  
**B Deliverable**  
**C Context**

**D Input Activities**

**G For**

**E Base Line for Measurement**

**F Data Source for Measurement**

### 1. LOCAL CONTINUATION

**A. REQUIRED LOCAL HEALTH DEPARTMENT/TRIBE (Planning) (1 of 5): By December 31, 2010, (insert name of LHD/tribe) will engage in a continuous planning process with local and regional partners to respond to public health emergencies.**

B. An agency report to include a summary of partners included in planning and the updates and changes made in 2010 to the agency's Public Health Emergency Preparedness Plan and other related plans.

C. This objective relates directly to the 2007 recommendation made by the Wisconsin Preparedness Leadership Group to develop a measurable goal and objective to create, maintain and update comprehensive plans to respond to public health emergencies. The local agency is responsible to meet and plan with local and regional partners to prepare for public health emergency event responses and to annually update the local Public Health Emergency Preparedness (PHEP) Plan and other related plans. This is in addition to the ongoing agency responsibilities to orient their staff members in their roles and responsibilities during an emergency event response. In part, this planning should include the development of community plans, protocols, and/or Memorandums of Understanding (MOU) regarding the distribution and dispensing of vaccines, antivirals, personal protective equipment (PPE), and other countermeasures for their jurisdiction. In 2007 and 2008, the recommendations of Antiviral Distribution Expert Panel addressed the need for Wisconsin to have a plan in place for antiviral medications and personal protective equipment to be distributed statewide. This issue is seen as a "critical component of public health and medical preparedness" (PHP Grant Guidance, pg 9).

The intent of this objective is to focus on implementing processes and systems to assure planning is done in a coordinated and effective manner. The agency's work plan should be considered an ongoing tool and work in progress that is updated as appropriate with the agency's preparedness goals and objectives. The PHEP and other related plans are to be compliant with the National Incident Management System (NIMS) and use the Incident Command System (ICS). Other related plans may reference mass clinics, the Interim Pharmaceutical Stockpile (IPS), and redundant/crisis/risk communications. Updates to the Strategic National Stockpile (SNS), will include an annual review with the Technical Assistance Review (TAR) tool. Local and regional partners may include human service agencies, hospitals, clinics, law and fire departments, schools, businesses, emergency management, other neighboring health departments, tribes, PHP consortia, the Division of Public Health, Wisconsin Emergency Management, and other state agencies. Specific plans to be addressed will be outlined in the Local Health Department Workplan.

E. This objective builds on prior years' efforts for continued planning with local and regional partners to respond to public health emergencies, including the annual update of the agency's Public Health Emergency Preparedness Plan and other related plans.

F. Agency records

G. The National Association of City and County Health Officers (NACCHO) Project Public Health Ready (PPHR) has developed a planning assessment tool that *may* be used to help update local PHEP and other related plans.

## **2. LOCAL REVISED**

### **A. REQUIRED LOCAL HEALTH DEPARTMENT/TRIBE**

**(Competencies/Training) (2 of 5) By December 31, 2010, staff of (insert name of LHD/Tribe) will engage in a continuous competency maintenance or improvement process.**

B. A summary to include: 1) a standardized report with the target benchmark number of agency staff for each Focus Area and level of competence rated as basic, intermediate or advanced; the actual number of agency staff that are competent in each Focus Area and level of competence; and the subsequent percentage of agency staff competent for each Focus Area and level of competence; 2) evidence of efforts to maintain or improve competencies, such as trainings and exercises.

C. This is a continuation of an objective in 2008 and 2009 building on assuring staff competency. Gaps identified in 2009 should be used to develop trainings and/or exercises to maintain or improve competencies at the local, regional, and state level. All LPHA will do assessments based on the same set of competencies as identified in the WI PHP Competency Inventory Set for 2010. The level of competency will be measured as either basic, intermediate, or advanced, with the *goal* being for every staff to be at the basic level in order to promote continuity of operations (i.e. if staff can't identify a Category A agent then they at least need to be able to identify who they would go to that does have that capability). If staff are assessed and found to not meet the basic level, that is still acceptable. Local Health Officers (or designee for setting benchmarks) can identify competencies as being "Not Applicable" for their staff though they are encouraged to hold everyone to the "basic" expectation. Each local agency may use an assessment method of their choosing as long as it addresses all Focus Areas identified in the WI PHP Competency Inventory Set for 2010. DPH will provide a standardized presentation that LPHA may use, or they may create their own.

The standardized template report back to the Division of Public Health (DPH) will consist of the aforementioned data criteria; this is the same reporting format that was used in 2009. Each local agency has the option to keep the name-identified data at their agency. "Public health staff" for Tribes includes all staff who respond during a public health emergency.

E. This objective builds on prior years' efforts for public health staff to participate in appropriate public health preparedness emergency response training.

F. Agency records

G. One of the goals of this objective is to develop a statewide training gap analysis in order to schedule trainings more effectively and consequently use PHP funding more efficiently. It is strongly recommended that any training scheduled be posted on the Wisconsin TrainingFinder Real-time Affiliate Integrated Network (TRAIN) to further encourage promotion of shared resources. TRAIN can be found at <http://wi.train.org>.

### **3. LOCAL REVISED**

**A. REQUIRED LOCAL HEALTH DEPARTMENT/TRIBE (Exercises) (3 of 5): By December 31, 2010, (insert name of LHD/tribe) will participate in a mass clinic exercise (tabletop, functional, or full-scale) or real event that meets the requirements set by the Centers for Disease Control (CDC).**

B. An agency report to include: 1) evidence of advance postings of all exercises to the National Exercise Schedule (NEXS), 2) a copy of the HSEEP-compliant After-Action Report/Improvement Plan (AAR/IP) for each exercise or real event posted on the Health Alert Network (HAN) no later than 60 days after the event, and 3) a summary of the corrective actions implemented in 2010

C. Each public health preparedness local and/or regional exercise is to:

- 1) Address the CDC performance standards: ensure that medical countermeasures can be rapidly dispensed to the effected population; ensure that critical medical supplies and equipment are appropriately secured, managed, distributed, and restocked in a timeframe appropriate to the incident; ensure adequate personnel are appropriately trained to accomplish these standards (See PHP Grant Guidance, pg 9);
- 2) Incorporate the National Incident Management System (NIMS) and the Incident Command System (ICS) (PHP Grant Guidance, pg 12);
- 3) Be compliant with Homeland Security Exercise and Evaluation Program (HSEEP) exercise guidelines including using HSEEP trained Exercise Evaluators and completing the AAR/IP for all real events and exercises no later than 60 days after the event. The AAR/IP may be found in the exercise guidelines contained in HSEEP Volume III or by accessing the HSEEP website at <https://hseep.dhs.gov>. A copy of the actual AAR/IP, or a message indicating the exercise was done with the date, lead agency, exercise name and type (actual event, table top, functional, or full-scale) and person to contact to review the actual AAR/IP content should be posted on the HAN (See PHP Grant Guidance, pg 11 and 36). Specific exercise target capabilities to be addressed will be outlined in the Local Health Department Workplan;
- 4) Post each exercise in advance on the National Exercise Schedule (NEXS) (see PHP Grant Guidance, pg 9); Note: this is not required if the objective was met through a real event.

5) Coordinate and communicate with DPH staff in any exercise scenario that would require DPH support (i.e. staff, resources) if the scenario were a real event.

E. This objective builds on prior years' efforts to participate in an annual public health emergency preparedness exercise or real event, to follow the CDC and other requirements and guidelines for evaluation and documentation, and to improve plans and systems based on the results of the exercise or real event.

F. Agency records

G. It is recommended that the Wisconsin Emergency Assistance Volunteer Registry (WEAVR), the CityWatch partner communication and alerting system, or the Wisconsin Electronic Disease Surveillance System (WEDSS) be used in planned exercises or real events.

#### **4. LOCAL REVISED**

**A. REQUIRED LOCAL HEALTH DEPARTMENT/TRIBE (Performance Measures) (4 of 5): By December 31, 2010, (insert name of LHD/tribe) will complete the 14 Performance Measures.**

B. An agency report to include the Performance Measures Matrix spreadsheet.

C. It is assumed that consortia staff will take the lead in conducting the PM drills for their LHDs. In those instances where consortia staff will *not* be taking the lead, Regional Office staff and/or internal LHD staff may also serve in this function. Staff that are conducting the testing must also enter the data into the identified database (either Access or Excel). Both real events and drills are acceptable methods of testing the PMs. The expectations for documentation are the same for both. Testing PMs during hours versus after hours is defined within the PM Matrix tool. Determination of which PMs Tribal entities will participate in should be agreed upon by the tribe, consortium, and contract administrator.

In the event that the Performance Measure drills are combined and executed during a functional or full-scale exercise, the following requirements must be fulfilled in addition to the Performance Measures Matrix spreadsheet: 1) evidence of advance postings exercise to the National Exercise Schedule (NEXS), 2) a copy of the HSEEP-compliant After-Action Report/Improvement Plan (AAR/IP) or approved message posted on the Health Alert Network (HAN) no later than 60 days after the event, 3) a summary of the corrective actions implemented in 2010, 4) incorporate the National Incident Management System (NIMS) and the Incident Command System (ICS) (PHP Grant Guidance, pg 12), 5) compliance with Homeland Security Exercise and Evaluation Program (HSEEP) exercise guidelines, and 6) coordination and communication with DPH staff in any exercise scenario that would require DPH support (i.e. staff, resources) if the scenario were a real event.

E. This objective builds on prior years' efforts to standardize drills at the local level. Standardizing data analysis will provide information for quality improvement at individual department levels. This process identifies the specific data elements that need to be recorded to complete the measure. The same reporting tools will be used in 2010 (with minor updates) to collect the data consistently.

F. Agency records

G. It is recommended that the Wisconsin Emergency Assistance Volunteer Registry (WEAVR), the CityWatch partner communication and alerting system, or the Wisconsin Electronic Disease Surveillance System (WEDSS) be used in planned drills, exercises, or real events.

## **5. LOCAL CONTINUED (AT-RISK POPULATIONS)**

**A. REQUIRED LOCAL HEALTH DEPARTMENT/TRIBE (At-Risk Populations) (5 of 5): By December 31, 2010, (insert name of LHD/tribe) will collaborate with community partners to develop an integrated public health response addressing at-risk populations during public health emergencies.**

B. An agency report to include: 1) evidence of participation in discussions related to at-risk populations such as meeting minutes and/or sign-in sheets showing meeting attendance, and 2) copies of associated protocols, plans (including updates and changes), or Memorandums of Understanding (MOU) developed related to at-risk populations and public health emergencies in their jurisdiction as available.

C. This objective relates directly to the federal Pandemic and All Hazards Preparedness Act that **requires** all agencies receiving funding to meet the goal of addressing the public health and medical needs of at-risk individuals in the event of a public health emergency. Before, during, and after a public health emergency, members of at-risk populations may have additional needs in one or more of the following functional areas: maintaining independence, communication, transportation, supervision, and medical care. In addition to those individuals specifically recognized as at-risk in the statute, i.e., children, senior citizens, and pregnant women, individuals who may need additional response assistance should include those who have disabilities; live in institutionalized settings; are from diverse cultures; have limited English proficiency or are non-English speaking; are transportation disadvantaged; have chronic medical disorders; and have pharmacological dependency. The Wisconsin Division of Public Health, in recognizing this mandate, convened a Special Populations Taskforce which produced a Special Populations Toolkit to be used by local entities in pre-planning for at-risk populations in a public health emergency. In recognizing the relevance of special populations in public health preparedness planning, certain indicators were included in the risk formula that were used to calculate funding allocations in 2009 and 2010 to local entities. In addition, the PHP Grant Guidance also states that the State Office for Aging (or equivalent office for addressing the emergency preparedness, response and recovery needs of the elderly) must be engaged in order to further our work in planning for the elderly in our communities

(PHP Guidance, pg 8). This objective also reinforces efforts in planning for special populations at a mass clinic, which is also a target measured in the Technical Assistance Review (TAR).

D. Recommended activities could include: 1) convening community meetings to discuss the Special Populations Toolkit, 2) convening a meeting with volunteer organizations in their jurisdiction to discuss sheltering in a public health emergency, or 3) include Special Populations/At-Risk planning in their mass clinic plans.

E. This objective builds on prior years' efforts for continued planning with local and regional partners to plan for special populations when responding to public health emergencies.

F. Agency records

### **Year 2010 Template Objectives for Public Health Preparedness - Cities Readiness Initiative**

#### Legend

**A Objective Statement**

**B Deliverable**

**C Context**

**G For Your Information**

**D Input Activities**

**E Base Line for Measurement**

**F Data Source for Measurement**

#### **1. CRI CONTINUATION**

**A. By July 31, 2010, (insert name of jurisdiction) will continue to develop and implement a scalable Cities Readiness Initiative (CRI) plan incorporating alternate methods of dispensing to provide oral medications during an incident to their entire jurisdiction within 48 hours.**

B. A copy of the agency's Cities Readiness Initiative (CRI) Plan with at least one alternate method of dispensing to provide oral medications during an event to the agency's jurisdiction within 48 hours.

C. Recipients should continue to coordinate planning and program implementation activities to ensure that state and local health departments, hospitals, other health care entities, and state and local public safety and emergency management agencies are able to mount a collective response featuring seamless interaction of their event-specific capabilities in the following areas: 1) dispensing of oral medications at the Points Of Dispensing (POD) site/s, 2) providing oral medications to first responders and critical infrastructure personnel, 3) public information and communications, 4) distribution of medical materiel to healthcare facilities and 5) tactical communications between command and control elements This activity is required by the Centers for Disease

Control Public Health Preparedness Cooperative Agreement. (Budget Period 10 Guidance page 9).

F. Agency Records

G. Input Activities: Potential agency input activities may include: Identify POD sites to accommodate the provision of antibiotics to the affected population, recruit volunteer staff for POD operations, and developing POD specific security plans. Examples of alternative methods include: Drive-thru POD, company prophylaxis, mobile mass prophylaxis teams. Potential agency input activities may include: Determining threshold criteria for shifting from a clinical dispensing model to a non-clinical model of dispensing.

## 2. CRI REVISED

**A. By July 31, 2010, (insert name of jurisdiction) will conduct three different drills from the Cities Readiness Initiative (CRI) suite of 8 possible drills provided by the Division of Public Health (DPH).**

B. Documentation of the results of agency drills will be done as follows:

- Completion of an After Action Report for any drill performed from the first suite of drills
- Completion of a standardized data collection matrix as provided by the Wisconsin Division of Public Health for any drill performed from the second suite of drills

Agencies who conduct these drills during a functional or full-scale exercise need to submit the Homeland Security Exercise and Evaluation Program (HSEEP) compliant After Action Report/Improvement Plan/ Corrective Action Plan. To comply with the Pandemic and All Hazards Preparedness Act (PAHPA) legislation, the planning/local jurisdiction(s) that comprises the 25% most populous within a CRI Metropolitan Statistical Area (MSA) must conduct at least one of the three drills prior to December 31, 2009 with the remaining two drills conducted by July 31, 2010.

C. Recipients will conduct three operational drills or may incorporate the three drills into a functional or full-scale exercise during the funding period. Please note, this does *not* include completing the same drill three separate times. The results of the drills or exercise should be used to improve their operational plans to receive, distribute and dispense mass prophylaxis. Evaluation of a jurisdiction's functional or full-scale exercise elements is to be supported by utilizing peer data collectors from neighboring jurisdiction or other states who have the corresponding subject matter experience/expertise and have been trained in the HSEEP. Exercise evaluators should have experience and subject-matter expertise in the area they are assigned to observe and cannot be from an agency directly involved with the exercise. Evaluators are not required for drills. This activity is required by the Centers for Disease Control Public Health Preparedness Cooperative Agreement. (Budget Period 10 Guidance page 9, 8, b., and page 17)

F. Agency Records

G.

### **3. CRI CONTINUATION**

**A. By July 31, 2010, (insert name of jurisdiction) will complete all Centers for Disease Control and Prevention (CDC) Cities Readiness Initiative (CRI) required assessments and metrics.**

B. A copy of the agency's completed CDC CRI assessment and metrics.

C. Recipients should continue to coordinate planning and program implementation activities to ensure that state and local health departments, hospitals, other health care entities, and state and local public safety and emergency management agencies are able to mount a collective response featuring seamless interaction of their event-specific capabilities in the following areas: 1) dispensing of oral medications at the Points of Dispensing (POD) site(s), 2) providing oral medications to first responders and critical infrastructure personnel, 3) public information and communications, 4) distribution of medical materiel to healthcare facilities and 5) tactical communications between command and control elements. This activity is required by the Centers for Disease Control Public Health Preparedness Cooperative Agreement. (Budget Period 10 Guidance page 9).

F. Agency records

### **4. CRI NEW**

**A. By July 31, 2010, (insert name of jurisdiction) as part of a CRI Metropolitan Statistical Area (MSA) will conduct or participate in at least one Homeland Security Exercise and Evaluation Program (HSEEP) compliant functional or full-scale mass prophylaxis dispensing exercise that includes all pertinent jurisdictional leadership and Emergency Support Function leads, planning and operational staff, and all applicable personnel.**

B. Documentation of the agency's HSEEP compliant After Action Report/Improvement Plan and summary of corrective actions implemented. Evidence to show the planning documents and the schedule for the functional or full-scale exercise were listed on the National Exercise Schedule (NEXS).

C. Recipients will conduct or participate in a functional or full scale exercise during the funding period and use the results of the exercise evaluation/corrective action plans to improve their operational plans to receive, distribute and dispense mass prophylaxis. Evaluation of a jurisdiction's exercise elements is to be supported by utilizing peer data collectors from neighboring jurisdiction or other states who have the corresponding subject matter experience/expertise and have been trained in the HSEEP. Exercise evaluators should have experience and subject-matter expertise in the area they are assigned to observe and cannot be from an agency directly involved with the exercise.

The exercise design, scheduling, and evaluation will be coordinated with the Division of Public Health. Evaluators are not required for drills. This activity is required by the Centers for Disease Control Public Health Preparedness Cooperative Agreement. (Budget Period 10 Guidance page 9).

F. Agency records

## Year 2010 Template Objectives for Public Health Preparedness – Consortia

Legend		
<b>A Objective Statement Your Information</b>	<b>D Input Activities</b>	<b>G For</b>
<b>B Deliverable</b>	<b>E Base Line for Measurement</b>	
<b>C Context</b>	<b>F Data Source for Measurement</b>	

### 1. CONSORTIUM CONTINUED (Technical Assistance)

**A. REQUIRED CONSORTIUM (1 of 1) By December 31, 2010, preparedness standards and capabilities will be improved in the (insert name of Public Health Preparedness Consortium) jurisdiction through technical assistance provided to city/county/tribe public health member agencies in planning for public health emergencies.**

B. A report to include a summary of templates, plans, tools, procedures, protocols, exercise after action reports/improvement plans and other resources created for member agencies as they specifically relate to all five of the 2010 Local Public Health Preparedness objectives and CRI objectives (as applicable).

C. The technical assistance provided by the consortium includes but is not limited to: professional consultation, resource identification and sharing, on-site visits, meetings, phone conferences; one-to-one, small or large group training sessions arranged, coordinated or provided by the consortium and presented to the agency staff and partners within their jurisdiction; compiling, writing and summarizing information and data; developing pilot projects, forms, plans, templates, tools, products or reports for use by the consortium or its member agencies; advocating for and representing the interests of the consortium members by participating in preparedness and other types of meetings at the local, regional and statewide level. The consortium will assist all member agencies in achieving all of their contract objectives and share preparedness materials with other consortia and DPH as requested.

E. This objective builds on prior years' efforts to provide support and technical assistance to consortium members and their public health partners at the local, regional and state level to plan and coordinate public health emergency response systems and processes.

F. Agency records