

*Texas Department of State Health Services*

## **Community Preparedness Section**



# **Local Health Department Planning Guidance**

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**Version 1**

## **For Additional Information**

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## Section I. Reorganizing Your Plan Structure

In March 2006, near the inception of the previous Public Health Emergency Preparedness funding cycle, the Texas Department of State Health Services released guidance for developing and organizing local health department emergency plans and standard operating guidelines. The guidance called for 22 separate appendices to the jurisdiction’s Annex H (Health and Medical Services); however, many of the appendices were redundant or unnecessary for local health department focus in fulfilling its unique emergency response roles and responsibilities. Additionally, with the release of 89 new Centers for Disease Control (CDC) standards for local, regional, and state plans ([http://www.cdc.gov/phpr/capabilities/DSLR\\_capabilities\\_July.pdf](http://www.cdc.gov/phpr/capabilities/DSLR_capabilities_July.pdf)), the time is right for a new model. The purpose of this document to present a new local health department plan structure that aligns with CDC standards and the state-level planning structure.

There are many benefits to changing the local health department plan structure to the model proposed below. For instance, existing state health and medical plans model the new structure. The State Annex H and appendices, for the most part, will now align with local annexes and appendices. The enhanced alignment of local, regional, and state plans will also provide common plan titles and topics at all levels. As mentioned, the new structure will eliminate plans where public health has little if any role. Finally, as Figure 1 illustrates, the new structure will build on the former to capitalize on plan development to date.

Figure 1 provides detail on how the new structure will align with the existing local health department plans. This chart can be used to map the transition to the new structure, as existing plans will serve as the basis for updating plans to meeting the CDC Preparedness Capability standards outlined in Section II.

**Figure 1: Comparison between New and Existing Local Health Department Plans**

New Planning Structure	Corresponding Existing Plans
<b>Annex H: Public Health and Medical Services</b>	Appendix 8: Health and Medical Services
<ul style="list-style-type: none"> <li>• <b>Appendix 1: Coordination and Control</b></li> </ul>	Appendix 15: Direction and Control
<ul style="list-style-type: none"> <li>• <i>Attachment 1: Administration</i></li> </ul>	Attachment 2 to Appendix 15: LHD/EOC Management
<ul style="list-style-type: none"> <li>• Tab A: Incident Command System Organization</li> </ul>	Attachment 1 to Appendix 15: Incident Command System Organization
<ul style="list-style-type: none"> <li>• Tab B: Unified/Area Command</li> </ul>	Tab A to Attachment 1 to Appendix 15: Unified/Area Command
<ul style="list-style-type: none"> <li>• <i>Attachment 2: Logistics</i></li> </ul>	Appendix 14: Resources Management
<ul style="list-style-type: none"> <li>• <i>Attachment 3: Staffing</i></li> </ul>	Appendix 9: Staffing Management
<ul style="list-style-type: none"> <li>• Tab A: Volunteer Coordination</li> </ul>	Attachment A to Appendix 9: Volunteers
<ul style="list-style-type: none"> <li>• Tab B: Responder Safety and Health</li> </ul>	Attachment B to Appendix 9: Worker Safety

<ul style="list-style-type: none"> <li>• <b>Appendix 2: Communications</b></li> </ul>	Appendix 2a: Communications (Communications and Emergency Response [CERC] plan)
<ul style="list-style-type: none"> <li>• <i>Attachment 1: Emergency Warning and Notification</i></li> </ul>	Appendix 2: Warning
<ul style="list-style-type: none"> <li>• <i>Attachment 2: Crisis and Emergency Risk Communications</i></li> </ul>	Not previously included in planning structure.
<ul style="list-style-type: none"> <li>• <b>Appendix 3: Community Recovery</b></li> </ul>	Appendix 11: Recovery
<ul style="list-style-type: none"> <li>• <i>Attachment 1: Continuity of Operations</i></li> </ul>	Attachment 1 to Appendix 11: Business Continuity Plan
<ul style="list-style-type: none"> <li>• <b>Appendix 4: Mass Fatality Management</b></li> </ul>	Not previously included in planning structure.
<ul style="list-style-type: none"> <li>• <b>Appendix 5: Disaster Behavioral Health Services</b></li> </ul>	Attachment D to Appendix 8: Behavioral Health
<ul style="list-style-type: none"> <li>• <b>Appendix 6: Biological Terrorism Response (Optional)</b></li> </ul>	Attachment A to Appendix 8: Bioterrorism Preparedness
<ul style="list-style-type: none"> <li>• <b>Appendix 7: Pandemic Influenza Response (Optional)</b></li> </ul>	Tab 1 to Attachment C to Appendix 8: Pandemic Influenza
<ul style="list-style-type: none"> <li>• <b>Appendix 8: Medical Countermeasures</b></li> </ul>	Tab 1 to Attachment A to Appendix 8: Strategic National Stockpile
<ul style="list-style-type: none"> <li>• <i>Attachment 1: Receipt, Staging and Storage (Health Service Region responsibility)</i></li> </ul>	SOG A: RSS
<ul style="list-style-type: none"> <li>• <i>Attachment 2: Coordination with Treatment Centers (relate to Attachment 3 Tab A)</i></li> </ul>	SOG B: Coordination with Treatment Centers
<ul style="list-style-type: none"> <li>• <i>Attachment 3: Inventory Control</i></li> </ul>	SOG C: Inventory Control
<ul style="list-style-type: none"> <li>• <i>Attachment 4: Repackaging</i></li> </ul>	SOG D: Repackaging
<ul style="list-style-type: none"> <li>• <i>Attachment 5: Security</i></li> </ul>	SOG E: Security
<ul style="list-style-type: none"> <li>• <i>Attachment 6: Dispensing</i></li> </ul>	SOG F: Dispensing
<ul style="list-style-type: none"> <li>• <i>Attachment 7: Command and Control (related to Appendix 1)</i></li> </ul>	SOG G: Command and Control
<ul style="list-style-type: none"> <li>• <i>Attachment 8: Tactical Communications</i></li> </ul>	SOG H: Communications
<ul style="list-style-type: none"> <li>• <i>Attachment 9: 1<sup>st</sup> Responder Prophylaxis</i></li> </ul>	Tab 2 to Attachment A to Appendix 8: 1 <sup>st</sup> Responder Prophylaxis
<ul style="list-style-type: none"> <li>• <i>Attachment 10: CHEMPACK Program (if applicable)</i></li> </ul>	Tab 3 to Attachment A to Appendix 8: CHEMPACK (if applicable)
<ul style="list-style-type: none"> <li>• <i>Attachment 11: Local Pharmacies</i></li> </ul>	Not previously included in planning structure.
<ul style="list-style-type: none"> <li>• <b>Appendix 9: Epidemiology and Laboratory</b></li> </ul>	Attachment C to Appendix 8: Epidemiology and Surveillance
<ul style="list-style-type: none"> <li>• <i>Attachment 1: Disease Reporting</i></li> </ul>	Tab 6 to Attachment C to Appendix 8: Disease Reporting
<ul style="list-style-type: none"> <li>• <i>Attachment 2: Laboratory Response</i></li> </ul>	Tab 4 to Attachment C to Appendix 8: Laboratory Response (LRN plans, if applicable)

<ul style="list-style-type: none"> <li>• <i>Attachment 3: Communicable Disease Control Measures</i></li> </ul>	Tab 5 to Attachment C to Appendix 8: Isolation and Quarantine
<ul style="list-style-type: none"> <li>• <i>Attachment 4: BioWatch Program (if applicable)</i></li> </ul>	Not previously included in planning structure.
<ul style="list-style-type: none"> <li>• <b>Appendix 10: Mass Care Support</b></li> </ul>	Appendix 3: Shelter and Mass Care
<ul style="list-style-type: none"> <li>• <i>Attachment 1: Evacuation</i></li> </ul>	Appendix 5: Evacuation
<ul style="list-style-type: none"> <li>• <i>Attachment 2: Shelter-in-Place</i></li> </ul>	Not previously included in planning structure.
<ul style="list-style-type: none"> <li>• <i>Attachment 3: Hospital and Medical Services Coordination</i></li> </ul>	Attachment E to Appendix 8: Hospital and Medical Services Coordination
<ul style="list-style-type: none"> <li>• Tab A: Medical Facilities</li> </ul>	Appendix 1: Local Health and Medical Facilities
<ul style="list-style-type: none"> <li>• Tab B: Triage</li> </ul>	Tab 1 to Attachment E to Appendix 8: Triage

**Note:** The following appendices were required in previous planning guidance. Local health departments are NOT required to maintain these appendices, rather they are expected to work with local emergency management to ensure that public health and medical issues are addressed in annexes where there may be a public health and medical role,. It is recommended that local health departments research the CDC Public Health Preparedness Capabilities: National Standards for State and Local Planning guidance and DSHS’ support role in corresponding state annexes as a potential model for local public health and medical roles.

- Appendix 4 to Annex H: Radiological Protection (Local Annex D)
- Appendix 6 to Annex H Fire Fighting (Local Annex F)
- Appendix 7 to Annex H: Law Enforcement (Local Annex G)
- SOG A of Tab 1 of Attachment 1 of Appendix 8 to Annex H: RSS (Health Service Region responsibility)
- Tabs 2 and 3 of Attachment C to Appendix 8 to Annex H: SARS and Smallpox (address in LHD Appendix 9 to Annex H: Epidemiology and Laboratory)
- Appendix 12 to Annex H: Public Works and Engineering (Local Annex K)
- Appendix 13 to Annex H: Energy and Utilities (Local Annex L)
- Attachment A to Appendix 3: Animal Care (if applicable)
- Appendix 16 to Annex H: Hazard Mitigation (Local Annex P)
- Appendix 17 to Annex H: Hazmat and Oil Spill (Local Annex Q)
- Appendix 18 to Annex H: Search and Rescue (Local Annex R)
- Appendix 19 to Annex H: Transportation (Local Annex S)
- Appendix 20 to Annex H: Donations Management (Local Annex T)
- Appendix 21 to Annex H: Legal (Local Annex U)
- Appendix 22 to Annex H: Terrorist Response (Local Annex V)
- Attachment C to Appendix 9: Citizen Corp, if applicable (Local Annex T, and as applicable, in Tab A to Attachment 3 to Appendix 1)

## Section II. Guidance for Addressing CDC Planning Elements

Figure 2 below provides guidance on incorporating CDC standards into the new planning structure. After completing the capabilities assessment, as outlined in the *Budget Period (BP) 11 Public Health Emergency Preparedness Work Plan for Local Health Departments*, this document will assist local health departments to integrate the CDC standards annually according to the capabilities prioritized in the assessment. In the following years, the capabilities assessment will prioritize the remaining capabilities and plan updates.

The information in the third column from the left identifies where the information in the priority resource element *may* be located. This is a starting place, as many of the current plans may not go into the detail required by the CDC. As well, local health departments may have additional plans and resources available that have not been identified in this document, hence this guidance should be considered a minimum level or skeletal framework of required plans. Also, the guidance column provides instructions and resources available to meet the priority resource element requirements.

**Note:** Per CDC Public Health Preparedness Capabilities: National Standards for State and Local Planning, local health departments are not required to “own” all the priority resource elements. It is permissible to “have access to” the plans (such as local emergency management plans) that contain the priority resource element.

**Figure 2: Guidance for Addressing CDC Planning Priority Resource Elements**

CDC Preparedness Capability	CDC Planning Priority Resource Elements	DSHS Considerations and Guidance
<b>1. Community Preparedness</b>	<p><i>Function 1, P1:</i> Written plans should include policies and procedures to identify populations with the following:</p> <ul style="list-style-type: none"> <li>• Health vulnerabilities such as poor health status</li> <li>• Limited access to neighborhood health resources (e.g., disabled, elderly, pregnant women and infants, individuals with other acute medical conditions, individuals with chronic diseases, underinsured persons, persons without health insurance)</li> <li>• Reduced ability to hear, speak, understand, or remember</li> <li>• Reduced ability to move or walk independently or respond quickly to directions during an emergency</li> <li>• Populations with health vulnerabilities that may be caused or exacerbated by chemical, biological, or radiological exposure</li> </ul>	<p>The previous Public Health Emergency Preparedness (PHEP) project period included activities to identify “populations requiring assistance during evacuation/shelter-in-place.”</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Review the existing jurisdictional Annex C: Shelter and Mass Care and/or the health department’s Appendix 3 to Annex H: Shelter and Mass Care to locate jurisdictional/departmental policies and procedures to identify populations with functional and/or access needs.</li> </ul> <p>Demographic data is not only valuable for mass care planning, but for all response functions. DSHS’ recommendation to fulfill</p>

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	<p>These procedures and plans should include the identification of these groups through the following elements:</p> <ul style="list-style-type: none"> <li>• Review/access to existing health department data sets</li> <li>• Existing chronic disease programs/maternal child health programs, community profiles</li> <li>• Utilizing the efforts of the jurisdiction strategic advisory council</li> <li>• Community coalitions to assist in determining the community's risks</li> </ul>	<p>this CDC priority resource element is to:</p> <ul style="list-style-type: none"> <li>□ Work with the local office of emergency management to briefly describe all policies, procedures, methods, and/or initiatives to identify vulnerable populations, as defined in the priority resource element, within Section IV: Situations &amp; Assumptions of <b>Annex H: Public Health and Medical Services</b>. Methods may include, but are not limited to: <ul style="list-style-type: none"> <li>• Coordinating with community coalitions and advisory councils to assess jurisdictional vulnerability. Any groups utilized should be referenced in <b>Annex H: Public Health and Medical Services</b>, as described below in the considerations for Function 2, Priority Resource Element 1.</li> <li>• Use of 2-1-1 or CodeRED to self-identify.</li> <li>• Collaborating with other departmental and jurisdictional programs to locate data sources that can be used to assess population health vulnerability.</li> <li>• Incorporating disability data, as provided in <i>Tab E: Selected County Demographic, Functional and Medical Needs Data</i> of the <i>Functional Needs Support Services Toolkit</i>:  <a href="https://www.preparingtexas.org/preparedness.aspx?page=32137bc8-eed7-42bb-ad7e-2765fd8abdb9">https://www.preparingtexas.org/preparedness.aspx?page=32137bc8-eed7-42bb-ad7e-2765fd8abdb9</a></li> </ul> </li> <li>□ Conduct an analysis of the jurisdiction's population. County, census tract, or zip code level population estimates should be summarized in table form within Section IV: Situations &amp; Assumptions of <b>Annex H: Public Health and Medical Services</b>.</li> </ul>

CDC Preparedness Capability	CDC Planning Priority Resource Elements	DSHS Considerations and Guidance
<p><b>1. Community Preparedness</b></p>	<p><i>Function 1, P2:</i> Written plans should include a jurisdictional risk assessment, utilizing an all-hazards approach with the input and assistance of the following elements:</p> <ul style="list-style-type: none"> <li>Public health and non-public health subject matter experts (e.g., emergency management, state radiation control programs/radiological subject matter experts (<a href="http://www.crcpd.org/Map/RCPmap.htm">http://www.crcpd.org/Map/RCPmap.htm</a>))</li> <li>Existing inputs from emergency management risk assessment data, health department programs, community engagements, and other applicable sources, that identify and prioritize jurisdictional hazards and health vulnerabilities</li> </ul> <p>This jurisdictional risk assessment should identify the following elements:</p> <ul style="list-style-type: none"> <li>Potential hazards, vulnerabilities, and risks in the community related to the public health, medical, and mental/behavioral health systems</li> <li>The relationship of these risks to human impact, interruption of public health, medical, and mental/behavioral health services</li> <li>The impact of those risks on public health, medical, and mental/behavioral health infrastructure</li> </ul> <p>Jurisdictional risk assessment must include at a minimum the following elements:</p> <ul style="list-style-type: none"> <li>A definition of risk</li> <li>Use of Geospatial Informational System or other mechanism to map locations of at-risk populations</li> <li>Evidence of community involvement in determining areas for risk assessment or hazard mitigation</li> <li>Assessment of potential loss or disruption of essential services such as clean water, sanitation, or the interruption of healthcare services, public health agency infrastructure</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Publish a <i>summary</i> of the Jurisdictional Risk Assessment results within Section IV: Situations &amp; Assumptions of <b>Annex H: Public Health and Medical Services</b>.</li> <li><input type="checkbox"/> Refer to the <i>Texas Jurisdictional Risk Assessment (under development)</i> for a definition of risk.</li> </ul>

CDC Preparedness Capability	CDC Planning Priority Resource Elements	DSHS Considerations and Guidance
<p><b>1. Community Preparedness</b></p>	<p><i>Function 2, P1:</i> Written plans should include a policy and process to participate in existing (e.g., led by emergency management) or new partnerships representing at least the following 11 community sectors: business; community leadership; cultural and faith-based groups and organizations; emergency management; healthcare; social services; housing and sheltering; media; mental/behavioral health; state office of aging or its equivalent; education and childcare settings.</p>	<ul style="list-style-type: none"> <li>□ Update in Section VI: Organization &amp; Assignment of Responsibilities of the local jurisdiction’s <b>Annex H: Public Health and Medical Services</b> how the health department coordinates with external partners. This may include, but is not limited to: <ul style="list-style-type: none"> <li>• List external organizations that may be able to support public health emergency response operations</li> <li>• Attending planning committees/advisory group meetings</li> <li>• Comment and review process for plans that engages external partners</li> <li>• Provide list of all jurisdictional annexes in which LHD has a supporting role</li> </ul> </li> </ul>
<p><b>1. Community Preparedness</b></p>	<p><i>Function 2, P2:</i> Written plans should include a protocol to encourage or promote medical personnel (e.g., physicians, nurses, allied health professionals) from community and faith-based organizations and professional organizations to register and participate with community Medical Reserve Corps or state Emergency Systems for Advance Registration of Volunteer Health Professionals programs to support health services during and after an incident.</p>	<ul style="list-style-type: none"> <li>□ Describe in <b>Tab A of Attachment 3 of Appendix 1 to Annex H: Volunteer Coordination</b> the department’s strategy(ies) to recruit medical volunteers. Examples may include, but are not limited to: <ul style="list-style-type: none"> <li>• Links to web-based registration for local Medical Reserve Corps units</li> <li>• The use of social media to market volunteer opportunities</li> <li>• Presentations to local community and faith-based organizations</li> </ul> </li> </ul>

CDC Preparedness Capability	CDC Planning Priority Resource Elements	DSHS Considerations and Guidance
<p><b>1. Community Preparedness</b></p>	<p><i>Function 4, P1:</i> Written plans should include documentation that public health has participated in jurisdictional approaches to address how children’s medical and mental/behavioral healthcare will be addressed in all-hazard situations, including but not limited to the following elements:</p> <ul style="list-style-type: none"> <li>• Approaches to support family reunification</li> <li>• Care for children whose caregivers may be killed, ill, injured, missing, quarantined, or otherwise incapacitated for lengthy periods of time</li> <li>• Increasing parents’ and caregivers’ coping skills</li> <li>• Supporting positive mental/behavioral health outcomes in children affected by the incident</li> <li>• Providing the opportunity to understand the incident</li> </ul>	<p>This requirement links to Function 2, Priority Resource Element 1.</p> <ul style="list-style-type: none"> <li>□ Document in Section VI: Organization &amp; Assignment of Responsibilities of the local jurisdiction’s <b>Annex H: Public Health and Medical Services</b> participating committees/advisory groups that include jurisdictional pediatric medical and behavioral health experts.</li> </ul> <p><u>Note:</u> If committees/advisory groups do not exist to address children’s medical and mental/behavioral healthcare issues, the health department should organize jurisdictional partners to address the priority resource’s five required elements within plans.</p> <ul style="list-style-type: none"> <li>□ Consider incorporating group recommendations into the concept of operations of applicable plans including, but not limited to: <ul style="list-style-type: none"> <li>• <b>Appendix 5 to Annex H: Disaster Behavioral Health</b></li> <li>• <b>Appendix 10 to Annex H: Mass Care Coordination</b></li> <li>• <b>Attachment 1 to Appendix 10 to Annex H: Evacuation</b></li> <li>• <b>Attachment 2 to Appendix 10 to Annex H: Shelter-in-Place</b></li> <li>• <b>Attachment 3 to Appendix 10 to Annex H: Hospital and Medical Services Coordination</b></li> </ul> </li> </ul> <p>For more information on children’s mental/behavioral health see <i>Helping Children Recover from the Emotional Aftermath of a Disaster</i> at:  <a href="http://www.dshs.state.tx.us/preparedness/factsheet_children_emo-rec.shtm">http://www.dshs.state.tx.us/preparedness/factsheet_children_emo-rec.shtm</a></p>

CDC Preparedness Capability	CDC Planning Priority Resource Elements	DSHS Considerations and Guidance
<p><b>2. Community Recovery</b></p>	<p><i>Function 1, P1:</i> Written plans should include processes for collaborating with community organizations, emergency management, and healthcare organizations to identify the public health, medical, and mental/behavioral health system recovery needs for the jurisdiction’s identified hazards.</p>	<ul style="list-style-type: none"> <li>□ Detail in Section V: Concept of Operations of <b>Appendix 3 to Annex H: Community Recovery</b> how the health department will collaborate with emergency management, healthcare organizations, community organizations, and DSHS Community Assessment for Public Health Response (CASPER) strike teams (<a href="http://www.dshs.state.tx.us/compred/rna/protocols.shtm">http://www.dshs.state.tx.us/compred/rna/protocols.shtm</a>) to obtain information specific to the public health, medical, and mental/behavioral health system status and needs.</li> </ul>
<p><b>2. Community Recovery</b></p>	<p><i>Function 1, P2:</i> Written plans should include how the health agency and other partners will conduct a community assessment and follow-up monitoring of public health, medical, and mental/behavioral health system needs after an incident.</p>	<ul style="list-style-type: none"> <li>□ Build into <b>Appendix 3 to Annex H: Community Recovery</b> a concept of operations for how health department will coordinate with DSHS Community Assessment for Public Health Response (CASPER) strike teams and communicate assessment findings to the local Emergency Operations Center (EOC). For more information see <i>Pocket Guide: Texas CASPER Strike Team</i>, May 2011.</li> <li>□ Describe in <b>Appendix 3 to Annex H: Community Recovery</b> any additional public health, medical and mental/behavioral health community assessments health department may complete or contract to complete following a response.</li> </ul>

CDC Preparedness Capability	CDC Planning Priority Resource Elements	DSHS Considerations and Guidance
<p><b>2. Community Recovery</b></p>	<p><i>Function 1, P3:</i> Written plans should include the following elements (either as a stand-alone Public Health Continuity of Operations Plan or as a component of another plan):</p> <ul style="list-style-type: none"> <li>• Definitions and identification of essential services needed to sustain agency mission and operations</li> <li>• Plans to sustain essential services regardless of the nature of the incident (e.g., all-hazards planning)</li> <li>• Scalable work force reduction</li> <li>• Limited access to facilities (social distancing, staffing or security concerns)</li> <li>• Broad-based implementation of social distancing policies if indicated</li> <li>• Positions, skills and personnel needed to continue essential services and functions (Human Capital Management)</li> <li>• Identification of agency vital records (legal documents, payroll, staff assignments) that support essential functions and/or that must be preserved in an incident</li> <li>• Alternate worksites</li> <li>• Devolution of uninterruptible services for scaled down operations</li> <li>• Reconstitution of uninterruptible services</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Review existing Attachment 1 to Appendix 11 to Annex H: Business Continuity Plan</li> <li><input type="checkbox"/> Ensure <b>Attachment 1 of Appendix 3 to Annex H: Continuity of Operations</b> includes all of the elements mentioned in the CDC priority resource.</li> <li><input type="checkbox"/> Refer to <i>DSHS Continuity of Operations Plan</i> as a guide, which is located at: <a href="http://www.dshs.state.tx.us/Layouts/ContentPage.aspx?PageID=34554&amp;id=34614&amp;terms=COOP">http://www.dshs.state.tx.us/Layouts/ContentPage.aspx?PageID=34554&amp;id=34614&amp;terms=COOP</a></li> </ul>
<p><b>3. Emergency Operations Coordination</b></p>	<p><i>Function 2, P1:</i> Written plans should include standard operating procedures that provide guidance for the management, operation, and staffing of the public health emergency operations center or public health functions within another emergency operations center. The following should be considered for inclusion in the standard operating procedures:</p> <ul style="list-style-type: none"> <li>• Activation procedures and levels, including who is authorized to activate the plan and under what circumstances</li> <li>• Notification procedures; procedures recalling and/or assembling required incident command/management personnel and for ensuring facilities are available and operationally ready for assembled staff</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Review existing Appendix 15 to Annex H: Direction and Control which should contain guidance and procedures for the activation, notification of staff, and operation of the departmental and/or jurisdictional EOC.</li> <li><input type="checkbox"/> Ensure bulleted items are included and current in <b>Attachment 1 to Appendix 1 to Annex H: Administration</b></li> <li><input type="checkbox"/> Develop within <b>Tab B of Attachment 1 to Appendix 1 to Annex H: Unified/Area Command</b> an Incident Command System organization chart for incidents that cross jurisdictional lines requiring unified command.</li> </ul>

CDC Preparedness Capability	CDC Planning Priority Resource Elements	DSHS Considerations and Guidance
		<input type="checkbox"/> Refer to <i>State Medical Operations Center (SMOC) Operating Guide</i> as a guide.
<b>3. Emergency Operations Coordination</b>	<p><i>Function 3, P1:</i> Written plans should include a template for producing Incident Action Plans. The following should be considered for inclusion in Incident Action Plans as indicated by the scale of the incident:</p> <ul style="list-style-type: none"> <li>• Incident goals</li> <li>• Operational period objectives (major areas that must be addressed in the specified operational period to achieve the goals or control objectives)</li> <li>• Response strategies (priorities and the general approach to accomplish the objectives)</li> <li>• Response tactics (methods developed by Operations to achieve the objectives)</li> <li>• Organization list with Incident Command System chart showing primary roles and relationships</li> <li>• Assignment list with specific tasks</li> <li>• Critical situation updates and assessments</li> <li>• Composite resource status updates</li> <li>• Health and safety plan (to prevent responder injury or illness)</li> <li>• Logistics plan (e.g., procedures to support Operations with equipment and supplies)</li> <li>• Responder medical plan (providing direction for care to responders)</li> <li>• Map of the incident or of ill/injured persons (e.g., map of incident scene)</li> <li>• Additional component plans, as indicated by the incident</li> </ul>	<input type="checkbox"/> From previous planning requirements, existing Appendix 15 to Annex H: Direction and Control should contain Incident Action Plan (IAP) templates. Review existing plan.  <input type="checkbox"/> Ensure templates are up-to-date in <b>Appendix 1 to Annex H: Coordination and Control</b> and consider the recommendations mentioned in the bullets listed in the priority resource element.  Forms can be accessed at: <a href="http://training.fema.gov/EMIWeb/IS/ICSResource/ICSResCntr_Forms.htm">http://training.fema.gov/EMIWeb/IS/ICSResource/ICSResCntr_Forms.htm</a>

CDC Preparedness Capability	CDC Planning Priority Resource Elements	DSHS Considerations and Guidance
<p><b>3. Emergency Operations Coordination</b></p>	<p><i>Function 4, P1:</i> Written plans should include processes and protocols to ensure the continued performance of pre-identified essential functions during a public health incident and during an incident that renders the primary location where the functions are performed inoperable. This can be a stand-alone plan or annex but at a minimum the plan must include these elements:</p> <ul style="list-style-type: none"> <li>• Definitions and identification of essential services needed to sustain agency mission and operations</li> <li>• Plans to sustain essential services regardless of the nature of the incident (e.g., all-hazards planning)</li> <li>• Scalable workforce reduction</li> <li>• Limited access to facilities (e.g., social distancing and staffing or security concerns)</li> <li>• Broad-based implementation of social distancing policies if indicated</li> <li>• Positions, skills, and personnel needed to continue essential services and functions (Human Capital Management)</li> <li>• Identification of agency vital records (e.g., legal documents, payroll, and staff assignments) that support essential functions and/or that must be preserved in an incident</li> <li>• Alternate worksites</li> <li>• Devolution of uninterruptible services for scaled-down operations</li> <li>• Reconstitution of uninterruptible services</li> </ul>	<p>This information is addressed in Capability 2, <i>Function 1, P3</i>.</p> <p><input type="checkbox"/> Ensure all bulleted items are incorporated into <b>Attachment 1 of Appendix 3 to Annex H: Continuity of Operations</b>.</p> <p>Refer to <i>DSHS Continuity of Operations Plan</i> as a guide at: <a href="http://www.dshs.state.tx.us/Layouts/ContentPage.aspx?PageID=34554&amp;id=34614&amp;terms=COOP">http://www.dshs.state.tx.us/Layouts/ContentPage.aspx?PageID=34554&amp;id=34614&amp;terms=COOP</a></p>
<p><b>3. Emergency Operations Coordination</b></p>	<p><i>Function 5, P1:</i> Written plans should include demobilization procedures for public health operations. The following should be considered for inclusion:</p> <ul style="list-style-type: none"> <li>• General information about the demobilization process</li> <li>• Responsibilities/agreements for reconditioning of equipment/resources</li> <li>• Responsibilities for implementation of the Demobilization Plan</li> <li>• General release priorities (i.e., resource type such as staff or equipment to be released) and detailed steps and processes for releasing those resources</li> </ul>	<p><input type="checkbox"/> Build into <b>Appendix 1 to Annex H: Coordination and Control</b> demobilization procedures based on the resource element considerations. Consider use of the Incident Command System (ICS) Form 221 – “Demobilization Checkout.”</p> <p>Refer to <i>State Medical Operations Center (SMOC) Operating Guide</i> as a guide.</p>

CDC Preparedness Capability	CDC Planning Priority Resource Elements	DSHS Considerations and Guidance
<p><b>4. Emergency Public Information and Warning</b></p>	<ul style="list-style-type: none"> <li>• Directories (e.g., maps and telephone listings)</li> </ul> <p><i>Function 1, P1:</i> Written plans should include description of the roles and responsibilities for the Public Information Officer, support staff (depending on incident and subject matter expertise), and potential spokesperson(s) to convey information to the public.</p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Review existing Appendix 2a to Annex H: Communications and/or Crisis and Emergency Risk Communication Plan.</li> <li><input type="checkbox"/> Ensure roles and responsibilities are described in <b>Attachment 2 to Appendix 2 to Annex H: Crisis and Emergency Risk Communications (CERC) Plan.</b></li> </ul> <p>Refer to <i>DSHS CERC Plan</i> as a guide at:  <a href="http://www.dshs.state.tx.us/riskcomm/tools.shtm">http://www.dshs.state.tx.us/riskcomm/tools.shtm</a></p>
<p><b>4. Emergency Public Information and Warning</b></p>	<p><i>Function 1, P2:</i> Written plans should include message templates that address jurisdictional vulnerabilities, should be maintained on a jurisdictionally defined regular basis, and include the following elements:</p> <ul style="list-style-type: none"> <li>• Stakeholder identification</li> <li>• Potential stakeholder questions and concerns</li> <li>• Common sets of underlying concerns</li> <li>• Key messages in response to the generated list of underlying stakeholder questions and concerns</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Review existing CERC Plan.</li> <li><input type="checkbox"/> Utilize the results of the Jurisdictional Hazard Risk Assessment (Capability 1, <i>Function 1, P2</i>) to include hazard-specific templates that are most applicable to the jurisdiction.</li> <li><input type="checkbox"/> Verify the four elements are included in message templates in <b>Attachment 2 to Appendix 2 to Annex H: Crisis and Emergency Risk Communications Plan.</b></li> </ul> <p>Refer to links provided in CDC guidance for message templates:</p> <ul style="list-style-type: none"> <li>• <a href="http://www.emergency.cdc.gov/firsthours/resources/messagetemplate.asp">http://www.emergency.cdc.gov/firsthours/resources/messagetemplate.asp</a></li> <li>• <a href="http://www.emergency.cdc.gov/firsthours/resources/index.asp">http://www.emergency.cdc.gov/firsthours/resources/index.asp</a></li> <li>• <a href="http://www.bt.cdc.gov/firsthours/terrorist.asp">http://www.bt.cdc.gov/firsthours/terrorist.asp</a></li> </ul>

CDC Preparedness Capability	CDC Planning Priority Resource Elements	DSHS Considerations and Guidance
<p><b>5. Fatality Management</b></p>	<p><i>Function 1, P1:</i> Written plans should include memoranda of agreement, memoranda of understanding, mutual aid agreements, contracts, and/or letters of agreement with other agencies to support coordinated activities and with other jurisdictions to share resources, facilities, services, and other potential support required during the management of fatalities. Requests should be determined by the local authority and follow the jurisdictional escalation process (i.e., local to state to federal).</p> <ul style="list-style-type: none"> <li>• State and federal resources (to include Disaster Mortuary Operational Response Teams) are requested when anticipated resource needs exceed the local capacity. County/jurisdictional plans should address mass fatality planning and thresholds for requesting additional resources.</li> <li>• Federal resources should be engaged/notified through the U.S. Department of Health and Human Services (HHS) Regional Emergency Coordinators.</li> <li>• Resources available through mutual aid (e.g., Emergency Management Assistance Compact (EMAC), memoranda of understanding, and/or memoranda of agreement) should be engaged/notified through appropriate channels (EMAC Coordinator, emergency management)</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Review existing Local/Regional Mass Fatality Management Plan (if available).</li> <li><input type="checkbox"/> Build into <b>Appendix 4 to Annex H: Mass Fatality Management</b> memoranda of agreement (MOA)/memoranda of understanding (MOU) with external partners and develop thresholds for requesting state resources.</li> </ul>
<p><b>5. Fatality Management</b></p>	<p><i>Function 3, P1:</i> Written plans should include a procedure for the collection of ante mortem data. Consideration should be given to the inclusion of these elements:</p> <ul style="list-style-type: none"> <li>• Data collection/dissemination methods <ul style="list-style-type: none"> <li>○ Call Center or 1-800 number</li> <li>○ Family Reception Center</li> <li>○ Family Assistance Center</li> </ul> </li> <li>• Staff who can perform the following functions: <ul style="list-style-type: none"> <li>○ Administrative activities</li> <li>○ Interviews of families in order to acquire ante mortem data</li> <li>○ System data entry of ante mortem data</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Review existing Local/Regional Mass Fatality Management Plan (if available).</li> <li><input type="checkbox"/> Clarify local health department role in the ante mortem data collection process in Local/Regional Mass Fatality Management Plan, and if assigned, incorporate ante mortem data collection procedures into <b>Appendix 4 to Annex H: Mass Fatality Management</b>.</li> </ul> <p>For more information refer to <i>DSHS Mass Fatality Planning Toolkit</i>, August 2010 at:  <a href="http://www.dshs.state.tx.us/compreg/msn/MFMPlanningToolkit.doc">www.dshs.state.tx.us/compreg/msn/MFMPlanningToolkit.doc</a></p>

CDC Preparedness Capability	CDC Planning Priority Resource Elements	DSHS Considerations and Guidance
5. Fatality Management	<p><i>Function 4, P1:</i> Written plans should include processes and protocols developed in conjunction with jurisdictional mental/behavioral health partners to identify services to provide to survivors after an incident involving fatalities. Written plans should include a contact list of pre-identified resources that could provide mental/behavioral health support to responders and families according to the incident. Consideration should be given to the inclusion of the following elements:</p> <ul style="list-style-type: none"> <li>• Mental/behavioral health professionals</li> <li>• Spiritual care providers</li> <li>• Hospices</li> <li>• Translators</li> <li>• Embassy and Consulate representatives when international victims are involved</li> </ul>	<ul style="list-style-type: none"> <li>☐ List in <b>Appendix 4 to Annex H: Mass Fatality Management</b> any memoranda of agreement/ understanding (link to Capability 5, Function 1, P1) with mental/behavioral health provider to assist with Family Assistance Center (FAC) operations.</li> <li>☐ Reference Family Assistance Center functions in <b>Appendix 5 to Annex H: Disaster Behavioral Health Services</b></li> </ul> <p>For more information on FACs refer to <i>DSHS Mass Fatality Planning Toolkit</i>, August 2010 at: <a href="http://www.dshs.state.tx.us/compreg/msn/MFMPlanningToolkit.doc">www.dshs.state.tx.us/compreg/msn/MFMPlanningToolkit.doc</a></p>
5. Fatality Management	<p><i>Function 4, P2:</i> Written plans should include list of staff selected in advance of an incident that could potentially fill the fatality management roles adequate to a given response.</p>	<ul style="list-style-type: none"> <li>☐ Build into <b>Appendix 4 to Annex H: Mass Fatality Management</b> an ICS chart for the Mass Fatality Management Branch including staff selected to fulfill roles and responsibilities.</li> </ul> <p>For more information refer to <i>DSHS Mass Fatality Planning Toolkit</i>, August 2010 at: <a href="http://www.dshs.state.tx.us/compreg/msn/MFMPlanningToolkit.doc">www.dshs.state.tx.us/compreg/msn/MFMPlanningToolkit.doc</a></p>
5. Fatality Management	<p><i>Function 5, P1:</i> Written plans should include protocols that ensure that the health department, through healthcare coalitions or other mechanisms, supports the coordination of healthcare organization fatality management plans with the jurisdictional fatality management plan.</p>	<ul style="list-style-type: none"> <li>☐ Ensure approval process for plans outlined in <b>Annex H: Public Health and Medical</b> includes appropriate partners.</li> </ul> <p>For more information refer to <i>DSHS Mass Fatality Planning Toolkit</i>, August 2010 at: <a href="http://www.dshs.state.tx.us/compreg/msn/MFMPlanningToolkit.doc">www.dshs.state.tx.us/compreg/msn/MFMPlanningToolkit.doc</a></p>

CDC Preparedness Capability	CDC Planning Priority Resource Elements	DSHS Considerations and Guidance
6. Information Sharing	<p><i>Function 1, P1:</i> Written plans should include processes to engage stakeholders that may include the following:</p> <ul style="list-style-type: none"> <li>• Law enforcement</li> <li>• Fire</li> <li>• Emergency Medical Services</li> <li>• Private healthcare organizations (e.g., hospitals, clinics, large corporate medical provider organizations and urgent care centers)</li> <li>• Fusion centers</li> </ul>	<p>This planning priority is addressed in Capability 1: Community Preparedness, <i>Function 2, P1</i>.</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Update <b>Annex H: Public Health and Medical Services</b> annually to include the names of all known planning committees that the health department participates in.</li> </ul>
6. Information Sharing	<p><i>Function 1, P2:</i> Written plans should include a role-based public health directory that will be used for public health alert messaging. The directory profile of each user includes the following elements:</p> <ul style="list-style-type: none"> <li>• Assigned roles</li> <li>• Multiple device contact information</li> <li>• Organizational affiliation</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Review existing Appendix 2 to Annex H: Warning.</li> <li><input type="checkbox"/> Build into <b>Attachment 1 of Appendix 2 to Annex H: Emergency Warning and Notification</b> a directory of staff that receive Texas Public Health Information Network (TxPHIN) alerts.</li> <li><input type="checkbox"/> Ensure multiple device contact information is captured for response staff in <b>Attachment 1 of Appendix 2 to Annex H: Emergency Warning and Notification</b>.</li> </ul>
6. Information Sharing	<p><i>Function 2, P1:</i> Written plans should include a listing of data-exchange requirements for each stakeholder (including the use of common terminology, definitions, and lexicon by all stakeholders) that adhere to available national standards for data elements to be sent and data elements to be received.</p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Reference <i>Texas Partner Communication and Alerting Guidelines</i>, available for download on TxPHIN, which dictate data-exchange requirements for stakeholders including the use of common terminology, definitions, and lexicon by all stakeholders in <b>Attachment 1 of Appendix 2 to Annex H: Emergency Warning and Notification</b>.</li> </ul>
6. Information Sharing	<p><i>Function 2, P2:</i> Written plans should include health information exchange protocols for each stakeholder that identify determinants for exchange and which may include the following elements:</p> <ul style="list-style-type: none"> <li>• Unusual cluster(s) or illness that threaten closure of institutional settings (e.g., illness among healthcare workers or prisoners)</li> <li>• High burden of illness or a cluster of illness confined to a specific population (e.g., racial or ethnic group, or vulnerable populations)</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Develop a matrix as a part of <b>Attachment 1 of Appendix 2 to Annex H: Emergency Warning and Notification</b> identifying response partners (e.g. office of emergency management, DSHS health service region office, Trauma Service Area Regional Advisory Councils, medical examiner offices, etc.) and specific triggers that will determine when information will be shared.</li> </ul>

CDC Preparedness Capability	CDC Planning Priority Resource Elements	DSHS Considerations and Guidance
	<ul style="list-style-type: none"> <li>• Illness burden that is expected to overwhelm local medical or public health resources</li> <li>• A public health laboratory finding of interest (e.g., a novel virus identified by lab) that is not picked up clinically or through other surveillance</li> <li>• Large numbers of patients with similar and unusual symptoms</li> <li>• Large number of unexplained deaths</li> <li>• Higher than expected morbidity and mortality associated with common symptoms and/or failure of patients to respond to traditional therapy</li> <li>• Simultaneous clusters of similar illness in noncontiguous areas—Received threats or intelligence</li> <li>• Incidents in other jurisdictions that raise possible risk in home jurisdiction (e.g., elevation of pandemic influenza alert level)</li> </ul>	<p>The triggers should be based on the Jurisdictional Hazard Risk Assessment (<i>Capability 1, Function 1, P2</i>) and the priority resource element bullet points.</p>
<p><b>6. Information Sharing</b></p>	<p><i>Function 3, P1:</i> Written plans should include a protocol for the development of public health alert messages that include the following elements:</p> <ul style="list-style-type: none"> <li>• Time sensitivity of the information</li> <li>• Relevance to public health</li> <li>• Target audience</li> <li>• Security level or sensitivity</li> <li>• The need for action may include <ul style="list-style-type: none"> <li>○ Awareness</li> <li>○ Request a response back</li> <li>○ Request that specific actions be taken</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Review existing Appendix 1 to Annex H: Warning and/or CERC Plan.</li> <li><input type="checkbox"/> Build into <b>Attachment 2 of Appendix 2 to Annex H: Crisis and Emergency Risk Communication</b> a protocol for the development of public health alert messages based on the five priority resource element bullet points.</li> </ul> <p>For more information see the <i>CERC Checklists</i> at: <a href="http://www.dshs.state.tx.us/riskcomm/tools.shtm">http://www.dshs.state.tx.us/riskcomm/tools.shtm</a></p>
<p><b>7. Mass Care</b></p>	<p><i>Function 2, P1:</i> Written plans should include an assessment form to be used in shelter environmental health inspections, including at a minimum the following elements:</p> <ul style="list-style-type: none"> <li>• Identification of barriers for disabled individuals</li> <li>• Structural integrity</li> <li>• Facility contamination (e.g., radiological, nuclear, or chemical)</li> <li>• Adequate sanitation (e.g., toilets, showers, and hand washing)</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Build into <b>Appendix 10 to Annex H: Mass Care Support</b> procedures for the inspection of planned and unplanned shelters for facility accessibility and environmental health and safety.</li> </ul> <p>Refer to <i>Functional Needs Support Services Toolkit</i> at: <a href="https://www.preparingtexas.org/preparedness.aspx?page">https://www.preparingtexas.org/preparedness.aspx?page</a></p>

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	stations) and waste removal <ul style="list-style-type: none"> <li>• Potable water supply</li> <li>• Adequate ventilation</li> <li>• Clean and appropriate location for food preparation and storage</li> </ul>	<a href="https://www.preparingtexas.org/preparedness.aspx?page=32137bc8-eed7-42bb-ad7e-2765fd8abdb9">=32137bc8-eed7-42bb-ad7e-2765fd8abdb9</a>
7. Mass Care	<i>Function 2, P2:</i> Written plans should include a list of pre-identified site(s) that have undergone an initial assessment to determine their adequacy to serve as congregate locations (based on the size, scope, and nature of potential incidents and jurisdictional risk assessment).	<input type="checkbox"/> Review existing Annex C: Shelter and Mass Care <input type="checkbox"/> Verify information on sites is updated in jurisdiction’s <b>Annex C: Shelter and Mass Care.</b>
7. Mass Care	<i>Function 3, P1:</i> Written plans should include memoranda of understanding, memoranda of agreement, or letters of agreement with medication providers, including but not limited to the following elements: <ul style="list-style-type: none"> <li>• Requesting medication from providers</li> <li>• Bringing medication to congregate locations</li> <li>• Storing and distributing medication at congregate locations</li> <li>• Referring and transporting individuals to pharmacies and other providers for medication</li> </ul>	<input type="checkbox"/> Reference in <b>Attachment 3 to Appendix 10 to Annex H: Hospital and Medical Services Coordination</b> MOU/MOA with pharmacy providers to serve shelter residents. Ensure agreements address the request, delivering, storage, and distribution processes.  For more guidance, refer to <i>Functional Needs Support Services Toolkit</i> at: <a href="https://www.preparingtexas.org/preparedness.aspx?page=32137bc8-eed7-42bb-ad7e-2765fd8abdb9">https://www.preparingtexas.org/preparedness.aspx?page=32137bc8-eed7-42bb-ad7e-2765fd8abdb9</a>
7. Mass Care	<i>Function 3, P2:</i> Written plans should include a scalable congregate location staffing model based on number of individuals, resources available, competing priorities, and time frame in which intervention should occur that is incident-driven and, at a minimum, includes the ability to provide the following elements: <ul style="list-style-type: none"> <li>• Medical care services</li> <li>• Management of mental/behavioral disorders</li> <li>• Environmental health assessments (e.g., food, water, and sanitation)</li> <li>• Data collection, monitoring, and analysis</li> <li>• Infection control practices and procedures</li> </ul>	<input type="checkbox"/> Review existing Appendix 3 to Annex H: Shelter and Mass Care.  General populations and medical care services shelters have written plans with scalable congregate location staffing models but do not have all the elements prescribed.  <input type="checkbox"/> Describe in <b>Appendix 10 to Annex H: Mass Care Support</b> how health department will work with emergency management to address all elements for general population shelters.

CDC Preparedness Capability	CDC Planning Priority Resource Elements	DSHS Considerations and Guidance
7. Mass Care	<p><i>Function 3, P3:</i> Written plans should include procedures to coordinate with partner agencies to transfer individuals from general shelters to specialized shelters or medical facilities if needed, including the following procedural elements:</p> <ul style="list-style-type: none"> <li>• Patient information transfer (e.g., current condition and medical equipment needs)</li> <li>• Physical transfer of patient</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Build into <b>Attachment 1 to Appendix 10 to Annex H: Evacuation</b>, health department roles and responsibilities for the transfer of individuals to medical shelters or medical facilities.</li> </ul> <p>Refer to <i>Functional Needs Support Services Toolkit</i> at:  <a href="https://www.preparingtexas.org/preparedness.aspx?page=32137bc8-eed7-42bb-ad7e-2765fd8abdb9">https://www.preparingtexas.org/preparedness.aspx?page=32137bc8-eed7-42bb-ad7e-2765fd8abdb9</a></p>
7. Mass Care	<p><i>Function 3, P4:</i> Written plans should include a process to coordinate with partner agencies to monitor populations at congregate locations, including but not limited to the following processes:</p> <ul style="list-style-type: none"> <li>• Establishing registries for exposed or potentially exposed individuals for long-term health monitoring</li> <li>• Separate shelter facilities for monitoring individuals at congregate locations</li> <li>• Identifying, stabilizing and referring individuals who need immediate medical care or decontamination</li> <li>• Prioritization of at-risk populations at congregate locations that have specific needs after a radiation incident (e.g., children, elderly, and pregnant women)</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Review existing Appendix 3 to Annex H: Shelter and Mass Care</li> <li><input type="checkbox"/> Build into <b>Attachment 3 to Appendix 10 to Annex H: Hospital and Medical Services Coordination</b> health department processes to monitor populations. Include specific information for each of the bulleted items in the priority resource element.</li> </ul> <p>For more information, see:</p> <ul style="list-style-type: none"> <li>• <a href="http://emergency.cdc.gov/radiation/pdf/population-monitoring-guide.pdf">http://emergency.cdc.gov/radiation/pdf/population-monitoring-guide.pdf</a></li> <li>• <a href="http://www.remm.nlm.gov/">http://www.remm.nlm.gov/</a></li> <li>• <a href="http://www.crcpd.org/Map/RCPmap.htm">http://www.crcpd.org/Map/RCPmap.htm</a></li> </ul>
7. Mass Care	<p><i>Function 3, P5:</i> Written plans should include a scalable congregate location staffing matrix identifying at least one back-up for each population monitoring and decontamination response role. Skill sets at a minimum should include the following elements:</p> <ul style="list-style-type: none"> <li>• The ability to manage population monitoring operation</li> <li>• The ability to monitor arrivals for external contamination and assess exposure</li> <li>• The ability to assist with decontamination services</li> <li>• The ability to assess exposure and internal contamination</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Build into <b>Appendix 10 to Annex H: Hospital and Medical Services Coordination</b> local health department staffing model to monitor populations and assist with decontamination services.</li> <li><input type="checkbox"/> For more information, see: <ul style="list-style-type: none"> <li>• <a href="http://www.naccho.org/topics/environmental/radiation/index.cfm">http://www.naccho.org/topics/environmental/radiation/index.cfm</a></li> <li>• <a href="http://www.emergency.cdc.gov/radiation/crc/vcrc.asp">http://www.emergency.cdc.gov/radiation/crc/vcrc.asp</a></li> <li>• <a href="http://www.emergency.cdc.gov/radiation/pdf/popula">http://www.emergency.cdc.gov/radiation/pdf/popula</a></li> </ul> </li> </ul>

CDC Preparedness Capability	CDC Planning Priority Resource Elements	DSHS Considerations and Guidance
		<p><a href="#">tion-monitoring-guide.pdf</a></p> <ul style="list-style-type: none"> <li>• <a href="http://orise.orau.gov/reacts/">http://orise.orau.gov/reacts/</a></li> </ul>
<p><b>7. Mass Care</b></p>	<p><i>Function 4, P1:</i> Written plans should include a process to conduct ongoing shelter population health surveillance, including the following elements:</p> <ul style="list-style-type: none"> <li>• Identification or development of mass care surveillance forms and processes</li> <li>• Determination of thresholds for when to start surveillance</li> <li>• Coordination of health surveillance plan with partner agencies' (e.g., Red Cross) activities (For additional or supporting detail, see Capability 14: Public Health Surveillance and Epidemiological Investigation)</li> </ul>	<ul style="list-style-type: none"> <li>□ Build into <b>Appendix 10 to Annex H: Mass Care Support</b> the local health department processes for the surveillance of planned and unplanned shelters for symptoms of conditions of public health significance manifested by shelter guests. Address all three bullet points in procedures.</li> </ul> <p>For more information see <i>General Shelter Surveillance Form</i> at:  <a href="http://www.dshs.state.tx.us/layouts/contentpage.aspx?pageid=8589954779&amp;id=8589954959&amp;terms=Shelter+Surveillance">http://www.dshs.state.tx.us/layouts/contentpage.aspx?pageid=8589954779&amp;id=8589954959&amp;terms=Shelter+Surveillance</a></p>
<p><b>7. Mass Care</b></p>	<p><i>Function 4, P2:</i> Written plans should include templates for disaster-surveillance forms, including Active Surveillance and Facility 24-hour Report forms.</p>	<ul style="list-style-type: none"> <li>□ Reference in <b>Appendix 10 to Annex H: Mass Care Support</b> all forms used for public health surveillance and disease reporting during emergencies.</li> </ul> <p>Form examples can be accessed at:  <a href="http://www.dshs.state.tx.us/layouts/contentpage.aspx?pageid=8589954779&amp;id=8589954959&amp;terms=Shelter+Surveillance">http://www.dshs.state.tx.us/layouts/contentpage.aspx?pageid=8589954779&amp;id=8589954959&amp;terms=Shelter+Surveillance</a></p>
<p><b>8. Medical Countermeasure Dispensing</b></p>	<p><i>Function 1, P1:</i> 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:</p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• Agent or cause of the incident</li> </ul>	<ul style="list-style-type: none"> <li>□ Review existing SOG G in Tab 1 of Attachment A to Appendix 8 to Annex H: Command and Control.</li> <li>□ Verify initial request justification guidelines and procedures are outlined in <b>Attachment 7 to Appendix 8 to Annex H: Command and Control (Local Technical Assistance Review (TAR) Requirement 3.2)</b></li> <li>□ Reference in <b>Attachment 7 to Appendix 8 to Annex H: Command and Control</b> additional plans, procedures,</li> </ul>

CDC Preparedness Capability	CDC Planning Priority Resource Elements	DSHS Considerations and Guidance
	<ul style="list-style-type: none"> <li>• Severity of the incident</li> <li>• Potential medical countermeasures</li> <li>• Time line for establishing medical countermeasure dispensing operations</li> <li>• Personnel and staffing mix</li> </ul>	<p>and/or protocol that may be used to identify the medical countermeasures required based on the results of the Jurisdictional Hazard Risk Assessment (<i>Capability 1, Function 1, P2</i>).</p>
<p><b>8. Medical Countermeasure Dispensing</b></p>	<p><i>Function 2, P1:</i> 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:</p> <ul style="list-style-type: none"> <li>• Assessment of local inventory/medical countermeasure caches</li> <li>• Identification of local pharmaceutical and medical-supply wholesalers</li> <li>• 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.</li> <li>• 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)</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Review existing SOG C in Tab 1 of Attachment A to Appendix 8 to Annex H: Strategic National Stockpile Inventory Control.</li> <li><input type="checkbox"/> Build into <b>Attachment 3 to Appendix 8 to Annex H: Inventory Control</b> a list of local caches (updated annually).</li> <li><input type="checkbox"/> List in <b>Attachment 11 to Appendix 8 to Annex H: Local Pharmacies</b> all jurisdictional pharmacies.</li> <li><input type="checkbox"/> Verify regulatory standards are referenced in <b>Attachment 3 to Appendix 8 to Annex H: Inventory Control</b>, if the jurisdiction has purchased medical countermeasures.</li> </ul> <p>DSHS is considering the use of decision matrices to request additional countermeasures, but has not released guidance at this time.</p>

CDC Preparedness Capability	CDC Planning Priority Resource Elements	DSHS Considerations and Guidance
<p><b>8. Medical Countermeasure Dispensing</b></p>	<p><i>Function 3, P1:</i> 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.</p>	<ul style="list-style-type: none"> <li>□ List in <b>Appendix 8 to Annex H: Medical Countermeasures</b> in the Authorities and References Section or as a separate attachment, the agreements required to perform the dispensing function.</li> </ul>
<p><b>8. Medical Countermeasure Dispensing</b></p>	<p><i>Function 3, P2:</i> Written plans should include processes and protocols to govern the activation of dispensing modalities.</p> <ul style="list-style-type: none"> <li>• 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: <ul style="list-style-type: none"> <li>○ Traditional public health operated (e.g., open points of dispensing)</li> <li>○ Private organizations (e.g., closed points of dispensing)</li> <li>○ Pharmacies</li> <li>○ Provider offices and clinics</li> <li>○ Military/tribal</li> <li>○ Incarcerated population</li> <li>○ Other jurisdictionally approved dispensing modalities</li> </ul> </li> <li>• Initiate notification protocols with the dispensing locations. The following information should be determined for the sites: <ul style="list-style-type: none"> <li>○ Dispensing site name/identifier</li> <li>○ Demand estimate (number of people planning to visit the site)</li> <li>○ Required throughput</li> <li>○ Staff required to operate one shift</li> <li>○ Number of shifts of distinct staff</li> <li>○ Staff availability</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>□ Review existing SOG F in Tab 1 of Attachment A to Appendix 8 to Annex H: Dispensing.</li> <li>□ Delineate all of the dispensing modalities that have been established in the jurisdiction within <b>Attachment 6 to Appendix 8 to Annex H: Dispensing *</b>, including type and identified population. Refer to baseline documentation from the Local TAR.</li> <li>□ Ensure that within <b>Attachment 6 to Appendix 8 to Annex H: Dispensing</b> a procedure for notifying and activating alternate dispensing modalities exists.</li> </ul> <p>DSHS Central Office and Regional SNS coordinators are currently working on how to address legal barriers such as functional needs of at-risk individuals in plans.</p> <p>* Note: Site-specific manuals should exist for all staffed dispensing locations.</p>

CDC Preparedness Capability	CDC Planning Priority Resource Elements	DSHS Considerations and Guidance
	<ul style="list-style-type: none"> <li>○ Total number of staff required to operate the dispensing location through the whole incident</li> <li>● Plan for functional needs of at-risk individuals (e.g., wheelchair access for handicapped)</li> <li>● 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: <ul style="list-style-type: none"> <li>○ Clinical standards of care</li> <li>○ Licensing</li> <li>○ Civil liability for volunteers</li> <li>○ Liability for private sector participants</li> <li>○ Property needed for dispensing medication</li> </ul> </li> </ul>	
<p><b>8. Medical Countermeasure Dispensing</b></p>	<p><i>Function 4, P1:</i> Written plans should include processes and protocols to govern the activation of dispensing of medical countermeasures to the target population.</p> <ul style="list-style-type: none"> <li>● 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</li> <li>● Ensure that the permanent medical record (or log/file) of the recipient indicates the following information as deemed necessary: <ul style="list-style-type: none"> <li>○ The date the medical countermeasure was dispensed</li> <li>○ Information on the medical countermeasure including, but not limited to, product name, national drug control number, and lot number</li> <li>○ 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</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Review existing SOG F in Tab 1 of Attachment A to Appendix 8 to Annex H: Dispensing.</li> <li><input type="checkbox"/> Verify screening and registration* procedures are included in <b>Attachment 6 to Appendix 8 to Annex H: Dispensing</b> and/or site-specific plans.</li> </ul> <p>* Note: Bullet two of the priority resource element describes necessary information for information sheets.</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Reference radiological protocols for screening and decontamination. A CDC recommended protocol can be accessed at: <a href="http://emergency.cdc.gov/radiation/pdf/population-monitoring-guide.pdf">http://emergency.cdc.gov/radiation/pdf/population-monitoring-guide.pdf</a></li> </ul>

CDC Preparedness Capability	CDC Planning Priority Resource Elements	DSHS Considerations and Guidance
	<p>prescriber, name of patient (if stated on prescription), and directions for use, and cautionary statements.</p> <ul style="list-style-type: none"> <li>○ The edition date of the information statement (e.g., pre-printed drug information sheets) distributed</li> <li>● Ensure medical countermeasure recipient receives the information sheet matching the medical countermeasure dispensed</li> <li>● 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)</li> </ul>	
<p><b>8. Medical Countermeasure Dispensing</b></p>	<p><i>Function 5, P1:</i> Written plans should include processes and protocols to govern reporting of adverse events. The following items should be considered in the plans:</p> <ul style="list-style-type: none"> <li>● Guidance and communications messages/campaign that articulates the importance of adverse reporting regardless of suspected cause</li> <li>● Process to ensure individuals receive the information sheet about potential adverse events of the medical countermeasure dispensed and how to report adverse events</li> <li>● Triage protocols when receiving notifications of adverse events</li> <li>● Protocols when receiving notifications of adverse events. Information required to document adverse events includes the following: <ul style="list-style-type: none"> <li>○ Patient, provider, and reporter demographics</li> <li>○ Adverse event</li> <li>○ Relevant diagnostic tests/laboratory data</li> <li>○ Recovery status</li> <li>○ Vaccine(s)/pharmaceutical(s) received, including receipt location, date, vaccine/pharmaceutical type, lot number, and dose number</li> </ul> </li> <li>● Utilize existing federal and jurisdictional adverse event reporting system, processes and protocols</li> </ul>	<ul style="list-style-type: none"> <li>□ Review existing SOG H in Tab 1 of Attachment A to Appendix 8 to Annex H: Communications.</li> <li>□ Develop methods to refer individuals with adverse to call the CDC Vaccine Adverse Event Reporting System (VAERS) (vaccine) or Texas Health and/or Human Services Commission (HHSC) 2-1-1 (all other medical countermeasures) in <b>Attachment 8 to Appendix 8 to Annex H: Tactical Communications.</b></li> </ul>

CDC Preparedness Capability	CDC Planning Priority Resource Elements	DSHS Considerations and Guidance
<p><b>9. Medical Material Management and Distribution</b></p>	<p><i>Function 1, P1:</i> 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:</p> <ul style="list-style-type: none"> <li>• Type of site (commercial vs. government)</li> <li>• Physical location of site</li> <li>• 24-hour contact number</li> <li>• Hours of operation</li> <li>• 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</li> <li>• 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</li> <li>• 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</li> </ul>	<p>This is a DSHS Health Service Region responsibility and is not required in local health department plans.</p>
<p><b>9. Medical Material Management and Distribution</b></p>	<p><i>Function 1, P2:</i> 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:</p> <ul style="list-style-type: none"> <li>• Type of vendor (commercial vs. government)</li> <li>• Number and type of vehicles, including vehicle load capacity and configuration</li> <li>• Number and type of drivers, including certification of drivers</li> <li>• Number and type of support personnel</li> <li>• Vendor’s response time</li> <li>• Vendor’s ability to maintain cold chain, if necessary to the incident!</li> </ul>	<p>This is a DSHS Central Office responsibility and is not required in local health department plans.</p>

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	<p>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.</p>	
<p><b>9. Medical Material Management and Distribution</b></p>	<p><i>Function 1, P3:</i> Written plans should include protocols for medical and health-related agencies and organizations to report medical material levels to public health at least weekly, but potentially more frequently.</p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Review existing SOG C of Tab 1 to Attachment A to Appendix 8 to Annex H: Inventory Control.</li> <li><input type="checkbox"/> Develop in <b>Attachment 3 to Appendix 8 to Annex H: Inventory Control</b> procedures for reporting data to the Health Service Region.</li> <li><input type="checkbox"/> Reference current inventory management system to be used for tracking inventory during an incident in <b>Attachment 3 to Appendix 8 to Annex H: Inventory Control</b>.</li> </ul>
<p><b>9. Medical Material Management and Distribution</b></p>	<p><i>Function 2, P1:</i> Written plans should include a process to request medical material (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:</p> <ul style="list-style-type: none"> <li>• Assessment of local inventory/medical countermeasure caches</li> <li>• Identification of local pharmaceutical and medical-supply wholesalers</li> <li>• Assessment of asset request trigger indicators, thresholds, and validation strategies to guide decision making</li> <li>• A process for requesting medical countermeasures through the Emergency Management Assistance Compact</li> <li>• A process for requesting medical countermeasures from the federal level, which takes into account <ul style="list-style-type: none"> <li>○ Stafford Act vs. non-Stafford Act declarations</li> <li>○ National Emergencies Act</li> <li>○ Coordination between federal and state resources, including</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Review existing SOG C in Tab 1 of Attachment A to Appendix 8 to Annex H: Strategic National Stockpile Inventory Control.</li> <li><input type="checkbox"/> Build into <b>Attachment 3 to Appendix 8 to Annex H: Inventory Control</b> a list of local caches (updated annually).</li> <li><input type="checkbox"/> Review existing SOG G in Tab 1 of Attachment A to Appendix 8 to Annex H: Command and Control.</li> <li><input type="checkbox"/> Verify initial request justification guidelines and procedures are outlined in <b>Attachment 7 to Appendix 8 to Annex H: Command and Control</b> (<i>Local Technical Assistance Review (TAR) Requirement 3.2</i>)</li> <li><input type="checkbox"/> Verify regulatory standards are referenced in <b>Attachment 3 to Appendix 8 to Annex H: Inventory Control</b>, if the</li> </ul>

CDC Preparedness Capability	CDC Planning Priority Resource Elements	DSHS Considerations and Guidance
	<ul style="list-style-type: none"> <li>○ memoranda of understanding between CDC and the state</li> <li>○ Role of U.S. Department of Health and Human Services Regional Emergency Coordinators, if necessary to the incident.</li> <li>● A process for justifying medical countermeasure requests</li> <li>● 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)</li> </ul>	<p>jurisdiction has purchased medical countermeasures.</p> <p>DSHS is considering the use of asset trigger indicators and decision matrices to request additional countermeasures, but has not released guidance at this time.</p>
<p><b>9. Medical Material Management and Distribution</b></p>	<p><i>Function 3, P1:</i> Written plans should include protocols for reporting to jurisdictional, state, regional, and federal authorities. At a minimum, report should include the following elements:</p> <ul style="list-style-type: none"> <li>● Amount of materiel received (including receipt date/time and name of individual who accepted custody of materiel)</li> <li>● Amount of materiel distributed</li> <li>● Amount of materiel expired</li> <li>● Current available balance of materiel</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> The inventory management system tracks the elements listed in the planning priority resource element.</li> <li><input type="checkbox"/> Reference inventory management system as the method for tracking the priority resource elements in <b>Attachment 3 to Appendix 8 to Annex H: Inventory Control.</b></li> </ul>
<p><b>9. Medical Material Management and Distribution</b></p>	<p><i>Function 4, P1:</i> 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:</p> <ul style="list-style-type: none"> <li>● Contact information for security coordinator</li> <li>● Coordination with law enforcement and security agencies to secure personnel and facility</li> <li>● Acquisition of physical security measures (e.g., cages, locks, and alarms) for materiel within the receiving site</li> <li>● Maintenance of security of medical materiel in transit</li> </ul>	<p>This is a DSHS Health Service Region responsibility and is not required for local health department plans.</p>
<p><b>9. Medical Material Management and Distribution</b></p>	<p><i>Function 5, P1:</i> 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</p>	<p>This is a DSHS Health Service Region responsibility and is not required for local health department plans.</p>

CDC Preparedness Capability	CDC Planning Priority Resource Elements	DSHS Considerations and Guidance
	intermediary distribution site or if the health department is responsible for delivering materiel.	
<b>9. Medical Material Management and Distribution</b>	<i>Function 6, P1:</i> 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.	This is a DSHS Health Service Region responsibility and is not required for local health department plans.
<b>10. Medical Surge</b>	<i>Function 1, P1:</i> Written plans should include documentation of staff assigned and trained in advance to fill public health incident management roles as applicable to a given response. Health departments must be prepared to staff emergency operations centers at agency, local, and state levels as necessary.	<ul style="list-style-type: none"> <li><input type="checkbox"/> Review existing Appendix 15 to Annex H: Direction and Control.</li> <li><input type="checkbox"/> Document in <b>Tab A to Appendix 1 to Annex H: Incident Command System</b> public health staff roles in departmental and/or jurisdictional emergency operations center(s) and/or the Regional Medical Operations Center.</li> <li><input type="checkbox"/> Include a listing of required Incident Command System (ICS) training for each public health-staffed position.</li> </ul>
<b>10. Medical Surge</b>	<i>Function 1, P2:</i> Written plans should include documentation that all joint (e.g., healthcare organizations, public health, and emergency	<ul style="list-style-type: none"> <li><input type="checkbox"/> Review jurisdictional Basic Emergency Management Plan and Annex H: Health and Medical Services.</li> </ul>

CDC Preparedness Capability	CDC Planning Priority Resource Elements	DSHS Considerations and Guidance
	<p>management) emergency incidents, exercises, and preplanned (i.e., recurring or special) events operate in accordance with Incident Command Structure organizational structures, doctrine, and procedures, as defined in the National Incident Management System.</p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Verify all structures, doctrine, and procedures are National Incident Management System (NIMS) compliant by completing Federal Emergency Management Agency FEMA’s National Incident Management System Compliance Assistance Support Tool (NIMCAST) and providing data to jurisdictional office of emergency management.</li> <li><input type="checkbox"/> Document in <b>Tab A to Appendix 1 to Annex H: Incident Command System</b> NIMS compliant organizational charts with local health department filled positions indicated for all departmental and/or jurisdictional emergency operations center(s) and/or Regional Medical Operations Center.</li> </ul>
<p><b>10. Medical Surge</b></p>	<p><i>Function 1, P3:</i> Written plans should include process to ensure access into the jurisdiction’s bed-tracking system to maintain visibility of bed availability across the jurisdiction.</p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Within <b>Appendix 1 to Annex H: Coordination and Control</b>, describe how bed-tracking system data is accessed at any and all jurisdictional emergency operations center(s) and/or Regional Medical Operations Center.</li> </ul>
<p><b>10. Medical Surge</b></p>	<p><i>Function 1, P4:</i> Written plans should include processes to engage in healthcare coalitions and understand the role that each coalition partner will play to obtain and provide situational awareness. Coalitions are not expected to replace or relieve healthcare systems of their institutional responsibilities during an emergency, or to subvert the authority and responsibility of the state or local jurisdiction. The purpose of jurisdictional healthcare coalitions is as follows:</p> <ul style="list-style-type: none"> <li>• Integrate plan and activities of all participating healthcare systems into the jurisdictional response plan and the state response plan</li> <li>• Increase medical response capabilities in the community, region and state</li> <li>• Prepare for the needs of at-risk individuals and the general population in their communities in the event of a public health emergency</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Review existing Attachment E to Appendix 8 to Annex H: Hospital and Medical Coordination</li> <li><input type="checkbox"/> Provide in <b>Annex H: Public Health and Medical Services</b> health department’s membership in local or area public health and medical disaster planning group(s).</li> </ul>

CDC Preparedness Capability	CDC Planning Priority Resource Elements	DSHS Considerations and Guidance
	<ul style="list-style-type: none"> <li>• Coordinate activities to minimize duplication of effort and ensure coordination among federal, state, local and tribal planning, preparedness, response, and de-escalation activities</li> <li>• Maintain continuity of operations in the community vertically with the local jurisdictional emergency management organizations</li> <li>• Unify the management capability of the healthcare system to a level that will be necessary if the normal day-to-day operations and standard operating procedures of the health system are overwhelmed, and disaster operations become necessary</li> <li>• Support sufficient jurisdiction-wide situational awareness to ensure that the maximum number of people requiring care receive safe and appropriate care, which may involve, but is not limited to, facilitating the triage and/or distribution of people requiring care to appropriate facilities throughout the jurisdiction and providing appropriate support to these facilities to support the provision of optimal and safe care to those individuals</li> </ul>	
10. Medical Surge	<p><i>Function 1, P5:</i> Written plans should include processes (e.g., MOUs or other written agreements) to work in conjunction with emergency management, healthcare organizations, coalitions, and other partners to develop written strategies that clearly define the processes and indicators as to when the jurisdiction's healthcare organizations and health care coalitions transition into and out of conventional, contingency, and crisis standards of care. Jurisdiction should utilize the risk assessment to build jurisdiction-specific strategies and triggers.</p>	<ul style="list-style-type: none"> <li>□ Document in <b>Annex H: Public Health and Medical Services</b> any MOU/MOA necessary to maintain relationships with health care organizations for medical surge.</li> </ul>
10. Medical Surge	<p><i>Function 2, P1:</i> Written plans should include the following elements:</p> <ul style="list-style-type: none"> <li>• Documentation of process or protocol for how the health agency will access volunteer resources through the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) and the Medical Reserve Corps program of credentialed personnel available for assistance during an incident.</li> <li>• Documentation of processes for coordinating with health professional volunteer entities (e.g., MRC) and other personnel resources from various levels. (ESAR-VHP Compliance Requirements)</li> </ul>	<ul style="list-style-type: none"> <li>□ Review existing Attachment A to Appendix 9 to Annex H: Volunteers.</li> <li>□ Integrate in <b>Tab A to Appendix 1 to Annex H: Volunteer Management</b>, systems for tracking Strategic National SNS Point of Dispensing (POD) volunteers into ESAR-VHP.</li> </ul>

CDC Preparedness Capability	CDC Planning Priority Resource Elements	DSHS Considerations and Guidance
10. Medical Surge	<p><i>Function 2, P2:</i> Written plans should include documentation of the process for how the public health agency will engage in healthcare coalitions and other response partners regarding the activation of alternate care systems. Documentation should also include the following elements:</p> <ul style="list-style-type: none"> <li>• Written list of healthcare organizations with alternate care system plans</li> <li>• Written list of home health networks and types of resources available that are able to assist in incident response</li> <li>• List of pre-identified site(s) that have undergone an initial assessment to determine their adequacy to serve as an alternate care facility</li> </ul>	<ul style="list-style-type: none"> <li>□ Develop a matrix in <b>Tab A to Attachment 3 to Appendix 10 to Annex H: Medical Facilities</b> that lists all healthcare providers/systems (e.g. urgent care facilities, hospital emergency rooms, Federally Qualified Health Centers (FQHC), etc.) in jurisdiction that can expand to provide medical care during an incident.</li> </ul> <p>Also include pre-identified site(s) that have undergone an initial assessment to determine their adequacy to serve as an alternate care facility.</p> <ul style="list-style-type: none"> <li>□ Include as column headings in the matrix: <ul style="list-style-type: none"> <li>• Facilities that contain alternate care system plans</li> <li>• Facility’s resources available to assist in medical surge augmentation.</li> <li>• Facility-identified triggers whereby the local health department will be called on to assist.</li> </ul> </li> </ul>
10. Medical Surge	<p><i>Function 2, P3:</i> Written plans should include processes and protocols to identify essential situational awareness information for federal, state, local, and non-governmental agencies; private sector agencies; and other Emergency Support Function # 8 partners. Jurisdictional processes to identify essential situational awareness requirements should consider the following elements:</p> <ul style="list-style-type: none"> <li>• Identifying essential information</li> <li>• Defining required information</li> <li>• Establishing requirements</li> <li>• Determining common operational picture elements</li> <li>• Identifying data owners</li> <li>• Validating data with stakeholders</li> </ul>	<ul style="list-style-type: none"> <li>□ Build into <b>Appendix 2 to Annex H: Communications</b>, a process to identify essential situational information.</li> </ul> <p>Refer to the dashboard templates within the <i>State Medical Operations Center Guideline</i>.</p>

CDC Preparedness Capability	CDC Planning Priority Resource Elements	DSHS Considerations and Guidance
10. Medical Surge	<p><i>Function 2, P4:</i> Written plans should include documentation of participation from jurisdictional and regional pediatric providers and leaders from a variety of settings (e.g., maternal and child health programs, clinic-based, hospital-based, home healthcare, and rehabilitation) in jurisdictional response planning. Plans should include but are not limited to the following elements:</p> <ul style="list-style-type: none"> <li>• Process to identify gaps in the provision of pediatric care</li> <li>• Process to access pediatric providers or pediatric medical liaisons for consultation related to clinical care. In order to access the appropriate level of care or consultation, plans should include lists of healthcare organizations that can stabilize and/or manage pediatric traumatic and medical emergencies and that have written inter-facility transfer agreements that cover pediatric patients.</li> </ul>	<ul style="list-style-type: none"> <li>☐ Coordinate with Regional Advisory Council/Hospital Preparedness Council to identify gaps in jurisdiction’s pediatric care system. Incorporate any identified gaps into vulnerability assessment (See Capability 1, Function 1, P1).</li> <li>☐ Outline in <b>Appendix 1 to Annex H: Coordination and Control</b>, the process to access pediatric providers (i.e contact information) to help determine the appropriate standard of care during response.</li> <li>☐ List in <b>Tab A to Attachment 3 to Appendix 10 to Annex H: Medical Facilities</b> healthcare organizations that can stabilize and/or manage pediatric trauma emergencies.</li> </ul>
10. Medical Surge	<p><i>Function 3, P1:</i> Written plans should include processes and protocols to communicate situational awareness information to federal, state, local, and non-governmental agencies; private sector agencies; and other Emergency Support Function #8 partners at least weekly, but potentially more frequently (e.g., as often as once per operational period).</p>	<ul style="list-style-type: none"> <li>☐ Review existing Appendix 2a to Annex H: Communications.</li> <li>☐ Provide in <b>Appendix 2 to Annex H: Communications</b> processes for sharing situational awareness information with partners in emergency and non-emergency situations.</li> </ul>
10. Medical Surge	<p><i>Function 3, P2:</i> Written plans should include documentation that public health participates in the development and execution of healthcare coalition plans to address the functional needs of at-risk individuals. Plans should include a written list of healthcare organizations and community providers that are able to address the functional needs for at-risk individuals and a process to communicate with healthcare organizations and community providers to maintain a current list of available services that support the functional needs of at-risk individuals.</p>	<ul style="list-style-type: none"> <li>☐ See Capability 1, Function 1, P1. Establish or join a vulnerable populations community coalition and reference in <b>Annex H: Public Health and Medical Services</b>.</li> <li>☐ Include in <b>Tab A to Attachment 3 to Appendix 10 to Annex H: Medical Facilities</b> matrix the facilities available to address the function needs of at-risk individuals. Refer to <i>Functional Needs Support Services Toolkit</i> at: <a href="https://www.preparingtexas.org/preparedness.aspx?page=32137bc8-eed7-42bb-ad7e-2765fd8abdb9">https://www.preparingtexas.org/preparedness.aspx?page=32137bc8-eed7-42bb-ad7e-2765fd8abdb9</a></li> </ul>

CDC Preparedness Capability	CDC Planning Priority Resource Elements	DSHS Considerations and Guidance
10. Medical Surge	<p><i>Function 3, P3:</i> Written plans should include processes to support or implement family reunification. Considerations should include the following elements:</p> <ul style="list-style-type: none"> <li>• Capturing and transferring the following known identification information throughout the transport continuum: <ul style="list-style-type: none"> <li>○ Pickup location (e.g., cross streets, latitude &amp; longitude, and/or facility/school)</li> <li>○ Gender and name (if possible)</li> <li>○ For nonverbal or critically ill children, collect descriptive identifying information about the physical characteristics or other identifiers of the child.</li> <li>○ Keep the primary caregiver (e.g., parents, guardians, and foster parents) with the patient to the extent possible</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Build into <b>Appendix 10 to Annex H: Mass Care Coordination</b> the health department’s support role in implementing family reunification.</li> </ul>
10. Medical Surge	<p><i>Function 4, P1:</i> Written plans should include a process for the jurisdiction to coordinate with state emergency medical services to demobilize transportation assets used in the incident.</p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Review existing Appendix 14 to Annex H: Resource Management.</li> <li><input type="checkbox"/> Build into <b>Attachment 2 to Appendix 1 to Annex H: Logistics</b> the process to demobilize state medical assets used during the incident.</li> </ul> <p>Refer to state-level demobilization procedures within the <i>State Medical Operations Center Guideline</i>.</p>
10. Medical Surge	<p><i>Function 4, P2:</i> Written plans should include a process to demobilize surge staff to include other state (e.g., MRC) and federal medical resources (e.g., NDMS). Process should include identification of triggers that would identify the need for demobilization.</p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Build into <b>Attachment 2 to Appendix 1 to Annex H: Logistics</b> the process to demobilize medical surge staff used during the incident.</li> </ul> <p>Refer to state-level demobilization procedures within the <i>State Medical Operations Center Guideline</i>.</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Include in <b>Attachment 2 to Appendix 1 to Annex H: Logistics</b> a recommended threshold to help determine when surge staff should to be released.</li> </ul>

CDC Preparedness Capability	CDC Planning Priority Resource Elements	DSHS Considerations and Guidance
<p><b>11. Non-Pharmaceutical Interventions</b></p>	<p><i>Function 1, P1:</i> Written plans should include documentation of the applicable jurisdictional, legal, and regulatory authorities and policies for recommending and implementing non-pharmaceutical interventions in both routine and incident specific situations. This includes but is not limited to authorities for restricting the following elements:</p> <ul style="list-style-type: none"> <li>• Individuals</li> <li>• Groups</li> <li>• Facilities</li> <li>• Animals (e.g., animals with infectious diseases and animals with exposure to environmental, chemical, radiological hazards)</li> <li>• Consumer food products</li> <li>• Public works/utilities (e.g., water supply)</li> <li>• Travel through ports of entry</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Review jurisdictional Annex H: Health and Medical Services.</li> <li><input type="checkbox"/> Detail in <b>Attachment 3 to Appendix 9 to Annex H: Communicable Disease Control Measures</b> all applicable disease control authorities and laws.</li> </ul> <p>As an example see Appendix 7 to Annex H: Pandemic Influenza at:  <a href="http://www.dshs.state.tx.us/compred/plans/default.shtm">http://www.dshs.state.tx.us/compred/plans/default.shtm</a></p>
<p><b>11. Non-Pharmaceutical Interventions</b></p>	<p><i>Function 1, P2:</i> Written plans should include documentation of the following elements:</p> <ul style="list-style-type: none"> <li>• Contact information of at least two representatives from each partner agency/organization <ul style="list-style-type: none"> <li>○ Suggested community partners: schools, community organizations (e.g., churches and homelessshelters), businesses, hospitals, and travel/transportation industry planners</li> </ul> </li> <li>• Memoranda of understanding or other written acknowledgements/agreements with community partners outlining roles, responsibilities, and resources in non-pharmaceutical interventions</li> <li>• Agreements with healthcare providers which must include at a minimum: <ul style="list-style-type: none"> <li>○ Procedures to communicate case definitions determined by epidemiological surveillance</li> <li>○ Procedures for reporting identified cases of inclusion to the health department</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Review existing Tab 1 to Attachment C to Appendix 8 to Annex H: Pandemic Influenza Response.</li> <li><input type="checkbox"/> Build into <b>Attachment 3 to Appendix 9 to Annex H: Communicable Disease Control Measures</b> the roles, responsibilities, and contact information for community partners involved in the implementation of non-pharmaceutical interventions, especially those partners with responsibilities for managing the consequences of school closure.</li> </ul>

CDC Preparedness Capability	CDC Planning Priority Resource Elements	DSHS Considerations and Guidance
<p><b>11. Non-Pharmaceutical Interventions</b></p>	<p><i>Function 2, P1:</i> Written plans should include a jurisdictional non-pharmaceutical intervention “playbook” detailing plans for intervention recommendation and/or implementation, based on potential interventions identified from the jurisdictional risk assessment. Suggested categories of interventions include isolation, quarantine, school and child care closures, workplace and community organization/event closure, and restrictions on movement (e.g., port of entry screenings and public transportation). Each plan should address the following items, at a minimum:</p> <ul style="list-style-type: none"> <li>• Staff and subject matter expert roles and responsibilities</li> <li>• Legal and public health authorities for the intervention actions</li> <li>• Intervention actions</li> <li>• List of identified locations that have the specific equipment required for, or locations that are easily adaptable for the intervention</li> <li>• Contact information/notification plan of community partners involved in intervention (e.g., those providing services or equipment)</li> <li>• Identification of any issues that may be associated with the implementation of individual community-mitigation measures or the net effect of the implementation of measures (secondary effects)</li> <li>• Intervention-specific methods for information dissemination to the public (e.g. information cards to be distributed at ports of entry during movement restrictions)</li> <li>• Processes for de-escalation of intervention once it is no longer needed</li> <li>• Documentation of the intervention during an incident</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Review Tab 1 of Attachment C of Appendix 8 to Annex H: Pandemic Influenza Plan.</li> <li><input type="checkbox"/> Develop playbooks for implementing non-pharmaceutical interventions, based on the priority element recommendations, within <b>Attachment 3 to Appendix 9 to Annex H: Communicable Disease Control Measures.</b></li> </ul>
<p><b>11. Non-Pharmaceutical Interventions</b></p>	<p><i>Function 3, P1:</i> Written plans should include agreements with healthcare coalitions and other community partners to coordinate support services to individuals during isolation or quarantine scenarios.</p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> List all agreements with community based organizations, home care, and other agencies that may be used to provide assistance in <b>Attachment 2 to Appendix 10 to Annex H: Shelter-in-Place.</b></li> </ul>

CDC Preparedness Capability	CDC Planning Priority Resource Elements	DSHS Considerations and Guidance
<p><b>11. Non-Pharmaceutical Interventions</b></p>	<p><i>Function 3, P2:</i> Written plans should include procedures to support the separation of cohorts of potentially exposed travelers from the general population at ports of entry. Plans should include but are not limited to the following elements:</p> <ul style="list-style-type: none"> <li>• Identification of resources (e.g., staff, facilities, and equipment) at or near ports of entry to be used for separation of cohorts</li> <li>• Scalable plans to accommodate cohorts of various sizes in identified facilities</li> <li>• Local and state Communicable Disease Response Plan compatible with CDC’s Division of Global Migration and Quarantine guidance</li> <li>• Applicable state/local legal authorities for detention, quarantine, and conditional release of potentially exposed persons and isolation of ill persons</li> <li>• Processes for transportation of cohorts to, and security at, pre-identified sites</li> </ul>	<ul style="list-style-type: none"> <li>□ Build into <b>Attachment 3 to Appendix 9 to Annex H: Communicable Disease Control Measures</b> procedures to support the separation of populations at ports of entries, if applicable. Include the bulleted priority resource elements.</li> </ul>
<p><b>12. Public Health Laboratory Testing</b></p>	<p><i>Function 1, P1:</i> Written plans must include at a minimum the identification of laboratories and laboratory networks within the jurisdiction as well as procedures for interaction with the following laboratories and groups:</p> <ul style="list-style-type: none"> <li>• Laboratory Response Network Biological (LRN)-B reference laboratories within the jurisdiction <ul style="list-style-type: none"> <li>○ Support and ensure LRN-B reference laboratory communication with all LRN-B sentinel and all other LRN-B reference laboratories within the jurisdiction</li> </ul> </li> <li>• CDC’s LRN chemical (LRN-C) laboratories within the jurisdiction</li> <li>• CDC’s LRN radiological (LRN-R) laboratories within the jurisdiction (if program funds become available)</li> <li>• Other state laboratories within the jurisdiction <ul style="list-style-type: none"> <li>○ e.g., non-LRN public health, environmental, agricultural, veterinary, and university laboratories</li> <li>○ Federal laboratory networks and member laboratories within the jurisdiction</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>□ Review existing Tab 4 to Appendix 8 to Attachment C to Annex H: Laboratory Response.</li> <li>□ List laboratories within jurisdiction and describe interactions within <b>Attachment 2 to Appendix 9 to Annex H: Laboratory Response.</b></li> </ul>

CDC Preparedness Capability	CDC Planning Priority Resource Elements	DSHS Considerations and Guidance
	<ul style="list-style-type: none"> <li>○ e.g., the Food Emergency Response Network, National Animal Health Laboratory Network, and the Environmental Response Laboratory Network</li> <li>● Poison control centers for chemical or radiological exposure incidents, such as food poisoning</li> </ul>	
<p><b>12. Public Health Laboratory Testing</b></p>	<p><i>Function 1, P2:</i> Written plans must include the following elements:</p> <ul style="list-style-type: none"> <li>● Documented procedures for contacting sentinel laboratories in the event of a public health incident</li> <li>● Coordination of jurisdiction-wide stakeholders involved in chemical, biological, radiological, nuclear, and explosive response and their standard response guidelines</li> </ul>	<ul style="list-style-type: none"> <li>□ Review existing Tab 4 to Appendix 8 to Attachment C to Annex H: Laboratory Response.</li> <li>□ Detail <b>Attachment 2 to Appendix 9 to Annex H: Laboratory Response</b> in protocols for communicating and sending samples to: <ul style="list-style-type: none"> <li>● Nearest Laboratory Response Network (LRN)-B, LRN-C, and/or LRN-R</li> <li>● DSHS State Laboratory</li> <li>● Texas Poison Control Network (TPCN)</li> <li>● Other laboratories for which agreements exist</li> </ul> </li> </ul>
<p><b>12. Public Health Laboratory Testing</b></p>	<p><i>Function 3, P1:</i> Written plans should include the following considerations for surge capacity:</p> <ul style="list-style-type: none"> <li>● Options to optimize procedures based on regular and surge</li> </ul>	<ul style="list-style-type: none"> <li>□ Reference laboratory surge plan or build procedures in <b>Attachment 2 to Appendix 9 to Annex H: Laboratory Response</b> to manage surge testing.</li> </ul>

CDC Preparedness Capability	CDC Planning Priority Resource Elements	DSHS Considerations and Guidance
	<p>personnel, equipment, and facility resources for short-term (e.g., days) and long-term (e.g., weeks to months) response efforts. Options should also be based on best practices and models available on the LRN website or other sources.</p> <ul style="list-style-type: none"> <li>• Triage policies that address how the laboratory will manage surge testing, that may include: <ul style="list-style-type: none"> <li>○ Referral of samples to other jurisdictional laboratories</li> <li>○ Prioritization of testing based upon sample type</li> <li>○ Prioritization of testing based upon risk or threat assessment</li> <li>○ Contingencies to assure newborn screening in a surge situation. Newborn screening can be assured by memoranda of agreement or contracts with commercial vendors</li> </ul> </li> <li>• Ensuring that laboratory testing and reporting can be performed for extended shifts based on need for Level 1 and Level 2 LRN-C laboratories. (Not applicable for territories)</li> </ul> <p>Ensuring that laboratory testing, quality assurance and control review, and reporting can be performed forextended shifts based on need for LRN-R laboratories, if program funds become available.</p>	
<p><b>13. Public Health Surveillance and Epidemiological Investigation</b></p>	<p><i>Function 1, P1:</i> 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.</p>	<ul style="list-style-type: none"> <li>□ Reference in Appendix 9 to Annex H: Epidemiology and Laboratory the Texas laws (Health &amp; Safety Code, Chapters 81, 84, and 87) that provide the legal framework for mandatory reporting of health conditions to DSHS.</li> </ul> <p>Reporting procedures are detailed in the Texas Administrative Code (TAC). Health care providers, hospitals, laboratories, schools, and others are required to report patients who are suspected of having a notifiable disease / condition (Chapter 97, Title 25, Texas Administrative Code).</p>

CDC Preparedness Capability	CDC Planning Priority Resource Elements	DSHS Considerations and Guidance
<p><b>13. Public Health Surveillance and Epidemiological Investigation</b></p>	<p><i>Function 1, P2:</i> 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.</p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Summarize in <b>Attachment 1 to Appendix 9 to Annex H: Disease Reporting</b> how health department personal health information during investigations.</li> <li><input type="checkbox"/> DSHS notification protocol meets federal laws and standards.</li> </ul>
<p><b>13. Public Health Surveillance and Epidemiological Investigation</b></p>	<p><i>Function 1, P3:</i> Written plans should include processes and protocols to gather and analyze data from the following:</p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• 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 <ul style="list-style-type: none"> <li>○ Participation in the CDC BioSense data-sharing program is encouraged</li> </ul> </li> <li>• Surveillance of major causes of mortality, including the use of vital statistics as a data source</li> <li>• Surveillance of major causes of morbidity</li> <li>• Written plans should be able to adapt to include novel and/or emerging public health threats.</li> <li>• Environmental conditions</li> <li>• Hospital discharge abstracts</li> <li>• Information from mental/behavioral health agencies</li> <li>• Population-based surveys</li> <li>• Disease registries</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Review existing Attachment C to Appendix 8 to Annex H: Epidemiology and Surveillance Response Plan, Tab 6 to Attachment C to Appendix 8 to Annex H: Disease Reporting.</li> <li><input type="checkbox"/> Outline in <b>Attachment 1 to Appendix 9 to Annex H: Disease Reporting</b> <ul style="list-style-type: none"> <li>• The processes and procedures for how notifiable conditions, unusual expressions, and clusters of disease are received and reported to DSHS Health Service Region for all conditions, including immediately reportable conditions.</li> <li>• Processes for accessing/utilizing syndromic surveillance data.</li> <li>• Procedures for death reporting</li> <li>• Any other surveillance conducted by the health department</li> </ul> </li> </ul>

CDC Preparedness Capability	CDC Planning Priority Resource Elements	DSHS Considerations and Guidance
	<ul style="list-style-type: none"> <li>• Immunization registries/Immunization information systems</li> <li>• Active case finding (e.g., by healthcare logs and record reviews)</li> </ul>	
<b>13. Public Health Surveillance and Epidemiological Investigation</b>	<i>Function 1, P4:</i> 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.	<input type="checkbox"/> Review existing Tab 6 of Attachment C to Appendix 8 to Annex H: Disease Reporting. <input type="checkbox"/> Describe in <b>Attachment 1 to Appendix 9 to Annex H: Disease Reporting</b> how health department is set up to receive disease reports from providers for notifiable conditions, unusual expressions, and clusters of diseases on a 24/7 basis.
<b>13. Public Health Surveillance and Epidemiological Investigation</b>	<i>Function 1, P5:</i> 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	<input type="checkbox"/> Review existing Tab 6 of Attachment C to Appendix 8 to Annex H: Disease Reporting. <input type="checkbox"/> <b>Attachment 1 to Appendix 9 to Annex H: Disease</b>

CDC Preparedness Capability	CDC Planning Priority Resource Elements	DSHS Considerations and Guidance
	<p>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.</p>	<p><b>Reporting</b> should outline procedures for how notifiable conditions* will be reported to DSHS Health Service Region.</p> <p>Nationally notifiable conditions are reported through daily messaging to CDC through National Electronic Disease Surveillance System (NEDSS). <b>Appendix 9 to Annex H: Epidemiology and Surveillance</b> should reference protocol for submitting electronic, NEDSS Based System (NBS) case investigation records and assuring the quality of electronic submissions.</p> <p>*Note: Texas notifiable conditions include all of the nationally notifiable conditions except Babesiosis; Coccidioidomycosis; Giardiasis; Hepatitis C, past or present; Streptococcal toxic-shock syndrome; Toxic-shock syndrome (other than streptococcal); and non-type b Haemophilus influenzae invasive disease.)</p>
<p><b>13. Public Health Surveillance and Epidemiological Investigation</b></p>	<p><i>Function 2, P1:</i> Written plans should include investigation report templates that contain the following minimal elements:</p> <ul style="list-style-type: none"> <li>• Context / Background</li> <li>• Information that helps to characterize the incident, including the following: <ul style="list-style-type: none"> <li>○ Population affected (e.g., estimated number of persons exposed and number of persons ill)</li> <li>○ Location (e.g., setting or venue)</li> <li>○ Geographical area(s) involved</li> <li>○ Suspected or known etiology</li> </ul> </li> <li>• Initiation of Investigation</li> <li>• Information regarding receipt of notification and initiation of the investigation, including the following: <ul style="list-style-type: none"> <li>○ Date and time initial notification was received by the agency</li> <li>○ Date and time investigation was initiated by the agency</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Review existing Tab 6 of Attachment C to Appendix 8 to Annex H: Disease Reporting.</li> <li><input type="checkbox"/> Reference in <b>Appendix 9 to Annex H: Epidemiology and Surveillance</b> investigation templates used in health department.</li> </ul> <p>Templates can be accessed at to the Infectious Disease Control Unit website at:  <a href="http://www.dshs.state.tx.us/idcu/investigation/">http://www.dshs.state.tx.us/idcu/investigation/</a></p>

CDC Preparedness Capability	CDC Planning Priority Resource Elements	DSHS Considerations and Guidance
	<ul style="list-style-type: none"> <li>• Investigation Methods</li> <li>• Epidemiological or other investigative methods employed, including the following: <ul style="list-style-type: none"> <li>○ Any initial investigative activity (e.g., verified laboratory results)</li> <li>○ Data collection and analysis methods (e.g., case-finding, cohort/case-control studies, environmental)</li> <li>○ Tools that were relevant to the investigation (e.g., epidemic curves, attack rate tables, and questionnaires)</li> <li>○ Case definitions (as applicable)</li> <li>○ Exposure assessments and classification</li> <li>○ Review of reports developed by first responders, lab testing of environmental media, reviews of environmental testing records, industrial hygiene assessments, questionnaires</li> </ul> </li> <li>• Investigation Findings/Results - all pertinent investigation results, including the following: <ul style="list-style-type: none"> <li>○ Epidemiological results</li> <li>○ Laboratory results (as applicable)</li> <li>○ Clinical results (as applicable)</li> <li>○ Other analytic findings (as applicable)</li> </ul> </li> <li>• 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</li> <li>• 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</li> <li>• 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.</li> </ul>	

CDC Preparedness Capability	CDC Planning Priority Resource Elements	DSHS Considerations and Guidance
<b>13. Public Health Surveillance and Epidemiological Investigation</b>	<i>Function 3, P1:</i> 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.	<ul style="list-style-type: none"> <li><input type="checkbox"/> Review existing Tab 5 to Attachment C to Appendix 8 to Annex H: Isolation and Quarantine.</li> <li><input type="checkbox"/> Detail in <b>Attachment 3 to Appendix 9 to Annex H: Communicable Disease Control measures</b> individual, property, area and carrier quarantine procedures.</li> </ul>
<b>13. Public Health Surveillance and Epidemiological Investigation</b>	<i>Function 4, P1:</i> 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.	<ul style="list-style-type: none"> <li><input type="checkbox"/> Develop in <b>Appendix 9 to Annex H: Epidemiology and Surveillance</b> procedures for communicating epidemiology response improvement plans.</li> </ul>
<b>14. Responder Safety and Health</b>	<i>Function 1, P1:</i> Written plans should 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 (e.g., environmental health, occupational health and safety, jurisdictional Local Emergency Planning Committee, risk-specific subject matter experts). This documentation should include the following elements: <ul style="list-style-type: none"> <li>• Limits of exposure or injury necessitating response</li> <li>• Job-specific worker safety guides (e.g., radiation, heat, fire, and infrastructure damage resulting in other chemical release)</li> <li>• Potential for post-event medical and mental/behavioral health follow-up assessments</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Review existing Attachment B to Appendix 9: Worker Safety.</li> <li><input type="checkbox"/> In <b>Tab B to Attachment 3 to Appendix 1 to Annex H: Responder Safety and Health</b> identify and assess risks to public health response workers, related to jurisdiction's identified risks. Address the priority resource element bulleted items in the risk analysis.</li> </ul>
<b>14. Responder Safety and Health</b>	<i>P2:</i> Written plans should include documentation that 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 will need to have to execute potential roles. Roles for consideration may include the	<ul style="list-style-type: none"> <li><input type="checkbox"/> Review existing Attachment B to Appendix 9 to Annex H: Workers Safety.</li> <li><input type="checkbox"/> Document in <b>Tab B to Attachment 3 to Appendix 1 to Annex H: Responder Safety and Health</b> protocol on risk-related immunizations and personal protective equipment for all public health responders based on response role.</li> </ul>

CDC Preparedness Capability	CDC Planning Priority Resource Elements	DSHS Considerations and Guidance
	following elements: <ul style="list-style-type: none"> <li>• Conducting environmental health assessments</li> <li>• Potable water inspections</li> <li>• Field surveillance interviews</li> </ul>	
<b>14. Responder Safety and Health</b>	<p><i>Function 2, P1:</i> Written plans should include recommendations for risk-related personal protective equipment for public health responders that have been developed in conjunction with partner agencies (e.g., state environmental health, state occupational health and safety, and risk-specific subject matter experts).</p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Review existing Attachment B to Appendix 9 to Annex H: Workers Safety.</li> <li><input type="checkbox"/> List in <b>Tab B to Attachment 3 to Appendix 1 to Annex H: Responder Safety and Health</b> Personal Protective Equipment (PPE) provided for health department responders.           <ul style="list-style-type: none"> <li>• Describe processes or procedures to assure that public health responders are fit-tested, trained, and medically cleared to use personal protective equipment indicated for their particular response role prior to the time of the incident.</li> <li>• Detail how health department will access (e.g., through mutual aid agreements or other mechanism) backup/cache equipment for incident response.</li> </ul> </li> </ul>
<b>14. Responder Safety and Health</b>	<p><i>Function 4, P1:</i> Written plans should include process and protocols for how the public health agency, in conjunction with lead partners (e.g., occupational health and safety) will participate in surveillance activities to monitor levels of environmental exposure, environmental effects on the responders, and/or incident-related injuries.</p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Describe in <b>Tab B to Attachment 3 to Appendix 1 to Annex H: Responder Safety and Health</b> procedures to report safety issues, injuries or conditions during and after response and recovery.</li> </ul>
<b>15. Volunteer Management</b>	<p><i>Function 1, P1:</i> Written plans should address anticipated volunteer needs in response to incidents or situations identified in the jurisdictional risk assessment including the following elements:</p> <ul style="list-style-type: none"> <li>• Identification of functional roles</li> <li>• Skills, knowledge, or abilities needed for each volunteer task or role</li> <li>• Description of when the volunteer actions will happen</li> <li>• Identification of jurisdictional authorities that govern volunteer liability issues and scope of practice</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Build into <b>Tab A to Attachment 3 to Appendix 1 to Annex H: Volunteer Coordination</b> expected volunteer needs based on the jurisdictional risk assessment. Include the bulleted items in the volunteer needs assessment.</li> </ul>

CDC Preparedness Capability	CDC Planning Priority Resource Elements	DSHS Considerations and Guidance
15. Volunteer Management	<p><i>Function 1, P2:</i> Written plans should include memoranda of understanding or other letters of agreement with jurisdictional volunteer sources. Suggested partners include but are not limited to the following groups:</p> <ul style="list-style-type: none"> <li>• Professional medical organizations (e.g., nursing and allied health)</li> <li>• Professional guilds (e.g., behavioral health)</li> <li>• Academic institutions</li> <li>• Faith-based organizations</li> <li>• Voluntary Organizations Active in Disasters</li> <li>• Medical Reserve Corps</li> <li>• Non-profit, private, and community-based volunteer groups</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Reference in <b>Tab A to Attachment 3 to Appendix 1 to Annex H: Volunteer Coordination</b> any MOU/MOA with volunteer organizations.</li> </ul>
15. Volunteer Management	<p><i>Function 3, P1:</i> Written plans should include a template for briefing volunteers of current incident conditions, including the following elements:</p> <ul style="list-style-type: none"> <li>• Instructions on the current status of the emergency</li> <li>• Volunteers’ role (including how the volunteer is to operate within incident management)</li> <li>• Just-in-time training</li> <li>• Safety instructions</li> <li>• Any applicable liability issues related to the incident and the volunteers’ roles, psychological first aid, and/orvolunteer stress management</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Review existing Attachment A to Appendix 9 to Annex H: Volunteers.</li> <li><input type="checkbox"/> Describe in <b>Appendix 2 to Annex H: Communications</b> how situational reports/ incident action plans will be shared with public health and medical volunteers.</li> </ul>
15. Volunteer Management	<p><i>Function 3, P2:</i> Written plans should include a process to manage spontaneous volunteers. The process should include, at a minimum, the following elements:</p> <ul style="list-style-type: none"> <li>• Process to communicate to the public whether spontaneous volunteers should report, and, if so, where and to whom</li> <li>• Method to inform spontaneous volunteers how to register for use in future emergency responses</li> <li>• Method to refer spontaneous volunteers to other organization (e.g., non-profit or Medical Reserve Corps)</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Review existing Attachment A to Appendix 9 to Annex H: Volunteers.</li> <li><input type="checkbox"/> Outline health department’s process and policies for managing spontaneous volunteers in <b>Tab A to Attachment 3 to Appendix 1 to Annex H: Volunteer Coordination.</b></li> </ul>
15. Volunteer	<p><i>Function 4, P1:</i> Written plans should include a process for releasing</p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Review existing Attachment A to Appendix 9 to Annex H:</li> </ul>

CDC Preparedness Capability	CDC Planning Priority Resource Elements	DSHS Considerations and Guidance
<b>Management</b>	<p>volunteers, to be used when the public health department has the lead role in volunteer coordination. The process should include steps to accomplish the following:</p> <ul style="list-style-type: none"> <li>• Demobilize volunteers in accordance with the incident action plan</li> <li>• Assure all assigned activities are completed, and/or replacement volunteers are informed of the activities' status</li> <li>• Determine whether additional volunteer assistance is needed from the volunteer</li> <li>• Assure all equipment is returned by volunteer</li> <li>• Confirm the volunteer's follow-up contact information</li> </ul>	<p>Volunteers.</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Describe procedures for demobilizing volunteers in <b>Tab A to Attachment 3 to Appendix 1 to Annex H: Volunteer Coordination.</b></li> </ul>
<b>15. Volunteer Management</b>	<p><i>Function 4, P2:</i> Written plans should include a protocol for conducting exit screening during out-processing, to include documentation of the following:</p> <ul style="list-style-type: none"> <li>• Any injuries and illnesses acquired during the response</li> <li>• Mental/behavioral health needs due to participation in the response</li> <li>• When requested or indicated, referral of volunteer to medical and mental/behavioral health services</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Outline exit screening process for volunteers in <b>Tab A to Attachment 3 to Appendix 1 to Annex H: Volunteer Coordination</b></li> </ul>

## Section III. Submitting Plans for Technical Assistance

### Submittal Procedures

1. Plans should be emailed to [PreparednessPlanning@dshs.state.tx.us](mailto:PreparednessPlanning@dshs.state.tx.us) or mailed to ATTN: Planning Team P.O. Box 149347 Austin, Texas 78714-9347 prior to the 5-year anniversary date to permit sufficient time for review.
2. Plans must be signed and contain the most recent revision date.
3. Once the plans have been emailed or mailed, send an e-mail message to the DSHS Central Office Preparedness Planner for your assigned region. (See Appendix 2). Your e-mail should include:
  - a. List of documents emailed or mailed
  - b. Point of contact for your agency should there be any questions

### Review Process

1. When plans have been emailed or mailed, the assigned Community Preparedness Planner will review the plans and write an assessment within 60 days.
2. The assessment will be shared and discussed with the Health Service Regional Preparedness Planner before emailing it to the local health department.
3. Technical assistance will be coordinated between the health service region and DSHS central office.

## Appendix 1: Acronym List

<b>CASPER</b>	Community Assessment for Public Health Response
<b>CDC</b>	Centers for Disease Control and Prevention
<b>CERC</b>	Crisis and Emergency Risk Communication
<b>cGMP</b>	current Good Manufacturing Process
<b>DSHS</b>	(Texas) Department of State Health Services
<b>EMAC</b>	Emergency Management Assistance Compact
<b>EOC</b>	Emergency Operations Center
<b>ESAR-VHP</b>	Emergency System for Advance Registration of Volunteer Health Professionals
<b>FAC</b>	Family Assistance Center
<b>FQHC</b>	Federally Qualified Health Center
<b>HHSC</b>	(Texas) Health and Human Service Commission
<b>IAP</b>	Incident Action Plan
<b>ICS</b>	Incident Command System
<b>LRN</b>	Laboratory Response Network
<b>MOA</b>	Memorandum of Agreement
<b>MOU</b>	Memorandum of Understanding
<b>MRC</b>	Medical Reserve Corps
<b>NBS</b>	NEDSS Based System
<b>NEDSS</b>	National Electronic Disease Surveillance System
<b>NIMS</b>	National Incident Management System
<b>NIMSCAST</b>	NIMS Compliance Assistance Support Tool
<b>POD</b>	Point of Dispensing
<b>PPE</b>	Personal Protective Equipment
<b>SMOC</b>	State Medical Operations Center
<b>SNS</b>	Strategic National Stockpile
<b>SOG</b>	Standard Operating Guidelines
<b>SOP</b>	Standard Operating Procedures
<b>TAR</b>	Technical Assistance Review
<b>TDEM</b>	Texas Division of Emergency Management
<b>TPCN</b>	Texas Poison Control Network
<b>TxPHIN</b>	Texas Public Health Information Network
<b>VAERS</b>	Vaccine Adverse Event Reporting System

## Appendix 2: DSHS Points of Contact



### Preparedness Coordination Branch Coverage Map

*Planners, Exercisers and Trainers*



**Tom Hunt**  
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**E- Annette Vande Werken**  
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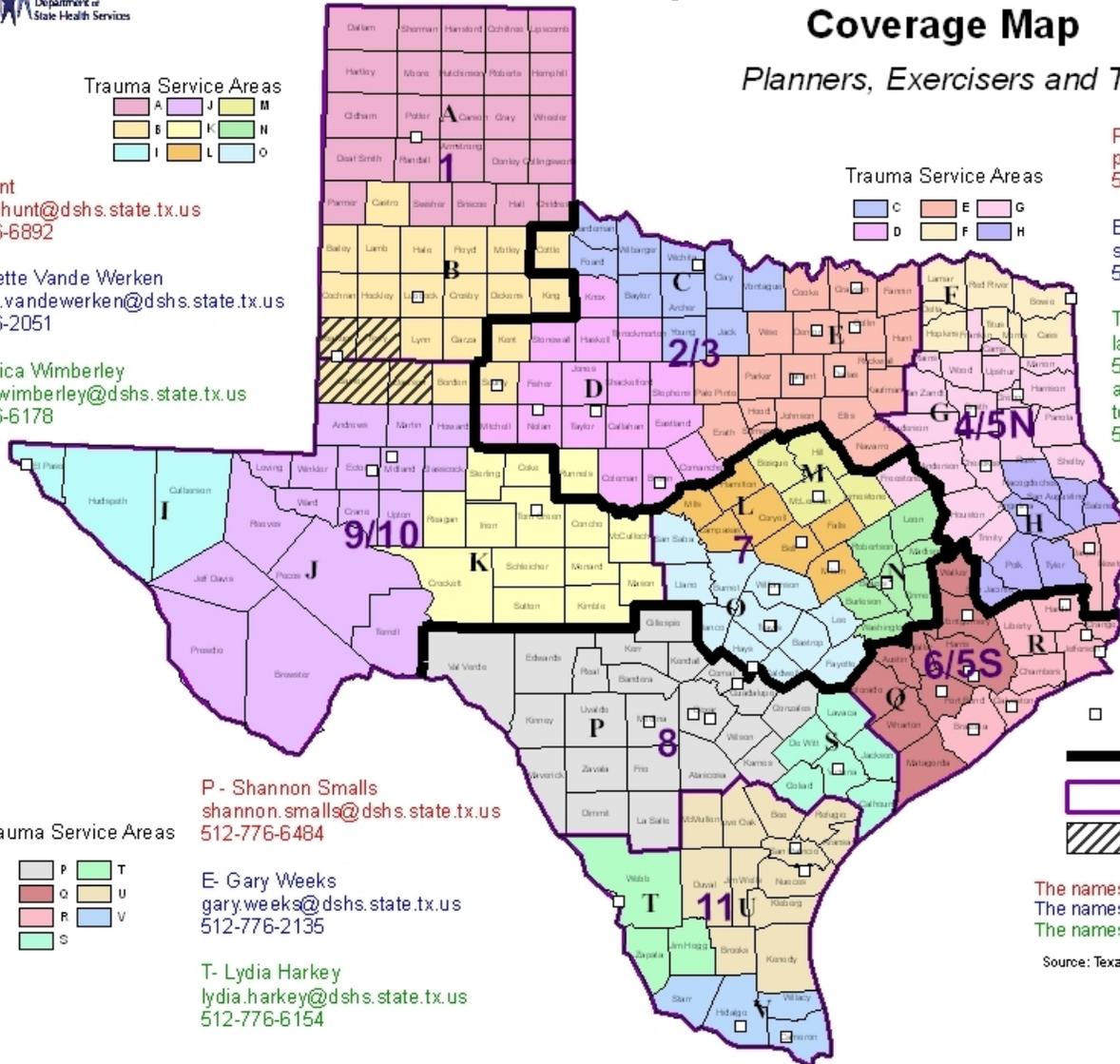
**T- Jessica Wimberley**  
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**P- Priscilla Boston**  
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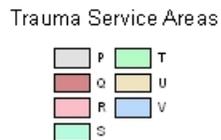
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**E- Gary Weeks**  
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**T- Lydia Harkey**  
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512-776-6154



- Local Health Dept.
- Coverage boundary
- ▭ DSHS Region
- ▨ South Plains Health District

The names of the planners are listed in red  
The names of the exercisers are in blue  
The names of the trainers are in green

Source: Texas Department of State Health Services,  
Community Preparedness  
June 2011, thaywood