Health, Housing & Human Services
CLACKAMAS COUNTY

Rodney A. Cook
Director

October 17, 2024

BCC Agenda Date/Item: _____

Board of County Commissioners
Clackamas County

Approval of Amendment to the Revenue Intergovernmental Agreement with the Oregon Health Authority to fund Public Health Services. Amendment Value is $612,356.27 for 1 year. Total Agreement Value is increased to $12,097,806.27 and 2 years. Funding is through the Oregon Health Authority. No County General Funds are involved.

Previous Board Action/Review	Previous Board actions: June 29, 2023, Agenda item 230629 IIIC1, October 5, 2023, Agenda item 231005.III.4, November 9, 2023, Agenda item 231108II.E.5, March 7, 2023, Agenda item 240307 I.C.3, May 2, 2024, Agenda item 2024052.I.E3, July 25, 2024, Agenda item 240725III.F2 Issues Topic: October 15 2024		
Performance Clackamas	1. Ensure safe, healthy, and secure communities		
Counsel Review	Yes	**Procurement Review**	No
Contact Person	Philip Mason-Joyner, Public Health Director	**Contact Phone**	(503) 742-5956

EXECUTIVE SUMMARY: The Public Health Division (PHD) of the Health, Housing & Human Services Department requests approval of Amendment #10 adding $612,356.27 to the Revenue Intergovernmental Agreement with Oregon Health Authority (OHA), adding anticipated funding to Program Elements supporting current Public Health Services through June 30, 2025 (the end of the state's biennium).

It is OHA's practice to issue amendments adding funding to second biennial year Program Elements once the first biennial year of an agreement closes, effectively rebalancing available funding across the Program Elements. Amendment #10 adds this anticipated funding to the following Program Elements (PE):

- $1,517.82 – Infection Prevention Training for the Communicable Disease Program (PE01-12)
- $65,492 – Cities Readiness Initiative for the All-Hazard Preparedness Program (PE02)
- $152,335 – Public Health Emergency Preparedness and Response (PE12-01)
- $31,921 – Maternal, Child and Adolescent Health for the Nurse Home Visiting Program (PE42-03)
- $240,000 – School Based Heath Centers Services (PE44-01)
- $38,860.71 – Reproductive Health Community Participation & Assurance of Access (PE46-05)

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- $57,063.07 – Pubic Health Modernization Implementation (PE51-01)
- $25,166.67 – Overdose Prevention for the Opioid Program (PE62)

Per the OHA, Amendment #10 is effective on July 15, 2024, regardless of the date signed, and funds services through June 30, 2025.

RECOMMENDATION:

Staff recommends that the Board approve Amendment #10 to Intergovernmental Agreement #11176.

Respectfully submitted,

Rodney A. Cook

Rodney A. Cook, Director
Health, Housing, and Human Services

Agreement #180003

AMENDMENT TO OREGON HEALTH AUTHORITY 2023-2025 INTERGOVERNMENTAL AGREEMENT FOR THE FINANCING OF PUBLIC HEALTH SERVICES

In compliance with the Americans with Disabilities Act, this document is available in alternate formats such as Braille, large print, audio recordings, Web-based communications and other electronic formats. To request an alternate format, please send an e-mail to *dhs-oha.publicationrequest@state.or.us* or call 503-378-3486 (voice) or 503-378-3523 (TTY) to arrange for the alternative format.

This Tenth Amendment (this "Amendment") to Oregon Health Authority 2023-2025 Intergovernmental Agreement for the Financing of Public Health Services, effective July 1, 2023, (as amended, the "Agreement"), is between the State of Oregon acting by and through its Oregon Health Authority ("OHA") and Clackamas County, ("LPHA"), the entity designated, pursuant to ORS 431.003, as the Local Public Health Authority for Clackamas County. OHA and LPHA are each a "Party" and together the "Parties" to the Agreement.

RECITALS

WHEREAS, OHA and LPHA wish to modify the set of Program Element Descriptions set forth in Exhibit B of the Agreement

WHEREAS, OHA and LPHA wish to modify the Fiscal Year 2025 (FY25) Financial Assistance Award set forth in Exhibit C of the Agreement.

WHEREAS, OHA and LPHA wish to modify the Exhibit J information required by 2 CFR Subtitle B with guidance at 2 CFR Part 200 (FY25);

AGREEMENT

NOW, THEREFORE, in consideration of the premises, covenants and agreements contained herein and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties hereto agree as follows:

1. This Amendment is effective on July 15, 2024, regardless of the date this amendment has been fully executed with signatures by every Party and when required, approved by the Department of Justice. However, payments may not be disbursed until the Amendment is fully executed.

2. The Agreement is hereby amended as follows:

a. Exhibit A "Definitions", Section 18 "Program Element" is hereby amended to add Program Element titles and funding source identifiers and remove PE36 funding source identifier as follows:

PE NUMBER AND TITLE • **SUB-ELEMENT(S)**	**FUND TYPE**	**FEDERAL AGENCY/ GRANT TITLE**	**CFDA#**	**HIPAA RELATED (Y/N)**	**SUB-RECIPIENT (Y/N)**
PE02 - Cities Readiness Initiative					
PE 02 Cities Readiness Initiative (CRI) Program	FF	Public Health Emergency Preparedness	93.069	N	Y
PE12 - Public Health Emergency Preparedness and Response (PHEP)					
PE 12-01 Public Health Emergency Preparedness Program (PHEP)	FF	CDC/Public Health Emergency Preparedness	93.069	N	Y
PE 12-02 COVID-19 Response	FF	CDC/Public Health Emergency Response: Cooperative Agreement for Emergency Response: Public Health Crisis Response	93.354	N	Y
~~PE 36 - Alcohol Drug Prevention Education Program~~					
~~PE 36 - Alcohol and Drug Prevention Education Program~~	~~FF~~	~~SAMHSA/Substance Abuse Prevention & Treatment Block Grant~~	~~93.959~~	~~N~~	~~Y~~
PE46 - Reproductive Health					
PE 46-05 RH Community Access	FF	DHHS/Family Planning Services	93.217	N	Y
PE62 - Overdose Prevention					
PE 62 Overdose Prevention	FF	SAMHSA/State Targeted Response to the Opioid Crisis Grants	93.788	N	Y
	FF	CDC/Injury Prevention and Control Research and State and Community Based Programs	93.136	N	Y

b. Exhibit B Program Elements **#02 "Cities Readiness Initiative (CRI) Program"** and **#12 "Public Health Emergency Preparedness and Response (PHEPR) Program"** and **#46 "Reproductive Health"** and **#62 "Overdose Prevention"** are hereby added by Attachment A attached hereto and incorporated herein by this reference.

c. Exhibit C, Section 1 of the Agreement, entitled "Financial Assistance Award" for FY25 is hereby deleted and replaced in its entirety by Attachment B, entitled "Financial Assistance Award (FY25)", attached hereto and incorporated herein by this reference. Attachment B must be read in conjunction with Section 3 of Exhibit C.

d. Exhibit J of the Agreement entitled "Information required by 2 CFR Subtitle B with guidance at 2 CFR Part 200 (FY25)" is amended to add to the federal award information datasheet as set forth in Attachment C, attached hereto and incorporated herein by this reference.

3. LPHA represents and warrants to OHA that the representations and warranties of LPHA set forth in Section 4 of Exhibit F of the Agreement are true and correct on the date hereof with the same effect as if made on the date hereof.

4. Capitalized words and phrases used but not defined herein shall have the meanings ascribed thereto in the Agreement.

5. Except as amended hereby, all terms and conditions of the Agreement remain in full force and effect.

6. This Amendment may be executed in any number of counterparts, all of which when taken together shall constitute one agreement binding on all parties, notwithstanding that all parties are not signatories to the same counterpart. Each copy of this Amendment so executed shall constitute an original.

IN WITNESS WHEREOF, the parties hereto have executed this Amendment as of the dates set forth below their respective signatures.

7. Signatures.

STATE OF OREGON, ACTING BY AND THROUGH ITS OREGON HEALTH AUTHORITY

Approved by: _____

Name: /for/ Nadia A. Davidson

Title: Director of Finance

Date: _____

CLACKAMAS COUNTY LOCAL PUBLIC HEALTH AUTHORITY

Approved by: _____

Printed Name: _____

Title: _____

Date: _____

DEPARTMENT OF JUSTICE – APPROVED FOR LEGAL SUFFICIENCY

Agreement form group-approved by Lisa Gramp, Senior Assistant Attorney General, Tax and Finance Section, General Counsel Division, Oregon Department of Justice by email on August 14, 2024, copy of email approval in Agreement file.

REVIEWED BY OHA PUBLIC HEALTH ADMINISTRATION

Reviewed by: _____

Name: Rolonda Widenmeyer (or designee)

Title: Program Support Manager

Date: _____

Attachment A
Program Element Descriptions

Program Element #02: Cities Readiness Initiative (CRI) Program

OHA Program Responsible for Program Element:

Public Health Division/Center for Public Health Practice/Health Security, Preparedness & Response Section

1. Description.

Funds provided under this Agreement for this Program Element may only be used in accordance with, and subject to, the requirements and limitations set forth below, to deliver Cities Readiness Initiative (CRI) Program activities. Requirements for the LPHA's in the CRI planning jurisdiction (CRI LPHA), and the CRI Regional Program (Regional CRI), housed in Washington County, but that serves the LPHA, are established through this Program Element.

The CRI Program focuses on plans and procedures that support medical countermeasure distribution and dispensing (MCMDD) for all-hazards events. For the 2019-2024 performance period, CDC will require all CRI LPHAs to ensure elements of planning and operational readiness for two specific threats: the intentional release of a Category A agent, such as anthrax, and an Emerging Infectious Disease (EID), primarily pandemic influenza. CDC has determined key operational readiness elements for both planning scenarios.

All changes to this Program Element are effective upon receipt of grant award unless otherwise noted in Exhibit C of the Financial Assistance Award.

2. Definitions Specific to Cities Readiness Initiative (CRI) Program

a. **Centers for Disease Control and Prevention (CDC):** The nation's lead public health agency, which is one of the major operating components of the U.S. Department of Health and Human Services.

b. **CRI LPHAs:** LPHAs in the CRI planning jurisdiction which includes Washington, Multnomah, Clackamas, Yamhill and Columbia counties in Oregon.

c. **Department of Homeland Security (DHS):** The federal agency responsible for protecting the United States territory from terrorist attacks and responding to natural disasters.

d. **PHEP ORR Reporting and Tracking System (PORTS) Application:** Online data collection system for collecting program evaluation documents.

e. **Homeland Security Exercise and Evaluation Program (HSEEP):** A capabilities and performance-based program that provides standardized policy, methodology, and language for designing, developing, conducting, and evaluating all exercises.

f. **Integrated Preparedness Plan (IPP):** The 2020 revision to HSEEP renamed the program to IPP.

g. **National Incident Management System (NIMS):** The DHS' system for integrating effective practices in emergency preparedness and response into a comprehensive national framework for incident management. NIMS enables emergency responders at all levels and in different disciplines to effectively manage incidents no matter the cause, size or complexity. More information can be viewed at *https://www.fema.gov/national-incident-management-system*.

h. **Operational Drills:** A set of three drills as required by the ORR. The drills include: staff call down, site activation, and facility setup.

i. **Operational Readiness Review (ORR):** The evaluation tool assessing the LPHA's CRI Program: materials, products, plans, exercises, and activities. This assessment is conducted by a

team of state, and local preparedness staff using an online system developed by the CDC. The ORR is used to assess how ready CRI counties are to respond to a MCMDD response.

j. **Point of Dispensing (POD) Site:** A site such as a high school gymnasium at which prophylactic medications are dispensed to the public.

k. **Portland Metro Cities Readiness Initiative (CRI) Program Area, Metropolitan Statistical Area (MSA):** The Cities Readiness Initiative is a CDC program that aids cities and metropolitan areas in increasing their capacity to receive and dispense medicines and medical supplies during a large-scale public health emergency such as a bioterrorism attack. The counties forming the Portland Metro CRI Program Area are Clackamas, Washington, Multnomah, Columbia, and Yamhill LPHAs in Oregon, and Clark and Skamania LPHAs in Washington State. Washington State is responsible for all CRI activities and funding for the Clark County LPHA and Skamania County LPHA. Additional information about the CRI Program and the cooperative agreement "Guidance for Public Health Emergency Preparedness" is viewable at: http://www.cdc.gov/phpr/coopagreement.htm.

l. **Push Partner:** A community organization that is trained, willing, and able to assist in a public health emergency. Also known as Closed PODs.

m. **Public Health Emergency Preparedness (PHEP):** local public health programs designed to better prepare Oregon to respond to, mitigate and recover from emergencies with public health impacts.

n. **Public Health Preparedness Capabilities:** A national set of standards, created by the CDC, for public health preparedness capability-based planning that will assist state and local planners in identifying gaps in preparedness, determining the specific jurisdictional priorities, and developing plans for building and sustaining response capabilities.

o. **Regional CRI Program Coordinator:** Individual that supports the CRI work of each CRI LPHA in the CRI jurisdiction. This coordinator is housed in Washington County but reports to and takes guidance from each of the CRI LPHAs and their PHEP Coordinators and/or teams.

p. **Strategic National Stockpile (SNS):** A program developed by the CDC to provide: 1.) rapid delivery of a broad spectrum of pharmaceuticals, medical supplies, and equipment for an ill-defined threat in the early hours of an event; 2.) shipments of specific items when a specific threat is known; and 3.) technical assistance to distribute SNS material. SNS program support includes the 12-hour Push Pack, stockpile and vendor managed inventory, vaccines, federal buying power, CHEMPACK, and Federal Medical Stations.

3. Alignment with Modernization Foundational Programs and Foundational Capabilities.

Activities and services delivered under this Program Element align with Foundational Programs and Foundational Capabilities, as defined in Oregon's Public Health Modernization Manual, (http://www.oregon.gov/oha/PH/ABOUT/TASKFORCE/Documents/public_health_modernization_manual.pdf) as well as with public health accountability outcome and process metrics (if applicable) as follows:

a. Foundational Programs and Capabilities (As specified in Public Health Modernization Manual)

Program Components	**Foundational Program**					**Foundational Capabilities**						
	CD Control	Prevention and health promotion	Environmental health	Access to clinical preventive services: Population Health	Access to clinical preventive services: Direct services	Leadership and organizational competencies	Health equity and cultural responsiveness	Community Partnership Development	Assessment and Epidemiology	Policy & Planning	Communications	Emergency Preparedness and Response
Asterisk (*) = Primary foundational program that aligns with each component *X = Other applicable foundational programs*						*X = Foundational capabilities that align with each component*						
CRI Work Plan	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**
Public Health Preparedness Capabilities	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**
Contingent Emergency Response Funding	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**

b. The work in this Program Element helps Oregon's governmental public health system achieve the following Public Health Accountability Metric:

Not applicable

c. The work in this Program Element helps Oregon's governmental public health system achieve the following Public Health Modernization Process Measure:

Not applicable

4. Procedural and Operational Requirements.

By accepting and using the Financial Assistance awarded under this Agreement and for this Program Element, CRI LPHA agrees to conduct activities in accordance with the following requirements:

a. CRI LPHA must use funds for this Program Element in accordance with its CRI Program Budget, template set forth in Attachment 1, required to be submitted and approved by OHA on or before August 15.

b. CRI LPHA must submit a work plan to OHA State Medical Countermeasures (MCM) Coordinator and Regional CRI Coordinator. Work plan may be included into PHEP PE-12 work plan but must be clearly designated. Proposed work plan is due on or before August 15.

c. CRI LPHA must provide feedback and approval of the Regional CRI work plan. The CRI Regional Coordinator, housed within the Washington County LPHA, has the responsibility for submitting the regional CRI work plan. The final approved Regional CRI work plan is due to OHA on or before September 1. The Regional CRI work plan must present objectives and related activities, identify responsible parties, and establish timelines for the Regional CRI Program that:

(1) Enable each CRI LPHA to successfully complete the ORR tool and any accompanying tools, including, but not limited to ORR Action Plans;

(2) Enable each CRI LPHA to meet exercise requirements; and

(3) Provide programmatic oversight responsibilities.

(4) Provide other reports about the Regional CRI Program as OHA may reasonably request from time to time.

d. CRI LPHA must complete the following requirements:

(1) Complete Operational Readiness Review (ORR) each fiscal year. Each CRI LPHA, unless otherwise advised, shall complete the submission of ORR to include Dispensing Planning Form, Distribution Planning Form, POD Information Forms, Training and Exercise Planning Form, and Jurisdictional Data Sheet (JDS). These must be submitted no later than 6/15 of each year. During site assessment years (see item 2) these forms are due no later than 21 days prior to the scheduled site visit.

(2) Every other year, starting in FY 19-20, each CRI LPHA, unless otherwise advised, shall coordinate an ORR site assessment meeting to include, at a minimum, the following invitees: local CRI or PHEP program representative, CRI Regional Coordinator, local emergency management, and OHA State MCM Coordinator. In the Site Assessment years supporting documentation must be submitted with the forms that require it per most recent CDC ORR Guidance. Completed ORR forms and supporting documentation must be submitted to OHA State MCM Coordinator 21 days prior to review date using the PORTS system.

(3) If a new RSS site is needed or wanted the site must be validated with a site visit by the state Medical Countermeasures Coordinator.

(4) Unless otherwise advised, build and maintain a MCM Action Plan that highlights the items the CRI LPHA is working on to bring the county to Established Status. Action Plan must be reviewed with OHA State MCM Coordinator quarterly and submitted two weeks before the end of the quarter to the OHA State MCM Coordinator.

(5) Exercise Requirements. Each CRI LPHA shall develop and conduct an exercise program that tests MCM dispensing related emergency response plans and adheres to HSEEP guidance including an after action report, improvement plan and exercise evaluation guide. Exercises completed to meet PE-02 can be used to meet PE-12 requirements if appropriate documentation, as cited in PE-12, is submitted. Each CRI LPHA must complete the following exercises:

(a) Three Operational Drills by June 15, unless given specific permission for extension by OHA State MCM Coordinator. Complete three annual dispensing drills (facility setup, staff notification and assembly, and site activation), alternating each year between anthrax and pandemic influenza scenarios. Documentation of the three required drills must be submitted through the PORTS system no later than June 15 of the fiscal year in which the drills are conducted, unless given specific permission for extension by OHA State MCM Coordinator.

(b) Two Tabletop Exercises (TTX) in each 5-year period. Complete two TTXs every five years, one to demonstrate readiness for an anthrax scenario and one for a pandemic influenza scenario. Documentation of the required TTXs must be submitted through the PORTS system no later than June 15 of the fiscal year in which each TTX is conducted, unless given specific permission for extension by OHA State MCM Coordinator.

(c) One Functional Exercise (FE) in each 5-year period. Complete a FE once every five years, focusing on vaccination of at least one critical workforce group, to demonstrate readiness for a pandemic influenza scenario. Documentation of the FE must be submitted through the PORTS system no later than June 15 of the fiscal year in which the FE is conducted, unless given specific permission for extension by OHA State MCM Coordinator.

(d) One Medical Countermeasures Full Scale Exercise (FSE) in 5-year period. Each CRI LPHA must participate in one FSE in the 5-year cooperative agreement period. The FSE must demonstrate operational readiness for a pandemic influenza scenario and include at least one POD set up with throughput drill. Each CRI LPHA must document FSE through the PORTS system along with the Dispensing Throughput Drill no later than June 15 of the fiscal year in which the FSE is conducted, unless given specific permission for extension by OHA State MCM Coordinator.

(e) One annual PHEP exercise incorporating access and functional needs (AFN) partners by June 15, unless given specific permission for extension by OHA State MCM Coordinator. Requirement can be fulfilled by incorporating at least one AFN partner in a drill, tabletop, functional, full-scale exercise, or during an incident or public health event in which an AFN partner participated. Documentation of the required exercise must be submitted through the PORTS system no later than June 15 of the fiscal year in which the exercise is conducted, unless given specific permission for extension by OHA State MCM Coordinator.

5. Public Health Preparedness Capabilities Requirements.

The capabilities, functions and tasks below correspond with the capabilities, functions, and tasks located in the Public Health Preparedness Capabilities which can be found at http://www.cdc.gov/phpr/capabilities/ . Where possible the CRI Program will support the CDC and Oregon Hospital Preparedness Program (HPP) priority capabilities which can be found in Program Element #12 “Public Health Emergency Preparedness Program (PHEP)” to the current Public Health Financial Assistance Agreement series between LPHAs and OHA.

Contingent Emergency Response Funding: Such funding is subject to restrictions imposed by CDC at the time of the emergency and would provide funding under circumstances when a delay in award would result in serious injury or other adverse impact to the public.

Since the funding is contingent upon Congressional appropriations, whether contingent emergency response funding awards can be made will depend upon the facts and circumstances that exist at the time of the emergency; the particular appropriation from which the awards would be made, including whether it contains limitations on its use; authorities for implementation; or other relevant factors. No activities are specified for this authorization at this time.

6. General Requirements.

All services and activities supported in whole or in part with funds provided under this Agreement shall be delivered or conducted in accordance with the following requirements:

a. **Non-Supplantation.** Funds provided under this Agreement shall not be used to supplant state, local, other non-federal, or other federal funds.

b. **Audit Requirements.** In accordance with federal guidance, each county receiving funds shall audit its expenditures of CRI Program funding not less than once every two years. Such audits shall be conducted by an entity independent of the county and in accordance with the federal Office of Management and Budget Circular .. Audit reports shall be sent to OHA, which will provide them to the CDC. Failure to conduct an audit or expenditures made not in accordance with the CRI Program guidance and grants management policy may result in a requirement to repay funds to the federal treasury or the withholding of funds.

c. **CRI Coordination.** CRI LPHA shall collaborate with Regional CRI Coordinator, housed in Washington County, on all CRI activities. The Regional CRI Coordinator will be OHA's chief point of contact for CRI Program and the CRI LPHA, or their designee, will be OHA's chief point of contact for PE-02 concerns.

7. General Revenue and Expense Reporting.

LPHA must complete an "Oregon Health Authority Public Health Division Expenditure and Revenue Report" located in Exhibit C of the Agreement. These reports must be submitted to OHA each quarter on the following schedule:

Fiscal Quarter	Due Date
First: July 1 – September 30	October 30
Second: October 1 – December 31	January 30
Third: January 1 – March 31	April 30
Fourth: April 1 – June 30	August 20

8. Reporting Requirements.

a. By April 15 of each year, using estimated award amounts and detailing expected costs of operating the Regional CRI Program during the period of July 1 through June 30 of the following year, the Regional CRI Coordinator will propose a budget for the CRI Regional Program and CRI LPHA to the CRI LPHAs using a funding formula approved by CRI LPHAs. Upon approval by all CRI LPHAs, Regional CRI Coordinator will submit PE-02 funding amounts to OHA State MCM Coordinator. OHA will notify CRI LPHAs of final awards for the fiscal year on or after July 1st when Notice of Award is received by the Federal Funder (CDC). CRI LPHAs must submit a budget to OHA by August 15 of each year, using actual award amounts provided by OHA and detailing expected costs of operating the CRI program during the period of July 1 through June 30 of each year.

b. [Washington County **ONLY**] The award of funds under this Agreement to Washington County LPHA must include funds to assist in the implementation of the Regional CRI Program requirements as outlined in this Program Element throughout the Regional CRI Program. Washington County LPHA shall use the portion of the CRI award designated by the LPHAs in the CRI jurisdiction, to fund a CRI Coordinator position who will work under guidance from CRI LPHAs and with technical assistance from OHA.

c. CRI LPHA must, at minimum, participate in quarterly CRI meetings that include, at minimum, the CRI Program Coordinator, a representative from each CRI LPHA and the OHA State MCM Coordinator.

d. CRI funding is not guaranteed as carryover to a subsequent fiscal year if funds are unspent in any given fiscal year.

9. Performance Measures.

Performance Measure 0.1 Each CRI LPHA, unless otherwise advised by OHA, must, to OHA's satisfaction, complete the ORR including updated Dispensing Planning Form, Distribution Planning Form, POD Information Forms, Training and Exercise Planning Form, and Jurisdictional Data Sheet with supporting documents, through the PORTS system, to the OHA State MCM Coordinator by June 15, or if it is the CRI LPHA's site assessment year, 21 days prior to the site assessment date. (Refer to Section 4.f.(1) "Operational Readiness Review" of this Program Element).

Performance Measure 0.2 Each CRI LPHA must, to OHA's satisfaction, execute and submit appropriate documentation to the OHA State MCM and CRI Program Coordinators for three separate, unique, Operational Drills before June 15, unless given specific permission for extension by OHA State MCM Coordinator, each year. Coordinating LPHA will submit through the PORTS system to the OHA State MCM Coordinator. These Operational Drills can be used to meet the requirements set forth in PM 1.1. (Refer to CRI Work Plan Section 4.f.(4) "Exercise Requirements" of this Program Element).

Performance Measure 1.1 CRI LPHAs must, at least once annually, disseminate a preparedness, situational awareness or public health message and include a request for an update of contact information to the partners identified in this Performance Measure (PM) 1.1. (Refer to Capability 1: Community Preparedness).

Attachment 1
CRI Program Budgets

Cities Readiness Initiative Annual Budget

[Enter County Name]

July 1, 2023 - June 30, 2024

				Total
PERSONNEL			Subtotal	**$0**
	List as an Annual Salary	% FTE based on 12 months	0	
Position 1 with details			0	
			0	
Position 2 with details			0	
			0	
Position 3 with details			0	
Position 4 with details			0	
Fringe Benefits @ _____			0	
TRAVEL				**$0**
Total In-State Travel:				
Hotel Costs: **Per Diem Costs:** **Mileage:** **Registration Costs:** **Misc. Costs:**				
Out-of-State Travel:		$0		
Air Travel Costs: **Hotel Costs:** **Per Diem Costs:** **Mileage or Car Rental Costs:** **Registration Costs:** **Misc. Costs:**				
CAPITAL EQUIPMENT (individual items that cost $5,000 or more)		$0		**$0**
SUPPLIES		$0		**$0**

CONTRACTUAL (list each Contract separately and provide a brief description)	$0		**$0**
OTHER	$0		**$0**
TOTAL DIRECT CHARGES			**$0**
TOTAL INDIRECT @ XX% of Direct Expenses (or describe method):			**$0**
TOTAL BUDGET:			**$0**

Prepared by:

NOTES:

Salaries should be listed as a full time equivalent (FTE) of 2,080 hours per year - for example an employee working .80 with a yearly salary of $62,500 (annual salary) which would compute to the sub-total column as $50,000

% of FTE should be based on a full year FTE percentage of 2080 hours per year - for example an employee listed as 50 hours per month would be 50*12/2080 = .29 FTE

Program Element #12: Public Health Emergency Preparedness and Response (PHEPR) Program

OHA Program Responsible for Program Element:

Public Health Division/Center for Public Health Practice/Health Security, Preparedness & Response Section

1. Description. Funds provided under this Agreement for this Program Element may only be used in accordance with, and subject to, the requirements and limitations set forth below to deliver the Oregon Health Authority (OHA) Public Health Emergency Preparedness and Response (PHEPR) Program.

The PHEPR Program shall address prevention, protection, mitigation, response, and recovery phases for threats and emergencies that impact the health of people in its jurisdiction through plan development and revision, exercise and response activities based on the 15 Centers for Disease Control and Prevention (CDC) Public Health Emergency Preparedness and Response Capabilities.[1]

Emergency Preparedness and Response is one of the seven foundational capabilities described in the Oregon Public Health Modernization Manual. [2] . The foundational capabilities are needed for governmental public health to meet its charge to improve the health of everyone in Oregon. The vision for this foundational capability as stated in the Public Health Modernization Manual is as follows: "A healthy community is a resilient community that is prepared and able to respond to and recover from public health threats and emergencies."

This Program Element, and all changes to this Program Element are effective the first day of the month noted in the Issue Date section of Exhibit C of the Financial Assistance Award unless otherwise noted in the Comments and Footnotes of Exhibit C of the Financial Assistance Award.

2. Definitions Specific to Public Health Emergency Preparedness and Response.

a. Access and Functional Needs: Population defined as those whose members may have additional response assistance needs that interfere with their ability to access or receive medical care before, during, or after a disaster or public health emergency,[3] including but not limited to communication, maintaining health, independence, support and safety, and transportation. Individuals in need of additional response assistance may include children, people who live in congregate settings, older adults, pregnant and postpartum people, people with disabilities,[4] people with chronic conditions, people with pharmacological dependency, people with limited access to transportation, people with limited English proficiency or non-English speakers, people with social and economic limitations, and people experiencing houselessness.[5]

b. Base Plan: A plan that is maintained by the LPHA, describing fundamental roles, responsibilities, and activities performed during prevention, preparedness, mitigation, response, and recovery phases of FEMA's disaster management cycle. This plan may be titled as the Emergency Support Function #8, an annex to the County Emergency Operations Plan, Public Health All-Hazards Plan, or other title that fits into the standardized county emergency preparedness nomenclature.

c. Budget Period: The intervals of time (usually 12 months) into which a multi-year project period is divided for budgetary/ funding use. For purposes of this Program Element, the Budget Period is July 1 through June 30.

d. CDC: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention.

e. **CDC Public Health Emergency Preparedness and Response Capabilities:** The 15 capabilities developed by the CDC to serve as national public health preparedness standards for state and local planning.[1]

f. **Due Date:** If a Due Date falls on a weekend or holiday, the Due Date will be the next business day following.

g. **Equity:** The State of Oregon definition of Equity acknowledges that not all people, or all communities, are starting from the same place due to historic and current systems of oppression. Equity is the effort to provide different levels of support based on an individual's or group's needs in order to achieve fairness in outcomes. Equity actionably empowers communities most impacted by systemic oppression.[6] Historically underserved and marginalized populations include but are not limited to people with Access and Functional Needs and disabilities, racial/ethnic minorities, people who are economically disadvantaged, those whose second language is English, and rural and remote communities, etc.

h. **Health Alert Network (HAN):** A web-based, secure, redundant, electronic communication and collaboration system operated by OHA, available to all Oregon public health officials, hospitals, labs and other health service providers. The data it contains is maintained jointly by OHA and all LPHAs. This system provides continuous, high-speed electronic access to public health information including the capacity for broadcasting information to registered partners in an emergency, 24 hours per day, 7 days per week, 365 days per year. The secure HAN has a call- down engine that can be activated by state or local HAN administrators.

i. **Health Security Preparedness and Response (HSPR):** A state-level program that is a joint effort with the Conference of Local Health Officials (CLHO) and Native American Tribes (Tribes) to develop public health systems to prepare for and respond to major threats, acute threats, and emergencies that impact the health of people in Oregon.

j. **Health Care Coalition (HCC):** A coordinating body that incentivizes diverse and often competitive health care organizations and other community partners with differing priorities and objectives and reach to community members to work together to prepare for, respond to, and recover from emergencies and other incidents that impact the public's health.

k. **Hospital Preparedness Program:** (HPP) Grant funding from the U.S. Department of Health and Human Services Administration for Strategic Preparedness & Response (ASPR) in preparing for, responding to, and recovering from the adverse health effects of emergencies and disasters.

l. **Medical Countermeasures (MCM):** Vaccines, antiviral drugs, antibiotics, antitoxins, etc. in support of treatment or prophylaxis to the identified population in accordance with public health guidelines or recommendations. This includes the Strategic National Stockpile (SNS), a CDC program developed to provide rapid delivery of pharmaceuticals, medical supplies, and equipment in the early hours of an ill-defined threat, a large shipment of specific items when a specific threat is known or technical assistance to distribute SNS material.

m. **Medical Reserve Corps (MRC):** The Medical Reserve Corps is a network in the U.S. of community-based volunteer units. LPHAs with MRCs have developed these volunteer organizations to help meet the public health needs of their communities.

n. **MRC-STTRONG:** Applicable only to LPHAs who have successfully been notified of their award as a sub-recipient of OHA's MRC-STTRONG application. STTRONG is an ASPR Cooperative Agreement to strengthen the MRC network – focusing on emergency preparedness, response, and health Equity needs. Funded projects will bolster community response capabilities, building on the invaluable role that the MRC played during our fight against COVID-19.

o. **National Incident Management System (NIMS):** The U.S. Department of Homeland Security system for integrating effective practices in emergency preparedness and response into a comprehensive national framework for incident management. The NIMS enables emergency responders at all levels and in different disciplines to effectively manage incidents no matter what the cause, size or complexity.[7]

p. **Public Information Officer (PIO)**: The person responsible for communicating with the public, media, and/or coordinating with other agencies, as necessary, with incident-related information.[8]

q. **Public Health Accreditation Board:** A non-profit organization dedicated to improving and protecting the health of the public by advancing the quality and performance of tribal, state, local and territorial public health departments.[9]

r. **Public Health Emergency Preparedness and Response (PHEPR):** Local public health programs designed to better prepare Oregon to prevent, protect, mitigate, respond to, and recover from emergencies with public health impacts.

s. **Public Health Preparedness Capability Surveys:** A series of surveys sponsored by HSPR for capturing information from LPHAs for HSPR to report to CDC and inform trainings and planning for local partners.

t. **Regional Emergency Coordinator (REC)**: Regional staff that work within the Health Security, Preparedness, and Response section of the Oregon Health Authority. These staff support the Public Health Emergency Preparedness and Response (PHEPR) and Healthcare Coalition (HCC) programs. The PHEPR REC supports local public health authorities' public health emergency preparedness activities and assures completion of required activities as outlined in this PE-12 document.

3. **Alignment with Modernization Foundational Programs and Foundational Capabilities.** The activities and services that the LPHA has agreed to deliver under this Program Element align with Foundational Programs and Foundational Capabilities and the public health accountability metrics (if applicable), as follows (see Oregon's Public Health Modernization Manual, (http://www.oregon.gov/oha/PH/ABOUT/TASKFORCE/Documents/public_health_modernization_manual.pdf):

a. **Foundational Programs and Capabilities** (As specified in Public Health Modernization Manual)

Program Components	**Foundational Program**					**Foundational Capabilities**						
	CD Control	Prevention and health promotion	Environmental health	Access to clinical preventive services		Leadership and organizational competencies	Health Equity and cultural responsiveness	Community Partnership Development	Assessment and Epidemiology	Policy & Planning	Communications	Emergency Preparedness and Response
				Population Health	Direct services							

Asterisk (*) = Primary foundational program that aligns with each component *X = Other applicable foundational programs*						*X = Foundational capabilities that align with each component*						
Planning	X	X	X	X		X	X	X	X	X	X	X
Partnerships and MOUs	X	X	X	X		X	X	X	X	X	X	X
Surveillance and Assessment	X	X	X	X		X	X	X	X	X	X	X
Response and Exercises	X	X	X	X		X	X	X	X	X	X	X
Training and Education	X	X	X	X		X	X	X	X	X	X	X

Note: Emergency preparedness crosses over all foundational programs.

b. The work in this Program Element helps Oregon's governmental public health system achieve the following Public Health Accountability Metric:

Not applicable

c. The work in this Program Element helps Oregon's governmental public health system achieve the following Public Health Modernization Process Measure:

Not applicable

4. Procedural and Operational Requirements. By accepting and using the Financial Assistance awarded under this Agreement and for this Program Element, LPHA agrees to conduct activities in accordance with the following requirements:

a. Engage in activities as described in its approved PHEPR Work Plan and Integrated Preparedness Plan (IPP), which are due to OHA HSPR on or before August 15 and which has been approved by OHA HSPR by September 15. LPHA must use the PHEPR Work Plan Template Instructions and Guidance which OHA will provide to LPHA.

b. Focus on health Equity by assessing and addressing Equity gaps during all facets of the disaster management cycle (prevention, protection, mitigation, response, recovery) to reduce and/or eliminate disproportionate impacts on historically underserved and marginalized populations, including but not limited to people with Access and Functional Needs and disabilities, racial/ethnic minorities, people who are economically disadvantaged, those whose second language is English, and rural and remote communities, etc. All response plans, procedures, workplans, exercises, or other activities performed under the PE-12 should address disparities and health inequities and work collaboratively with members of affected populations and community-based organizations to identify ways to minimize or eliminate disproportionate impacts and incorporate these solutions into all activities.[2]

c. Use funds for this Program Element in accordance with its approved PHEPR budget, which is due to OHA HSPR on or before August 15 and which has been approved by OHA HSPR by September 15. LPHA must use the PHEPR Budget Template, which is set forth in Attachment 1, incorporated herein with this reference.

(1) Contingent Emergency Response Funding: Such funding, as available, is subject to restrictions imposed by the CDC at the time of the emergency and would provide funding under circumstances when a delay in award would result in serious injury or other adverse impact to the public.

Since the funding is contingent upon Congressional appropriations, whether contingent emergency response funding awards can be made will depend upon the facts and circumstances that exist at the time of the emergency; the particular appropriation from

which the awards would be made, including whether it contains limitations on its use; authorities for implementation; or other relevant factors. No activities are specified for this authorization at this time.

(2) **Non-Supplantation.** Funds provided under this Agreement for this Program Element must not be used to supplant state, local, other non-federal, or other federal funds.

(3) **Public Health Preparedness Staffing.** LPHA must identify a PHEPR Coordinator who is directly funded from the PHEPR grant. LPHA staff who receive PHEPR funds must have planned activities identified within the approved PHEPR Work Plan. The PHEPR Coordinator will be the OHA's chief point of contact related to grant deliverables. LPHA must implement its PHEPR activities in accordance with its approved PHEPR Work Plan.

(4) **Use of Funds.** Funds awarded to the LPHA under this Agreement for this Program Element may only be used for activities related to the CDC Public Health Emergency Preparedness and Response Capabilities in accordance with Attachment 2 (Use of Funds), incorporated herein with this reference and an approved PHEPR budget using the template set forth as Attachments 1 to this Program Element.

(5) **Modifications to Budget.** Modifications to the budget exceeding a total of $5,000, adding a new line item, or changing the indirect line item by any amount require submission of a revised budget to the Regional Emergency Coordinator (REC) and final receipt of approval from the HSPR fiscal officer.

(6) **Conflict between Documents.** In the event of any conflict or inconsistency between the provisions of the approved PHEPR Work Plan or PHEPR Budget and the provisions of this Agreement, this Agreement shall control.

(7) **Unspent funds**. PHEPR funding is not guaranteed as a carryover to a subsequent fiscal year if funds are unspent in any given fiscal year.

d. **Statewide and Regional Coordination:** LPHA must coordinate and participate with state, regional, and local Emergency Support Function partners and stakeholders to include, but not limited to, other public health and health care programs, HCCs, emergency management agencies, EMS providers, behavioral/mental health agencies, community-based organizations (CBOs), older adult-serving organizations, and educational agencies and state childcare lead agencies as applicable.[10]

(1) Attendance by LPHA leadership, PHEPR coordinator, or other staff involved in preparedness activities or conferences is strongly encouraged.

(2) Participation in emergency preparedness subcommittees, work groups and projects for the sustainment of public health emergency preparedness and response as appropriate is required.

(3) LPHA must collaborate with HCC partners to develop and maintain plans, conduct training and exercises, and respond to public health threats and emergencies using a whole-community approach to preparedness management that includes:[10]

(a) Prioritizing health Equity as referenced in Section 4b.

(b) Coordination with community-based organizations.

(c) Development or expansion of child-focused planning and partnerships.

(d) Engaging field/area office on aging.

(e) Engaging behavioral health partners and stakeholders.

(4) LPHA shall participate and engage in planning at the local level in all required statewide exercises as referenced in the Workplan Minimum Requirements and IPP Blank Template tabs, which OHA has provided to LPHA.

(5) LPHA shall participate in activities associated with local, regional, or statewide emerging threats or incidents as identified by HSPR or LPHA that includes timely assessment and sharing of essential elements of information for identification and investigation of an incident with public health impact, as agreed upon by HSPR and the CLHO Emergency Preparedness and Response subcommittee.[10]

(6) LPHA shall work to develop and maintain a portfolio of community partnerships to support prevention, preparedness, mitigation, response and recovery efforts. Portfolio must include viable contact information from local community-based organizations and community sectors as defined by the CDC: business; community leadership; cultural and faith-based groups and organizations; emergency management; healthcare; human services; housing and sheltering; media; mental/behavioral health; office of aging or its equivalent; education and childcare settings.

(7) As applicable for MRC-STTRONG recipients only, LPHA shall coordinate with the MRC Unit Coordinator, volunteers, the OHA MRC State Program Office, the National MRC Program, community partners, and any other necessary stakeholders for the duration of the MRC-STTRONG project period (June 1, 2023 – May 31, 2025).

(8) As applicable for HPP recipients only, LPHA shall coordinate with the HPP Regional Emergency Coordinator at the OHA MRC State Program Office for the duration of the HPP project period (July 1, 2023 – June 30, 2024).

e. **Public Health Preparedness Capability Survey:** LPHA must complete all applicable Public Health Preparedness Capability Survey(s) sponsored by HSPR by November 1 of each year or an applicable Due Date based on CDC requirements.[1]

f. **PHEPR Work Plan:** PHEPR Work Plans must be written with clear and measurable objectives in support of the CDC Public Health Emergency Preparedness and Response Capabilities with timelines and include:

(1) At least three broad program goals that address gaps, operationalize plans, and guide the following PHEPR Work Plan activities.

(a) Planning

(b) Training and education

(c) Exercises.

(d) Community Education and Outreach and Partner Collaboration.

(e) Administrative and Fiscal activities.

(2) Activities should include or address health Equity considerations as outlined in Section 4b.

(3) Local public health leadership will review and approve PHEPR Work Plans.

g. **PHEPR Work Plan Performance:** LPHA must complete all minimum requirements of the PE- 12 by June 30 each year. If LPHA does not meet the minimum requirements of the PE-12 for each of the three years during a triennial review period, not due to unforeseen public health events, it may not be eligible to receive funding under this Program Element in the next fiscal year. Minimum requirements are delineated in the designated tab of the PHEPR Work Plan Template which OHA has provided to LPHA. Work completed in response to a HSPR-required

exercise, a response to an uncommon disease outbreak, or other uncommon event of significance that requires an LPHA response and is tied to the CDC Public Health Emergency Preparedness and Response Capabilities may, upon HSPR approval, be used to replace PHEPR Work Plan activities interrupted or delayed.

h. 24/7/365 Emergency Contact Capability:

(1) LPHA must establish and maintain a single telephone number whereby, physicians, hospitals, other health care providers, OHA and the public can report public health emergencies within the LPHA service area.

(a) The contact number must be easy to find through sources in which the LPHA typically makes information available including local telephone directories, traditional websites, and social media pages. It is acceptable for the publicly listed phone number to provide after-hours contact information by means of a recorded message. LPHA must list and maintain both the switchboard number and the 24/7/365 numbers on the HAN.

(b) The telephone number must be operational 24 hours a day, 7 days a week, 365 days a year and be an eleven-digit telephone number available to callers from outside the local emergency dispatch. LPHA may use an answering service or their Public Safety Answering Point (PSAP) in this process, provided that the eleven-digit telephone number of the PSAP is made available for callers from outside the locality.2

(c) The LPHA telephone number described above must be answered by a knowledgeable person with the ability to properly route the call to a local public health administrator or designee.

(2) An LPHA official must respond within 60 minutes, to calls received on 24/7/365 telephone number, during statewide communication drills and quarterly tests.[2]

(a) Quarterly test calls to the 24/7/365 telephone line will be conducted by HSPR program staff.

(b) Following a quarterly test, LPHA must take any corrective action on any identified deficiency within 30 days of such test or communication drills, to the best of their ability.

i. HAN:

(1) A HAN Administrator must be appointed for LPHA and this person's name and contact information must be provided to the HSPR REC and the State HAN Coordinator.

(2) The HAN Administrator must:

(a) Agree to the HAN Security Agreement and State of Oregon Terms and Conditions.

(b) Complete appropriate HAN training for their role.

(c) Ensure local HAN user and county role directory is maintained (add, modify and delete users; make sure users have the correct license).

(d) Act as a single point of contact for all LPHA HAN issues, user groups, and training.

(e) Serve as the LPHA authority on all HAN related access (excluding hospitals and Tribes).

(f) Coordinate with the State HAN Coordinator to ensure roles are correctly distributed within each county.

(g) Ensure participation in OHA Emergency Support Function 8 (Health and Medical) tactical communications exercises. Deliverable associated with this exercise will be the test of the LPHA HAN system roles via alert confirmation for: Health Officer, Communicable Disease (CD) Coordinator(s), Preparedness Coordinator, PIO and LPHA County HAN Administrator within one hour.[2]

(h) Initiate at least one local call down exercise/ drill for LPHA staff annually. If the statewide HAN is not used for this process, LPHA must demonstrate through written procedures how public health staff and responding partners are notified during emergencies.

(i) Perform general administration for all local implementation of the HAN system in their respective organizations.

(j) Review LPHA HAN users two times annually to ensure users are updated, assigned their appropriate roles and that appropriate users are deactivated.

(k) Facilitate in the development of the HAN accounts for new LPHA users.

j. Integrated Preparedness Plan (IPP): LPHA must annually submit to HSPR on or before August 15, an updated IPP as part of their annual work plan update.[1] The IPP must meet the following conditions:

(1) Demonstrate continuous improvement and progress toward increased capability to perform functions and tasks associated with the CDC Public Health Emergency Preparedness and Response Capabilities.

(2) Address health Equity considerations as outlined in Section 4b.

(3) Include priorities that address lessons learned from previous exercises events, or incidents as described in the LPHA's After Action Reports (AAR)/ Improvement Plans (IP).

(4) LPHA must work with Emergency Management, local health care partners and other community partners to integrate exercises and align IPPs, as appropriate.

(5) Identify at least two exercises per year if LPHA's population is greater than 10,000 and one exercise per year if LPHA's population is less than 10,000.

(6) Identify a cycle of exercises that increase in complexity over a three-year period, progressing from discussion-based exercises (e.g., seminars, workshops, tabletop exercises, games) to operation-based exercises (e.g., drills, functional exercises and full-scale exercises); exercises of similar complexity are permissible within any given year of the plan.

(7) A HSPR-required exercise, a response to an uncommon disease outbreak, or other uncommon event of significance that requires an LPHA response and is tied to the CDC Public Health Emergency Preparedness and Response Capabilities may, upon HSPR approval, be used to satisfy exercise requirements.

(8) For an exercise or incident to qualify, under this requirement the exercise or incident must:

(a) Exercise:

LPHA must:

- Submit to HSPR REC 30 days in advance of each exercise an exercise

notification or exercise plan that includes a description of the exercise, exercise objectives, CDC Public Health Emergency Preparedness and Response Capabilities addressed, a list of invited participants, and a list of exercise planning team members. An incident/exercise notification form that includes the required notification elements is included in Attachment 3 and is incorporated herein with this reference.

- Involve two or more participants in the planning process.
- Involve two or more public health staff and/ or related partners as active participants.
- Submit to HSPR REC an After-Action Report that includes an Improvement Plan within 60 days of every exercise completed. An improvement plan template is included as part of the incident/exercise notification form in Attachment 3.

(b) Incident:

During an incident, LPHA must:

- Submit LPHA incident objectives or Incident Action Plan to HSPR REC within 48 hours of receiving notification of an incident that requires an LPHA response. An incident/exercise notification form that includes the required notification elements is included in Attachment 3.
- Submit to HSPR REC an After-Action Report that includes an Improvement Plan within 60 days of every incident or public health response completed. An improvement plan template is included as part of the incident/exercise notification form in Attachment 3.

(9) LPHA must coordinate exercise design and planning with local Emergency Management and other partners for community engagement, as appropriate.2

(10) Staff responsible for emergency planning and response roles must be trained for their respective roles consistent with their local emergency plans and according to CDC Public Health Emergency Preparedness and Response Capabilities,[1] the Public Health Accreditation Board[9], and the National Incident Management System.[7] The training portion of the plan must:

(a) Include training on how to discharge LPHA statutory responsibility to take measures to control communicable disease in accordance with applicable statute.

(b) Identify and train appropriate LPHA staff [11] to prepare for public health emergency response roles and general emergency response based on the local identified hazards.

k. Maintaining Training Records: LPHA must maintain training records that demonstrate NIMS compliance for all local public health staff for their respective emergency response roles.[7]

l. Plans: LPHA must maintain and execute emergency preparedness procedures and plans as a component of its jurisdictional Emergency Operations Plan.

(1) LPHA must establish and maintain at a minimum the following plans:

(a) Base Plan.

(b) Medical Countermeasure Dispensing and Distribution (MCMDD) plan.[12]

(c) Continuity of Operations Plan (COOP)[10]

(d) Communications and Information Plan.

(2) All plans, annexes, and appendices must:

(a) Be updated whenever an After-Action Report improvement item is identified as requiring a change or biennially at a minimum,

(b) Address, as appropriate, the CDC Public Health Emergency Preparedness and Response Capabilities based on the local identified hazards,

(c) Be functional and operational by June 30, 2023,10

(d) Comply with the NIMS,7

(e) Include a record of changes that includes a brief description, the date, and the author of the change made, and

(f) Include health Equity considerations as outlined in Section 4b.

m. MRC-STTRONG: Any deliverables resulting from this project should recognize ASPR, OHA, and MRC sponsoring organizations for their respective contributions to the body of work.

(1) Roles and responsibilities

LPHA shall:

(a) Manage the approved MRC-STTRONG projects identified in finalized MRC-STTRONG application. Before use of the federal ASPR logo, LPHA must consult with the OHA MRC State Program.

(b) Participate in an annual OHA MRC State Program check-in: LPHA shall attend two check-in meetings with OHA MRC State Program and other sub-recipients to provide progress reports and engage collaboratively with other units for resource sharing.

(c) Complete performance measurement and evaluation tasks including the quarterly and annual reporting, LPHA status report (spent/unspent/encumbered), , and annual check-ins with the OHA MRC State Program Office.

(2) Deliverables:

(a) Standard Workplan: LPHA shall populate and maintain a workplan template provided by the OHA MRC State Program Office.

- This workplan must be referenced during the two annual OHA MRC State Program check-ins to discuss and monitor progress.
- As applicable, the workplan must integrate steps that incorporate population and membership driven methodologies for resource allocations that center equitable distribution of material or consumable resources and training resources.

(b) Reporting Requirement: LPHA shall submit all required reports and any additional reporting as requested, throughout the course of the project.

(c) LPHA shall present monthly to the MRC Unit Coordinator network during the 1st year (7/1/2023-6/30/2024) and at least once to the coordinator in the 2nd year of the project (7/1/2024-6/30/2025), regarding progress or outcomes of their project.

(d) National preparedness network abstracts: LPHA is *encouraged* to submit abstracts to present at state and national preparedness conferences and other technical assistance resource sharing platforms.

- **Limitations and Restrictions:** The following special conditions are in place for the Terms and Conditions of funding under this Program Element PE12-04: Purchase of uniforms: These supplies must meet the guidelines established for use as personal protective equipment found in "MRC Safety Equipment Guidelines for MRC-STTRONG Awardees" in Attachment 4 which is incorporated herein with this reference.
- Uniform components must be returned to the respective unit/program office at the end of the event/project/volunteer tenure. Note: If the federal/ASPR MRC logo is expected to be utilized or placed on any items, please ensure to consult with a member of the MRC- STTRONG Project Team on the logo use guidelines.

(e) **Change Approval Requirements**: Any deviations from what was approved in the original application (for example, key personnel changes, work plan changes, budget changes) must be reviewed and approved by the OHA MRC State Program Office, Grants Management Specialist and the ASPR's Project Officer. Contact the OHA MRC State Program Office to initiate workplan/budget changes.

5. General Revenue and Expense Reporting. LPHA must complete an "Oregon Health Authority Public Health Division Expenditure and Revenue Report" located in Exhibit C of this Agreement. These reports must be submitted to OHA each quarter on the following schedule:

Fiscal Quarter	Due Date
First: July 1 – September 30	October 30
Second: October 1 – December 31	January 30
Third: January 1 – March 31	April 30
Fourth: April 1 – June 30	August 30

a. **MRC-STTRONG:** LPHA have the following expectations for revenue and expense reporting:

(1) **Annual Federal Financial Report:** Due to the OHA MRC State Program Office

(2) **LPHA Status Report:** Due to the OHA MRC State Program Office no later than March 2, 2025. The **LPHA** Status Report communicates the status of allocated funds (spent/unspent/encumbered) 3-months prior to end of project period (March 2, 2025). The OHA MRC State Program will provide a reporting template to LPHA.

6. Reporting Requirements.

a. **PHEPR Work Plan.** LPHA must implement its PHEPR activities in accordance with its OHA HSPR-approved PHEPR Work Plan. Dependent upon extenuating circumstances, modifications to this PHEPR Work Plan may only be made with OHA HSPR agreement and approval. Proposed PHEPR Work Plan will be due on or before August 15. Final approved PHEPR Work Plan will be due on or before September 15.

b. **Mid-year and end of year PHEPR Work Plan reviews**. LPHA must complete PHEPR Work Plan updates in coordination with their HSPR REC on at least a minimum of a semi-annual basis.

(1) Mid-year work plan reviews may be conducted between October 1 and March 31.

(2) End of year work plan reviews may be conducted between April 1 and August 15.

c. **Triennial Review.** This review will be completed in conjunction with the statewide Triennial Review schedule as determined by the Office of the State Public Health Director. A year-end work plan review may be scheduled in conjunction with a Triennial Review. This Agreement will be integrated into the Triennial Review Process.

d. **Integrated Preparedness Plan (IPP).** LPHA must annually submit an IPP to HSPR REC on or before August 15. Final approved IPP will be due on or before September 15.

e. **Exercise Notification.** LPHA must submit to HSPR REC 30 days in advance of each exercise an exercise notification that includes a description of the exercise, exercise objectives, CDC Public Health Emergency Preparedness and Response Capabilities addressed, a list of invited participants, and a list of exercise planning team members.

f. **Response Documentation.** LPHA must submit LPHA incident objectives or an Incident Action Plan to HPSR REC within 48 hours of receiving notification of an incident that requires an LPHA response.

g. **After-Action Report / Improvement Plan.** LPHA must submit to HSPR REC an After-Action Report/Improvement Plan within 60 days of every exercise, incident, or public health response completed.

h. **MRC-STTRONG LPHA Progress Reports:** These required reports aim to capture impact of MRC STTRONG funded activities as they relate to ASPR Strategic Focus Areas, MRC STTRONG goals, and expanded emergency preparedness and response capabilities.

(1) **Annual Progress Reports:** If LPHA is funded under this PE12-04, LPHA shall submit annual program reports. As part of the progress report financial information will be reported both per major category of expense and by objective. OHA ASPR will provide a template for these reports.

(a) Scheduled Due Dates for annual reports from LPHA to the MRC State Program (OHA-PHD):

STTRONG Budget Period	Annual Report Due Date
2023 - 2024	August 1, 2024
2024 - 2025	August 1, 2025

(2) **Quarterly Progress Reports:** LPHA, if funded under this PE12-04 shall submit quarterly program progress reports. As part of the progress report financial information will be reported both per major category of expense and by objective. ASPR will provide a template for these reports.

(a) Scheduled Due Dates for quarterly reports from LPHA to the MRC State Program (OHA-PHD):

BP Quarter	Quarter Period	Quarterly Report Due Date
2023 - 2024 Budget Period		
1	June – August	September 15, 2023
2	September – November	December 15, 2023
3	December – February	March 15, 2024
4	March – May	June 14, 2024
2024 - 2025 Budget Period		
1	June – August	September 13, 2024
2	September – November	December 13, 2024
3	December – February	March 14, 2025
4	March – May	June 13, 2025

(3) **Other MRC-STTRONG Reports:** Additional reports may apply to LPHA's project. OHA will contact you if it requires additional information to be submitted to ASPR.

(a) **MRC National Website:** For any activities reported in the MRC activity reporting system that are affiliated with your MRC-STTRONG project, please include key words "MRC-STTRONG" in the activity report and/or description.

(b) **Other Reporting Requirements** as identified by OHA throughout the project period.

7. **Performance Measures:** LPHA will progress local emergency preparedness planning efforts in a manner designed to achieve the 15 CDC National Standards for State and Local Planning for Public Health Emergency Preparedness and is evaluated by Mid-year, End of Year and Triennial Reviews.[1]

ATTACHMENT 1*[1]

PHEPR Program Annual Budget

_____ County

July 1, 2022 - June 30, 2023

				Total	Total
PERSONNEL			Subtotal	$0	$0
	List as an Annual Salary	% FTE based on 12 months	0		
(Position Title and Name)			0		
Brief description of activities, for example, This position has primary responsibility for _____ County PHEP activities.					
Fringe Benefits @ (__)% of describe rate or method			0		
TRAVEL				$0	$0
Total In-State Travel: (describe travel to include meals, registration, lodging and mileage)		$0			
Hotel Costs: **Per Diem Costs:** **Mileage or Car Rental Costs:** **Registration Costs:** **Misc. Costs:**					
Out-of-State Travel: (describe travel to include location, mode of transportation with cost, meals, registration, lodging and incidentals along with number of travelers)		$0			
Air Travel Costs: **Hotel Costs:** **Per Diem Costs:** **Mileage or Car Rental Costs:** **Registration Costs:** **Misc. Costs:**					
CAPITAL EQUIPMENT (individual items that cost $5,000 or more)		$0		$0	$0
SUPPLIES		$0		$0	$0
CONTRACTUAL (list each Contract separately and provide a brief description)		$0		$0	$0
Contract with (____) Company for $_____, for (_____) services. *Contract with (____) Company for $_____, for (_____) services.* *Contract with (____) Company for $_____, for (_____) services.*					
OTHER		$0		$0	$0
TOTAL DIRECT CHARGES				$0	$0
TOTAL INDIRECT CHARGES @ ___% of Direct Expenses or describe method				$0	$0
TOTAL BUDGET:				$0	$0
Date, Name and phone number of person who prepared budget					

NOTES:

Salaries should be listed as a full time equivalent (FTE) of 2,080 hours per year - for example an employee working .80 with a yearly salary of $62,500 (annual salary) which would computer to the sub-total column as $50,000

% of FTE should be based on a full year FTE percentage of 2080 hours per year - for example an employee listed as 50 hours per month would be 50*12/2080 = .29 FTE

* A fillable template is available from a HSPR REC

Attachment 2: Use of Funds

Subject to CDC grant requirements, funds may be used for the following:

a. Reasonable program purposes, including personnel, travel, supplies, and services.

b. To supplement but not supplant existing state or federal funds for activities described in the budget.

c. To purchase basic, non-motorized trailers with prior approval from the CDC OGS.

d. For overtime for individuals directly associated (listed in personnel costs) with the award with prior approval from HSPR.

e. For deployment of PHEPR-funded personnel, equipment, and supplies during a local emergency, in- state governor-declared emergency, or via the Emergency Management Assistance Compact (EMAC).

f. To lease vehicles to be used as means of transportation for carrying people or goods, e.g., passenger cars or trucks and electrical or gas-driven motorized carts with prior approval from HSPR.

g. To purchase material-handling equipment (MHE) such as industrial or warehouse-use trucks to be used to move materials, such as forklifts, lift trucks, turret trucks, etc. Vehicles must be of a type not licensed to travel on public roads with prior approval from HSPR.

h. To purchase caches of antibiotics for use by first responders and their families to ensure the health and safety of the public health workforce.

i. To support appropriate accreditation activities that meet the Public Health Accreditation Board's preparedness-related standards

Subject to CDC grant requirements, funds may not be used for the following:

a. Research.

b. Clinical care except as allowed by law. Clinical care, per the CDC Funding Opportunity Announcement FOA, is defined as "directly managing the medical care and treatment of patients."

c. The purchase of furniture or equipment - unless clearly identified in grant application.

d. Reimbursement of pre-award costs (unless approved by CDC in writing).

e. Publicity or propaganda purposes, for the preparation, distribution, or use of any material designed to support or defeat the enactment of legislation before any legislative body.

f. The salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to influence the enactment of legislation, appropriations, regulation, administrative action, or Executive order proposed or pending before any legislative body.

g. Construction or major renovations.

h. Payment or reimbursement of backfilling costs for staff.

i. Paying the salary of an individual at a rate in excess of Executive Level II or $187,000.00 per year.

j. The purchase of clothing such as jeans, cargo pants, polo shirts, jumpsuits, or t-shirts.

k. The purchase or support of animals for labs, including mice.

l. The purchase of a house or other living quarter for those under quarantine.

m. To purchase vehicles to be used as means of transportation for carrying people or goods, such as passenger cars or trucks and electrical or gas-driven motorized carts.

ATTACHMENT 3*

Incident/Exercise Summary Report

Notification *Exercise: Due 30 Days Before Exercise* *Incident: Within 48 hours of notification of incident requiring a response*				
Name of Exercise or Incident:	Name of Exercise or Incident and OERS number, if relevant		**Date(s) of LPHA Play:**	Dates of Play
Scope **Type of Exercise/Event:**	☐ Drill	☐ Functional Exercise	☐ Planned Event/Training	
	☐ Tabletop Exercise	☐ Full Scale Exercise	☐ Incident/Declared Emergency	
Participating Organizations:	List all the names (if available) and agencies participating in your exercise			
Duration:	How long will the exercise last? Or start/end time		**Location**	Location of exercise, if known
Objectives:	List 1 to 3 SMART objectives			
Primary Activities:	List primary activities to be conducted with this incident or exercise			
Design Team:	List people who are participating in designing the exercise by name, agency			
Point of Contact:	Typically, the PHEP Coordinator's name		**LPHA or Tribe:**	Agency Name
POC Email:	Enter POC's email address		**Phone:**	Phone

Capabilities Addressed	
BIOSURVEILLANCE ☐ 12: Public Health Laboratory Testing ☐ 13: Public Health Surveillance and Epidemiological Investigation **COMMUNITY RESILIENCE** ☐ 1: Community Preparedness ☐ 2: Community Recovery **COUNTERMEASURES AND MITIGATION** ☐ 8: Medical Countermeasure Dispensing and Administration ☐ 9: Medical Materiel Management and Distribution ☐ 11: Nonpharmaceutical Interventions ☐ 14: Responder Safety and Health	**INCIDENT MANAGEMENT** ☐ 3: Emergency Operations Coordination **INFORMATION MANAGEMENT** ☐ 4: Emergency Public Information and Warning ☐ 6: Information Sharing **SURGE MANAGEMENT** ☐ 5: Fatality Management ☐ 7: Mass Care ☐ 10: Medical Surge ☐ 15: Volunteer Management

After Action Report *To be completed within 60 days of exercise or incident completion*	
Strengths:	What were the strengths identified during this exercise or incident?
Areas of Improvement:	Were there any areas of improvement identified? List all in this space, then complete improvement plan on next page.

Improvement Plan

To be completed with action review
and submitted to liaison within 60 days of exercise or incident completion

Name of Event or Exercise	Name of Exercise or Incident	Date(s)	Date(s) of Exercise or Incident

CDC Public Health Capability Addressed	Issue(s)/Area(s) of Improvement	Corrective Action	Timeframe	Date Completed
Capability Name	Describe the issue or refer to an item number in the after action report	Corrective action or planned activity	When do you expect to complete this activity?	To be filled in when completed
		Corrective action or planned activity	When do you expect to complete this activity?	To be filled in when completed
	Describe the issue or refer to an item number in the after action report	Corrective action or planned activity	When do you expect to complete this activity?	To be filled in when completed
		Corrective action or planned activity	To be filled in when completed	To be filled in when completed
Capability Name	Describe the issue or refer to an item number in the after action report	Corrective action or planned activity	When do you expect to complete this activity?	To be filled in when completed
		Corrective action or planned activity	When do you expect to complete this activity?	To be filled in when completed
	Describe the issue or refer to an item number in the after action report	Corrective action or planned activity	When do you expect to complete this activity?	To be filled in when completed
		Corrective action or planned activity	To be filled in when completed	To be filled in when completed
Capability Name	Describe the issue or refer to an item number in the after action report	Corrective action or planned activity	When do you expect to complete this activity?	To be filled in when completed
		Corrective action or planned activity	When do you expect to complete this activity?	To be filled in when completed
	Describe the issue or refer to an item number in the after action report	Corrective action or planned activity	When do you expect to complete this activity?	To be filled in when completed
		Corrective action or planned activity	To be filled in when completed	To be filled in when completed

Attachment 4

U.S. Department of Health & Human Services

ASPR Administration for Strategic Preparedness & Response

MRC Safety Equipment Guidelines for MRC-STTRONG Awardees:

Purpose: These guidelines are intended to provide guidance on the purchase and use of Medical Reserve Corps (MRC) personal protective equipment (PPE) and force protection items under the Funding Opportunity: MRC- State, Territory and Tribal Nations, Representative Organizations for Next Generation (MRC-STTRONG) Awards. These guidelines apply to PPE and force protection purchases with ***MRC-STTRONG Awards funding only***.

Important Note: All purchase requests will be reviewed on a case-by-case basis by the HHS Project Officer and Grants Management Specialist and will require pre-approval.

1) Safety equipment must fall under the purposes of personal protective equipment, security, and/or identification during a planned or unplanned event where MRC personnel are deployed.
   a) Personal protective equipment: MRC personnel may need personal protective equipment (PPE) to keep them safe during natural disasters, biological hazards, accidental releases, infectious disease outbreaks, and terrorism events. PPE can be used to minimize worker exposure to hazards, but they are the last line of defense after engineering controls and administrative controls.
      i) Emergency response-type PPE is classified into four levels, ranging from the most protective (Level A) to the least protective (Level D). Workers must be trained on the conditions that require PPE and the procedures to prevent and reduce exposure, including decontamination and proper disposal procedures. LEVEL A* Highest level of respiratory, skin, and eye protection. LEVEL B* Highest level of respiratory protection with a lower level of skin protection. LEVEL C* Same level of skin protection as Level B, with a lower level of respiratory protection. LEVEL D* No respiratory protection and only minimal skin protection.[1]
   b) Security and Identification: MRC security/identification items should only be used and worn by MRC leadership and volunteers who have been identified and vetted by their housing organization. Wearing MRC-identified items allows MRC personnel to be easily identified during an unplanned or planned event where MRC volunteers are deployed.
2) PPE and force protection items must be returned to the originating distribution office or program after the volunteer tenure has ended.
3) Purchased items must meet the classifications as described above under PPE and/or must be worn for security or identification purposes. All purchase requests will be reviewed on a case-by-case basis by the HHS Project Officer and Grants Management Specialist and will require pre-approval.

[1] U.S. Department of Labor, Occupational Safety and Health Administration (OSHA): PPE for Emergency Response and Recovery Workers and General Description and Discussion of the Levels of Protection and Protective Gear

References

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Program Element # 46: Reproductive Health

OHA Program Responsible for Program Element:

Public Health Division/Center for Prevention & Health Promotion/Adolescent, Genetics & Reproductive Health Section

1. Description. Funds provided under this Agreement for this Program Element may only be used in accordance with, and subject to, the requirements and limitations set forth below.

Funds provided through this Program Element support LPHA's efforts in developing and sustaining community-wide partnerships and assurance of access to culturally responsive, high-quality, and evidence-based reproductive health services.

Health disparity data highlight pre-existing, deeply entrenched societal inequities that may inhibit individuals' ability to access services and achieve reproductive autonomy. Therefore, it is critical that interventions aimed at access to services be wide-reaching and sensitive to the unique circumstances and challenges of different communities.

This Program Element, and all changes to this Program Element are effective the first day of the month noted in Issue Date section of Exhibit C Financial Assistance Award unless otherwise noted in Comments and Footnotes of Exhibit C of the Financial Assistance Award.

2. Definitions Specific to Reproductive Health.

Not applicable.

3. Program with Modernization Foundational Programs and Foundational Capabilities. The activities and services that the LPHA has agreed to deliver under this Program Element align with Foundational Programs and Foundational Capabilities and the public health accountability metrics (if applicable), as follows (see Public Health Modernization Manual at: https://www.oregon.gov/oha/PH/ABOUT/TASKFORCE/Documents/public_health_modernization_manual.pdf):

a. Foundational Programs and Capabilities (As specified in Public Health Modernization Manual)

Program Components	**Foundational Program**					**Foundational Capabilities**						
	CD Control	Prevention and health promotion	Environmental health	Access to clinical preventive services: Population Health	Access to clinical preventive services: Direct services	Leadership and organizational competencies	Health equity and cultural responsiveness	Community Partnership Development	Assessment and Epidemiology	Policy & Planning	Communications	Emergency Preparedness and Response
Asterisk (*) = Primary foundational program that aligns with each component *X = Other applicable foundational programs*						*X = Foundational capabilities that align with each component*						
Partnerships and Community Engagement				*			X	X	X	X		

Gaps and Barriers to RH Services		X		*			X	X	X			
Programmatic and/or Policy Solutions		X		*			X	X		X	X	

b. The work in this Program Element helps Oregon's governmental public health system achieve the following Public Health Accountability Metric:

Not Applicable

c. The work in this Program Element helps Oregon's governmental public health system achieve the following Public Health Modernization Process Measure:

Not Applicable

4. Procedural and Operational Requirements. By accepting and using the Financial Assistance awarded under this Agreement and for this Program Element, LPHA agrees to conduct activities in accordance with the following requirements:

a. LPHA must deliver all PE 46 activities supported in whole or in part with funds provided under this Agreement in compliance with the requirements of the Federal Title X Program as detailed in statutes and regulations, including but not limited to 42 USC 300 et.seq., 42 CFR Part 50 subsection 301 et seq., and 42 CFR Part 59 et seq., the Title X Program Requirements, and OPA Program Policy Notices (PPN).

b. LPHA must develop and engage in activities as described in its Local Program Plan as follows:

(1) The Local Program Plan must be developed using the guidance provided in Attachment 1, Local Program Plan Guidance, incorporated herein with this reference.

(2) The Local Program Plan must address the Program Components as defined in Section 3 of this Program Element, that meet the needs of their specific community.

(3) The Local Program Plan must include activities that address community need and readiness and are reasonable based upon funds approved in the OHA approved local program budget.

(4) The Local Program Plan must outline how LPHA intends to ensure access to reproductive health services through meaningful community engagement and partnerships and the development of responsive policies and programattic actions.

(5) The Local Program Plan must be submitted to OHA by June 15th of each year for OHA approval.

(6) OHA will review and approve all Local Program Plans to ensure that they meet statutory and funding requirements relating to assurance of access to reproductive health services.

c. LPHA must use funds for this Program Element in accordance with its local program budget, which has been approved by OHA. LPHA must complete and submit its local program budget for PE 46 funds, by June 15th of each year for OHA approval, using the Local Program Budget Template and as set forth in Attachment 2, incorporated herein with this reference. Modification to the approved local program budget may only be made with OHA approval.

5. General Revenue and Expense Reporting. LPHA must complete an "Oregon Health Authority Public Health Division Expenditure and Revenue Report" located in Exhibit C of the Agreement. These reports must be submitted to OHA each quarter on the following schedule:

Fiscal Quarter	Due Date
First: July 1 – September 30	October 30
Second: October 1 – December 31	January 30
Third: January 1 – March 31	April 30
Fourth: April 1 – June 30	August 20

6. Reporting Requirements.

LPHA must provide an annual plan and budget; a mid-year progress report; and a final report with documentation.

7. Performance Measures.

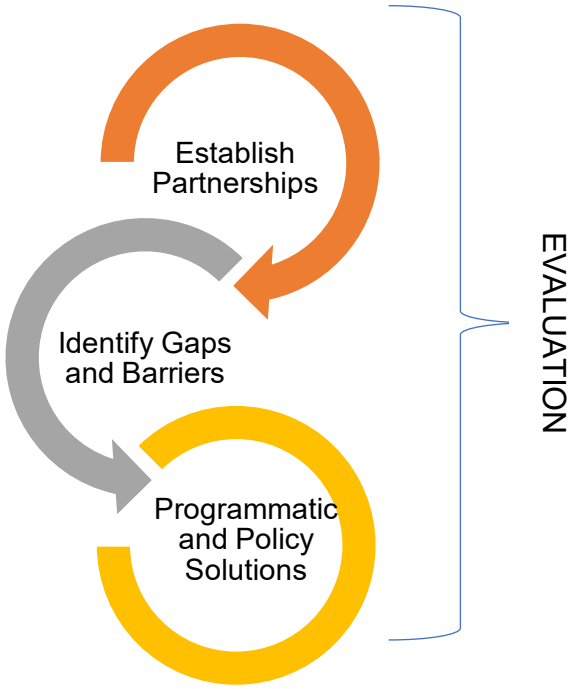
Not applicable

Attachment 1
Reproductive Health Program – FY 24 Local Program Plan Guidance
Community Partnerships and Assurance of Access toReproductive Health Services

Vision: Oregonians have access to comprehensive, culturally responsive, high-quality, and evidence-based reproductive health (RH) services in their surrounding community.

PE46 Goal: Assure access to RH services in your county through meaningful community engagement and partnerships and the development of responsive policies and programattic actions.

Instructions
LPHA should determine where their agency best fits on the continuum of program components identified to meet the overarching goal. Using the PE 46 Workplan Template, LPHAs must identify at least one objective, with supporting activities, for Program Component 1: Partnerships and Community Engagement. LPHAs that have well established partnerships (i.e. long-standing partnerships, coalition, or workgroup) are encouraged to identify one additional component (2 or 3) and associated objective(s) and activities based on previous PE46 work and current situation. Evaluation should be integrated within each component. LPHAs will develop and track outputs and expected outcomes within their workplan.



The intent is for an LPHA to move to the next component on the continuum each year. However, it is understood that the work may not necessarily be linear and one may need to circle back to an earlier step.

Program Component 1: Partnerships and Community Engagement
Partnerships and community engagement are at the core of PE46. Through these relationships, the LPHA and your partners will develop and implement a PE46 plan that includes assessment of gaps and barriers, policy and/or programmatic activities to address identified gaps and barriers, and an evaluation of such changes. There should be shared understanding of the goal and expected outcomes of the partnerships. While formal agreements are not required, they may be beneficial to ensure buy-in and continued participation in your efforts.

Partnerships with other health care providers and/or RHCare agencies is highly encouraged. In addition, consider developing partnerships outside the health care sector. This may include local governmental, private, or non-profit agencies focused on culture, education, criminal justice, housing, social justice, sexual/domestic violence, workforce development, and/or parenting, to name a few.

Consider convening a reproductive and sexual health workgroup/coalition or work with already established groups focused on improving quality of life/health disparaties/inequities for the populations you are trying to serve. When working with an already established group, ensure their already established goals align with and are beneficial to the goal of increasing access to reproductive health. Work together to integrate reproductive health into work plans, meeting agendas, etc.

Think about inviting and engaging community members, the populations you are trying to serve, to be partners. This could be in the form of a community advisory board or youth advisory council.

Program Component 1 – Example Objectives:

- Create and/or sustain a reproductive health coalition with ___(#) of community partners that meet quarterly.
- Formally integrate PE46 goals into _____ Meeting (name of already existing committee, coalition, or task force) by _____ (date).
- Identify and meet with ____ (#) new community partners to discuss your goals and how a partnership will benefit each other by ____ (date).
- Create partnership agreements with ____ (#) community providers/organizations identifying roles and areas of collaboration by ____ (date).

Program Component 2: Gaps and Barriers to RH Services

In collaboration with your community partners established in Component 1, identify barriers to access and gaps in RH services. This can be done through formal community needs assessments, surveys, focus groups, key informant interviews, etc. Consider what types of community and/or health assessments are already taking place in your community. There may be opportunities to add questions or input to gather specific information related to RH services. If you are trying to better understand a specific population in your community, work with a community-based organization who is already serving them and consult with them on the best way to learn more about their RH needs and barriers to service. This could be done through focus groups or surveys on a smaller scale to better understand their needs. When considering who to assess, go beyond your current clientle to better understand why community members are not accessing services.

Program Component 2 - Example Objectives:

- Develop and conduct ___ (#) surveys among youth ages 12-18 to assess need for and barriers to RH services in Quarter 2 and 3 of FY24.
- Develop an interview guide for key informant interviews by ____ (date).
    - Conduct ___ (#) of key informant issues in Quarter 2.
- Share assessment results through __ (#) community listening sessions in Quarter 4.
- Analyze and develop a written assessment report based on survey results by the end of Quarter 4.
- Develop an online dashboard to highlight assessment results by the end of FY24.
- Prioritize assessments results for development of programmatic or policy solutions by the end of Quarter 4.

Program Component 3: Programmatic and/or Policy Solutions

The programmatic and/or policy solutions should be developed in response to the identified gaps and/or barriers found under Program Component 2. In collaboration with your community partners, develop and implement ideas on how to overcome those gaps and barriers.

Program Component 3 - Example Objectives:

- In conjunction with community partners, review assessment findings and develop __ (#) programmatic or policy solutions by _____ (date).
- In Quarter 3 of FY24, host ___ (#) community listening and/or planning sessions to develop program or policy solutions.
- Implement ___ (#) programmatic and/or policy solutions based on assessment results by the end of FY24.
- Develop outcome measures to determine success of _____ (solution) by the end of Quarter 1.
- Analyze outcome measures of _____ (solution) by the end of Quarter 4.

Attachment 2

Local Program Budget Template

OREGON HEALTH AUTHORITY **Fiscal Year:** _____
Program Element #46
Reproductive Health Program

Organization Name: _____

Budget period From: _____ **To:** _____

Do not inlclude any expenses included in the provision of clinical services

Budget			
Categories	**OHA/PHD (PE46)**	**Non-OHA/PHD (In Kind)**	**Total PE 46 Budget**
Salaries			$ -
Benefits			$ -
Personal Services (Salaries and Benefits)	$ -	$ -	$ -
Professional Services/Contracts Describe:			$ -
Travel - Describe:			$ -
Supplies - Describe:			$ -
Facilities			$ -
Telecommunications			$ -
Catering/Food			$ -
Other - Describe:			$ -
Total Services and Supplies	$ -	$ -	$ -
Capital Outlay			$ -
Indirect: Rate (%):_____			$ -
TOTAL Budget	$ -	$ -	$ -

_____
Prepared by (print name)

_____ _____
Email Telephone

Program Element # 62 Overdose Prevention

OHA Program Responsible for Program Element:

Public Health Division/Center for Prevention & Health Promotion/Injury & Violence Prevention/Overdose Prevention Program

Background:

Substance use disorder and drug overdose are increasing health threats in Oregon. A 2020 National Survey on Drug Use and Health ranks Oregon at #2 in the country for rate of substance use disorder and #1 in illicit drug use disorder, prescription opioid misuse, and methamphetamine use. Oregon has seen a recent increase in overdoses from illicit fentanyl and non-opioid drugs, such as methamphetamine. OHA aims to reduce the burden of substance use disorder and overdose through several key strategies, including increasing equitable access to Harm Reduction supplies, supporting overdose response planning and coordination, increasing access to substance use disorder treatment, supporting safe and effective non-opioid pain management, providing tools and guidelines to support appropriate prescribing, and collecting and reporting data to inform response, prevention, and policy.

10. Description. Funds provided under this Agreement for this Program Element may only be used in accordance with, and subject to, the requirements and limitations set forth below, to implement Overdose Prevention activities.

Funds provided under this Agreement are to be used to implement strategies that prevent opioid overuse, opioid misuse, substance use disorder, drug overdose, and related harms from substance use. Funds are designed to serve counties or regions with a high burden of drug overdose deaths and hospitalizations. Funds should complement other substance use disorder or overdose prevention initiatives and leverage additional funds received by other organizations throughout the county to reduce overdose deaths and hospitalizations.

LPHA is expected to collaborate with multi-disciplinary partners and collaborators to develop, plan, implement, and evaluate culturally relevant interventions using tailored prevention strategies that emphasize reaching groups disproportionately affected by substance use disorder and overdose. LPHA should collaborate with other projects within the county that address the community's challenges related to drug overdose deaths. The funded activities for this Program Element seek to promote the OHA's overdose prevention aims and collaboration expectations.

All changes to this Program Element are effective the first day of the month noted in the Issue Date section of Exhibit C of the Financial Assistance Award unless otherwise noted in the Comments and Footnotes of Exhibit C of the Financial Assistance Award.

11. Definitions Specific to this PE

Harm Reduction is a public health approach that focuses on mitigating the harmful consequences of drug use, including transmission of infectious disease and prevention of overdose, through provision of care that is intended to be free of stigma and centered on the needs of people who use drugs. Harm Reduction strategies may include overdose education and naloxone distribution, low-threshold access to medications for opioid use disorder, drug checking (e.g., using fentanyl test strips), and education about safer drug use.

12. Alignment with Modernization Foundational Programs and Foundational Capabilities. The activities and services that the LPHA has agreed to deliver under this Program Element align with Foundational Programs and Foundational Capabilities and the public health accountability metrics (if applicable), as follows (see Oregon's Public Health Modernization Manual, (http://www.oregon.gov/oha/PH/ABOUT/TASKFORCE/Documents/public_health_modernization_manual.pdf):

a. Foundational Programs and Capabilities (As specified in Public Health Modernization Manual)

Program Components	Foundational Program					Foundational Capabilities						
	CD Control	Prevention and health promotion	Environmental health	Access to clinical preventive services: Population Health	Access to clinical preventive services: Direct services	Leadership and organizational competencies	Health equity and cultural responsiveness	Community Partnership Development	Assessment and Epidemiology	Policy & Planning	Communications	Emergency Preparedness and Response
Asterisk (*) = Primary foundational program that aligns with each component *X = Other applicable foundational programs*						*X = Foundational capabilities that align with each component*						
Community-Based Linkage to Care		*				X	X	X	X	X	X	X
Clinician/Health System Engagement		*				X	X	X	X	X	X	X
Public Safety Partnerships/ Interventions		*				X	X	X	X	X	X	X
Harm Reduction		*				X	X	X	X	X	X	X

b. The work in this Program Element helps Oregon's governmental public health system achieve the following Public Health Accountability Metric, Health Outcome Measure:

Not applicable

c. The work in this Program Element helps Oregon's governmental public health system achieve the following Public Health Accountability Metric, Local Public Health Process Measure:

Not Applicable

13. Procedural and Operational Requirements. By accepting and using the Financial Assistance awarded under this Agreement and for this Program Element, LPHA agrees to conduct activities in accordance with the following requirements:

LPHA must:

a. Submit local program Work Plan and local program budget to OHA for approval by October 15 every year. Local program Work Plan must include three or more of the following components:

(1) Convene or strengthen a county and/or regional coordinating body comprised of multisector partners to assist with strategic planning and implementation of substance use disorder and/or overdose prevention efforts. Include stakeholders such as: collaborating providers and organizations, Coordinated Care Organizations, peer recovery mentor

organizations, law enforcement and first responder agencies, Harm Reduction organizations, persons with lived experiences, and representatives of diverse populations.

(2) Develop, plan, implement, and evaluate an overdose emergency response plan. Convene and coordinate with local partners (i.e. health preparedness, law enforcement, first responders, hospital emergency departments, Harm Reduction partners, substance misuse prevention partners, and others). Assess and update response plans throughout the grant period.

(3) Review, coordinate, and disseminate local data to promote public awareness of the burden and opportunities to prevent drug overdose.

(4) Liaise with local, county, and/or regional organizations providing overdose prevention, Harm Reduction, treatment, and/or recovery services to ensure coordination and reduce duplication of efforts.

(5) Coordinate with the individuals and/or organizations responsible for determining how local governments will allocate opioid settlement funds within the county and/or region to implement complementary overdose prevention activities. Support coordination of local resource allocation.

(6) Community-Based Linkage to Care – Implement activities that help initiate linkage to care, facilitate care retention, prevent treatment interruption, and/or maintain access to recovery services.

(7) Clinician/Health System Engagement – Collaborate with Coordinated Care Organizations and/or other health system partners to provide clinician education on evidence-based practices for pain management; screening, diagnosis, and linkage to care opportunities for opioid use disorder (OUD) and stimulant use disorder (StUD); and other OUD/StUD-related clinician education priorities.

(8) Public Safety Partnerships/Interventions – Develop and maintain public health and public safety (PH/PS) partnerships; improve data sharing, availability, and use; provide education on preventing and responding to overdose; implement evidence-informed and evidence-based overdose prevention strategies.

(9) Harm Reduction – Implement and support activities that reduce stigma towards people who use drugs and facilitate Harm Reduction interventions based on local need; utilize navigators to connect people to services; ensure persons who use drugs have access to overdose prevention and reversal tools, treatment options, and drug checking equipment; develop and sustain partnerships with syringe service programs and Harm Reduction organizations; create and disseminate education and communication materials; leverage existing Harm Reduction services and resources to expand access and prevent a duplication of efforts.

b. Engage in activities as described in LPHA's local program Work Plan, which has been approved by OHA.

c. Use funds for this Program Element in accordance with LPHA's local program budget, which has been approved by OHA. Modification to the local program budget may only be made with OHA approval.

d. Ensure that staffing is at the appropriate level to address all sections in this Program Element. LPHA must designate or hire a lead staff person to carry out and coordinate all the activities described in this Program Element, and act as a point of contact between the LPHA and OHA.

e. Provide the workspace and administrative support required to carry out the activities outlined in this Program Element.

f. Attend all Overdose Prevention meetings reasonably required by OHA. Travel expenses shall be the responsibility of the LPHA.

g. Cooperate with OHA on program evaluation throughout the duration of this Agreement, as well as with final project evaluation.

h. Meet with a state level evaluator soon after execution of this Agreement to help inform the OHA evaluation plan.

14. General Revenue and Expense Reporting. LPHA must complete an "Oregon Health Authority Public Health Division Expenditure and Revenue Report" located in Exhibit C of this Agreement. These reports must be submitted to OHA each quarter on the following schedule:

Fiscal Quarter	Due Date
First: July 1 – September 30	October 30
Second: October 1 – December 31	January 30
Third: January 1 – March 31	April 30
Fourth: April 1 – June 30	August 20

15. Reporting and Work Plan Requirements.

a. LPHA must submit quarterly Progress Reports.

b. In addition to Section 5, General Revenue and Expense Reporting, LPHA must submit quarterly Overdose Prevention Expense Reports.

c. OHA will provide the required format and current service data for use in completing the Work Plan, Progress and Expense Reports.

d. The local program Work Plan may be modified throughout the project period based on shifting priorities, emerging needs, and LPHA capacity. LPHA must receive OHA approval for the revised local program Work Plan to ensure it meets program requirements and remains within the scope of this Program Element.

16. Performance Measures.

If LPHA completes fewer than 75% of planned activities in the description above, for two consecutive calendar quarters in one state fiscal year, LPHA will not be eligible to receive funding under this Program Element in the next state fiscal year.

ATTACHMENT B

Exhibit C
Financial Assistance Award (FY25)

State of Oregon
Oregon Health Authority
Public Health Division

1) Grantee	2) Issue Date	This Action
Name: Clackamas County	Monday, July 15, 2024	Amendment
Street: 2051 Kaen Rd., Suite 637		FY 2025
City: Oregon City	3) Award Period	
State: OR Zip: 97045-4035	From July 1, 2024 through June 30, 2025	

4) OHA Public Health Funds Approved

Number	Program	Previous Award Balance	Increase / Decrease	Current Award Balance
PE01-01	State Support for Public Health	$530,718.00	$0.00	$530,718.00
PE01-12	ACDP Infection Prevention Training	$0.00	$1,517.82	$1,517.82
PE02	Cities Readiness Initiative	$0.00	$65,492.00	$65,492.00
PE07	HIV Prevention Services	$11,687.84	$0.00	$11,687.84
PE12-01	Public Health Emergency Preparedness and Response (PHEP)	$0.00	$152,335.00	$152,335.00
PE13	Tobacco Prevention and Education Program (TPEP)	$500,000.00	$0.00	$500,000.00
PE40-01	WIC NSA: July - September	$240,695.00	$0.00	$240,695.00
PE40-02	WIC NSA: October - June	$722,085.00	$0.00	$722,085.00
PE40-05	Farmer's Market	$6,500.00	$0.00	$6,500.00
PE42-03	MCAH Perinatal General Funds & Title XIX	$0.00	$31,921.00	$31,921.00
PE42-04	MCAH Babies First! General Funds	$35,482.00	$0.00	$35,482.00
PE42-11	MCAH Title V	$119,732.00	$0.00	$119,732.00
PE42-12	MCAH Oregon Mothers Care Title V	$3,054.00	$0.00	$3,054.00
PE43-01	Public Health Practice (PHP) - Immunization Services	$427,023.00	$0.00	$427,023.00

4) OHA Public Health Funds Approved

Number	Program	Previous Award Balance	Increase / Decrease	Current Award Balance
PE44-01	SBHC Base	$0.00	$240,000.00	$240,000.00
PE44-02	SBHC - Mental Health Expansion	$135,300.00	$0.00	$135,300.00
PE46-05	RH Community Participation & Assurance of Access	$0.00	$38,860.71	$38,860.71
PE50	Safe Drinking Water (SDW) Program (Vendors)	$201,388.00	$0.00	$201,388.00
PE51-01	LPHA Leadership, Governance and Program Implementation	$1,421,861.00	$57,063.07	$1,478,924.07
PE62	Overdose Prevention-Counties	$0.00	$25,166.67	$25,166.67
PE73	HIV Early Intervention and Outreach Services	$738,575.00	$0.00	$738,575.00
PE76	Tobacco Retail License Program	$129,352.00	$0.00	$129,352.00
		$5,223,452.84	$612,356.27	$5,835,809.11

5) Foot Notes:

PE07	07/2024: SFY25 1-month funding allocation for July 2024; funds to be spent by 07/31/2024.
PE40-01	07/2024: SFY2025 Q1 unspent funds cannot be carried forward to the following Q2.
PE40-05	7/2024: SFY25 Q1 WIC Farm Direct mini grant award available 7/1/24-9/30/24. Unspent SFY25 Q1 funds may be carried over to Q2-4 period with request from grantee and an amendment to extend the SOW dates, for this grant only.

6) Comments:

PE40-01	7/2024: Funds available 7/1/24-9/30/24. Must spend $48,139 on Nutrition Ed, $8,571 on BF Promotion
PE40-02	7/2024: Funds available 10/1/24-6/30/25. Must spend $144,417 on Nutrition Ed, $25,712 on BF Promotion
PE46-05	7/15/2024: Award Available 7/1/24-3/31/25 only.
PE62	7/15/2024: $25,166.67 available 7/1/24-8/31/24 only.

7) Capital outlay Requested in this action:

Prior approval is required for Capital Outlay. Capital Outlay is defined as an expenditure for equipment with a purchase price in excess of $5,000 and a life expectancy greater than one year.

Program	Item Description	Cost	PROG APPROV	

ATTACHMENT C

Exhibit J
Information required by CFR Subtitle B with guidance at 2 CFR Part 200 (FY25)

PE01-12 ACDP Infection Prevention Training

Federal Award Identification Number:	6NU50CK000541
Federal Award Date:	10/13/23
Budget Performance Period:	08/1/2023-07/31/2026
Awarding Agency:	CDC
CFDA Number:	93.323
CFDA Name:	Epidemiology & Laboratory Capacity for Infectious Diseases (ELC)
Total Federal Award:	531508255
Project Description:	Oregon 2020 Epidemiology & Laboratory Capacity for Prevention and Control of Emerging Infectious Diseases (ELC)
Awarding Official:	Zoe Kaplan
Indirect Cost Rate:	17.79%
Research and Development (T/F):	FALSE
HIPPA	No
PCA:	53867
Index:	50401

Agency	UEI	Amount	Grand Total:
Clackamas	NVWKAVB8JND6	$1,517.82	$1,517.82

PE02 Cities Readiness Initiative

Federal Award Identification Number:	NU90TU000054
Federal Award Date:	06/11/24
Budget Performance Period:	07/01/2024-06/30/2025
Awarding Agency:	CDC
CFDA Number:	93.069
CFDA Name:	Public Health Emergency Preparedness
Total Federal Award:	8464953.00
Project Description:	Public Health Emergency Preparedness (PHEP) Cooperative Agreement
Awarding Official:	Rachel M Forche
Indirect Cost Rate:	17.79
Research and Development (T/F):	FALSE
HIPPA	No
PCA:	53667
Index:	50407

Agency	UEI	Amount	Grand Total:
Clackamas	NVWKAVB8JND6	$65,492.00	$65,492.00

PE12-01 Public Health Emergency Preparedness and Response (PHEP)

Federal Award Identification Number:	NU90TU000054
Federal Award Date:	06/11/24
Budget Performance Period:	07/01/2024-06/30/2025
Awarding Agency:	CDC
CFDA Number:	93.069
CFDA Name:	Public Health Emergency Preparedness
Total Federal Award:	8465953
Project Description:	Public Health Emergency Preparedness (PHEP) Cooperative Agreement
Awarding Official:	Rachel M Forche
Indirect Cost Rate:	17.79
Research and Development (T/F):	FALSE
HIPPA	No
PCA:	53564
Index:	50407

Agency	UEI	Amount	Grand Total:
Clackamas	NVWKAVB8JND6	$152,335.00	$152,335.00

PE46-05 RH Community Participation & Assurance of Access

Federal Award Identification Number:	FPHPA006556
Federal Award Date:	03/19/24
Budget Performance Period:	04/01/2024-03/31/2025
Awarding Agency:	DHHS
CFDA Number:	93.217
CFDA Name:	Family Planning Services
Total Federal Award:	4960500.81
Project Description:	Oregon Reproductive Health Program
Awarding Official:	Tisha Reed
Indirect Cost Rate:	17.79%
Research and Development (T/F):	FALSE
HIPPA	No
PCA:	52789
Index:	50333

Agency	UEI	Amount	Grand Total:
Clackamas	NVWKAVB8JND6	$38,860.71	$38,860.71

PE62 Overdose Prevention-Counties

Federal Award Identification Number:	NU17CE010191
Federal Award Date:	08/23/23
Budget Performance Period:	09/01/2023-08/31/2024
Awarding Agency:	CDC
CFDA Number:	93.136
CFDA Name:	Injury Prevention and Control Research and State and Community Based Programs
Total Federal Award:	3854849
Project Description:	Oregon Data to Action in States
Awarding Official:	Brownie Anderson-Rana
Indirect Cost Rate:	17.79
Research and Development (T/F):	FALSE
HIPPA	No
PCA:	52125
Index:	50339

Agency	UEI	Amount	Grand Total:
Clackamas	NVWKAVB8JND6	$25,166.67	$25,166.67