Agreement #154134

TENTH AMENDMENT TO OREGON HEALTH AUTHORITY 2017-2019 INTERGOVERNMENTAL AGREEMENT FOR THE FINANCING OF PUBLIC HEALTH SERVICES

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This Tenth Amendment to Oregon Health Authority 2017-2019 Intergovernmental Agreement for the Financing of Public Health Services, effective July 1, 2017, and restated July 1, 2018 (as amended the "Agreement"), is between the State of Oregon acting by and through its Oregon Health Authority ("OHA") and Yamhill County, acting by and through its Public Health ("LPHA"), the entity designated, pursuant to ORS 431.003, as the Local Public Health Authority for Yamhill County.

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 2019 (FY19) 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.

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:

AGREEMENT

1. Exhibit A "Definitions", Section 16 "Program Element" is amended to add Program Element titles and funding source identifiers as follows:

PE NUMBER AND TITLE • SUB-ELEMENT(S)	FUND TYPE	FEDERAL AGENCY/ GRANT TITLE	CFDA#	HIPAA RELATED (Y/N)	SUB-RECIPIENT (Y/N)
PE 46 Reproductive Health Community Participation & Assurance	FF	DHHS/Family Planning Services	93.217	Y	Y

2. Exhibit B Program Element #12 "Public Health Preparedness Program (PHEP)" is hereby superseded and replaced in its entirety by Attachment A attached hereto and incorporated herein by this reference.

3. Exhibit B Program Element #13 "Tobacco Prevention Education Program (TPEP)" is hereby superseded and replaced in its entirety by Attachment B attached hereto and incorporated herein by this reference.

4. Exhibit B Program Element #46 "Reproductive Health" is hereby added to the Agreement by Attachment C attached hereto and incorporated herein by this reference.

5. Section 1 of Exhibit C entitled "Financial Assistance Award" of the Agreement for FY19 is hereby superseded and replaced in its entirety by Attachment D attached hereto and incorporated herein by this

reference. Attachment D must be read in conjunction with Section 3 of Exhibit C as restated July 1, 2018, entitled "Explanation of Financial Assistance Award" of the Agreement.

6. Exhibit J "Information required by 2 CFR Subtitle B with guidance at 2 CFR Part 200" is amended to add to the federal award information datasheet as set forth in Attachment E, attached hereto and incorporated herein by this reference.

7. LPHA represents and warrants to OHA that the representations and warranties of LPHA set forth in Section 2 of Exhibit E of the Agreement are true and correct on the date hereof with the same effect as if made on the date hereof.

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

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

10. The parties expressly ratify the Agreement as herein amended.

11. 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.

12. This Amendment becomes effective on the date of the last signature below.

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

13. **Signatures.**

By: Karen Strohmeier

Name: /for/ Lillian Shirley, BSN, MPH, MPA

Title: Public Health Director

Date: 12/7/18

YAMHILL COUNTY LOCAL PUBLIC HEALTH AUTHORITY

By: [signature]

Name: SILAS HALLORAN-STEINER

Title: HHS DIRECTOR

Date: 11/6/18

DEPARTMENT OF JUSTICE – APPROVED FOR LEGAL SUFFICIENCY

Agreement form group-approved by D. Kevin Carlson, Assistant Attorney General, Tax and Finance Section, General Counsel Division, Oregon Department of Justice by email on August 16, 2018, copy of email approval in Agreement file.

REVIEWED BY OHA PUBLIC HEALTH ADMINISTRATION

By: [signature]

Name: Derrick Clark *(or designee)*

Title: Program Support Manager

Date: 12-1-18

Accepted by Yamhill County Board of Commissioners on 11/29/18 by Board Order # 18-422

Attachment A

Program Element #12: Public Health Emergency Preparedness Program (PHEP)

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 Public Health Emergency Preparedness Program (PHEP).

The PHEP shall address mitigation, preparedness, response and recovery phases for public health emergencies through plan development and revision, exercise and response activities based on the 15 Centers for Disease Control and Prevention (CDC) Public Health Preparedness Capabilities.

Emergency preparedness is one of the seven foundational capabilities described in the Oregon Public Health Modernization Manual. 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 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.[1]

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 Relevant to PHEP Programs Specific to Public Health Emergency Preparedness.

a. Access and Functional Needs: Means those actions, services, accommodations, and programmatic, architectural, and communication modifications that a covered entity must undertake or provide to afford individuals with disabilities a full and equal opportunity to use and enjoy programs, services, activities, goods, facilities, privileges, advantages, and accommodations in the most integrated setting, in light of the exigent circumstances of the emergency and the legal obligation to undertake advance planning and prepare to meet the disability-related needs of individuals who have disabilities as defined by the ADA Amendments Act of 2008, P.L. 110-325, and those associated with them.[2]

b. Base Plan: A plan that is maintained by Local Public Health Authority, describing fundamental roles, responsibilities and activities performed during preparedness, mitigation, response and recovery phases. 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, 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 Preparedness Capabilities: The 15 capabilities developed by the CDC to serve as national public health preparedness standards for state and local planning.[3]

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

g. 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 service providers. The data it contains is maintained jointly by OHA and all LPHAs. This system provides continuous, high-speed electronic access for Oregon public health officials and service providers to public health information including the capacity for broadcasting information to Oregon public health officials and service providers 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.

h. **Health Security Preparedness and Response (HSPR):** A state level program to that is a joint effort with the Conference of Local Health Officials (CLHO) and Native American Tribes (Tribes) to develop systems, plans and procedures to prepare Oregon 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.

i. **Health Care Coalition (HCC):** A health care coalition (HCC) as 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.

j. **Medical Countermeasures (MCM):** Vaccines, antiviral drugs, antibiotics, antitoxin, 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 for an ill-defined threat in the early hours of an event, a large shipment of specific items when a specific threat is known or technical assistance to distribute SNS material. SNS program support includes vendor managed inventory (VMI) and Federal Medical Stations.

k. **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. [5]

l. **Public Information Officers (PIOs)**: The communications coordinators or spokespersons for governmental organizations.

m. **Public Health Accreditation Board (PHAB):** 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. [6]

n. **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.

o. **Public Health Preparedness Capability Surveys:** A series of surveys sponsored by HSPR for capturing information from LPHAs in order for HSPR to report to CDC.

3. **Program Components.** Activities and services delivered under this Program Element align with Foundational Programs and Foundational Capabilities, as defined in Oregon's Public Health Modernization Manual,[1] (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*						
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 local PHEP work plan, which is due to OHA HSPR on or before August 1st and which has been approved by OHA HSPR (PHEP Work Plan). The Local PHEP Work Plan Template is set forth in Attachment 1, incorporated herein with this reference.

b. Use funds for this Program Element in accordance with its local PHEP budget, which is due to OHA HSPR on or before August 1st and which has been approved by OHA HSPR (PHEP Budget) The format for this budget is set forth in Attachment 2, incorporated herein with this reference. Modifications to the budget exceeding $5,000 require submission of a revised budget to the liaison and final receipt of approval from the HSPR fiscal officer.

(1) 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.

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

(3) **Public Health Preparedness Staffing.** LPHA must identify a PHEP Coordinator who is directly funded from PHEP grant. LPHA staff who receive PHEP funds must have planned activities identified within the Local PHEP Plan Work Plan. The PHEP Coordinator will be the OHA's chief point of contact related to program issues. LPHA must implement its PHEP activities in accordance with its approved Local PHEP 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 Preparedness Capabilities in accordance with an approved local PHEP budget using the template set forth as Attachment 2 to this Program Element. Modifications to the budget exceeding $5,000 require submission of a revised budget to the liaison and final receipt of approval from the HSPR fiscal officer.

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

c. **Statewide and Regional Coordination:** LPHA must attend HSPR meetings and participate as follows:

(1) Attendance at one of the HSPR co-sponsored preparedness conferences, which includes Oregon Epidemiologists' Meeting (OR-Epi) and Oregon Prepared Conference.

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

(3) Participation in a minimum of 75% of the regional or local HCC meetings.[7]

(4) Participation in the Statewide MCM Dispensing and Distribution full scale exercises and planning at the local level.[10]

(5) Participation in a minimum of 75% of statewide HSPR-hosted monthly conference calls for LPHAs and Tribes.

(6) Participation in activities associated with local, regional, or statewide emerging threats or incidents as identified by HSPR or LPHA. Timely assessment and sharing of essential elements of information for identification and investigation of an incident with public health impact, [9, 18, 21] as agreed upon by HSPR and the CLHO Emergency Preparedness and Response subcommittee.

(7) Work to develop and maintain a portfolio of community partnerships to support preparedness, mitigation, response and recovery efforts.[1, 14] Portfolio must include viable contact information from 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.[12]

d. **Public Health Preparedness Capability Survey:** LPHA must complete all applicable Public Health Preparedness Capability Survey(s) sponsored by HSPR by August 15 each year or applicable Due Date based on CDC requirements.[1, 8]

e. **PHEP Work Plan:** PHEP Work Plans must be written with clear and measurable objectives with timelines and include:

(1) At least three broad program goals that address operationalizing plans, identifying gaps and guide PHEP activities.

(2) Local public health leadership reviews and approves local PHEP work plans in support of any of the CDC Public Health Preparedness Capabilities.

(3) Planning in support of any of the CDC Public Health Preparedness Capabilities.

(4) Training and Education in support of any of the CDC Public Health Preparedness Capabilities.

(5) Exercises in support of any of the CDC Public Health Preparedness Capabilities.

(6) Planning will include Access and Functional Needs populations.

(7) Community Education and Outreach and Partner Collaboration in support of any of the CDC Public Health Preparedness Capabilities.

(8) Administrative and Fiscal activities in support of any of the 15 CDC PHP Capabilities.

f. **Emergency Preparedness Program PHEP Work Plan Performance**: LPHA must complete activities in their HSPR approved local PHEP work plans by June 30 each year. If LPHA completes fewer than 75% of the non-fiscal and non-administrative planned activities in its PHEP Work Plan for two consecutive years, not due to unforeseen public health events, it may not be eligible to receive funding under this Program Element in the next fiscal year. Work completed in response to a novel or uncommon disease outbreak or other event of significance, may be documented to replace PHEP Work Plan activities interrupted or delayed.

g. **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. [9, 15, 16]

(2) 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. [1, 9, 15, 16]

(3) 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 911 system in this process, but the eleven-digit telephone number of the local 911 operators shall be available for callers from outside the locality. [1, 9, 15, 16]

(4) 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.

(5) An LPHA official must respond within 60 minutes, to calls received on 24/7/365 telephone number, during statewide communication drills and quarterly tests. [13]

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

h. HAN

(1) A HAN Administrator must be appointed for LPHA and this person's name and contact information must be provided to the HSPR liaison and the State HAN Coordinator. [1, 9, 15]

(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. [13]

(h) If LPHA population is greater than 10,000, initiate at least one local HAN call down exercise/ drill for LPHA staff annually. If LPHA population is less than 10,000, 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.

(l) Participate in HAN/HOSCAP Administrator conference calls as appropriate.

i. Multi-Year Training and Exercise Plan (MYTEP): LPHA must annually submit to HSPR on or before September 1, an updated MYTEP. [1, 7, 8, 10, 15] The MYTEP must meet the following conditions:

(1) Demonstrate continuous improvement and progress toward increased capability to perform critical tasks.

(2) Include priorities that address lessons learned from previous exercises events, or incidents as described in the LPHA existing After Action Report (AAR)/ Improvement Plan (IP).

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

(4)

(a) 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.

(b) Identify a cycle of exercises that increase in complexity over a two-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. Disease outbreaks or other public health emergencies requiring an LPHA response may, upon HSPR approval, be used to satisfy exercise requirements. For an exercise or incident to qualify, under this requirement the exercise or incident must:

i. Exercise:

LPHA must:

- Submits to HSPR Liaison an exercise plan which includes scope, goals, objectives, activities, a list of invited participants and a list of exercise team members, for each of the exercises 30 days in advance of every exercise.
- Involve two or more participants in the planning process.
- Involve two or more public health staff and/ or related partners as active participants.
- Result in an After-Action Report (AAR)/Improvement Plan (IP) submitted to HSPR Liaison within 60 days for every exercise.

ii. Incident:

During an incident LPHA must:

- Submit the local response documentation or Incident Action Plan (IAP) describing LPHA role within incident response. [13]
- Submit an After-Action Report (AAR)/Improvement Plan (IP) to HSPR Liaison within 60 days of incident close or public health response ends.

(5) LPHA must coordinate exercise design and planning with local Emergency Management and other partners for community engagement,[1] as appropriate.

(6) Staff responsible for emergency planning and response roles must be trained for their respective roles consistent with their local emergency plans and according to CDCPublic Health Preparedness Capabilities,[13] the Public Health Accreditation Board, and the National Incident Management System. [5] 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 law.

(b) Identify and train appropriate LPHA staff [17] to prepare for public health emergency response roles and general emergency response based on the local identified hazards.

j. Maintaining Training Records: LPHA must maintain training records for all local public health staff with emergency response roles which demonstrate NIMS compliance. [11]

k. Plans: LPHA must maintain and execute emergency preparedness procedures and plans as a component of its jurisdictional Emergency Operations Plan. At a minimum, LPHA must establish and maintain:

(1) Base Plan. The Base Plan reviewed and revised every two years[22, 25] in coordination with the local emergency management agency schedule.

(2) Medical Countermeasure Dispensing and Distribution (MCMDD) plan[1, 8, 10, 15, 19, 20, 25]

(3) Continuity of operations plan (COOP).[1, 4, 15]

(4) Communications and Information Plan[16]

(5) All plans shall address, as appropriate, the CDC Public Health Preparedness Capabilities based on the local identified hazards.

(6) Plans are functional and operational by June 30, 2022.[8, 10, 24]

(7) All LPHA emergency procedures shall comply with the NIMS.[5, 23]

(8) The governing body of the LPHA shall maintain and update the other components and shall be adopted as local jurisdiction rules apply.

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 by the 25th of the month following the end of the first, second and third quarters, and no later than 50 calendar days following the end of the fourth quarter (or 12-month period).

6. Reporting Requirements.

a. PHEP Work Plan. LPHA must implement its PHEP activities in accordance with its HSPR approved PHEP Work Plan using the template set forth in Attachment 1 to this Program Element. Dependent upon extenuating circumstances, modifications to this PHEP Work Plan may only be made with HSPR agreement and approval. Proposed PHEP Work Plan will be due on or before August 1. Final approved PHEP Work Plan will be due on or before September 1.

b. Mid-year and end of year PHEP Work Plan reviews. LPHA must complete PHEP Work Plan updates in coordination with their HSPR liaison on at least a minimum of a semi-annual basis and by August 15 and February 15.

c. Triennial Review. This review will be completed in conjunction with the statewide Triennial Review schedule as determined by the Office of Community Liaison. This Agreement will be integrated into the Triennial Review Process.

d. LPHA shall annually submit a Multi-Year Training and Exercise Plan (MYTEP) to HSPR Liaison on or before September 1, an updated MYTEP.

e. LPHA shall submit to HSPR Liaison an exercise scope including goals, objectives, activities, a list of invited participants and a list of exercise team members, for each of the exercises 30 days in advance of each exercise.

f. LPHA shall submit to HSPR Liaison a local approved Incident Action Plan or local response documentation, before the start of the second operational period to OHA HSPR Liaison.

g. LPHA shall submit to HSPR Liaison an after-action report/improvement plan or documented lessons learned for every exercise hosting or participating in within 60 days after the completion of the exercise.

h. LPHA shall submit to HSPR Liaison an after-action report/improvement plan for every incident response within 60 days after completion of incident or end of public health response.

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.[3]

ATTACHMENT 1

Local PHEP Work Plan Template Instructions and Guidance
Oregon HSPR Public Health Emergency Preparedness Program

For grant cycle: July 1, 2018 – June 30, 2019**DUE DATE**

Proposed work plan will be due on or before August 1. Final approved work plan (PHEP Work Plan) will be due on or before September 1.

REVIEW PROCESS

Your approved PHEP Work Plan will be reviewed with your PHEP liaison by February 15 and August 15.

GENERAL STRATEGIES TO DEVELOP YOUR WORKPLAN

Refer to PE-12 section 4.e for more information.

WORKPLAN CATEGORIES

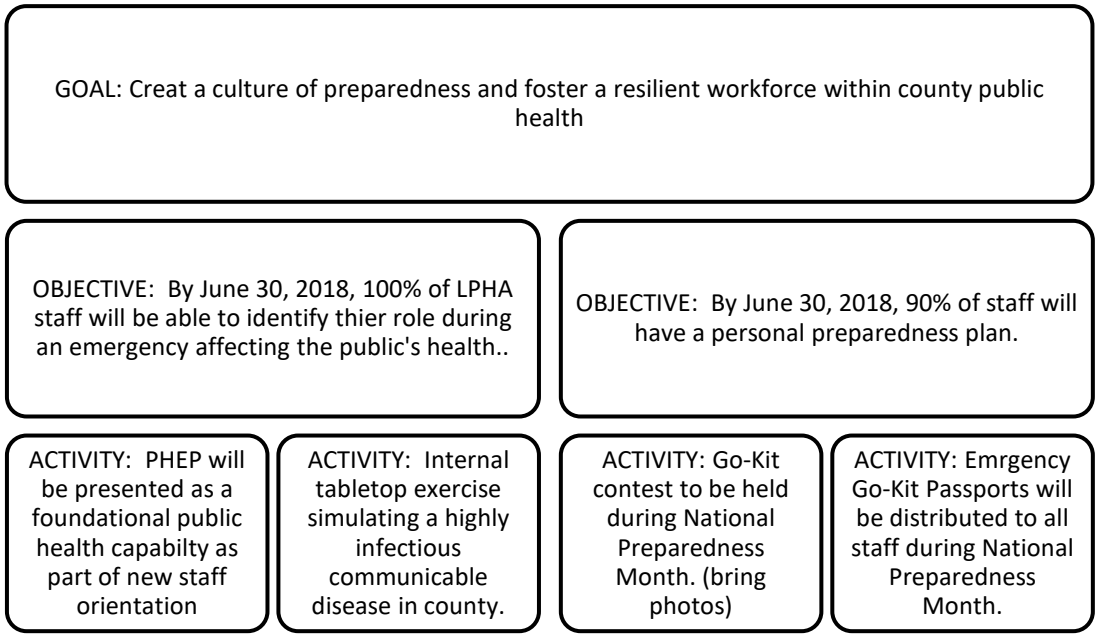
CDC Capability: Identify which CDC capability your program goals will address.

PROGRAM GOALS: Establish at least three broad program goals that address gaps and guide work plan activities. Goals are big picture outcomes you want to achieve from your workplan activities and must support a CDC Capability.

OBJECTIVES: Use clear and measurable objectives with identified time frames to describe what the LPHA will complete during the grant year. Objectives support goals. They are what you plan to accomplish.

ACTIVITES: Activities are how you plan to accomplish your goals.

Example of Goals, Objectives, and Activities



TRAINING AND EDUCATION: List planned preparedness trainings, workshops attended by preparedness staff.

DRILLS and EXERCISES: List all drills and exercises you plan to conduct and identify annual exercises in accordance with your two-year training and exercise plan attachment and as required in section 4.i of the PE-12 contract.

PLANNING: List all plans, procedures, updates, and revisions that need to be conducted in accordance with your planning cycle or any other planning activities that will be conducted this year. You should also review all after action reports completed during the previous grant year to identify planning activities that should be conducted this year.

PARTNER COLLABORATION: List all meetings regularly attended and/or led by public health preparedness program staff and any special collaborations you will be conducting this year.

COMMUNITY EDUCATION AND MEDIA OUTREACH: List any activities you plan conduct that that enhance community preparedness or resiliency including community events, public presentations, and social or traditional media campaigns.

INCIDENTS AND RESPONSE ACTIVITIES: List incidents and response activities that occurred during the current grant cycle. If an OERS Number was assigned, please include the number. Identify the outcomes from the incident and response activities, include date(s) of the incident and action taken.

UNPLANNED ACTIVITY: List activities or events that were not included when work plan was first approved. Please identify outcomes for the unplanned activity, include date(s) of occurrence and actions taken.

ACTUAL OUTCOMES: To be filled in after activity is conducted. Describe what is actually achieved and/or the products created from this activity.

DATE COMPLETED: When updating the work plan, record date of the completed activities and/or objective.

NOTES: For additional explanation.

PHEP Work Plan Template

Goal 1: Current HHS staff will receive ICS training appropriate for identified response role and responsibilities
Goal 2:
Goal 3:

Ongoing and Goal Related PHEP Program Work

Training and Education

Goal	Objectives	Planned Activities	Date Completed	Progress / Actual Outcome	Notes
3	***This is an example*** *By June 30, 2018, 75% of the identified HHS staff will complete the basic ICS training including NIMS 700 and IS-100.* *Goal 1.*	*September Staff meeting, all preparedness related training requirements/expectations reviewed. Explain the identified trainings--NIMS 700, NRF 800, IS-100 and IS-200 and who is to take these courses by the established time frames.*	*9/15/2018*	*20 of 30 HHS staff identified as needing 700, 800, and 100 completed the trainings by the end of December 2018.*	*Identified staff completed 700 and 800 series training online prior to December class.*
		December 15, 2018, first classroom training.	*12/15/2018*		
		July 18, 2018, second classroom training.	*3/18/2019*	*Five management staff completed IS-200 on March 18, 2019.*	
		July 12, 2018, third classroom training.	*5/12/2019*	*Remaining 10 staff completed 700, 800, and 100 trainings on May 12, 2019.*	
		PHEP coordinator will update all training records by July 25, 2018.	*6/15/2019*	*Trainings records updated on June 15, 2019*	
3, 4, 6, 7, 8, 9, 11, 12 and 13	*This is an example* *By June 30, 2018, 75% of the HHS staff will identify three individual expectations and three organizational*	*PHEP coordinator will work with management staff to determine staff training expectations by job classification.*	*9/1/2018*	*Met with management staff on September 1, 2018.*	

	expectations required during an emergency response. Goal 1.	*By September 1, 2017, PHEP coordinator will develop comprehensive emergency preparedness training and exercise plan (TEP) for the organization, both minimum and developmental training.*	*10/29/2018*	*Met with Emergency Management and other partners to develop TEP on 8/17/18. Sent TEP to Liaison on 9/01/18.*	
		PHEP Coordinator will develop a presentation for staff for orienting them to the organization's expectations, individual expectations and emergency response plans and procedures.	*9/15/2018*	*Presentation developed and gave to staff on 9/15/18*	
		PHEP Coordinator will present organization's expectations, individual expectations, and emergency response plans and procedures overview at All Staff meeting.	*9/15/2018*		
		Give a quiz to all staff by February 17, 2017 on the presentation provided in September on expectations and response plan.	*2/17/2019*	*82% of the staff responded to quiz. 73% did demonstrated retained knowledge on the expectations for the organization and the individual.*	
Unplanned Training and Education					

Drills and Exercises

Goal	Objectives	Planned Activities	Date Completed	Actual Outcomes	Notes
Unplanned Drills and Exercises					

Planning

Goal	Objectives	Planned Activities	Date Completed	Actual Outcomes	Notes
Unplanned Planning Activities					

Partner Collaboration					
Goal	**Objectives**	**Planned Activities**	**Date Completed**	**Actual Outcome**	**Notes**
Unplanned Partner Collaboration					

Community Outreach					
Goal	**Location**	**Activity / Event Name / Notes / Outcomes**	**Date Completed**	**Activity Hours**	**Total # of Attendees**
Unplanned Community Outreach					

INCIDENT AND RESPONSE ACTIVITIES				
CDC Cap. #s	**Incident Name/OERS #**	**Date(s)**	**Outcomes**	**Notes**

ATTACHMENT 2

Local PHEP Program Budget Template

Preparedness Program Annual Budget **_____ County** **July 1, 201_ - June 30, 201_**				**Total**
PERSONNEL			Subtotal	**$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.				
			0	
			0	
Fringe Benefits @ ( )% of describe rate or method			0	
TRAVEL				**$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**
SUPPLIES, MATERIALS and SERVICES (office, printing, phones, IT support, etc.)		$0		**$0**

CONTRACTUAL (list each Contract separately and provide a brief description)	$0		**$0**
Contract with (_) Company for $____, for (_____) services. *Contract with (_) Company for $____, for (_____) services.* *Contract with (_) Company for $____, for (_____) services.*			
OTHER	$0		**$0**
TOTAL DIRECT CHARGES			**$0**
TOTAL INDIRECT CHARGES @_____% of Direct Expenses or describe method			**$0**
TOTAL BUDGET:			**$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 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

Attachment 3
Bibliography

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4. Continuity Guidance Circular 1 (CGC 1), Federal Emergency Management Agency (FEMA), https://www.fema.gov/media-library-data/1386609058803-b084a7230663249ab1d6da4b6472e691/CGC-1-Signed-July-2013.pdf, July 2013

5. National Incident Management System (NIMS), Federal Emergency Management Agency (FEMA), https://www.fema.gov/national-incident-management-system, October 2017.

6. Public Health Accreditation Board, http://www.phaboard.org/.

7. United States Department of Health and Human Services 2017-2000 Hospital Preparedness Program (HPP) – Public Health Emergency Preparedness (PHEP) Cooperative Agreement, CDC-RFA, TP12-1701, Domain 1

8. United States Department of Health and Human Services 2017-2000 Hospital Preparedness Program (HPP) – Public Health Emergency Preparedness (PHEP) Cooperative Agreement, CDC-RFA, TP12-1701, Domain 2

9. United States Department of Health and Human Services 2017-2000 Hospital Preparedness Program (HPP) – Public Health Emergency Preparedness (PHEP) Cooperative Agreement, CDC-RFA, TP12-1701, Domain 3

10. United States Department of Health and Human Services 2017-2000 Hospital Preparedness Program (HPP) – Public Health Emergency Preparedness (PHEP) Cooperative Agreement, CDC-RFA, TP12-1701, Domain 4

11. Oregon Office of Emergency Management (OEM) National Incident Management System (NIMS) – *Who Takes What*, September 2014. http://www.oregon.gov/OEM/Documents/nims_who_takes_what.pdf

12. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC), Public Health Preparedness Capability #1, Community Preparedness, March 2011.

13. United States Department of Health and Human Services Centers for Disease Control and Prevention (CDC), Public Health Preparedness Capability #3, Emergency Operations Coordination, March 2011.

14. Community partnership development, Oregon Revised Statute §431.138, 2015.

15. Emergency preparedness and response, Oregon Revised Statute §431.133, 2015.

16. Communications, Oregon Revised Statute §431.134, 2015.

17. Leadership and organizational competencies, Oregon Revised Statute §431.136, 2015.

18. Assessment and epidemiology, Oregon Revised Statute §431.132, 2015.

19. Impending Public Health Crisis: Public Health Emergency Plans, Division 3 Public Health Preparedness, Oregon Administrative Rule §333-003-0200, 2008.

20. Impending Public Health Crisis: Diagnostic and Treatment Protocols, Division 3 Public Health Preparedness, Oregon Administrative Rule §333-003-0040, 2008.

21. Impending Public Health Crisis: Access to Individually Identifiable Health Information, Division 3 Public Health Preparedness, Oregon Administrative Rule §333-003-0050, 2008.

22. Participation of Local and Tribal Governments in the Emergency Management Performance Grant (EMPG) Program of the Federal Emergency Management Agency (FEMA), Oregon Administrative Rule §104-010-005, 2014.

23. Homeland Security Presidential Directive 5 (HSPD-5): Management of Domestic Incidents, February 2003.

24. Presidential Policy Directive 8 (PPD-8): National Preparedness, U.S. Department of Homeland Security, March 2011.

25. Homeland Security Presidential Directive 21 (HSPD-21): Public Health and Medical Preparedness, October 2007.

Attachment B

Program Element #13: Tobacco Prevention Education Program (TPEP)

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 Tobacco Prevention Education Program (TPEP). As described in the local program plan, activities are in the following areas:

a. Facilitation of Community and Statewide Partnerships: Accomplish movement toward tobacco-free communities through a coalition or other group dedicated to the pursuit of agreed upon local and statewide tobacco control objectives. Community partnerships should include local public health leadership, health system partners, non-governmental entities as well as community leaders.

(1) TPEP program should demonstrate ability to mobilize timely community support for local tobacco prevention objectives.

(2) TPEP program should be available and ready to respond to statewide policy opportunities and threats.

b. Creating Tobacco-Free Environments: Promote the adoption of tobacco-free policies, including policies in schools, workplaces and public places. Demonstrate community progress towards establishing jurisdiction-wide tobacco-free policies (e.g. local ordinances) for workplaces that still allow indoor smoking or expose employees to secondhand smoke. Establish tobacco-free policies for all county and city properties and government campuses.

c. Countering Pro-Tobacco Influences: Reduce the promotion of tobacco in retail environments by educating and aligning decision makers about policy options for addressing the time, place and manner tobacco products are sold. Counter tobacco industry advertising and promotion. Reduce youth access to tobacco products, including advancing tobacco retail licensure and other evidence-based point of sale strategies.

d. Promoting Quitting Among Adults and Youth: Promote evidence-based practices for tobacco cessation with health system partners and implementation of Health Evidence Review Commission initiatives, including cross-sector interventions. Integrate the promotion of the Oregon Tobacco Quit Line into other tobacco control activities.

e. Enforcement: Assist OHA with the enforcement of statewide tobacco control laws, including the Indoor Clean Air Act, minors' access to tobacco and restrictions on smoking through formal agreements with OHA, Public Health Division.

f. Reducing the Burden of Tobacco-Related Chronic Disease: Address tobacco use reduction strategies in the broader context of chronic diseases and other risk factors for tobacco-related chronic diseases including cancer, asthma, cardiovascular disease, diabetes, arthritis, and stroke. Assure LPHA decision making processes are based on data highlighting local, statewide and national tobacco-related disparities. Assure processes engage a wide variety of perspectives from those most burdened by tobacco including representatives of racial/ethnic minorities, Medicaid users, LGBTQ community members, and people living with disabilities, including mental health and substance use challenges.

The statewide Tobacco Prevention and Education Program (TPEP) is grounded in evidence-based best practices for tobacco control. The coordinated movement involves state and local programs working together to achieve sustainable policy, systems and environmental change in local communities that mobilize statewide. Tobacco use remains the number one cause of preventable death in Oregon and nationally. It is a major risk factor in developing asthma, arthritis, diabetes, stroke,

tuberculosis and ectopic pregnancy – as well as liver, colorectal and other forms of cancer. It also worsens symptoms for people already living with chronic diseases.

Funds provided under this Agreement are to be used to reduce exposure to secondhand smoke, prevent youth from using tobacco, promote evidence-based practices for tobacco cessation, educate decision makers about the harms of tobacco, and limit the tobacco industry's influence in the retail environment. Funds allocated to Local Public Health Authorities are to complement the statewide movement towards population-level outcomes including reduced tobacco disparities. 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 Tobacco Prevention Education Program (TPEP).

Oregon Indoor Clean Air Act (ICAA) (also known as the Smokefree Workplace Law) protects workers and the public from secondhand smoke exposure in public, in the workplace, and within 10 feet of all entrances, exits, accessibility ramps that lead to and from an entrance or exit, windows that open and air-intake vents. The ICAA includes the use of "inhalant delivery systems." Inhalant delivery systems are devices that can be used to deliver nicotine, cannabinoids and other substances, in the form of a vapor or aerosol. These include e-cigarettes, vape pens, e-hookah and other devices. Under the law, people may not use e-cigarettes and other inhalant delivery systems in workplaces, restaurants, bars and other indoor public places in Oregon.

3. Program Components. 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*						
Facilitation of Community Partnerships		*		X		X	X	X	X	X	X	
Creating Tobacco-free Environments		*		X		X	X	X	X	X	X	
Countering Pro-Tobacco Influences		*				X	X	X	X	X	X	
Promoting Quitting Among Adults and Youth		X		*		X	X	X	X	X	X	
Enforcement		*	X			X	X	X	X	X	X	
Reducing the Burden of Tobacco-Related Chronic Disease		*		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:

Adults who smoke cigarettes

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

Percent of community members reached by local (tobacco retail/smoke free) policies

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 local program plan, which has been approved by OHA and on file based on a schedule to be determined by OHA. OHA will supply the required format and current service data for use in completing the plan. LPHA must implement its TPEP

activities in accordance with its approved local program plan. Modifications to this plan may only be made with OHA approval.

b. Assure that LPHA leadership is appropriately involved and its local tobacco program is staffed at the appropriate level, depending on its level of funding, as specified in the award of funds for this Program Element.

c. Use the funds awarded under this Agreement for this Program Element in accordance with its Budget as approved by OHA and attached to this Program Element as Attachment 1 and incorporated herein by this reference. Modifications to the Budget may only be made with OHA approval. Funds awarded for this Program Element may not be used for treatment, direct cessation delivery, other disease control programs, or other efforts not devoted to tobacco prevention and education.

d. Attend all TPEP meetings reasonably required by OHA.

e. Comply with OHA's TPEP Guidelines and Policies.

f. Coordinate its TPEP activities and collaborate with other entities receiving TPEP funds or providing TPEP services.

g. In the event of any omission from, or conflict or inconsistency between, the provisions of the local program plan on file at OHA, the Budget set forth in Attachment 1 and the provisions of the Agreement and this Program Element, the provisions of this Agreement and this Program Element shall control.

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 by the 25th of the month following the end of the first, second and third quarters, and no later than 50 calendar days following the end of the fourth quarter (or 12 month period).

6. Reporting Requirements. LPHA must submit local program plan reports on a semi-annual schedule to be determined by OHA. The reports must include, at a minimum, LPHA's progress during the reporting period towards completing activities described in its local program plan. Upon request by OHA, LPHA must also submit reports that detail quantifiable outcomes of activities and data accumulated from community-based assessments of tobacco use. LPHA leadership and program staff must participate in reporting interviews on a schedule to be determined by OHA and LPHA.

7. Performance Measures.

a. LPHA must operate the Tobacco Prevention Education Program (TPEP**)** described in its local program plan and in a manner designed to make progress toward achieving the following Public Health Modernization Process Measure:

Percent of community members reached by local (tobacco retail/smoke free) policies

b. If LPHA completes fewer than 75% of the planned activities in its local program plan for two consecutive reporting periods in one state fiscal year LPHA will not be eligible to receive funding under this Program Element during the next state fiscal year.

Attachment 1
Local Program Budget

This a two year budget plan. For 7/1/17 - 6/30/18 the estimated award is $107,781. For 7/1/18-6/30/19 the estimated award is $107,289.

Please complete the following Line Item Budget for: **OHA TPEP PE13 for FY2017-19 (07/01/17-06/30/19)**

Identify only funds requested under the OHA TPEP PE13 RFA.

Please call your Community Programs Liaison with questions related to this form.

Agency:	Yamhill County Public Health			
Fiscal Contact:	Christina Malae			
E-mail address:	malaec@co.yamhill.or.us			
Phone Number:	503-434-7371	Fax Number:		

Budget Categories	Description						Total
(1) Salary	**Position #**	**Title of Position**	**Salary** (annual)	**% of time (FTE)**	**# of months requested**	**Total Salary**	
	1	Program Coordinator	$52,392	80.39%	24	84,234.00	
	2	Clerical Support	$32,581	21.18%	24	13,804.00	
	3	Accounting Support	$44,526	5.65%	24	5,030.00	
	4	Program Supervision	$70,113	4.87%	24	6,832.00	
	5	Administrative Support	$88,875	1.16%	24	2,067.00	
	TOTAL SALARY					$111,967.00	
	Narrative* :						**$111,967**
(2) Fringe Benefits	**Position #**	**Total Salary**	**Base** If Applicable	**%**	**=**	**Total Fringe**	
	1	84,234.00		62.45%	=	52,604.13	
	2	13,804.00		78.60%	=	10,849.94	
	3	5,030.00		70.78%	=	3,560.23	
	4	6,832.00		59.05%	=	4,034.30	
	5	2,067.00		42.50%	=	878.48	
	TOTAL FRINGE					$71,927.08	**$71,927**
(3) Equipment	**List equipment.** Include all equipment necessary for program (i.e. computer, printer).					$0	
	Narrative* :						**$0**
(4) Supplies	**Do not list**. These items include supplies for meetings, general office supplies ie. paper, pens, computer disks, highlighters, binders, folders, etc.					$1,714	**$1,714**
(5) Travel	This covers in-state, out-of-state, and travel to all required trainings.						
		In state		Out Of State		Subtotal	
	Narrative* :						
	Per Diem:	653				$653	
	Hotel:	1,730				$1,730	
	Air fare:	-				$0	
	Reg. fees:	-				$0	
	Other:	-				$0	
	Mileage:	Miles: 6293	X	.535	per mile	$3,367	**$5,750**
(6) Other	**Please list.**						
	Rent					$9,598	
	Telephone					$3,316	
	Copying, Printing, Publications					$1,069	
	Postage					$710	
	Public Health Officer					$3,365	
	Professional Development					$724	
	Legal, Payroll, Insurance, Audit					$3,209	
	Program Supplies (brochures, stickers, etc)					$1,722	**$23,713**
(7) Contracts: Contracts must be pre-approved by liaison	**List all sub-contracts** and all contractual costs, if applicable.						
						$0	
						$0	**$0**
(8) Total Direct Costs	(Sum of 1 through 7)						**$215,070**
(9)Cost Allocation and Indirect Rate	Indirect @	0.00%	**$0**				**$0**
(10) TOTALS	(Sum of 8 & 9). Should equal OHA TPEP PE13 Request.						**$215,070**

Attachment C

Program Element # 46: Reproductive Health

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 Reproductive Health services.

Funds provided through this Program Element support LPHA's efforts toward ensuring community-wide participation in the delivery of, and assurance of access to, culturally competent, high-quality, and evidence-based reproductive health services.

Nearly half of all pregnancies in Oregon are considered unintended. This rate has remained fairly static, both in Oregon and nationally, over the past few decades. The stubbornness of these rates underscores the complexity of the issue and the challenges faced by public health, health systems, and clinical experts in attempting to address it. One important strategy, improving utilization of effective contraceptive use among women at risk of pregnancy, has been recognized as a key metric among Coordinated Care Organizations serving Oregon's Medicaid population. Although unintended pregnancy is extremely pervasive across socio-economic, racial and age groups, disparities in what is considered unintended pregnancy do exist, as do disparities in maternal health and birth outcomes. It is more common for young women, unmarried and cohabitating women, those living in poverty, black women, and those who have relatively low educational attainment to report that their pregnancy was unintended. These disparities highlight pre-existing, deeply entrenched societal inequities that may inhibit individuals' ability to access services and to plan and make decisions regarding their reproductive health goals. Therefore, it is critical that interventions aimed at reducing unintended pregnancy be wide-reaching and sensitive to the unique circumstances and challenges of different communities. This Program Element uses a systems approach to ensure that LPHAs lead efforts to develop a community-based approach to ensuring that equitable access to family planning services is available – capitalizing upon the presence of other service providers to assist in meeting need.

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 Reproductive Health. Not applicable.

3. Program Components. 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*						
Develop strategic partnerships with shared accountability driving collective impact to support public health goals related to reproductive health				*			x	x	x	x		
Identify barriers to access and gaps in reproductive health services		x		*			x	x	x			
Develop and implement strategic plans to address these gaps and barriers to access to reproductive health services		x		*			x	x		x	x	
Ensure regional access to reproductive health services with a focus on serving individuals with limited resources	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:

Effective Contraceptive Use

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

Effective Contraceptive Use

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. All RH services supported in whole or in part with funds provided under this Agreement must be delivered 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 deliver all RH services supported in whole or in part with funds provided under this Agreement in compliance with ORS 431.145 and ORS 435.205 which defines the responsibility of LPHA to ensure access to clinical preventive services including family planning.

c. LPHA must develop and engage in activities as described in its local program plan as follows:

(1) Developed using the guidelines provided in Attachment 1, Local Program Plan Guidelines, incorporated herein with this reference.

(2) Address the Program Components as defined in Section 3 of this Program Element.

(3) Include activities that address community need and readiness and are reasonable based upon funds approved in the OHA approved local program budget.

(4) Outline how LPHA intends to assure provision of comprehensive, culturally responsive and high-quality, evidence-based reproductive health services with a focus on serving those with limited resources and experiencing health disparities.

(5) Submitted to OHA by June 15th of each year for OHA approval.

(6) OHA will review and approve all the local program plan to ensure that they meet statutory and funding requirements relating to assurance of access to Reproductive Health services.

d. LPHA must develop and 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, 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 this Agreement. These reports must be submitted to OHA by the 25th of the month following the end of the first, second and third quarters, and no later than 50 calendar days following the end of the fourth quarter (or 12 month period).

6. Reporting Requirements.

LPHA must provide progress reports as included in the OHA approved local program plan.

7. Performance Measures.

LPHA must operate the RH program in a manner designed to make progress toward achieving the following Public Health Modernization Process Measure:

Effective Contraceptive Use.

Attachment 1

Reproductive Health Program – Local Program Plan (FY19) Guidelines

Community Participation and Assurance of Access to Reproductive Health Services

Overarching Goal: Assurance of Access to Reproductive Health (RH) Services

Instructions:

Choose a *minimum of one* program component and *at least one* corresponding objective (either from what is listed below or devise your own). In addition, all LPHAs must choose one objective under Program Component D, as it indicates the LPHA's involvement in the provision of clinical services. LPHAs using these funds for cross-jurisdictional work must demonstrate how each county is represented and impacted by this work.

Program Component A: Develop strategic partnerships with shared accountability driving collective impact to support public health goals related to RH

Objective A1: Seek and sustain relationships with community partners representing populations experiencing health disparities and/or providing RH or related services to these populations.
Objective A2: By June 30, 2019, convene a minimum of # _____ partnership meetings focused on assuring access to RH services, minimizing gaps and barriers, and/or improving the quality of reproductive health services. (*Baseline = # of partnership meetings in 2017*).

Suggested activities: Create partnership agreements with community providers identifying roles and areas of collaboration; host or co-host community forums/outreach events; develop preliminary community plan.

Program Component B: Identify barriers to access and gaps in services

Objective B1: Conduct local assessment(s), in collaboration with the OR RH Program and community partners, of access to culturally competent and high-quality, evidenced-based RH services to identify barriers to access and gaps in services.
Objective B2: Evaluate the impact of local policies, interventions, and programs on access to culturally competent and high-quality, evidenced-based RH services and associated barriers and gaps.
Objective B3: Share data, summaries and reports, following assessment and/or evaluation, with community members, partners, policy makers, and others.

Suggested activities: Conduct survey or focus groups; interview key stakeholders and/or consumers; present findings and other data to community partners, members, and decision-makers.

Program Component C: Develop and implement strategic plans to address gaps and barriers to accessing RH services

Objective C1: With community partners and, as needed, the OR RH Program, develop plan for improved access to RH services, addressing how to reduce or eliminate health disparities.
Objective C2: Specifically engage communities experiencing health disparities so they can actively participate in planning to address their needs.
Objective C3: With community partners, implement plan for improved access to RH services.
Objective C4: Assure constituents community members are aware of RH providers within the community through multiple communication channels.

Suggested activities: Host community listening and planning sessions to create strategic plan; collaboratively develop and implement strategic outreach/marketing plan; develop online or print materials with information about RH providers within the community.

Program Component D: Ensure that access to high quality, comprehensive RH services is available within the region.

Objective D1: Provide clinical RH services by successfully completing RH provider application and certification process with OR RH Program that includes all available RH funding sources. Use quantitative and qualitative data to monitor, evaluate and modify effectiveness of RH service delivery system within the region.
Objective D2: In collaboration with Oregon RH Program, identify provider(s) within the region willing to provide RH services through RH Provider application and certification process with OR RH Program. Develop and execute a transition plan, ensuring that current clients are aware of options for continued care. Use quantitative and qualitative data to monitor, evaluate and modify effectiveness of RH service delivery system within the region.

Attachment 2

Local Program Budget Template

OREGON HEALTH AUTHORITY	**Fiscal Year:**		
Program Element #46			
Reproductive Health Program			
EMAIL TO: RH.program@state.or.us			
Sub Recipient Organization Name:			
Budget period From:		**To:**	

Budget

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

	Prepared by (print name)	
Email		Telephone

Attachment D
Financial Assistance Award (FY19)

State of Oregon
Oregon Health Authority
Public Health Division

1) Grantee
Name: Yamhill County Public Health
Street: 412 NE Ford St.
City: McMinnville
State: OR Zip Code: 97128

2) Issue Date
September 28, 2018

This Action
AMENDMENT
FY 2019

3) Award Period
From July 1, 2018 Through June 30, 2019

4) OHA Public Health Funds Approved

	Program	Award Balance	Increase/ (Decrease)	New Award Bal
PE01	State Support for Public Health	125,301		125,301
PE03	Tuberculosis Case Management	0		0
PE12	Public Health Emergency Preparedness and Response (PHEP)	89,230	1,007	90,237
PE13	Tobacco Prevention and Education Prgram (TPEP)	107,290		107,290
PE27-02	PDOP - Opiod State Targed Response (OSTR)	79,583		79,583
PE41	Reproductive Health Program	7,207		7,207
PE42-01	MCAH Title V CAH	11,215	0	11,215
PE42-02	MCAH Title V Flexible Funds	26,167	0	26,167
PE42-03	MCAH Perinatal General Funds & Title XIX	3,528		3,528
PE42-04	MCAH Babies First! General Funds	11,275		11,275
PE42-06	MCAH General Funds & Title XIX	6,622		6,622
PE43	Public Health Practice (PHP) - Immunization Services (Vendors)	28,803	0	28,803
PE44-01	SBHC Base	112,000		112,000
PE44-02	SBHC - Mental Health Expansion	86,600		86,600
PE46	RH Community Participation & Assurance of Access	0	15,905	15,905
PE50	Safe Drinking Water (SDW) Program (Vendors)	38,600		38,600
		733,421	16,912	750,333

5) Foot Notes:

PE03	1	Tuberculosis funding has been changed to a fee for service model.
PE41	1	Funding Period is for two month - 7/1/18 - 8/31/18 - Funds must be expended by August 31, 2018

State of Oregon
Oregon Health Authority
Public Health Division

1) Grantee	2) Issue Date	This Action
Name: Yamhill County Public Health	September 28, 2018	AMENDMENT FY 2019
Street: 412 NE Ford St.	3) Award Period	
City: McMinnville	From July 1, 2018 Through June 30, 2019	
State: OR Zip Code: 97128		

4) OHA Public Health Funds Approved

Program			Award Balance	Increase/ (Decrease)	New Award Bal
PE42-01	1	For all MCH funds: Funds will not be shifted between categories or fund types. The same program may be funded by more than one fund type, however, federal funds may not be used as match for other federal funds (such as Medicaid).			
PE42-01	2	Funds for the MCH Title V programs: Flexible funds, Child & Adolescent Health, and Oregon MothersCare for the period 7/1/18 – 9/30/18 must be spent by 9/30/18.			
PE42-02	1	For all MCH funds: Funds will not be shifted between categories or fund types. The same program may be funded by more than one fund type, however, federal funds may not be used as match for other federal funds (such as Medicaid).			
PE42-02	2	Funds for the MCH Title V programs: Flexible funds, Child & Adolescent Health, and Oregon MothersCare for the period 7/1/18 – 9/30/18 must be spent by 9/30/18.			
PE42-03	1	Funds will not be shifted between categories or fund types. The same program may be funded by more than one fund type, however, federal funds may not be used as match for other federal funds (such as Medicaid).			
PE42-04	1	For all MCH funds: Funds will not be shifted between categories or fund types. The same program may be funded by more than one fund type, however, federal funds may not be used as match for other federal funds (such as Medicaid).			
PE42-06	1	For all MCH funds: Funds will not be shifted between categories or fund types. The same program may be funded by more than one fund type, however, federal funds may not be used as match for other federal funds (such as Medicaid).			
PE43	1	All Award Must be Spent by the End of June 30, 2019			
PE43	2	Immunization Special Payments is Funded by State General Fund and Matched dollar for Dollar with Federal Medicaid Match.			

6) Comments:

PE50	$3,474 must be spent from 7/1/18 to 9/30/18. $10,422 must be spent from 10/1/18 to 6/30/19. (for portion of award with federal funding source CFDA 66.432)
PE03	$672 must be spent by 12/31/18
PE27-02	$79,583 in FY19 is balance of OSTR Year 2 Funding available 7/1/18-4/30/19 only.
PE42-01	$2,804 must be spent from 7/1/18 to 9/30/18. $8,411 must be spent from 10/1/18 to 6/30/19.
PE42-02	$6,542 must be spent from 7/1/18 to 9/30/18. $19,625 must be spent from 10/1/18 to 6/30/19.
PE46	PE46 7 Month award 9/1/18 to 3/31/19

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 E
Information required by CFR Subtitle B with guidance at 2 CFR Part 200

PE12: Public Health Emergency Preparedness

Funding Information Table

Federal Award Identification Number (FAIN):	Federal Funds
Federal Award Date:	TBD
Performance Period:	07/01/18-06/30/19
Federal Awarding Agency:	CDC
CFDA Number:	93.069
CFDA Name:	Public Health Emergency
Total Federal Award:	TBD
Project Description:	Public Health Emergency
Awarding Official:	TBD
Indirect Cost Rate:	16.41%
Research and Development (Y/N):	No

PCA: 53437

INDEX: 50407

Agency/Contractor	DUNS	Award
Yamhill	962184128	$90,237

PE43: Public Health Practice (PHP) - Immunization Services (Vendors)

Funding Information Table

Federal Award Identification Number (FAIN):	1805OR5ADM	State Fund Match
Federal Award Date:	10/1/2017	
Performance Period:	10/1/2017 - 9/30/2019	
Federal Awarding Agency:	CDC/Medicaid	
CFDA Number:	93.778	
CFDA Name:	Medical Assistance	
Total Federal Award:	2097876	
Project Description:	Immunization Medicaid	
Awarding Official:	N/A	
Indirect Cost Rate:	N/A	
Research and Development (Y/N):	No	

Agency/Contractor	DUNS	Award	Award	Total FY 2019
Yamhill	962184128	$14,401.50	$14,401.50	$28,803

PE46: RH Community Participation & Assurance of Access

Funding Information Table

Federal Award Identification Number (FAIN):	PA-FPH-18-001	TBD
Federal Award Date:		
Performance Period:	7/1/2018 - 8/31/2018	
Federal Awarding Agency:	DHHS OPA	
CFDA Number:	93.217	
CFDA Name:	Family Planning Services	
Total Federal Award:	$3,590,000	
Project Description:	Community Participation in Delivery and Assurance of Access to Reproductive Health Services	
Awarding Official:		
Indirect Cost Rate:	16.41%	
Research and Development (Y/N):	No	
PCA:	52746	TBD
INDEX:	50333	50333

Agency/Contractor	DUNS	Amount	Amount	Total
Yamhill	962184128	$0	$15,905	$15,905

B.O. 18-422
Exhibit "A"