PUBLIC HEALTH BOARD MEETING

735 S 200 W, Blanding, Utah 84511. Conference Room
July 22, 2024 at 12:00 PM

AGENDA

The public will be able to view the meeting on Google Meet.

Virtual Meeting Option

Video call link: https://meet.google.com/exx-kvbx-zhg
Or dial: (US) +1 971-770-1592 PIN: 725 724 776#

CALL TO ORDER

APPROVAL OF MINUTES

1. San Juan County Board of Health Minutes - June 20, 2024

PUBLIC COMMENT

BUDGET UPDATE

BUSINESS ACTION ITEMS

2. Consideration and approval of the San Juan County - Minimum Performance Standards SFY22 Amendment 3

3. Consideration and approval of the Public Health Emergency and Healthcare Preparedness Programs FY 24-28 - San Juan County Health Department

4. Health Officer Annual Review (Closed Session)

5. Set Board Meeting Schedule (Times and Locations) for 12 months)

DIRECTOR'S REPORT

6. WIC 2023 Report

INFORMATIONAL/RECOGNITION ITEMS

7. Board of Health Training Resources by Commissioner Harvey

- National Association of Counties - The County Role in Public Health
- Utah Association of Local Boards of Health (sent by noreply@myabsorb.com -- email kjones@ualhd.org to gain updated access)
- Mentoring from other Local Boards of Health
- Public Health Infrastructure funds

CONFIRM FUTURE MEETING TIME & LOCATION

ADJOURNMENT

In compliance with the Americans with Disabilities Act, persons needing auxiliary communicative aids and services for this meeting should contact the San Juan County Clerk's Office: 117 South Main, Monticello or telephone 435-587-3223, giving reasonable notice

PUBLIC HEALTH BOARD MEETING

1-BFP East Conference Room Blanding Family Practice Community Health Center, 910 S 300 W, Blanding, Utah
June 20, 2024 at 12:00 PM

AGENDA

The meeting will take place and be broadcast from 1-BFP East Conference Room in the Blanding Family Practice Community Health Center at 910 S 300 W, Blanding, Utah.

People may join virtually at this Video call link: https://meet.google.com/gar-tkvc-pit Or dial: (US) +1 231-769-0837 PIN: 320 055 912#

CALL TO ORDER at 12:17

Present:

Ron Skinner (Board Vice Chair)

Lois Young (Board Member)

Sylvia Zhonnie (Board Member)

Commissioner Jamie Harvey (Board Member)

Grant Sunada (Public Health Director)

Bridget Horrocks (Staff)

Revina Talker (Virtual - Board Member)

Tyler Ketron (Staff)

APPROVAL OF MINUTES and Agenda

1. March 2024 San Juan County Board of Health Minutes

Motion to approve: Lois

Second: Sylvia

All in favor

PUBLIC COMMENT- No public Comments

DIRECTOR'S REPORT

2. May 2024 Monthly Report by Grant Sunada, Public Health Director

Dr. Sunada discussed recent and upcoming events

3. 2023 Annual Report by Grant Sunada, Public Health Director (and Public Health team, as needed)

   Slyvia requested for comparison of annual reports statistics and asked for statistics for diabetes for 2023.

BUSINESS ACTION ITEMS

4. Nomination of Chairperson and Vice Chairperson, Presentation by Grant Sunada, Public Health Director, and Ron Skinner, Board of Health Vice Chairperson

   Discussed Steph Hiatt's application for board

   Motion: Lois

   Second: Sylvia

   All in favor

   Dr. Sunada recommended Ron Skinner as Chair and Sylvia as Vice Chair. Both accepted.

   Motion to vote for Ron Skinner as Chair: Lois

   Seconded: Sylvia

   Jamie and Revina voted in favor

   Ron abstained

   Motion to vote Sylvia as Vice Chair: Lois

   Seconded: Jamie

   Ron and Revina voted in favor

   Sylvia abstained

   Ron Skinner circled back to San Juan Public Health AC Unit dilemma from the Monthly Report. Questioned if another company besides Redd Mechanical could fix it.

5. Consideration and Approval of Medical Reserve Corps Contract, Presented by Grant Sunada, Public Health Director

Motion to approve: Sylvia

Seconded: Lois

All in favor

6. Monticello Cancer Screening Program Update by Grant Sunada, Public Health Director

Chair Skinner expressed concern about how the Screening Program is being managed by the county.

Commissioner Harvey asked if the Public Health Department had had a marketing plan.

Dr. Sunada said that the Department's marketing plan for the Cancer Screening Program had been presented to and approved by the HRSA (Health Resources and Services Administration - the funding agency), Victims of Mill Tailings Exposure committee, the Board of Health, and the County Commission.

7. Health Officer Annual Evaluation

San Juan County Human Resources recommended that the Board use the same process as last year. Board Chair Skinner and Vice Chair Zhonnie will review and administer survey questions developed by the Utah Association of Local Boards of Health to San Juan Public Health Sta

BOARD MEMBER REPORTS

White Mesa to be involved and have a meeting in White Mesa. Concern has been internet service but we are getting star link and that may be a solution.

CONFIRM FUTURE MEETING TIME & LOCATION

July 22nd at noon at San Juan Public Health Department Conference Room

Motion to adjourn: Lois

Second: Sylvia

All in favor

ADJOURNMENT at 2:31pm

In compliance with the Americans with Disabilities Act, persons needing auxiliary communicative aids and services for this meeting should contact the San Juan County Clerk's Office: 117 South Main, Monticello or telephone 435-587-3223, giving reasonable notice

SAN JUAN COUNTY

COMMISSION STAFF REPORT

MEETING DATE: July 22, 2024

ITEM TITLE, PRESENTER: Approval of San Juan County - Public Health Minimum Performance Standards SFY22 Amendment 2 by Grant Sunada, Public Health Director

RECOMMENDATION: Approval

SUMMARY

Use these funds to comply with Utah Administrative Code, Rule R380-40, Local Health Department (LHD) Minimum Performance Standards, including the following highlights:

2-4 '"Minimum performance standards" means the minimum duties performed by local health departments for public health administration, personal and population health, environmental health, and emergency preparedness in addition to the powers and duties listed in Section 26A-1-114….'

R380-40-6 "... county must demonstrate to the department that it can meet the minimum performance standards set out in this rule through the use of county and local funding sources in order to enter into a contract with the department for allocation state funds pursuant to Section 26A-1-115 and R380-50."

"…county shall demonstrate to the department it: (a) has the revenue within the county budget at the time the local health department begins operation to: (i) employ the following full time employees: (A) a health officer…; (B) a registered nurse…; (C) an environmental health scientist…; and (D) a business manager… and… human resources. (ii) assure … physician oversight…; (iii)...either a part-time or full-time basis: (A) a health education on specialist…; (B) an individual with epidemiology experience…; (b) assure business operations support to include a minimum budget/finance and human resources; (c) provide, equip, and maintain suitable offices, facilities, and infrastructure; (d) ...has the commitment and ability to continue funding the health department with revenue from county and local funding sources at an amount not less than the amount needed for (a) above; (e) has adopted a county ordinance to create and maintain a local board of health and health department; (f) has a commitment from the county attorney to serve as the legal advisor to the health department"

HISTORY/PAST ACTION

Approval.

FISCAL IMPACT

The funding for July 1, 2024 to June 30, 2025 will be $163,603.00 in state funds advanced in quarterly installments. Proposed use of the funding includes $86,555.20 toward public health administrative costs, $10,819.40 toward local epidemiology, and $10,819.40 toward community health assessment.

Requirements include submitting the County's annual per capita contribution to local health department for delivery of minimum performance standards no later than September 1 of each year. This contract requires that the County "ensure that the state contribution does not exceed the county contribution."

The combination of local and state funding for Public Health Minimum Performance Standards qualifies San Juan Public Health for the remaining 85% of funding in the form of LHD grants.

Utah Department of
Health & Human Services

UTAH DEPARTMENT OF HEALTH & HUMAN SERVICES
CONTRACT AMENDMENT

PO Box 144003, Salt Lake City, Utah 84114
288 North 1460 West, Salt Lake City, Utah 84116

2118107	212702557
Department Log Number	State Contract Number

1. CONTRACT NAME: The name of this contract is San Juan County - Minimum Performance Standards SFY22 Amendment 3.

2. CONTRACTING PARTIES: This contract amendment is between the Utah Department of Health & Human Services (DHHS) and San Juan County (CONTRACTOR).

PAYMENT ADDRESS
San Juan County
735 S 200 W, Ste 2
Blanding UT, 84511

MAILING ADDRESS
San Juan County
735 S 200 W, Ste 2
Blanding UT, 84511

Vendor ID: 06866HL
Commodity Code: 99999

3. PURPOSE OF CONTRACT AMENDMENT: The purpose of this amendment is to increase the contract amount, replace Attachment "A" and replace the Amendment language in the General Provisions in exchange for continued services. General Provisions Article 4, is hereby replaced in its entirety to read: “Amendments to this agreement must be in writing and signed by the parties except for the following for which written notification from the Department will constitute an amendment to the agreement without the Contractor signature; 1) change to the total agreement amount or rates; and 2) changes to financial reporting requirements”.

4. CHANGES TO CONTRACT:

1. The contract amount is being changed. The original amount was $388,157.00. The funding will be increased by $163,603.00 in state funds. New total funding is $551,760.00.
2. Attachment "A", effective July 1, 2024, is replacing Attachment "A" which was effective July 2023. The document title is changed. The reference to SUBRECIPIENT is changed to Contractor and the reference to the DEPARTMENT is changed to DHHS throughout the document. Article “III” Funding, Section A. is changed and Section A.4. is added, Article "V" Responsibilities of the Contractor, Section B. and C. are changed, and Section D. is added, Article "VI" Outcomes is changed, and, Article "VI" Amendments and Termination is deleted.
3. The termination date of this contract is being changed from 6/30/2026 to an evergreen date.

All other conditions and terms in the original contract and previous amendments remain the same.

5. EFFECTIVE DATE OF AMENDMENT: This amendment is effective 07/01/2024.

6. DOCUMENTS INCORPORATED INTO THIS CONTRACT BY REFERENCE BUT NOT ATTACHED:
   A. All other governmental laws, regulations, or actions applicable to services provided herein.
   B. All Assurances and all responses to bids as provided by the CONTRACTOR.
   C. Utah Department of Health & Human Services General Provisions and Business Associates Agreement currently in effect until 6/30/2028.

7. This contract, its attachments, and all documents incorporated by reference constitute the entire agreement between the parties and supersedes all prior written or oral agreements between the parties relating to the subject matter of this contract

Contract with Utah Department of Health & Human Services and San Juan County**, Log #** 2118107

IN WITNESS WHEREOF, the parties enter into this agreement.

CONTRACTOR

By: _____ _____
Jamie Harvey Date
County Commission Chair

STATE

By: _____ _____
Tracy S. Gruber Date
Executive Director, Department of Health & Human Services

Attachment A: Scope of Work

San Juan County - Minimum Performance Standards SFY22 Amendment 3

1. GENERAL PURPOSE:
   A. The general purpose of this contract is to provide public health services required by the Utah Administrative Code, R380-40, Local Health Department Minimum Performance Standards.

2. DEFINITIONS:
   A. "Contractor" means San Juan County on behalf of its health department.
   B. "DHHS" means Utah Department of Health and Human Services.

3. FUNDING:
   A. New total funding is $551,760.00.
      1. $58,180.00 for the period July 1, 2021 to June 30, 2022.
      2. $166,374.00 for the period July 1, 2022 to June 30, 2023.
      3. $163,603.00 for the period July 1, 2023 to June 30, 2024.
      4. $163,603.00 for the period July 1, 2024 to June 30, 2025.
   B. DHHS agrees to advance up to 25% of the annual award each quarter to the Contractor.
   C. DHHS agrees to adjust the fourth quarter payment to reflect actual expenditures submitted by the Contractor.

4. INVOICING:
   A. In addition to the General Provisions of the Contract, the Contractor must create a column in the Monthly Expenditure Report for the following category.
      1. MPS.
   B. In addition to the General Provisions of the Contract, the Contractor must submit the June invoice no later than July 15 of each year.

5. RESPONSIBILITIES OF THE CONTRACTOR:
   The CONTRACTOR must:

   A. Use these funds to comply with Utah Administrative Code, Rule R380-40, Local Health Department Minimum Performance Standards.
   B. Complete the Minimum Performance Standards Attestation Checklist no later than July 1 each year.
   C. Submit the County's annual per capita contribution to the local health department for delivery of minimum performance standards to the Utah Association of Local Health Departments no later than July 1 of each year.
   D. Ensure that the state contribution does not exceed the county contribution.

6. OUTCOMES:

The desired outcome of this contract is to maintain local public health infrastructure to perform essential public health services through exercising the powers outlined in 26A-1-114 to promote and protect the health and well-being of local communities.

A. Performance measure: Improved public health capacity in local communities.
B. Reporting: The Contractor shall submit the Minimum Performance Attestation Checklist each year.

San Juan Public Health Department
CY2024 Budget Proposal Summary

	2023	2024 CURRENT
Total Local Public Health Fund	$141,487	$141,487*
Local Mental Health Authority Request	-$90,898	-$94,374
Total Local Funds Remaining for Public Health Department	$50,589	$47,113*
Transfer TO Health Fund from County	$119,141	**$116,490***
County Minimum Performance Standards "Match" for Public Health	$166,374	$163,603
State Minimum Performance Standards Funding	$166,374	$163,603
TOTAL COUNTY CONTRIBUTION TO PUBLIC HEALTH	$169,730	**$163,603***

* Assuming Total Local Public Health Fund remains the same

- 75.5% (1.45M) of total Public Health revenue (1.92M) are cost-reimbursed
- Funding and fulfilling Utah Minimum Performance Standards qualifies us for federal funding and allows us to effectively and fully use grant funds
- Vital Records costs and a large portion (41%) of Environmental Health costs are covered by fees, local Public Health Tax, and State Minimum Performance Standard funding
- Public Health Emergency Preparedness and Preschool Development Grant matches are within the Minimum Performance Standards "match."

Uses of Local Public Health and State Minimum Performance Standards (MPS) Funding	
STATE MPS	
Administration (to reduce indirect rate)	$92,155.20
Community Health Needs Assessment	$5,751.96
Epidemiologist (~10% of FTE)	$10,000.00
Environmental Health Overspent	$6,692.84
Vital Records Overspent	$49,003.00
Total State Expenditures	**$163,603.00**
Total State Revenue - Expenditures	**$0.00**
LOCAL	
Administration (9% FTE)	$12,366.64
Staff Coordination Meetings (2hr/month)	$17,232.48
Nursing Director (25% FTE)	$28,945.76
Environmental Health Director (25% FTE)	$30,583.71
Health Promotion Director (25% FTE)	$27,970.82
Other Outside of Contract ($10,000 for WIC)	$18,742.59
Public Health Emergency Preparedness Match (10% of Total)	*$11,761.00*
Preschool Development Grant Match (30% of Total – Allows for in-kind)	*$9,000.00*
Total Local Expenditures	**$156,603.00**
Total Local Revenue - Expenditures	**$10,000.00**

COMMISSION STAFF REPORT

MEETING DATE: July 22, 2024

ITEM TITLE, PRESENTER: Consideration and Approval of the Public Health Emergency and Healthcare Preparedness Programs FY 24-28 contract between the Utah Department of Health and San Juan County, Presented by Grant Sunada, Public Health Director

RECOMMENDATION: Approval

SUMMARY

The general purpose of this contract is to provide for the continuation of activities designed to develop, sustain, and demonstrate progress toward achieving fifteen public health preparedness capabilities as they pertain to the local public health department's purview. These capabilities are Community Preparedness, Community Recovery, Emergency Operations Coordination, Emergency Public Information and Warning, Fatality Management, Information Sharing, Mass Care, Medical Countermeasure Dispensing and Administration, Medical Material Management and Distribution, Medical Surge, Nonpharmaceutical Interventions, Public Health Laboratory Testing, Public Health Surveillance and Epidemiological Investigation, Responder Safety and Health, and Volunteer Management.

HISTORY/PAST ACTION

Approval

FISCAL IMPACT

The service period of this contract is 07/01/2024 through 06/30/2025. The Deparment of Health and Human Services agrees to reimburse $125,610.00 with federal funds, in accordance with the provisions of this contract.

Budgeting requires a local match of 10% of the grant amount. This amount will be $12,561.00. Subrecipient's matching funds may be provided directly (through Subrecipient staff time) or through donations from public or private entities, which may be cash or in kind, fairly evaluated, including plant, equipment, or services. Per an email from the Department of Health of Human Services, this match may also count toward the Public Health Minimum Performance Standards (26A-1-114) county contribution.

Note: the Public Health Minimum Performance Standards contract requires that the County "ensure that the state contribution does not exceed the county contribution."

Utah Department of Health & Human Services

UTAH DEPARTMENT OF HEALTH & HUMAN SERVICES
CONTRACT

PO Box 144003, Salt Lake City, Utah 84114
288 North 1460 West, Salt Lake City, Utah 84116

2416416	242701411
DHHS Log Number	State Contract Number

1. CONTRACT NAME: The name of this contract is Public Health Emergency and Healthcare Preparedness Programs FY 24-28 - San Juan County Health Department

2. CONTRACTING PARTIES: This contract is between the Utah Department of Health & Human Services (DHHS) and San Juan County (CONTRACTOR).

PAYMENT ADDRESS
San Juan County
735 S 200 W, Ste 2
Blanding UT, 84511

MAILING ADDRESS
San Juan County
735 S 200 W, Ste 2
Blanding UT, 84511

Vendor ID: 06866HL
Commodity Code: 99999

3. GENERAL PURPOSE OF CONTRACT: The general purpose of this grant is to develop, sustain, and demonstrate progress toward achieving fifteen public health and the healthcare preparedness capabilities as they pertain to the local public health department's purview.

4. CONTRACT PERIOD: The service period of this contract is 07/01/2024 through 06/30/2025, unless terminated or extended by agreement in accordance with the terms and conditions of this contract.

5. CONTRACT AMOUNT: The DHHS agrees to pay $125,610.00 in accordance with the provisions of this contract. This contract is funded with 100% federal funds, 0% state funds, and 0% other funds.

6. CONTRACT INQUIRIES: Inquiries regarding this contract shall be directed to the following individuals:

CONTRACTOR CONTACT:
Grant Sunada
(435) 587-3838
gsunada@sanjuancounty.org

DHHS CONTACT:
Michelle R. Hale
(801) 419-8892
mhale@utah.gov

7. SUB – RECIPIENT INFORMATION:

UEI: WCVABP2FEVA2 Indirect Cost Rate: 0%

Federal Program Name:	Public Health Emergency Preparedness (PHEP) Cooperative Agreement	Award Number:	1 NU90TU000051-01-00
Name of Federal Awarding Agency:	CDC Office of Financial Resources	Federal Award Identification Number:	NU90TU000051
Assistance Listing:	Public Health Emergency Preparedness	Federal Award Date:	6/12/2024
Assistance Listing Number:	93.069	Funding Amount:	$117610

Federal Program Name:	Hospital Preparedness Program (HPP) Cooperative Agreement	Award Number:	5-U3REP190560 -01
Name of Federal Awarding Agency:	ASPR Acquisition Management Contracts and Grants	Federal Award Identification Number:	U3REP190560
Assistance Listing:	National Bioterrorism Hospital Preparedness Program	Federal Award Date:	6/30/2024
Assistance Listing Number:	93.889	Funding Amount:	$8000

8. REFERENCE TO ATTACHMENTS INCLUDED AS PART OF THIS CONTRACT:

Attachment A: Attachment A - PHEP-HPP
Attachment B: Attachment B - PHEP Base
Attachment C: Attachment C - MRC

9. DOCUMENTS INCORPORATED INTO THIS CONTRACT BY REFERENCE BUT NOT ATTACHED:
   A. All other governmental laws, regulations, or actions applicable to services provided herein.
   B. All Assurances and all responses to bids as provided by the CONTRACTOR.
   C. Utah Department of Health & Human Services General Provisions and Business Associates Agreement currently in effect until 6/30/2028.

10. This contract, its attachments, and all documents incorporated by reference constitute the entire agreement between the parties and supersedes all prior written or oral agreements between the parties relating to the subject matter of this contract.

Intentionally Left Blank

Contract with Utah Department of Health & Human Services and San Juan County**, Log #** 2416416

IN WITNESS WHEREOF, the parties enter into this agreement.

CONTRACTOR

By: _____ _____
Jamie Harvey Date
County Commission Chair

STATE

By: _____ _____
Tracy S. Gruber Date
Executive Director, Department of Health & Human Services

Attachment A: Scope of Work for Local Health Departments

Public Health Emergency Preparedness (PHEP) and

Hospital Preparedness Program (HPP) Cooperative Agreements

Public Health Emergency and Healthcare Preparedness Programs FY 2024-2028

Article 1

GENERAL PURPOSE

1.1 General Purpose. The general purpose of this grant is to develop, sustain, and demonstrate progress toward achieving fifteen public health and the healthcare preparedness capabilities as they pertain to the local public health department's purview.

Article 2

DEFINITIONS

Definitions. In this grant the following definitions apply:

"**ASPR**" means the federal Administration for Strategic Preparedness and Response.

"**Budget Period**" refers to the 12-month period beginning July 1 through June 30.

"**Budget Period 1**" refers to the first Budget Period, July 1, 2024, through June 30, 2025 of the 2024-2028 Project Period.

"**Carryover**" means unspent or unobligated balance of funds from prior Budget Periods that the Grantee may request to use in the current Budget Period.

"**CDC**" means Centers for Disease Control and Prevention.

"**Clinical Care**" means to directly managing the medical care and treatment of patients.

"**Cooperative Agreement**" means the federal Hospital Preparedness Program (EP-U3R-24-001) and Public Health Emergency Preparedness Program Cooperative Agreement (CDC-RFA-TU-24-0137).

"**HPP**" means Hospital Preparedness Program.

"**Local Health Department Preparedness Deliverable Tracker**" means the living report that encompasses all required LHD program deliverables for each program.

"**MCM**" means Medical Countermeasures which are FDA-regulated products (biologics, drugs, devices) that may be used in the event of a potential public health emergency.

"**No-Cost Extension**" means unspent or unobligated balance of funds from a prior Project Period that the Grantee may request to use in the current Project Period.

"**NOFO**" means notice of funding opportunity.

"**PHEP**" means Public Health Emergency Preparedness.

"**Project Period**" means the 5-year period of the 2024-2029 Cooperative Agreement, July 1, 2024, through June 30, 2029.

Article 3

CONTACT INFORMATION

3.1 For general programmatic questions, contact:

The Preparedness Grants General Email Box

prepgrants@utah.gov

3.2 For financial or budget assistance, contact:

Jerry Edwards, Financial Manager

Office of Fiscal Operations, Utah Department of Health and Human Services

(801) 538-6647

jedwards@utah.gov

Article 4

SERVICE REQUIREMENTS

4.1 The Grantee shall:

(1) follow programmatic and reporting requirements for each program as outlined in attachments B-C;

(2) submit all programmatic and reporting requirements to DHHS via email at prepgrants@utah.gov; and

(3) comply with current SAFECOM guidance. Additional information may be found at https://www.cisa.gov/safecom.

Article 5

DELIVERABLE TRACKING

5.1 DHHS acknowledges and documents the completion of the Grantee's programmatic and reporting requirements within the Local Health Department Preparedness Deliverable Tracker.

5.2 Changes to programmatic and reporting requirements that occur within the contract duration will be documented within the Local Health Department Preparedness Deliverable Tracker, and will supersede the programmatic and reporting requirements as listed in the succeeding attachments. The Grantee will be notified electronically of any changes to programmatic and reporting requirements and will utilize the Local Health Department Preparedness Deliverable Tracker to reference these changes.

Article 6

FUNDING

6.1 Funding.

(1) Budget Period 1: $125,610.00.

6.2 Budget Description:

(1) Attachment B - Public Health Emergency Preparedness (PHEP-Base) $117,610.00

(2) Attachment C - Medical Reserve Corps (HPP-MRC) $8,000.00

Article 7

INVOICING

7.1 **Invoicing**. The Grantee shall:

(1) identify each funding source in the monthly expenditure report.

(2) submit a final monthly expenditure report for the June funding transfer by a date in July provided by DHHS each fiscal year (typically the 6th business day in July).

Article 8

EXTENSIONS AND CARRYOVER

8.1 In the event that federal guidance provides a No-Cost Extension or Carryover of funds to DHHS, the Grantee may request a No-Cost Extension or Carryover of unobligated funds from the current Budget Period to the next Budget Period.

8.2 Requests are due by the Grantee to DHHS within 30 days as requested by DHHS. This date fluctuates annually and is at the discretion of ASPR and the CDC.

8.3 There is no guarantee new funds will be available to continue activities in the succeeding Budget Period(s).

8.4 Carryover limits shall be in accordance with the annual limits set by the CDC and ASPR. For the term of this grant, the Carryover limit is set at 100%.

8.5 DHHS will provide notification of approved No-Cost Extension or Carryover funding requests to the Grantee via email.

8.6 The Grantee shall use any approved No-Cost Extension or Carryover funds for DHHS-approved work plan activities which are consistent with the purpose or terms and conditions of the federal award to the recipient.

8.7 Approved No-Cost Extension or Carryover funds must be fully expended by June 30 of the following Budget Period. For example, Budget Period 1 ends on June 30, 2025, and approved Budget Period 1 Carryover funds must be fully expended by June 30, 2026.

8.8 The Grantee shall submit an end-of-year progress report encompassing all Carryover funded activities completed during the current Budget Period. This report is due to DHHS by August 15, annually.

Article 9

BUDGET REDIRECTIONS

9.1 The Grantee shall submit budget redirection requests to DHHS no later than March 15 annually.

9.2 All redirection requests must include:

(1) revised budget;

(2) revised work plan (if any activities are changed due to the funds adjustment); and

(3) justification statement for the request, including an explanation of budget and workplan items that were changed to accommodate the adjustment.

Article 10

USE OF FUNDS FOR RESPONSE

10.1 These funds are intended primarily to support preparedness activities that help ensure state and local public health departments are prepared to prevent, detect, respond to, mitigate, and recover from a variety of public health and healthcare threats.

10.2 **PHEP Funds for Response**:

(1) PHEP funds may, on a limited, case-by-case basis, be used to support response activities to the extent they are used for their primary purposes: to strengthen public health preparedness and enhance the capabilities of state, local, and tribal governments to respond to public health threats.

(2) Some PHEP planning activities may have immediate benefits when conducted or performed simultaneously with an actual public health emergency. It is acceptable to spend PHEP funds on PHEP planning activities that benefit the response effort, as long as the activities demonstrably support progress toward achieving CDC's 15 public health preparedness and response capabilities and demonstrate related operational readiness.

(3) The Grantee and DHHS must receive approval from CDC to use PHEP funds during response for new activities not previously approved as part of their annual funding applications or subsequent budget change requests.

(A) The approval process may include a budget redirection or a change in the scope of activities. Prior approval by the CDC grants management officer (GMO) is required for a change in scope under any award, regardless of whether there is an associated budget revision.

(B) Any change in scope must also be consistent with the Cooperative Agreement's underlying statutory authority, Section 319C-1 of the PHS Act, applicable cost principles, the notice of funding opportunity, and DHHS and Grantee applications, including the jurisdictional all-hazards plans.

(4) **HPP Funds for Response**

(A) The Pandemic and All-Hazards Preparedness and Advancing Innovation Act amended section 319C-2 of the Public Health Service Act (**"PHS"**) to allow HPP funds to be used for response activities. The Grantee, on a limited, case-by-case basis requiring prior approval from DHHS, shall use HPP funds to support response activities to the extent they are used for HPP's primary purpose: to prepare the health care delivery system for disasters and emergencies and to improve surge capacity.

(B) The Grantee may request to use funds for response if the response activities:

(i) are consistent with approved project goals, and/or;

(ii) can be used to fulfill training or exercise requirements, as described within the NOFO exercise and improve section; and

(iii) ASPR may issue guidance during specific events that may provide additional flexibility.

Article 11

FUNDING RESTRICTIONS

11.1 Expenses incurred during the grant period must support activities conducted during the same period.

11.2 The funding restrictions are as follows:

(1) Recipients may not use funds for research;

(2) Recipients may not use funds for Clinical Care except as allowed by law;

(3) Generally, recipients may not use funds to purchase furniture. Any such proposed spending must be clearly identified and justified in the budget;

(4) Reimbursement of pre-award costs is not allowed;

(5) Other than for normal and recognized executive-legislative relationships, no funds may be used for:

(A) 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; or

(B) 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;

(6) The Grantee shall perform a substantial role in carrying out project outcomes and not merely serve as a conduit for an award to another party or provider who is ineligible;

(7) Grantees may supplement but not supplant existing state or federal funds for activities described in the budget;

(8) Payment or reimbursement of backfilling costs for staff is not allowed;

(9) None of the funds awarded to these programs may be used to pay the salary of an individual at a rate in excess of Executive Level II or $199,300 per year;

(10) Funds may not be used to purchase or support (feed) animals for labs, including mice;

(11) Funds may not be used to purchase a house or other living quarters for those under quarantine. Rental may be allowed with approval from the CDC OGS via DHHS;

(12) Grantees may, with prior approval, use funds for overtime for personnel directly associated and budgeted with the project;

(13) Grantees may not use funds for construction or major renovations;

(14) Funds may not be used to purchase over-the road passenger vehicles. Grantee may, with prior approval;

(A) use funds to lease vehicles to be used as a means of transportation for carrying people or goods, e.g., passenger cars or trucks and electrical or gas-driven motorized carts during times of need;

(B) use funds to enter into formal transportation agreements with commercial carriers for moving medical materials, supplies, and equipment; and

(C) use funds to purchase material-handling equipment (MHE) such as industrial or warehouse-use trucks to move materials, such as forklifts, lift trucks, turret trucks, etc. Vehicles must be of a type not licensed to travel on public roads;

(D) Grantees may, with prior approval, purchase basic (non-motorized) trailers.

(15) The Grantee may not use funds to purchase promotional clothing. The Grantee may purchase clothing used for personal protective equipment (PPE) or response purposes, if it can be re-issued;

11.3 **Vaccines**: With prior CDC approval, Grantees may use funds to purchase caches of antibiotics for use by public health responders and their households to ensure the health and safety of the public health workforce during an emergency response, or an exercise to test response plans. Funds may not be used to supplant other funding intended to achieve this objective.

(1) With prior CDC approval via DHHS, Grantees may use funds to purchase caches of vaccines for public health responders and their households to ensure the health and safety of the public health workforce;

(2) With prior CDC approval via DHHS, Grantees may use funds to purchase caches of vaccines for select critical workforce groups to ensure their health and safety during an exercise testing response plans:

(A) Grantees must document in their submitted exercise plans the use of vaccines for select critical workforce personnel before CDC will approve the vaccine purchase;

(3) Grantees may not use PHEP funds to supplant other funding intended to achieve these objectives;

(4) Recipients of PHEP-funded vaccines (within the context of the exercise) may include:

(A) Persons who meet the criteria in the CDC-Advisory Committee on Immunization Practices (**ACIP**") recommendations www.cdc.gov/vaccines/acip/index.html for who should receive vaccine; and

(B) Persons who are not eligible to receive the vaccine through other entitlement programs such as Medicare, Medicaid, or the Vaccines for Children (VFC) program:

(i) VFC-eligible children or Medicare beneficiaries may participate in the exercise; however, they should be vaccinated with vaccines purchased from the appropriate funding source;

(5) Funds may not be used to purchase vaccines for seasonal influenza mass vaccination clinics or other routine vaccinations covered by ACIP schedules;

(6) Funds may not be used to purchase influenza vaccines for the general public;

(7) On a case-by-case basis and only with CDC prior approval via DHHS, PHEP funds may be used to purchase limited supplies of vaccines for emergency response activities that help jurisdictions strengthen their public health preparedness and response capabilities. This purchase should only be used when necessary for the rapid distribution and administration of medical countermeasures such as during a supply disruption (section 2802 of the PHS Act);

(8) Recipients may not use funds for Clinical Care except as allowed by law. PHEP-funded staff may administer MCMs such as antibiotics or vaccines as a public health intervention in the context of an emergency response or an exercise to test response plans. CDC does not consider this Clinical Care since it is not specific to one.

Article 12

PHEP FUNDED PUBLICATIONS

12.1 CDC Copyright Interests Provisions and Public Access Policy requires that all final, peer-reviewed manuscripts developed under the PHEP award upon acceptance for publication follow policy as provided on page 67, section 16 entitled, “Copyright Interests Provisions” of the Public Health Emergency Preparedness (PHEP) Cooperative Agreement award CDC-RFA-TU-24-0137.

Article 13

ASPR FUNDED PUBLICATIONS

13.1 All Grantee publications, including research publications, press releases, other publications or documents about research that is funded by ASPR must include the following two statements:

(1) A specific acknowledgment of grant support, such as:

(A) "Research reported in this [publication/press release] was supported by the Hospital Preparedness Program, administered by the Utah Office of Preparedness and Response and the Department of Health and Human Services Office of the Administration for Strategic Preparedness and Response under award number (NU90TU000051 [PHEP] or TBD [HPP]).”; and

(B) A disclaimer that says: "The content is solely the responsibility of the authors and does not necessarily represent the official views of the Department of Health and Human Services Office of the Administration for Strategic Preparedness and Response."

Attachment B: Public Health Emergency Preparedness (PHEP) Base

Public Health Emergency and Healthcare Preparedness Programs FY 2024-2028

Article 1

GENERAL PURPOSE

1.1 The Grantee shall use Public Health Emergency Preparedness (PHEP) funding to strengthen the capacity and capability of the local public health system to prepare for, respond to, and recover from public health threats and emergencies through a continuous cycle of planning, organizing, training, equipping, exercising, evaluating, and implementing corrective actions.

Article 2

DEFINITIONS

2.2 Definitions. In this grant the following definitions apply:

"ASPR" means the federal Administration for Strategic Preparedness and Response.

"**Budget Period**" refers to the 12-month period beginning July 1 through June 30.

"**Budget Period 1**" refers to the first budget period, July 1, 2024, through June 30, 2025 of the 2024-2028 Project Period.

"**Budget Period 2**" refers to the second budget period, July 1, 2025, through June 30, 2026 of the 2024-2028 Project Period.

"**Budget Period 3**" refers to the third budget period, July 1, 2026, through June 30, 2027 of the 2024-2028 Project Period.

"**Budget Period 4**" refers to the fourth budget period, July 1, 2027, through June 30, 2028 of the 2024-2028 Project Period.

"**Budget Period 5**" refers to the fifth budget period, July 1, 2028, through June 30, 2029 of the 2024-2028 Project Period.

"**CDC**" means Centers for Disease Control and Prevention.

"**CFR**" means the Code of Federal Regulations.

"**CHEMPACK**" containers of nerve agent antidotes and supplies that can be quickly accessed by first responders and medical professionals in a chemical incident.

"**IPP**" means Integrated Preparedness Plan.

"**MCM**" means Medical Countermeasures.

"**PHEP**" means Public Health Emergency Preparedness.

"**Project Period**" means the 5-year period of the 2024-2029 Cooperative Agreement, July 1, 2024, through June 30, 2029.

"**Public Health Preparedness Capabilities**" means the fifteen capabilities specific to public health as identified by the CDC and referenced in the Cooperative Agreement, titled Public Health Preparedness Capabilities: National Standards for State and Local Planning, found at https://www.cdc.gov/readiness/media/pdfs/CDC_PreparednesResponseCapabilities_October2018_Final_508.pdf.

Article 3

APPROACH

3.1 The Grantee will use the Public Health Emergency Preparedness and Response Capabilities, which

describe the 15 capability standards designed to support jurisdictions, and the Response Readiness

Framework, which identifies 10 cross-cutting program priorities, to design, develop, and implement

the outlined strategies and activities to improve their readiness to execute plans, respond to public

health threats and emergencies, and recover from them. The outlined strategies include:

(1) prioritize a risk-based approach to all-hazards planning and improve readiness, response, and recovery capacity for existing and emerging public health threats;

(2) improve whole community readiness, response, and recovery through enhanced partnerships and improved communication systems for timely situational awareness and risk communication; and

(3) improve capacity to meet jurisdictional administrative, budget, and public health surge management needs and to improve public health response workforce.

Article 4

SERVICE REQUIREMENTS

4.1 The Grantee's PHEP work plan and budget shall meet all requirements defined in this section and shall be evaluated by DHHS against the following criteria:

(1) whether the work plan narrative adequately describes planned activities for the project and/or budget period;

(2) whether the budget and work plan have a reasonable relationship, correlation, and continuity, where applicable, with data from past performance;

(3) whether the work plan includes adequate planned activities to prioritize, build and sustain public health capabilities and address the program priorities of the Response Readiness Framework (RRF);

(4) whether the work plan includes adequate planned activities which reflect progress to coordinate public health preparedness program activities and leverage program funding;

(5) whether the budget line-items contain sufficiently detailed justifications and cost calculations; and

(6) the completeness of the work plan and budget:

(A) DHHS agrees to review the PHEP work plan and budget.

(B) Following the initial review, DHHS staff may contact the Grantee to collect additional information if needed.

(C) Any programmatic questions regarding the submission requirements should be directed to the contact listed in Attachment A.

4.2 The Grantee shall submit a PHEP work plan to DHHS:

(1) The work plan is due to the DHHS by July 31, annually.

(2) The work plan shall include the program requirements listed in this Program Requirements.

(3) DHHS agrees to provide the PHEP work plan template via email thirty (30) days before the due date.

(4) The work plan must describe planned activities for each budget period within the five-year project period, and include:

(A) Continuing efforts to build and sustain the 15 Public Health Preparedness Capabilities found at https://www.cdc.gov/cpr/readiness/capabilities.htm;

(B) Activities to support the RRF program priority areas outlined in the Programmatic Requirements; and

(C) The goal of measurable progress toward achieving improved public health readiness, response, and recovery capability that follows standardized emergency management practices.

4.3 The Grantee shall submit progress reports to DHHS twice a year on activities performed.

(1) The mid-year progress report is due annually for each budget period by January 15, and:

(A) includes the performance period of July 1 through December 31 within the budget period;

(B) be fully completed by updating all mid-year progress report sections of the work plan; and

(C) include a progress report on PHEP work plan activities or changes and performance measurement activities.

(2) The end-of-year progress report is due annually for each budget period by August 15, and:

(A) Encompasses the performance period of July 1 through June 30 within the budget period;

(B) Be fully completed by updating the end-of-year progress report sections of the work plan; and

(C) Include an outcome report on PHEP work plan activities and performance measurement activities.

4.4 **Grantee Budget Requirements.** The Grantee shall:

(1) provide a detailed line-item budget and line-item justification of the funding amount to support program activities and reflect the 12-month budget period;

(2) use DHHS' provided budget template and submit to prepgrants@utah.gov by July 31, annually; and

(3) perform a substantial role in carrying out the project objectives.

4.5 **Grantee shall use funds to:**

(1) participate in the National Association of County and City Health Officials (NACCHO) Project

Public Health Ready recognition program, if desired;

(2) matching of Federal Funds. The Grantee shall:

(A) provide non-federal contributions as a match, in the amount of 10% of the grant reimbursed amount:

i. Grantee shall include the 10% match on the submitted budget and include narrative about the match.

(B) send signed documentation certifying non-federal contributions to prepgrants@utah.gov, using a form provided by DHHS, no later than July 31, annually;

(C) refer to 45 CFR § 75.306 for match requirements, including descriptions of acceptable match resources. Grantee's documentation of match shall follow procedures for generally accepted accounting practices and meet audit requirements.

(D) Grantee's matching funds may be provided directly (through Grantee staff time) or through donations from public or private entities, which may be cash or in kind, fairly evaluated, including plant, equipment, or services; and

(E) Amounts provided by the federal government or services assisted or subsidized to any significant extent by the federal government may not be included in determining such non-federal contributions.

Article 5

EVIDENCE-BASED BENCHMARK

5.1 CDC PHEP has defined program benchmarks as a method of accountability. Failure by DHHS or the Grantee to substantially meet a benchmark will subject the state to withholding of up to 30% of future funding.

5.2 **Benchmarks.** The Grantee shall:

(1) submit your pandemic influenza plan or integrated respiratory pathogen pandemic plan;

(2) submit a multiyear integrated preparedness plan (IPP);

(3) update the jurisdictional risk assessment to identify and prioritize populations that are potentially disproportionately impacted because of access and functional needs given the identified risks;

(4) include partners that represent prioritized populations in planning and exercises; and

(5) include communication objectives when exercising to identify and address misinformation and disinformation.

Article 6

PROGRAMMATIC REQUIREMENTS

6.1 **Risk assessment.** The Grantee shall complete and submit a risk assessment and data elements.

(1) The Grantee will utilize the Jurisdictional Risk Assessment (JRA) completed in budget period 5 of the previous project period and submit CDC-identified risk assessment data elements; and

(2) If needed, review and update the risk assessment to include people who are disproportionately impacted by public health emergencies.

6.2 **Planning.** The Grantee will develop, maintain, and update the following plans (which may be included as annexes or components in larger plans) at least once every 3 years. To the extent possible, the Grantee shall identify key data systems and data sources necessary to meet jurisdictional needs during an emergency response and include this information in emergency response plans:

(1) All-hazards preparedness and response plan;

(2) Infectious disease response plan;
(3) Pandemic influenza plan or integrated respiratory pathogen pandemic plan;

(4) Medical countermeasures (MCM) distribution and dispensing plan;

(5) Continuity of operations (COOP) plan;

(6) Chemical, biological, radiological, and nuclear (CBRN) response plan;

(7) Volunteer management plan;

(8) Crisis and Emergency Risk Communications (CERC) and information dissemination plans; and

(9) Administrative and budget preparedness plan.

6.3 Integrated Preparedness Plan. The Grantee will complete and submit a multiyear integrated preparedness plan (IPP) and data elements. The Grantee shall:

(1) conduct an integrated preparedness planning workshop (IPPW) for your organization and produce a 5-year IPP;

(2) include planning, training, and exercising priorities and integrate the exercise requirements into the IPP;

(A) the IPP must address the pandemic influenza plan (benchmark).

(3) participate in DHHS's annual integrated preparedness planning workshop (IPPW), as scheduled; and

(4) incorporate recovery operations into public health multiyear IPP.

6.4 **Exercises.** The Grantee shall:

(1) schedule, develop and conduct required exercises.

(2) use the CDC Exercise Framework Supplemental Guidance to develop exercise objectives and

adhere to the criteria outlined within the guidance document:

(3) determine the 5-year exercise schedule and document the dates in the IPP:

(A) the following exercises must be completed by June 30, 2029:

(i) administrative preparedness discussion-based exercise;

(ii) biological incident track:

(a) Biological incident (100); and
(b) Biological 200 functional exercise;

(iii) Capstone track:

(a) Capstone (100) Capstone 200 drill

(b) Capstone 300 functional exercise

(c) Capstone 400 full-scale exercise

(iv) Optional participation in DHHS facilitated discussion-based exercises for:

(a) Chemical incident

(b) Radiological/Nuclear incident

(c) Natural disasters

(d) This is not optional for Cities Readiness Initiative (CRI) awarded grantees.

6.5 **Medical countermeasures.** The Grantee shall maintain capacity and capability to distribute, dispense, administer medical countermeasures (MCMs) and manage medical materiel according to Public Health Emergency Preparedness and Response Capabilities: National Standards for State, Local, Tribal, and Territorial Public Health and ASPR Strategic National Stockpile (SNS) guidelines.

(1) If applicable, participate in review and updates of the DHHS CHEMPACK plan if there is a CHEMPACK in the Grantee's jurisdiction.

6.6 Partnerships. The Grantee shall include critical response and recovery partners in required plans and exercises.

6.7 **Risk communications.** The Grantee shall:

(1) develop or update crisis and emergency risk communication (CERC) and information dissemination plans, or risk communications plan;

(2) identify and implement communication surveillance, media relations, and digital communication strategies in exercises; and

(3) identify and implement specific CERC activities that meet the diverse needs of communities of focus.

6.8 Administrative preparedness. The Grantee shall:

(1) update administrative preparedness plans using lessons learned from emergency responses; and

(2) integrate administrative preparedness recommendations into training and exercises.

6.9 **Workforce.** The Grantee shall:

(1) complete training to ensure baseline competency and integration with preparedness requirements;

(2) develop plans, processes, and procedures to hire, recruit, train, and retain a highly qualified and diverse workforce; and

(3) provide guidance, direction, and training to maintain a ready responder workforce across the entire health department.

Article 7

OUTCOMES

7.1 **Outcomes.** The desired outcome of this grant as outlined in the CDC PHEP logic model is to prevent or reduce morbidity and mortality for all impacted populations from incidents with public health consequences whose scale, rapid onset, or unpredictability stresses the public health system. Short- and medium-term outcomes include:

(1) improved public health readiness, response, and recovery capability that follows standardized emergency management practices;

(2) implemented timely public health recommendations and control measures for all hazards;

(3) earliest identification and investigation of incidents with public health impact;

(4) timely communication of situational awareness and risk information;

(5) timely coordination and support of response and recovery activities with health care systems and partners;

(6) integrated equity into public health response and recovery;

(7) increased hiring and retention of surge staff resources; and

(8) prepared public health workforce ready to sustain public health investigations, response, and recovery.

7.2 **Performance Measure.** The Grantee shall:

(1) submit all performance measure data required by CDC PHEP:

(A) DHHS agrees to provide the required performance measure data elements as soon
as they are released by CDC PHEP, and no later than 30 days prior to the due date.

7.3 Reporting. The Grantee shall submit progress reports and program data, including descriptions of:

(1) progress in meeting the evidence-based benchmark;

(2) accomplishments that demonstrate the impact and value of the PHEP program in Grantee's jurisdiction;

(3) incidents requiring activation of the emergency operations center;

(4) activities on which PHEP funds were spent and the recipients of the funds;

(5) the extent to which stated goals and objectives as outlined in the PHEP work plan have been met;

(6) the extent to which funds were expended consistently with the funding applications; and

(7) situational awareness data during emergency response operations and other times as requested.

Attachment C: Medical Reserve Corps (MRC)

Public Health Emergency and Healthcare Preparedness Programs FY 2024-2028

Article 1

GENERAL PURPOSE

1.1 The Grantee shall use project funding to build and sustain the Medical Reserve Corps (MRC) in support of the healthcare system and Utah's Healthcare Coalitions (HCC).

Article 2

DEFINITIONS

2.3 Definitions. In this grant the following definitions apply:

"**Budget Period**" refers to the 12-month period beginning July 1 through June 30.

"**HCC**" means regional health care coalition.

"**MRC**" means Medical Reserve Corps.

"**Project Period**" means the 5-year period of the 2024-2029 Cooperative Agreement, July 1, 2024, through June 30, 2029.

"**Utah Responds**" means the Utah ESAR-VHP system.

Article 3

SERVICE REQUIREMENTS

3.1 **Service Requirements**. The Grantee shall:

(1) submit a work plan annually for each budget period within the five-year project period:

(A) the work plan shall be completed using a DHHS-provided template and address

the items listed in Program Requirements;

(B) DHHS agrees to provide the work plan template via email no later than thirty (30) days before the due date; and

(C) the work plan is due annually on July 31.

3.2 **Progress Report.** The Grantee shall:

(1) submit an annual end-of-year progress report for each budget period:

(A) the end-of-year progress report is due to the DHHS annually by August 15 and encompasses the performance period of July 1 through June 30 using the end-of-year fields within the work plan; and

(B) the end-of-year report will include a progress update on work plan activities and program requirements.

3.3 Work plan and budget submission requirements.

(1) The Grantee's work plan and budget shall meet all requirements defined in this Special Provisions attachment and will be evaluated by DHHS using the following criteria:

(A) whether the work plan narrative adequately describes planned activities;

(B) whether the work plan includes adequate planned activities to monitor and demonstrate Hospital Preparedness Program (HPP) performance measures;

(C) whether the work plan includes adequate planned activities that reflect progress to coordinate public health and healthcare preparedness program activities and leverage program funding streams;

(D) whether the budget line items contain sufficiently detailed justifications and cost calculations; and

(E) the completeness of the work plan and budget.

(2) DHHS agrees to review the submitted work plan.

(A) Following the initial review, DHHS staff may call or email Grantee's MRC Coordinator to collect additional information if needed.

(B) Any programmatic questions regarding the submission requirements should be directed to the contact listed in Attachment A.

3.4 Detailed line-item budget and justification.

(1) Grantee's budget is due to DHHS annually by July 31 or within 30 days of agreement execution, whichever is later, and shall:

(A) include a detailed line-item budget and line-item justification of the funding amount requested to support program activities for the upcoming budget period;

(B) provide a budget reflective of a 12-month budget period; and

(C) use the DHHS-provided budget template.

(2) DHHS agrees to provide a budget template via email no later than thirty (30) days before the due date.

Article 4

PROGRAM REQUIREMENTS

4.1 The Grantee shall:

(1) review their MRC unit profile annually and report at least quarterly for activities on the Administration for Strategic Preparedness and Response (ASPR) MRC Profile and Activity Reporting System at https://mrc.hhs.gov/login;

(2) provide additional information to support performance measure reporting, as requested;

(3) use Utah Responds, or a DHHS-approved alternate volunteer management system, for:

(A) enrollment;

(B) credentialing;

(C) tracking; and

(D) deployment of its MRC Unit.

(4) maintain a regular schedule to review and update MRC member profiles in the volunteer management system;

(5) develop, sustain, and revise volunteer management plans, to include at a minimum:

(A) volunteer recruitment and retention; and

(B) member roles and responsibilities for healthcare response such as:

(i) triage support staff;

(ii) emergency department staff;

(iii) medical shelter clinical staff;

(iv) search and rescue medical staff;

(v) field hospital clinical staff;

(vi) other items as determined by the HCC need and gap assessment; and

(vii) MRC Unit deployment and demobilization guidelines.

(6) participate as a member of its jurisdiction's HCC to address medical and facility response issues, including:

(A) identifying situations that would necessitate the need for volunteers in health care organizations;

(B) identifying processes to assist with volunteer coordination;

(C) estimating the anticipated number of volunteers and health professional roles based on identified situations and resource needs of the facility;

(D) identifying and addressing volunteer liability issues, the scope of practice issues, and third-party reimbursement issues that may deter volunteer use; and

(E) development of rapid credential verification processes to facilitate emergency response.

(7) provide opportunities for member training, education, and participation in exercises. These opportunities may include, but are not limited to:

(A) new member orientation and initial training;

(B) participation in call-down or deployment drill or exercises; and

(C) participation in the HCC and other community medical response exercise events.

4.2 The Grantee's MRC Unit Coordinator shall participate in state-level MRC leadership meetings and workshops.

4.3 With prior approval from the DHHS, the Grantee may use allocated funds to support MRC unit and member Core Competency implementation.

Article 5

OUTCOMES

5.1 Outcomes. The desired outcome of this grant is to strengthen the readiness of MRC volunteers across the state to provide surge capability and workforce capacity for public health and healthcare emergency response to support the community, HCC, and the LHD.

5.2 Performance Measures.

(1) Number of new volunteers recruited and retained volunteers annually; and

(2) Number of annual training sessions held for MRC volunteers; and

(3) Number of community events held annually; and

(4) Number of exercises leveraging MRC units.

5.3 Reporting. The Grantee shall provide annual progress reporting to DHHS.

San Juan Public Health WIC Report for 2023 to June 2024

Month	% Benefited*	# of Participants with Benefits
January	79.2%	207
February	82.0%	205
March	82.4%	204
April	80.2%	207
May	80.0%	210
June	82.5%	211
July	95.9%	195
August	91.3%	219
September	92.1%	229
October	89.4%	236
November	91.2%	226
December	91.5%	224
January 2024	93.24%	222
February 2024	92.14%	229
March 2024	91.77%	231
April 2024	91.89%	222
May 2024	87.72%	228
June 2024	85.96%	228

* Percent of participants with benefits (WIC card activated). Those without benefits missed a mid-certification or education class (once every 3 months).

SAN JUAN PUBLIC HEALTH

WIC July 2024 Participant Report

Year & Month	**Enrolled Individuals**	
2024 June	228	
2024 May	228	
2024 April	222	
Quarterly number of participants by Area	**Dec 2023**	**Jul 2024**
Monticello and LaSal	33	39
Blanding	110	108
Bluff, MC, Aneth, MV, and Mexican Hat	73	77
Family Appointments by Type	**May 2024**	**June 2024**
Certification (New to WIC)	9	10
Recertification	16	20
Mid Certification	6	10
Education	16	13
High Risk Follow Up	1	1

- WIC Benefits
  - WIC participants have “benefits” when they complete appointments every 3 months
  - WIC provides a nutritious and colorful variety of foods for your family. We offer great tasting items like yogurt, whole wheat pasta, and fresh fruits and vegetables. We also provide name brand breakfast cereals, juice, peanut butter, and many other healthy foods.

- Families on WIC receive a card that works like a debit card to purchase WIC foods. The WIC card makes shopping convenient and discreet! Click here to learn more about the WIC card.

- State Expectations
  - The number of participants benefited to be at or above 84%. Our percent benefited for San Juan Public Health is at 91.8%

- Appointment Policies and WIC Locations
  - When Public Health was housed in Monticello, WIC was available M-F because it was by appointment only.
  - When the Public Health office moved to Blanding, shifting to walk-in appointments are more culturally appropriate
  - The amount of time spent on WIC was the same, but it is concentrated on on WIC walk-in days
  - Now that Monticello has a WIC day (2nd Wednesdays), those are mostly by appointment only to fit the culture of Monticello
  - We are able to have virtual WIC appointments as long as we have referral data from their healthcare provider. This means that they would not have to come into our office for their appointment.
  - We are going to be an online state starting in August. That means we will be able to load participants' cards without them having to come into our office.

- Why Monticello WIC
  - Helps address need in Monticello for families without gas money.
  - Mobile WIC unit is more discreet and helps reduce the stigma
  - Extended COVID funds (through 2026) cover StarLink internet access and cover time and other costs by also making COVID testing available

- Next Goals
  - Expand to Bluff
  - Have a meeting on August 5th with the Mayor of Bluff to set up a day for our Mobile Van to do WIC appointments and COVID testing one day a month.

- Additional Information
  - We have community breastfeeding classes every 1st Wednesday of the Month.
  - We have a “Dr. Yum” nutrition class every 4th Wednesday of the Month at the Library Story Hour to teach kids about the importance of fruits and vegetables.
  - We donate unopened cans of formula to our local women's shelter.
  - We order special formula from the state contracted pharmacy for children that

have severe allergies, prematurity, or other eating difficulties.
    - Screen every mother who comes in for WIC for Perinatal Anxiety and Depression and have partnered with the University of Utah Moms Mental Health Program to get mothers the help and resources they might need. .
    - We have 3 breastfeeding peer counselors that are reaching out to every pregnant and postpartum mother on WIC to see if they have any breastfeeding concerns or questions.
    - This year is the 50th Anniversary for the WIC program.
    - We partner with our local Clinics and hospitals to keep them up to date on our health department resources that we have to offer.
    - We are partnering with the San Juan School District and Root for Kids Head Start on referring children who need extra help with Speech and Developmental Delays.
    - We work closely with our local Vendors to make sure our WIC participants are getting the formula and foods that they are allowed on the WIC program. This was a big concern of ours when the formula shortage was going on in 2022 through 2023. We worked with the State WIC office during this time and they were able to send us formula that our stores were not able to get in during this time.
    - We also have two IBCLCs on our WIC staff. IBCLC stands for International Board Certified Lactation Consultant. They are able to help any mother with breastfeeding issues, not just WIC participants.
    - At every WIC appointment we discuss nutrition concerns or questions a parent might have.
- Additional funding
    - During every WIC appointment we print off their child's immunization record and talk to mom about how they are doing with this and if they have any questions about immunizations.
    - During every WIC appointment we also talk to moms and dads about the importance of Lead screening for their children and how to avoid lead exposure.
    - $38,945.76 in annual funding from the San Juan County Contribution

NATIONAL ASSOCIATION of COUNTIES NACo

THE COUNTY ROLE IN PUBLIC HEALTH

FEBRUARY 2024

TABLE *of* CONTENTS

INTRODUCTION

Counties play a critical role in promoting and protecting the health of people and the communities in which they live, learn, work and play. As administrators and operators of the local health safety net, county agencies employ a wide range of public health services that protect resident health and well-being through the prevention of illness, injury and other adverse health outcomes.

A robust public health system centers equity and actively promotes policies, systems and overall community conditions that drive optimal health.[1]

Public health is an intersectional field that works to address the underlying causes of health outcomes. This work requires both intergovernmental collaboration between federal, state and local governments, as well as multisectoral partnerships across local government agencies.

This brief provides an overview of how counties provide integral public health services for all Americans, describes their public health authority, their role in preparedness and response efforts, and local public health efforts to address social determinants of health (SDOH) in our communities. The brief will also outline key federal policy recommendations for our federal partners to safeguard funding and authority for local public health services and programs.

10 Essential Public Health Services[1]

1. Assess and monitor population health status, factors that influence health and community needs and assets

2. Investigate, diagnose and address health problems and hazards affecting the population

3. Communicate effectively to inform and educate people about health, factors that influence it and how to improve it

4. Strengthen, support and mobilize communities and partnerships to improve health

5. Create, champion and implement policies, plans and laws that impact health

6. Utilize legal and regulatory actions designed to improve and protect the public's health

7. Assure an effective system that enables equitable access to the individual services and care needed to be healthy

8. Build and support a diverse and skilled public health workforce

9. Improve and innovate public health functions through ongoing evaluation, research and continuous quality improvement

10. Build and maintain a strong organizational infrastructure for public health

CHAPTER 1

COUNTY PUBLIC HEALTH INFRASTRUCTURE

Core functions of the Local Health Department [2,3]

Local Health Departments

Since the U.S. has a largely decentralized public health system, much of the responsibility for disease control and prevention falls on state and local health departments (LHD). Counties support the majority of America's approximately 2,800 local health departments and protect our residents' health, safety and quality of life.

SOCIAL DETERMINANTS OF HEALTH

Healthy People 2030 defines the social determinants of health (SDOH) as the conditions in which we are born, live, work and play that both directly and indirectly impact overall health and well-being. This framework also highlights five domains to organize the social determinants of health, including economic stability, education access and quality, health care access and quality, neighborhood and built environment and social and community context.

Approximately 70 percent of all local health departments are county-based, and another eight percent that serve multiple counties. Sixty-one percent of LHDs serve rural counties, or those with a population of less than 50,000 residents.[2]

With a shortage of rural health care providers and the closure of many rural health care facilities, LHDs are becoming an increasingly critical resource in these communities, providing essential health care services.

Additional Partners in the Local Public Health System

Local health departments are not doing this work alone, but in partnership with many other agency partners that make up the county public health system. **More than 95 percent of LHDs work with external partners like emergency responders, school systems, hospitals and others.[2]**

KEY COUNTY PARTNERS IN LOCAL PUBLIC HEALTH AND THEIR RESPECTIVE ROLES:

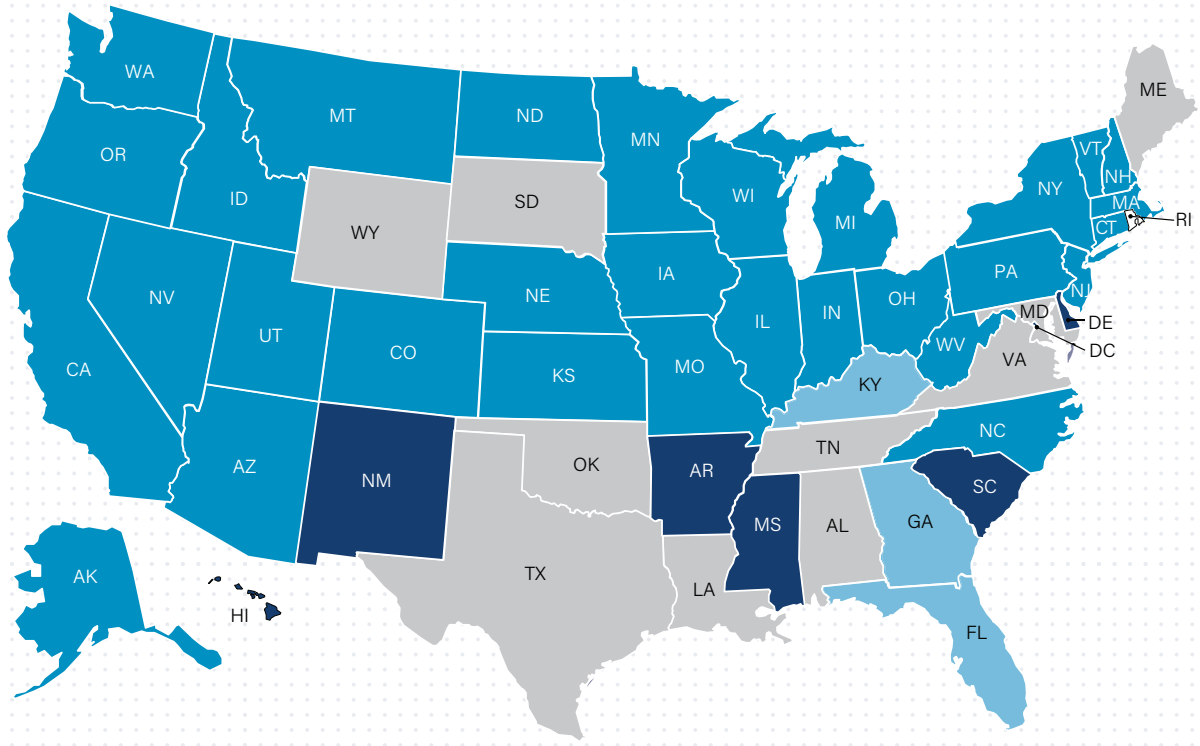
PARTNERS	PARTNERSHIP ROLE AND IMPORTANCE
Emergency Management Services (EMS)	EMS and first responders provide emergency medical care, promote public safety and security, and prevent real time death and injury during emergency situations.[4] EMS collaboration with LHDs is essential to get accurate data on emergencies, resident health and social determinants, and more. EMS is also an important partner for non-emergent care like vaccines, testing, planning responses to potential threats and acquiring the necessary resources to respond, such as PPE.[4]
K-12 Schools and Universities	K-12 schools assist LHDs by facilitation outreach to youth and families regarding available public health resources and interventions. Universities partner with LHDs and public health officials as thought leaders, providing resources to conduct research on public health issues impacting systems and populations and help to develop targeted solutions.
Local Government Partners	LHDs partner with many other sectors of local government to reach different populations and extend the reach of public health services to the jurisdiction. A common partner is the county human services department (if it is a separate entity), justice and public safety, parks and recreation, environment and natural resources, planning and development, transportation, and more. LHDs work collaboratively with all sectors of the local government and often serve as conveners of these systems to discuss the intersections of health and the respective field, as well as targeted solutions for the community.[5]
Hospitals	LHDs and hospitals have an important partnership, as they can collaborate and share their data on the local jurisdiction and patient populations to track risk factors, social determinants, chronic and infectious disease prevalence, and more. These relationships are also critical in times of crisis or large disease outbreaks when resources need to be coordinated to meet the need.
Community Health Centers	Partnerships with Federally Qualified Health Centers (FQHCs), Certified Community Behavioral Health Clinics (CCBHCs) and other community-based health centers are crucial for expanding access to shared resources, knowledge and data, and opportunities to collaborate on research like community health and needs assessments. These partnerships allow for greater capacity to assist residents in need and increase access to basic health and human services.[6]
Mental Health and Substance Use Providers	Mental health and substance use providers providers work with those with lived experience and can advocate on their behalf when making policy and programmatic decisions. They help to enhance connection to resources and services, while also bringing diverse perspectives to inform solutions, emergency preparedness planning, new initiatives, funding choices, etc.[7]
Community Health Workers (CHWs)	CHWs are trusted community members that work to connect people to culturally appropriate care, give informal counseling and guidance on health behaviors and facilitate communication between patients and health care providers. In some counties, CHWs can be known as promotores de salud, community health advisors, outreach workers, patient navigators and peer counselors.[8] CHWs are sometimes contracted through the LHD, while others are independent contractors.[9]

Counties support the majority of America's approximately 2,800 local health departments and protect our residents' health, safety and quality of life.

CHAPTER 2

ROLE OF PUBLIC HEALTH AUTHORITY

Type of LHD Governance by State[2]



RI was excluded from the study

N=2,459

- Local (all LHDs in state are units of local government)
- State (all LHDs in state are units of state government)
- Shared (all LHDs in state governed by both state and local authorities)
- Mixed (LHDs in state have more than one governance type)

Local health departments (LHDs) get their authority and much of their funding from the state government. State law dictates the responsibilities, funding, and scope of work of the LHD and what resources are available to address our community's public health concerns.

Across different states, a few common authority structures that exist are:[10]

- **Centralized/State:** The LHDs are a part of the state government
- **Decentralized/Local:** Local governments are the leaders of the LHDs

- **Mixed/Hybrid:** Mixture of local or state governed LHDs
- **Shared:** LHDs are governed by both state and local government

Beyond this distinction, there is even more variety in the authority and governance of LHDs. Up to one in five LHDs are combined into a Health and Human Services Agency (HHSA), instead of being a standalone health department, and 70 percent are governed by a local board of health (LBOH)[2]. It is more likely that if a state is decentralized, the LHD is governed by a LBOH, whereas those in a centralized state see their LBOH engage in more of an advisory role and are overseen by the state health agency.[11]

LBOHs receive authority from the state government and are often comprised of elected or appointed members who are meant to lead and oversee the delivery of public health services in their community. They can propose policy and rule recommendations and serve as an adjudicating body in the county or counties under the board's jurisdiction.[12] **The general role of LBOHs includes (but is not limited to):** [10, 13]

1. **Review and propose public health regulations**
2. **Recommend public health policies and priorities for the community and LHDs**
3. **Collaborate with LHDs on strategy and implementation**
4. **Ensure accountability to state statutes and other standards**
5. **Advocate for specific public health services based on community needs**

Public Health Authority Limitations

Since the COVID-19 public health emergency, the authority of state and local public health has changed dramatically. In many cases, this authority has become increasingly limited by local legislation. According to the Network for Public Health Law, from January 2021 to May 2022, a total of 185 laws were enacted to limit local public health authority. These laws include those that impact the authority of local health officials, address mask requirements, vaccines, and emergency measures, or shift authority between the state and local health officials. [14]

THE CENTER FOR PUBLIC HEALTH LAW NOTES THAT SINCE THEN, FROM MAY 2022 TO OCTOBER 2023[15]:

Out of 22 jurisdictions that have enacted a law to address authority to respond to public health emergencies, ***9 of those limit public health authority.***

7 states have also enacted laws that limit local health officials' authority *regarding public health emergency orders.*

Only ***4 jurisdictions*** *have enacted legislation to strengthen public health authority.*

Approximately 70 percent of all local health departments are county-based, and another eight percent that serve multiple counties

CHAPTER 3

COUNTY PUBLIC HEALTH IN ACTION

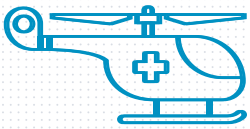
Snapshot: The Role of Local Public Health in Preparedness, Response and Recovery

Counties are on the frontlines of crises, working alongside state and federal partners to respond to natural disasters and public health threats. Emergency preparedness is a critical aspect of local public health. Disasters have broad consequences on the health and well-being of communities, often having downstream impacts to water quality, food security, environmental hazard exposures, increased flooding or extreme weather, loss of shelter, power outages, contact with animals and insects, increased injury or illness and more.[16]

During a disaster response, local public health is involved in various activities such as managing and communicating information, administering medical countermeasures (MCM) and personal protective equipment (PPE), managing surges, ensuring continuity of normal public health programs, conducting ongoing disease surveillance, and protecting vulnerable or at-risk populations.

At the federal level, the U.S. Department of Health and Human Services (HHS) has the legal authority for responding to public health emergencies. Within HHS is Office of the Assistant Secretary for Preparedness and Response (ASPR), created post-Hurricane Katrina, to adverse health effects of public health emergencies and disasters. Within ASPR, the Office of Emergency Management (OEM) provides resources and expertise to state and local communities to help them prepare for public health and medical emergencies.

*Since January of 2020, there have been **50 declarations of a public health emergency (PHE)** enacted by the U.S. Secretary of Health and Human Services, ranging from responding to COVID-19, wildfires, the opioid crisis, hurricanes, Monkey Pox, typhoons and severe storms.*[17]



*Since January 1, 2022, there have been **198 disasters declared**, most frequently for fires, severe storms, and flooding.*[18]

See below for an expanded list of critical functions of local public health entities in preparing for, responding to and recovering from disasters and other public health emergencies.[19, 20]

Preparedness

- Continued disease surveillance
- Creation and maintenance of a critical supply stockpile.
- Facilitate training for local residents, and employees
- Volunteer recruitment and training
- Communication on public health threats
- Plan response protocols
- Evaluate and test preparedness and response capacity
- General system maintenance and repairs
- Execute community health and hazard vulnerability assessments

Response

- Communicate and collaborate across sectors and jurisdictions
- Co-respond with other local emergency response agencies
- Communicate public health information to residents
- Support emergency shelters
- Distribute critical supplies
- Direct volunteer responders
- Participate in incident management through the EOC
- Care for vulnerable and at-risk population

Recovery

- Create and facilitate recovery plan
- Address resident and responder behavioral health needs
- Build future preparedness plans based on lessons learned
- Find gaps and pain points in response infrastructure
- Develop policies and partnerships to address identified gaps

Local public health and health departments often serve as the coordinating body of multiple systems to prepare and respond, convening emergency management, hospitals, emergency operation centers, and more. In this way, local public health is involved with a number of partners, not only to plan responses, but to enact response and recovery actions alongside local hospital system, emergency management teams and medical services, and other multi-sector partners.

KEY COUNTY PARTNERS IN PREPARDNESS AND RESPONSE AND THEIR RESPECTIVE ROLES:

PARTNERS	PARTNERSHIP ROLE AND IMPORTANCE
 **Emergency Management Services (EMS, emergency managers, etc.)**	EMS - First responders on the scene and trained to provide critical, rapid medical care in a variety of diisaster scenarios Emergency Managers - coordinate response efforts, public communications, various sector involvment, etc.
 **Medical Reserve Corps (MRC)**	Recruits and trains volunteer network to respond during disasters and public health emergencies Led by an MRC unit coordinator and matched to community needs, supporting a variety of public health preparedness and response functions locally
 **Local Health Departments or Agencies**	Collaborate with other sectors to mobilize a public health response Engage in disease surveillance, stockpile management and distribution, community preparedness and risk communication Assist alongside first responders and serve in the Emergency Operation Center (EOC).
 **Hospitals & Medical Personnel**	Provide rapid and essential medical care to communities Assist in providing care to injured or adversely impacted individuals during and following emergencies
 **Emergency Operation Centers (EOCs)**	Central location for coordinating emergency response and management Collects, analyzes, and shares information with responders and the public Supports resource procurement and allocation and policy decisions
 **Community Emergency Response Teams (CERTs)**	Educates volunteers on disaster preparedness Teaches basic response skills (ex. fire safety, search and rescue, medical operations, etc.)

MARICOPA COUNTY, ARIZ.: MEDICAL RESERVE CORPS EXPANSION[21]

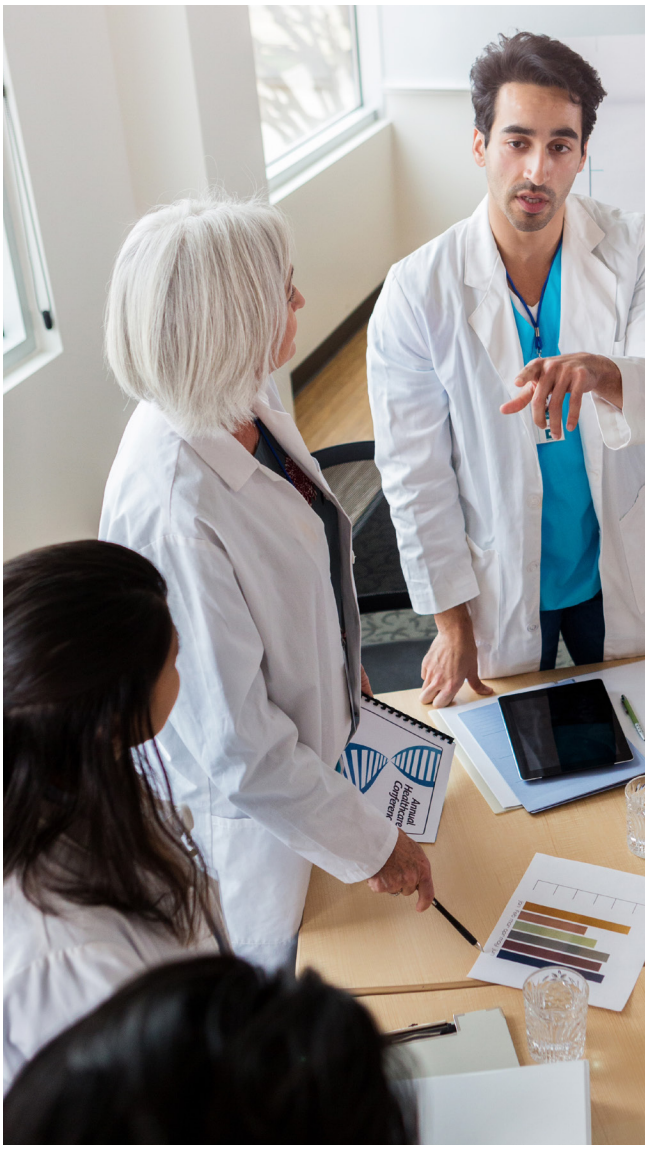
At the start of the COVID-19 pandemic, Maricopa County Department of Public Health (MCDPH) was experiencing an urgent demand for volunteers to respond to community needs from 2020-2022. To address this shortage of volunteers, the MCDPH Medical Reserve Corps (MRC) recruited and expanded their workforce from only 200 volunteers to over 27,000 at the peak in 2021. To date, the MCDPH MRC has over 12,000 registered volunteers in 2023, that consist of roughly half medical and half non-medical, demonstrating a continued high number of registered volunteers.

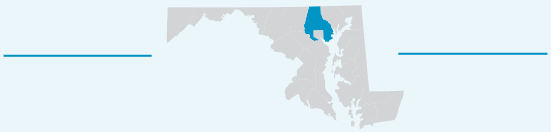
These MRC volunteers have filled critical needs with thousands of volunteer hours throughout the COVID-19 pandemic, including rapid response deployment to support vaccine clinics, tests and other clinical activities. The MRC volunteers were also used in response to the novel Monkeypox (MPXV) outbreak, supporting vaccine clinics as vaccinators and support staff to reach at-risk and underserved populations most effected by MPXV.

Overall, this unprecedented adaptation made by the MCDPH to expand the MRC volunteer workforce in response to needs identified during the COVID-19 pandemic response, have supported their continued response to new and emerging threats like MPXV and Dengue fever. Maricopa County, Ariz., as a result now has one of the largest MRC units that continues to support their response to a variety of public health and other emergencies.

Key Challenges in Public Health Preparedness and Response

- Lack of sustained and direct funding to local communities
- Outdated surveillance technology and data collection methods
- Siloed and outdated data systems
- Recruiting and retaining an adequate responder and public health workforce
- Building public trust and engaging at-risk stakeholders and vulnerable populations



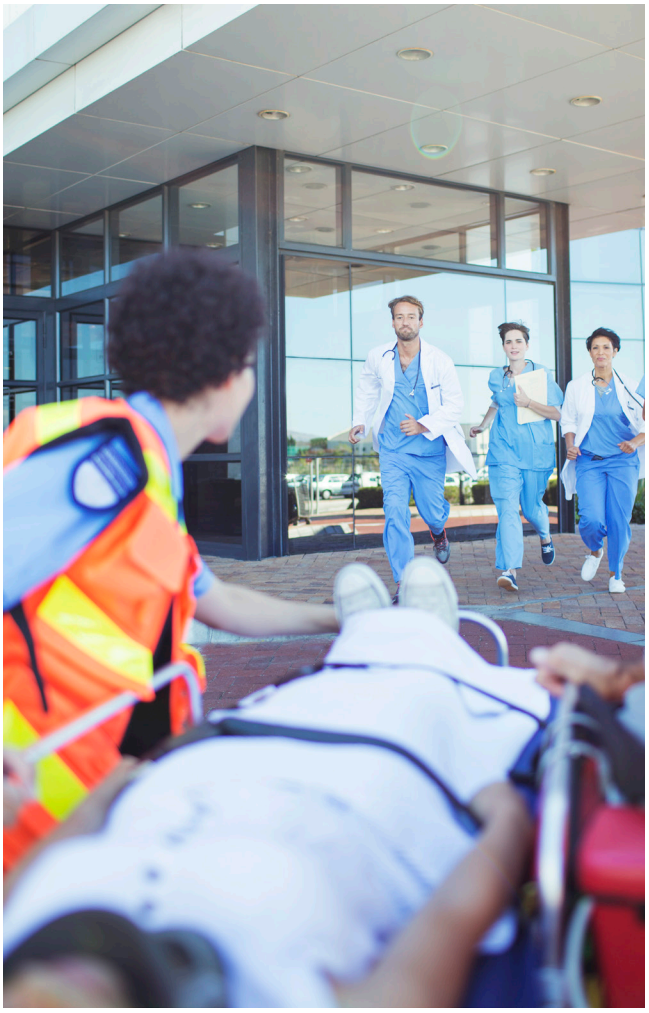


BALTIMORE COUNTY, MD.: COVID-19 MOBILE OPERATIONS OUTREACH VEHICLE (MOOV)[22]

Baltimore County's data team identified hot spots in the county down to the street level to increase vaccination rates for underserved areas. However, most of these locations were not suitable for a larger, mass-vaccination site. As a solution, Baltimore County created a small mobile strike team called "The MOOV" (Mobile Operations Outreach Vehicle) that could accommodate these locations. The Mobile Teams deployed a mechanism modeled after common practices used in the entertainment industry, such as live music, which allowed for greater numbers to be vaccinated in a shorter timeframe. All necessary materials, supplies, equipment, and even furniture were rapidly loaded into rolling work-box style road cases that allowed for an expeditiously coordinated mobilization. A small strike-team of staff quickly established a vaccination site in the hot spots and vaccinated up to 300 people over three hours with a skeletal crew dubbed Noah's Ark, which was comprised of two of each role including vaccinators, registrars, vaccine fillers, observation assistants, ushers, and logisticians who handled mobilization. Finally, a physician was added to help patients who had medical questions or other reasons for their hesitancy. Baltimore County anticipates that this unit will provide vaccines, testing, and other public health services to hard-to-reach demographics well beyond the COVID-19 response.

Snapshot: Impact of the Covid-19 Pandemic and Response

The COVID-19 pandemic posed a number of challenges for county public health resources and infrastructure. Despite the historically low investments in public health leading up to 2020, a dated infrastructure, and unpredictable resource allocations in response to disease outbreaks and disaster events, counties continued to actively innovate the way they deliver services and respond to a public health crisis.



COOK COUNTY, ILL.: HOUSING IS HEALTH: PARTNERING TO ESTABLISH A MEDICAL RESPITE CENTER[24]

Medical respite is defined as acute and post-acute medical care for persons experiencing homelessness who are too ill to recover on the streets, but not ill enough to be in a hospital.[25] Cook County Health (CCH) partnered to design, implement, and operate two Medical Respite Centers (MRCs) to address the needs of housing insecure patients, including COVID-19 positive individuals. The first MRC (MRC-SSY) was a partnership between CCH and the City of Chicago which served housing insecure COVID-19 positive adults who required a safe space for isolation. CCH designed and implemented the facility's infection control policies, a team-based approach with on-site and remote clinicians, and technology for data management, integration, and telehealth and the program successfully housed 51 clients for their full COVID-19 isolation period. In partnership with Housing Forward, CCH opened a second MRC (MRC-OP) in December 2020 which provides clinical oversight and operational support to 18-beds for post-acute care discharges. As of December 20, the MRC-OP accepted 15 of 17 referrals from health care partners, including CCH's Stroger Hospital, demonstrating the low-barrier for program entry.

Snapshot: Local Public Health and Health Equity

Counties are making concerted efforts to invest and improve health equity in their communities through their public health initiatives that aim to address the social determinants of health (SDOH). Counties are uniquely positioned to target SDOH with their access to data, connections to local leaders and decisionmakers, partnerships with other local services and community groups, convening power, and more[23]. These initiatives can include projects that target housing supports, programs that address health disparities, partnerships with community-based organizations and community health workers and more.

CHAPTER 4

KEY FEDERAL PROGRAMS AND POLICY RECOMMENDATIONS THAT SUPPORT LOCAL PUBLIC HEALTH

Counties support investments that enhance the local public health system's capacity to provide health promotion and injury and disease prevention services. Healthy communities depend upon a full array of interrelated county services and programs- which include access to healthy foods, community development plans, disaster preparedness and response and public works infrastructure projects that promote healthy living and access to affordable housing and shelter. Intergovernmental investments such as those recommended below, are the building blocks of better health outcomes, increased productivity and a reduction of disease related expenses for local governments.

1. PROVIDE FUNDING AND INCENTIVES TO RECRUIT AND RETAIN A DIVERSE PUBLIC HEALTH WORKFORCE.

Since 2008, LHDs have lost 21% of their workforce capacity and the COVID-19 pandemic has only exacerbated this decrease.[2] Many public health professionals have left the field due to burnout, low compensation, high levels of stress, and harassment from the public due to the COVID-19 response. For LHDs to continue to administer critical services to residents, continued funding and capacity building through workforce recruitment and retention must be supported. Unpredictable and insufficient federal investments, coupled with the stress of the COVID-19 pandemic response and the ongoing substance use crisis, have strained counties' ability to sustain core public health operations that keep residents healthy and safe. Local health departments which are underfunded and understaffed are less likely to be able to prepare and mobilize effectively, leaving our communities incredibly vulnerable. A strong workforce and consistent federal investments are essential to the overall health care infrastructure and ensure that our public health system operates efficiently and effectively.

2. PROTECT FUNDING FOR CORE LOCAL PUBLIC HEALTH SERVICES AND PREVENTION PROGRAMS.

Federal investments are responsible for nearly 25 percent of local health departments' revenue. Dedicated funding sources such as the Prevention and Public Health Fund (PPHF) are critical to helping counties support core local public health programs such as immunizations and chronic disease prevention. PPHF also invests in new and innovative programs tailored to the unique health problems facing our communities, including the underlying social determinants of health. Since the inception of the PPHF in FY 2010, new public health threats have emerged- such as substance use disorders and suicide epidemic, infectious disease outbreaks and increases in chronic illnesses- and federal resources have not kept pace. Despite funding essential public health work, the PPHF has already been cut by over $11.85 billion from FY 2013 – FY 2027. Further cutting PPHF funding, especially without increasing funding for local public health programs through regular appropriations, would negatively impact local public health departments already strained by having to respond to illness outbreaks like the current COVID-19 pandemic and the ongoing opioid crisis while maintaining core operations to keep residents healthy and safe.

3. EXPAND DIRECT TO COUNTY INVESTMENTS AND SUPPORT FOR BOLSTERING THEIR PUBLIC HEALTH PREPAREDNESS AND RESPONSE.

To meet the needs of residents, the local preparedness infrastructure must be upgraded as communities continue to face numerous environmental and natural disasters, alongside growing public health threats. Federal programs like the Centers for Disease Control and Prevention's Public Health Emergency Preparedness (PHEP) cooperative agreement program are essential in providing not only funding, but technical assistance and guidance, to help public health departments at all levels to better prepare and respond to public health threats and emergencies. In Fiscal Year (FY) 2022, the CDC awarded over $651.5 million in PHEP funding, primarily targeted at states. Given the significant role of counties in responding to disasters and emergencies, CDC and other federal agencies should ensure that local governments receive direct allocations or suballocations of PHEP resources to assist in the development of a more effective preparedness system in local communities, thereby strengthening the response capacity of our nation as a whole.

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