# 11 Mass Prophylaxis

# Mass Prophylaxis

## Capability Definition

The capability to protect the health of the population through administration of critical interventions in response to a public health emergency to prevent the development of disease among those who are exposed or are potentially exposed to public health threats. This capability includes the provision of appropriate follow-up and monitoring of adverse events medical care, as well as risk communication messages to address the concerns of the public.

## Capability Outcome

Appropriate drug prophylaxis and vaccination strategies are implemented in a timely manner upon the onset of an event, to prevent the development of disease in exposed individuals. Public information strategies include recommendations about specific actions individuals can take to protect their family, friends and themselves.

## Capability Discussion Points

When discussing and analyzing the NCR's homeland security preparedness capabilities, stakeholder participants should consider the following:

- The adequacy of mass prophylaxis and vaccination plans, with consideration to rate of set up and throughput.
- Whether or not these plans identify current and future resource requirements appropriately – such as the number, skill level, and availability of medical personnel, the impact of a nearby, secondary CBRNE/natural disaster, and the expiration of prophylactic supplies.
- The way in which public information messages are prepared and disseminated, how they provide information regarding how to protect oneself and how they should receive prophylaxis or vaccination (discuss how special emphasis is placed on reaching disenfranchised populations).
- Plans to enlist supplemental providers and volunteers. If no plans exist, consider how the NCR will enlist supplemental providers, security, and volunteers.
- Any legal issues that may arise with regard to standards of care in a mass prophylaxis campaign versus standards of care in a "normal" environment – i.e., immediate (licensing and credentialing), long-term (patients/public rights to recourse to adverse medical outcome), and occupational (needle stick injury to provider) legal issues should be addressed.
- The means/timing/technological requirements/technological barriers related to the delivery of public information messages.

## NCR Discussion Results on Mass Prophylaxis

| Resource | S/W | Comments |
|---|---|---|
| People | S | • The MRC. (6)<br>• Full time staff time is well trained, committed, and have participated in exercises (5)<br>• Strong core group of planners working on regional coordination; well exercised. (3)<br>• Curriculum is in place to train volunteers in mass prophylaxis activities (e.g., distribution).<br>• Strength of people in area; know how to handle emergencies.<br>• Successfully developed public information sharing mechanisms and messages.<br>• SNS planners are very knowledgeable and dedicated.<br>• Have good plans in place.<br>• Working well with all levels of the government to coordinate activities. |
| | W | • Need to continue recruiting, training, and credentialing volunteers for mass prophylaxis activities including PODs, home quarantine, etc. It is important to keep volunteers committed. (22)<br>• Priority needs to be placed on hospital staff and family receiving prophylaxis. (12)<br>• MRC needs to be funded. Number of volunteers need to be increased and there needs to be standardized training for volunteers across all jurisdictions. (8)<br>• Increase regional coordination of all relevant entities and planning for mass prophylaxis activities. (8)<br>• Increased number of health care staff (MDs, RNs, and pharmacy) is needed to be trained in mass prophylaxis activities. This will increase all capabilities and decrease competition for staff in emergency. (9)<br>• Need to perform study "gap analysis" to identify current number and skill level of MDs, RNs and pharmacy personnel in the region. (4)<br>• Need clear identification of EMS/fire role in distribution of mass prophylaxis. (4)<br>• Increased training needed in all areas, e.g. special needs response, dispersal, PPE training. (2)<br>• Need better way of sharing information in advance. Need a regional message. Need a coordinated communication process for all emergency agencies. (2)<br>• Need to increase the number of planners and staff to support mass prophylaxis. Need to incorporate lessons learned onto plans. (2)<br>• Need full time trainers and exercisers to support teaching mass prophylaxis activities in NCR. (2)<br>• Need to increase security and security training for non-law enforcement personnel to secure PODs.<br>• Need to consider special populations.<br>• Need system for credentialing volunteers<br>• Need to increase number of emergency preparedness staff.<br>• Need larger support from skilled volunteer force; can not rely on unskilled volunteers.<br>• Need system to identify credentialed people.<br>• Need to increase risk communication capabilities.<br>• Need increase support from other ESFs.<br>• Need to train more SNS planners for the NCR.<br>• Need increase in assessment<br>• Insufficient resources to support for staff of mass prophylaxis activities.<br>• Increase patient tracking is needed. |
| Equipment | S | • Much of needed equipment has been identified (3)<br>• Most prophylaxis equipment has been obtained (3)<br>• This is one of the easier categories to apply funding and this has been done in the NCR (2)<br>• Fit testing in place in some counties<br>• Have satellite phones/pagers/cells – all useful; had regional JIC, but I believe funding is going away |
| | W | • Lack of adequate storage for antibiotics, antivirals, vaccines, and other supplies (13)<br>• Need additional medical supplies for PODs and hospitals (13)<br>• Need tracking system for patients and supplies (10)<br>• Transportation capabilities for supplies and personnel is limited (7)<br>• There is inadequate communications equipment established (7)<br>• Pharmaceuticals need a better re-supply process (6)<br>• Need standardization of/distribution of equipment (6) |

| Resource | S/W | Comments |
|---|---|---|
| | | • No clear regional set of expectations for equipment; needs to be standardized across region (5)<br>• Need more PPE (4)<br>• Have not identified physical space to handle large number of patients (4)<br>• Need stronger logistical capabilities (4)<br>• Priority prophylaxis for first responders and fires receivers has not been adequately ensured (2)<br>• Lack of emergency power supplies (2)<br>• Need to address special needs, e.g., translation services (2)<br>• Lack of effective serialized equipment<br>• PODs are not interconnected<br>• Need to enhance and integrate response capability<br>• Need more money for management and prophylaxis<br>• Need database of volunteers<br>• Need laptops<br>• Lack of common decision making tools<br>• Need mobile unit to be available<br>• Lack interoperability<br>• Lack of equipment to support quarantine<br>• There is not a common decision support tool/no place to go to monitor equipment/coordinate resources/people etc.<br>• Do not have adequate number of hospital beds.<br>• PIO can only provide information once it is provided<br>• Volunteer supplies needed for MRC members, e.g., medical equipment, etc. |
| Training | S | • Training is on-going<br>• Progressive MRC training on-going<br>• Developing exercises<br>• People are resilient in the NCR<br>• Some hospitals in WHC have invested a lot of time in developing methods<br>• full time staff well trained<br>• Training/forums have been developed but we need more<br>• Have been able to conduct some small scale events |
| | W | • Have not optimized regional approach (23)<br>• Need behavioral health training (6)<br>• Not all resources are known by all groups (5)<br>• Need outline of what is required for volunteers (4)<br>• EMS roles (3)<br>• Educate staff/volunteers on operations of dispensing sites and hospital staff on recognition of disaster (3)<br>• Encourage disciplines to learn different skills (2)<br>• Many first responders can't get overtime for training (2)<br>• Keeping volunteers trained/ready is challenging; needs to be addressed (2)<br>• Training needs to be available to all ESF-8 (2)<br>• Need to train non & quasi-medical staff (2)<br>• Drills don't include Special Needs persons (2)<br>• Maryland law does allow governor to suspend licenses.  Need to pre-train some in the event of an emergency<br>• More flexible methods to develop training<br>• Don't have training academy for public health<br>• Need "Just-in-time" training for spontaneous volunteers<br>• Insufficient Training in IMS<br>• Not provided in hospital environment<br>• Special needs requirements<br>• Backfill approach does not apply well to public health<br>• No public awareness campaigns |

| Resource | S/W | Comments |
|---|---|---|
| | | • No conference held for Special Needs Person<br>• Don't have training to run multiple events<br>• POD volunteer disciplines<br>• POD security techniques training |
| Exercises/Evaluation | S | • Carrying out exercises. (8)<br>• Coordination of exercises increase propensity of volunteer sharing.<br>• PIOs are at the table while planning table-tops. |
| | W | • Need for different jurisdictions to train and exercise together to smooth out communication processes in case of an emergency. (9)<br>• Need to have joint (multi-ESFs or discipline) drills on a regular basis to implement plans for working together. (7)<br>• Infectious disease should be included in all other ESFs exercises. (5)<br>• Need an exercise for process volunteers and MRCs. (4)<br>• DAP analysis and other evaluation guidance needed to identify exercise needs. (4)<br>• Need training for SNPs. (2)<br>• Undefined roles for fire/ EMS. (2)<br>• No plan for IMT to help facilitate management of public health emergencies.<br>• Health care staff and agencies need training.<br>• Need table-top with top-level officials for appropriating antibiotics needed.<br>• Need exercises to test preparedness in hospital environments.<br>• Need regional exercise to evaluate where first receivers really stand.<br>• Need more exercises on public messaging.<br>• Need to include medical examiners in exercises.<br>• Need joint state and local drills.<br>• Need incident management training for public health personnel.<br>• Need more functional POD exercises.<br>• Need regional SNS.<br>• Need to exercise use of NCR triage barcode as a means to track victims from scene to hospital to communication of placement at the Red Cross.<br>• Need to improve after-action reports. |
| Plans, Policies and Procedures | S | • Have a solid all-hazards response plan and local plans (4)<br>• Jurisdictions have plans for operation of individual dispensing sites |
| | W | • Need for coordinated public information plan and public education plan that includes a medical component and reaches special populations (11)<br>• Need to transport volunteers – plan to do so/transport of people and drugs, e.g., flu vaccine, to PODs (including special populations) require planning and security (8)<br>• Dispensing plans are not fully developed and do not use a medical model/Need to develop baseline SOPs and mutual aid agreements/many legal questions with regional response that crosses state lines/need exercises as well (7)<br>• Lack of transparency in development of plans particularly at federal level (4)<br>• Medical Reserve Corps need to be connected to ESF #8 (3)<br>• Need to adopt IM (ICS) to ensure organizational approach to mass prophylaxis is in compliance with NIMS (2)<br>• Need to improve planning with hospitals and healthcare systems/need clear plan for provision of mass prophylaxis to health workers preferentially/plan for staffing sufficient to fully execute regional mass prophylaxis response/plan for hospital support/consistency among different health care providers and institutions<br>• Lack of clear authority regarding quarantine decisions |

## NCR Concept Papers and Initiative Plans

| CONCEPT PAPER<br><br>*Final* | January 25, 2005<br><br>Project Director: Gwendolyn T. Clerkley, Acting Health Officer<br>Prince Georges County Health Department<br>1701 McCormick Dr.<br>Largo, MD 20721<br>PH: 301-883-7819<br><br>Fiscal Manager:<br>Kimberly Y. Smith<br>PH: 301-883-7816<br><br>Author: Donna M. Foster, MRC Coordinator<br>Fairfax County Health Dept.<br>10777 Main St, Suite 320<br>Fairfax, Va. 22030<br>Tel: 703-246-8636<br>Email:donna.foster@fairfaxcounty. gov | | |
|---|---|---|---|
| **Project Title:** | **Surge Capacity for Public Health: Medical Reserve Corps in the National Capitol Region** | **Estimated Grant Amount** | $731,075 per year;<br>**$913,844 15 months of grant** |
| **NCR Strategic Goal Alignment:** | 2.4.1. Civic Involvement<br><br>**Target Capabilities Addressed: Mass prophylaxis; Medical Surge; Citizen participation** | **Allowability** | **This proposal does plan to allocate resources for personnel. A total of up to 8.0 FTE's for the participating jurisdictions are proposed.** |
| **Estimated Timeline** | May 2006 – Oct 2007 | **Dependencies and Cost Factors:** | This project will integrate the training component of this proposal with the ESF 8 Training Work Group |

**Problem Statement/Project Description:**

ESF 8 (Health and Medical) and ESF 15/16 (Volunteers) have collaborated to jointly endorse and submit this proposal to recruit, manage, and train Medical Reserve Corps (MRC) volunteers. This proposal builds on the UASI funding awarded for '05 as it adds an MRC sustainment objective. The MRCs are viewed as a critical public health resource by the Health Officers Committee as the MRCs provide the surge capacity for public health in the event of a bio-attack or other public health emergency such as Avian influenza. Since the MRCs are trained as public health volunteers and work under the direction and supervision, it is important that the MRCs be viewed as an essential component of ESF 8. It is important to underscore that these MRC volunteers have special and distinct roles that differ from those of the broader cadre of volunteers working with the other elements of the Citizen Corps and other volunteer groups.

MRC volunteers have already made significant contributions such as the Hurricane Katrina response locally and in the Gulf region, assistance with national events like the Reagan funeral and the inauguration in D.C. and also in providing flu vaccine to the community as was done in Loudoun County. The NCR has already MRC volunteers assist in other activities to help their local communities such as distribution of health promotion/disease prevention and emergency preparedness community education.

This proposal has two objectives: 1) to provide funding for local health departments or other MRC administrative bodies to sustain and further develop the Medical Reserve Corps; and 2) to coordinate across the NCR region on training,

credentialing, development of cross jurisdictional deployment protocols and procedures, mutual aid agreements, collaborate on regional recruitment strategies, and seek partnerships with area universities for training expertise and assistance.

Objective 1

At present, the Medical Reserve Corps operates in the following localities in the NCR: City of Alexandria, Arlington County, District of Columbia, Fairfax County (includes Falls Church and Fairfax cities), Loudoun County, Montgomery County, Prince Georges County and (under development in) Prince William County (includes Manassas and Manassas Park cities). Several of these programs will lose funding from DHHS in 2006 and others remain with no dedicated resources to focus on and develop the program.

It has been estimated that over 20,000 volunteers would be needed to accomplish mass prophylaxis distribution throughout the NCR.

At present, there are 5,277 MRC volunteers throughout the region, and of those, only 2,663 have received training. Deliverables for Objective 1 will be to increase total MRC membership and the number of trained MRC volunteers for 2006 to 6,793 total members with 4,165 of those trained, projected increases of 27% and 63% respectively. The principle that MRC's operate under is that if they can enroll and train about 40%-50% of the volunteers needed for entire population mass prophylaxis, then these trained persons can work along side spontaneous volunteers solicited by partner organizations under ESF -15 to get the job done.

In the event of a public health disaster, MRC's would be activated through their local public health department who would be the point of coordination for the local government response in collaboration with emergency management. If MRC's had insufficient resources to fully staff the response, spontaneous volunteers (medical and non-medical) would be solicited through local volunteer centers (ESF-15). MRC's units will receive, deploy, and train spontaneous volunteers solicited through the local volunteer centers.

The UASI 06 MRC project will continue collaboration with Citizen Corps Councils and its other programs (CERT, VIPS and Neighborhood Watch) and area volunteer centers begun under UASI 05 proposal 5D. The focus will be placed upon exploring opportunities to develop cross program cooperative ventures and ensure coordination of recruitment efforts undertaken by the partner organizations in ESF 15 so that MRC recruitment efforts are not duplicative.

Objective 2

A regional coordinator, operating as an independent contractor, would work with all participating jurisdictions MRC coordinators/directors, and a regional coordinating committee to bring MRC's into closer alignment in regard to training, regional outreach materials and credentials, and develop cross jurisdictional response protocols and procedures, and mutual aid agreements. The Coordinator will work with a regional project committee representing each MRC in the region along with representation of volunteer centers, Citizen Corps Councils and other important stakeholders. Special attention will be given to ensure that policies and procedures developed for the NCR do not run counter to those in place at the national and state levels. The regional coordinator will be responsible for administering this grant for Prince Georges County Health Department.

The deliverables for Objective 2 include; 1) common regional outreach material; 2) basic curriculum and training competencies for all MRC members throughout the NCR; 3) agreement for cross jurisdictional response and call up procedures;

**Preliminary Project Plan (Tasks, Resources, Deliverables, Collaborating Partners, etc.)**

| Task(s) | Owner(s) or Collaborating Partners | Deliverable(s) | Target Date(s) or Level of Effort |
|---|---|---|---|
| 1. Conduct targeted volunteer recruitment (includes personal contact, PSA's, direct mail, speaking engagements, news stories) | All MRC's; collaborating with Citizen Corps Council and local volunteer centers | 6793 total members (27% increase) | July 2006-Oct. 2007 |
| 2. Provide volunteer training (includes orientation, | All MRC's; collaborating with Red Cross, local health departments, state | 4165 trained members(63% increase | July 2006-Oct. 2007 |

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|---|---|---|---|
| operations at mass dispensing sites, disaster role training, emergency preparedness, incident command, training in potential disease agents, etc.) | health departments, area universities and other training resources | | |
| 3. Develop common outreach material | Regional Coordinator (consultant); collaborating with all MRC's and local health departments and state health departments | Common regional outreach materials for all MRC's. | July 2006-Dec. 2006 |
| 4. Determine basic training competencies and curriculum provided through several medium (in-person, web-based, CD's); this project will use information derived from the ESF 8 training assessment proposal | Same as # 3; also with national MRC<br>MRC will participate in the ESF 8 training assessment. | Basic core curriculum to be used by all MRC's in region | Nov. 2006 – June 2007 |
| 5. Establish cross jurisdictional response and call up protocols and procedures | Same as #3 | Written procedures | July 2006 – Sept. 2007 |

| Project Performance Measures | Baseline Value | Target Value-2006 |
|---|---|---|
| 1. New MRC volunteers | 5,277 | 6793 |
| 2. Newly trained MRC volunteers | 2,663 | 4165 |
| 3. Basic MRC regional training curriculum | Non-existent | Written and agreed upon |
| 4. Written cross jurisdictional response protocols/mutual aid agreements | Non-existent | Written and agreed upon |
| 5. NCR-wide outreach material | Non-existent | Written and agreed upon |

# INITIATIVE PLAN

**Surge Capacity for Public Health: Medical Reserve Corps in the National Capitol Region**

1. **Provide the Name of this Initiative. Describe how this Initiative will address the priority needs and strengths identified through the program and capability evaluation, and prioritization analysis.**

   Because public health has inadequate resources to effectively respond to large scale public health emergencies, it is critical that programs to enlist, train, and manage volunteers be supported. At present, there are about 5,700 volunteers enrolled in MRC's throughout the area and it is estimated that as many as 20,000 could be needed in a large scale event. The capability reviews conducted for mass prophylaxis and medical surge revealed that thorough plans were in place to accomplish mass prophylaxis, but that the human resources to fulfill the plans were dramatically lacking. Further, DHHS/OSG seed grants for some MRC's in the Metro area are expiring in 2006. Thus, program sustainment and resources to grow and further develop volunteers for MRC's are critical needs identified in the Mass Prophylaxis and Medical Surge as well as the Citizen Participation Capability Reviews.

2. **Regional Construct: Briefly describe the geographical context of this Initiative.**

   There are organized Medical Reserve Corps units in these localities: City of Alexandria, Arlington County, District of Columbia, Fairfax County (includes Falls Church and Fairfax cities), Loudoun County, Montgomery County, Prince Georges County, and (under development) Prince William County includes Manassas and Manassas Park cities). This proposal includes a request for a Regional Coordinator (consultant) to work with all the local MRC programs on cross jurisdictional issues.

   The local MRC's (8) of the NCR will oversee the project through an advisory council. Each MRC participating in this effort will be required to appoint one representative to serve on the advisory council. The council will meet at least monthly and keep formal records of its work. Volunteer centers representing the participating jurisdictions will also be asked to name representatives to participate in the advisory council to ensure that broad scale recruitment efforts undertaken on behalf of all Citizen Corps programs and those targeted recruitment efforts conducted by MRC's are well coordinated. The advisory council will make regular quarterly reports (written and oral) to the ESF 8 and ESF 15 (volunteerism) committee. Emergency managers, ESF 5, will also receive written reports about the project. The advisory council will meet monthly and approve the work plan and deliverables developed by the Regional (NCR) Coordinator who will focus on cross jurisdictional issues, training curriculum development, training partnerships with area universities, deployment protocols across state lines, coordination with the ESF 8 Training Work Group and other related training initiatives funded through UASI.

3. **Resources, Processes, and Tools: Identify the resources, processes and tools that already exist, and those that will need to be leveraged, created, or acquired for this Initiative. Briefly consider how these resources, processes and tools may be attained.**

   Each MRC unit has an overall mission to support public health both during emergencies and in ongoing public health priorities consistent with the national MRC goals and priorities and with the priorities of their localities. MRC units have their operating policies and procedures, training programs, and recruitment strategies.

   The NCRMRCs have established collaborative networks to include the other Citizen Corps programs, Volunteer Centers, VOADs, Red Cross, as well as organizations such as Medical and Dental

Societies, and universities. With funding these networks and collaborative efforts will be strengthened and expanded.

4. **Governance Structure: Describe the high-level governance structure (e.g., management plan, stakeholder involvement) required for successful implementation of this Initiative.**

(see Section 2 for a description of the project advisory body)
The Prince Georges County Health Department will provide the fiscal management for the project and provide office quarters and related support for the Regional Coordinator. The personnel (up to 8.0 FTE's-one for each of the participating MRC's) will be hired in accordance to the personnel systems operating within the parent administrative bodies, either local Health Departments (Alexandria, Arlington, Fairfax, Loudoun, Prince William, and Prince Georges County), Medical Society of the District of Columbia, or the Volunteer Center for Montgomery County.

5. **Program Management: Explain how this Initiative relates to the overall State homeland security program, and/or how it helps incorporate the three Overarching National Priorities.**

The health departments in each locality provide either direct management or a combination of liaison and operational direction to the MRCs. Each MRC operates under the direction of the emergency management structure for the locality.

The Virginia and Maryland MRCs work closely with their State MRC offices and may receive assistance and support. The State offices may serve as contact points for the national MRC especially during national events. The State MRCs are part of overall emergency response. In Virginia, the MRC office is part of the Health Department and in Maryland, the MRC office works directly under Maryland Department of Health and Mental Hygiene, Office of Emergency Preparedness and Response. The District of Columbia MRC is a Medical Society initiative in collaboration with the Health Department.

**National Overarching National Priority: To strengthen Mass Prophylaxis and Medical Surge Capability.**

This NCRMRC initiative will not only help build public health capacity to provide mass prophylaxis but may also help to meet public health surge by assisting with other public health activities such as monitoring, surveillance, tracking, and providing telephone support to individuals who may be at home in quarantine or isolation. MRC volunteers help to raise public health emergency preparedness and response awareness in communities.

By 2008 with continued support, the NCR MRC's are committed to increasing the pool registered volunteers to 9,101 moving the region significantly forward toward the goal of 20,000 volunteers needed to respond to broad scale public health disasters in the NCR.

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## *Scoring Sheet*

# Mass Prophylaxis

**Scoring Criteria:** All candidate Concept Papers are to scored on the basis of compliance with the following 5 criteria. Each criteria is to be scored from 1 to 10 points, with 1 being lowest compliance and 10 being the highest.

**Criteria #1:** How well does this Concept Paper/Initiative Plan address identified strengths and weaknesses of the 14 Priority Target Capabilities?

**Criteria #2:** How well does this Concept Paper/Initiative Plan address identified strengths and weaknesses of the 3 Overarching National Priorities?

**Criteria #3**: How appropriate is the funding requested with the deliverables proposed by the Concept Paper?

**Criteria #4**: How beneficial will this concept paper be in addressing regional needs?

**Criteria #5**: How important is it to implement this Concept Paper/Initiative Plan in FY 06?

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|---|---|---|---|---|---|---|---|---|---|---|---|
| | **Concept Paper** | Surge Capacity for Public Health: Medical Reserve Corps in the National Capitol Region | | | | | | | | | |
| | **Related Target Capabilities:** | Medical Surge, Citizen Preparedness and Participation | | | | | | | | | |
| **Score:** | Criteria #1 (1-10) | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| | Criteria #2 (1-10) | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| | Criteria #3 (1-10) | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| | Criteria #4 (1-10) | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| | Criteria #5 (1-10) | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| **Total:** | **(5-50)** | | | | | | | | | | |

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|---|---|---|---|---|---|---|---|---|---|---|---|
| | **Concept Paper** | <need to insert the title of a concept paper in this section> | | | | | | | | | |
| | **Related Target Capabilities:** | | | | | | | | | | |
| **Score:** | Criteria #1 (1-10) | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| | Criteria #2 (1-10) | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| | Criteria #3 (1-10) | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| | Criteria #4 (1-10) | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| | Criteria #5 (1-10) | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| **Total:** | **(5-50)** | | | | | | | | | | |

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|---|---|---|---|---|---|---|---|---|---|---|---|
| | **Concept Paper** | <need to insert the title of the concept paper from this section> | | | | | | | | | |
| | **Related Target Capabilities:** | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| **Score:** | Criteria #1 (1-10) | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| | Criteria #2 (1-10) | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| | Criteria #3 (1-10) | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| | Criteria #4 (1-10) | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| | Criteria #5 (1-10) | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| **Total:** | **(5-50)** | | | | | | | | | | |

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