



Continuation Guidance – Budget Year Five Attachment H Cross-cutting Benchmarks and Activities

Public health emergency preparedness requires that state and local health departments, hospitals, and other health care entities be able to mount a collective response featuring seamless interaction of their event-specific capabilities. To this end, activities by both the public health community and the health care community must be well integrated, and integration must be both vertical (i.e., between state and local activities) and horizontal (i.e., between public health and hospital/health system activities).

In addition, public health emergency preparedness activities should be coordinated closely with those of public safety and emergency management agencies, especially with respect to activities funded by the Department of Homeland Security and/or other federal agencies. States should actively support efforts by counties and municipalities to enhance their readiness for public health emergencies, including their capacity to rapidly accommodate state and federal assets (such as the Strategic National Stockpile) and emergency response teams (such as those provided by the National Disaster Medical System).

Although these Cross-Cutting Activities (or closely related Recipient Activities) appear in Focus Area Attachments A, B, C, E, F and G, **awardees should note that the full text and requirements of the Cross-Cutting Activities are Attachment H.**

The estimated costs for the activities described below are eligible for inclusion, with an appropriate distribution, in both the CDC and HRSA cooperative agreements.

Awardees will note that Attachment H does not include four of the five Cross-Cutting Critical Benchmarks that appeared in last year's guidance. Moreover, a new Cross-Cutting Critical Benchmark (#6) on pandemic influenza has been added. Awardees are expected to have achieved the four benchmarks that are not explicitly identified in this year's guidance by the end of the FY03 award (August 31, 2004).

A. CROSS-CUTTING CRITICAL BENCHMARKS

In association with the CDC and HRSA FY03 cooperative agreements, the HHS Office of the Assistant Secretary for Public Health Emergency Preparedness (OASPHEP) prescribed five Cross-Cutting Critical Benchmarks as follows:

- Cross-Cutting Critical Benchmark #1: Incident Management
- Cross-Cutting Critical Benchmark #2: Joint Advisory Committee for CDC and HRSA Cooperative Agreements
- Cross-Cutting Critical Benchmark #3: Laboratory Connectivity
- Cross-Cutting Critical Benchmark #4: Laboratory Data Standard
- Cross-Cutting Critical Benchmark #5: Jointly Funded Health Department/Hospital Activities



See the FY03 guidance for a detailed description of all 5 Cross-Cutting Critical Benchmarks.

OASPHEP will track awardees' progress toward these five Cross-Cutting Critical Benchmarks by reviewing the FY03 progress reports and the FY04 workplans. OASPHEP expects that awardees will have achieved benchmarks 1, 2, 3, and 5 on or before the end of the FY03 budget period (ending August 31, 2004) and thus is not repeating these benchmarks in association with the FY04 guidance. However, awardees that have not achieved these four benchmarks by the end of the FY03 budget period may be subject to funding restrictions on their FY04 award.

While expecting significant progress toward Cross-Cutting Benchmark #4 during the FY03 budget period, OASPHEP recognizes that implementation of the LOINC data standard may be limited to those occasions when the awardee or a subrecipient is upgrading or replacing a laboratory information system. Therefore, OASPHEP is repeating Cross-Cutting Benchmark #4 in association with the CDC and HRSA FY04 guidances with a view to fostering continuous incremental introductions of the LOINC data standards as opportunities warrant.

Further, OASPHEP is introducing a new Cross-Cutting Benchmark dealing with preparedness for and response to pandemic influenza. The benchmark emphasizes preparedness for the early stages of such a pandemic, when a safe and efficacious vaccine either will be non-existent or in severely limited supply.

Cross-Cutting Benchmark #4: Laboratory Data Standard

Adopt the Logical Observation Identifiers Names and Codes (LOINC), where applicable, as the standard codes for electronic exchange of laboratory results and associated clinical observations between and among clinical laboratories of public health departments, hospitals, and other entities, including academic health centers, that have a role in responding to bioterrorism and other public health emergencies. Adoption of and adherence to data standards can do much toward ensuring effective and efficient response to bioterrorism and other public health emergencies. On March 21, 2003, the Secretaries of Health and Human Services, Defense, and Veterans Affairs announced their joint adoption of the first set of uniform standards for electronic interchange of clinical health information (<http://www.hhs.gov/news/press/2003pres/20030321a.html>). Extension to the Laboratory Response Network and related laboratories is an important next step. Additional information about LOINC and its relationship to other data standards can be found at <http://www.loinc.org/>. During the course of the upcoming budget period, CDC will provide technical assistance regarding implementation of LOINC and, along with the Office of the Secretary, HHS, will participate in collaborative efforts to refine and extend the codes as necessary to meet the needs of public health emergency preparedness.

RECIPIENT ACTIVITIES:

Describe your status in adopting and implementing LOINC and plans for refinement or extension of LOINC. Include in the description the number and types of laboratories that have adopted LOINC, as well as those that are critical to your public health emergency preparedness but have



not adopted LOINC. Document any concerns that laboratories have about LOINC and the steps you have taken to collaboratively resolve those concerns. Finally, describe your plans for ensuring jurisdiction-wide adoption of LOINC.

Cross-Cutting Critical Benchmark #6: Preparedness for Pandemic Influenza

An influenza pandemic has a greater potential to cause rapid increases in death and illness than virtually any other natural health threat. Planning and preparedness during the inter-pandemic period are the keys to an effective response.

Three pandemics occurred during the 20th century, the most severe of which, in 1918, caused over 500,000 U.S. deaths and more than 20 million deaths worldwide. Recent outbreaks of human disease caused by avian influenza strains in Asia and Europe highlight the potential of new strains to be introduced into the population.

In the face of an influenza pandemic, reducing the burden of illness, maintaining social order, and blunting the adverse economic impacts constitute a public health imperative. Early in the pandemic, especially when vaccine either is non-existent or in severely short supply, implementation of stringent infection control measures may have a significant effect in slowing the progression of – if not quenching – the epidemic. Actions that warrant serious consideration are travel advisories and precautions, screening persons arriving from affected areas, closing schools, restricting public gatherings, and quarantine of exposed or symptomatic persons. Moreover, such traditional infection control measures could be enhanced by targeted therapeutic and prophylactic use of antiviral drugs if sufficient supplies of these countermeasures are available through normal commercial channels, local pharmaceutical caches, or the Strategic National Stockpile.

Planning by state and local health departments and by the health care system is needed to assure effective implementation of response activities and delivery of quality medical care in the context of increased demand for services. Coordination in planning and consistency in implementation with other emergency response plans, such as those for bioterrorist threats and SARS, can further improve efficiency and effectiveness.

An influenza pandemic will place a substantial burden on inpatient and outpatient health care services. Illness and absenteeism among health care workers in the context of increased demand for services will further strain the ability to provide quality care. In addition to a limited number of hospital beds and staff shortages, equipment such as respirators and supplies such as masks also may be in short supply overall or at individual facilities. The disruptions in the health care system that result from a pandemic may also have an impact on blood donation and supply. Planning by local health departments and the health care system is important to address these potential shortages.

Strategies to increase hospital bed availability include deferring elective procedures, more stringent triage for admission, and earlier discharge with follow-up by home health care personnel. Local coordination can help direct patients to hospitals with available beds and distribute resources to sites where they are needed. Health care facilities also can be established



in non-traditional sites such as schools, community centers, etc. as needed and based on availability of staff. Specific challenges in these settings such as infection control must be addressed. Most ill persons will not require hospital care but may need other support services. These include home health care, delivery of prescription drugs, and meals. Local planning is needed to address the delivery of these and other essential community functions such as police, fire, and utility services.

RECIPIENT ACTIVITIES:

FY04 Workplan: In no more than 5 pages, describe the jurisdiction's current plan for responding to pandemic influenza and discuss the envisioned approach to achieving Benchmark #6.

Interim Progress Report: Provide a draft of the jurisdiction's pandemic influenza response plan in association with the interim progress reports for CDC and HRSA FY04 cooperative agreements.

End of the FY04 Budget Period: Provide a copy of the complete pandemic influenza plan for the jurisdiction to OASPEP in accord with instructions that HHS will provide during the summer of 2005.

B. OTHER CROSS-CUTTING ACTIVITIES

Responses to the activities in this section should specifically and clearly illustrate collaboration and coordination between public health departments and hospitals/supporting healthcare entities. For each of the Cross-Cutting Activities identified below, please provide responses to the following three questions.

1. What activities are you planning for the next budget period that will ensure (a) continuing improvements in each of the Cross-Cutting activities identified below and (b) coordination and integration of efforts between the CDC and HRSA Cooperative Agreements?
2. What steps are you taking to help ensure sustainability of infrastructure, staff, and relationships (especially between the public health and hospital/health care communities) developed as a result of these cooperative agreements?
3. What collaborative efforts are being undertaken with local health departments and hospitals to develop an integrated regional approach?

Surveillance. Integration of disease surveillance systems at the state and local levels, including hospital-based surveillance systems so that relevant data on disease reporting is rapidly captured and analyzed. Systems should allow for electronic communication between hospitals and public health departments at all levels.

Coordination with Indian Tribes. Indian tribal government participation in state and local preparedness planning and implementation.



Populations with Special Needs. Activities that will be implemented to meet the specific needs of special populations that include, but are not limited to, people with disabilities, people with serious mental illness, minority groups, the non-English speaking, children, the homeless, and the elderly. These activities must take into consideration all operational and infrastructure issues as well as public information/risk communication strategies. Such activities must be integrated between the public health and the hospital communities.

Planning for Psychosocial Consequences of Bioterrorism and Other Public Health Emergencies. Efforts the state health department is making to work with state and local mental health agencies, hospitals, mental health providers, and public and private emergency response and social services entities in planning to meet the psychosocial needs of victims, those at risk, their families, psychological casualties both with and without medical illness, and emergency responders (including healthcare personnel, public health professionals, EMTs etc.).

Education and Training. Activities that the health department will undertake to train or ensure training of its staff and those in local health departments, hospitals, major community health care institutions, emergency response agencies, public safety agencies, etc. to respond in a coordinated (non-overlapping) manner in the event of a bioterrorist attack or other public health emergency to minimize duplication and fill gaps.

Involvement of Academic Health Centers. Activities that the state health department will be undertaking to involve academic health centers, if available in their regions, in their preparedness efforts.

Interoperability of IT Systems. Measures that the state will be taking to ensure the connectivity and interoperability, both vertically and horizontally, of its various IT systems with those of local health departments, hospitals, emergency management agencies, public safety agencies, neighboring states, federal public health officials and others.

Interstate Collaboration. Activities by states and local health departments in jurisdictions sharing a border with one or more states to foster interstate collaboration and coordination, especially in high population density areas along the state border(s). Special attention should be paid to any collaborative efforts undertaken by local health departments with hospitals in their communities to develop an integrated regional approach to a mass casualty event.

International Border States. Efforts by state and local health departments in jurisdictions sharing an international border with Mexico or Canada to foster cross-border collaboration and coordination. States may use funds to conduct necessary activities in support of bi-national planning, coordination, communications, program development, and exercises with Mexico or Canada if such actions directly contribute to health security in the United States.