



Public Health Emergency Preparedness Cooperative Agreement Follow-Up Questions and Answers: First Set

General Questions

Q: The guidance was posted on June 5, and applications are due July 15. This is only 40 days. Aren't applicants supposed to have 45 days to respond?

A: CDC Grants Management Policies indicate that applicants must be given a minimum of 30 days. Although we were striving for a 45 day turnaround time, we also want to ensure that we can award the funding by August 30 as we promised, so we have retained the due date of July 15.

Q: What are the primary differences in 2006 expectations compared with 2005?

A: In 2006, funding recipients are expected to continue to test and improve their capability to respond to public health emergencies. This year's continuation guidance continues to emphasize performance and measurement through responses to drills, exercises, and real events. In addition, there is an increased emphasis on the preparedness of major metropolitan areas to distribute medical countermeasures.

Q: What specifically are the expectations for local health department concurrence?

A: The following language concerning documentation of local concurrence, which appeared in the 2005 guidance, was inadvertently left out of the 2006 guidance:

CDC requires documentation with the cooperative agreement application that describes the process used by the State health department to engage local health departments to reach consensus, approval, or concurrence for the proposed use of non-earmarked cooperative agreement funds. Non-earmarked cooperative agreement funds are those funds not designated for urban areas ((e.g. Cities Readiness Initiative (CRI)), Early Warning Infectious Disease Surveillance (EWIDS), currently established Level 1 Chemical laboratories, or other specialty activities as defined in the guidance. The description should bear evidence that local health department officials have been engaged in the cooperative agreement application process and at least a majority, if not the total, approves or concurs with the application itself. This evidence may be demonstrated by:

- a. the consensus of a majority of local health officials whose collective jurisdictions encompass a majority of the State's population
 - b. the recommendation of the President of the State Association of County and City Health Officials (SACCHO) if a majority of local health officials whose collective jurisdictions encompass a majority of the State's population agree with the SACCHO's decision; OR
 - c. any other alternative method agreed to by the State Health Official and a majority of local health officials whose collective jurisdictions encompass a majority of the State's population
- State applicants will be required to submit a list of concurring local health departments and a brief description of the process used to engage local health departments to reach consensus, approval, or concurrence for the proposed use of funds. In addition, State applicants will be required to provide signed letters of concurrence upon request.

Q: How are we to continue with robust all hazards planning when base resources are reduced to support CRI and pandemic influenza?

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A: CDC supports all-hazards planning and has retained the base allocation of funding (\$3.91M for States and \$5M for cities) to ensure that core infrastructure can be retained. Neither CRI nor pandemic influenza activities have reduced the base resources.

Q: Will carryover be used in lieu of 'new money' in the awards?

A: As the awarding agency CDC has the discretion to:

- permit carryover of unobligated balances from one budget year to another, or
- utilize them in continuation funding.

It is likely that at least a portion of the estimated unobligated dollars will be used to fund this year's award. The decision to begin to partially use carryover funds as part of the awards is based on several considerations including: increased Congressional attention to ongoing unspent funds and the inclusion of terrorism preparedness and emergency response funds into the amount subject to CDC-wide assessments.

Q: Can core funds can be used to purchase antibiotics and vaccines for public health responders and their families, in addition to antivirals?

A: Yes, this is allowable.

Q: Is there a definition and criteria to guide the use of the term "urgent" when referring to "events of urgent public health consequence"?

A: Events of urgent public health consequence are those requiring an immediate commitment of public health assets.

Q: The guidance states "Further guidance on the development and evaluation of exercises and drills will be forthcoming from CDC." What does this mean? Does this refer to instructions for the coming year? (We are making drill decisions now.)

A: CDC is working with colleagues from DHHS and DHS to provide further guidance on expectation for the conduct and evaluation of exercises. Compliance with performance measures is one indication of measuring progress toward improved preparedness. We encourage States and cities that have developed templates for the conduct and after-action reporting of exercises to share them with others. CDC can also make templates available for State and local modification and use.

Q: What is the expectation related to our responsibility for Hazards and Vulnerability Assessments, mass care and shelter-in-place? These are typically handled by other agencies, the American Red Cross and law enforcement.

A: CDC's expectation is that public health agencies will review the Hazards and Vulnerability Assessments for implications for the public's health, which should be reflected in the preparedness plan. The UCLA Center for Public Health and Emergencies, has published a "Hazard Risk Assessment Instrument Workbook" developed as a guide to enable state and local public health agencies to conduct a risk assessment of their community. It is available through the following link to access the UCLA Center for Public Health and Emergencies webpage: www.cphd.ucla.edu. However, you will need to complete the free registration to access the workbook.

With regard to mass care and shelter-in-place, public health should account for these activities in its emergency preparedness planning, and coordinate with those responsible for these functions as appropriate to protect the public's health.

Q: We have noticed that there is no requirement in the guidance to work with Primary Care Associations and Community Health Centers. Is this still an expectation?

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A: Absolutely. Public health agencies should nurture relationships with these organizations, which offer many important resources, not the least of which is extensive experience with underserved vulnerable populations.

Q: Does Appendix 7, National Public Health Radio Network, apply to all of the grantees, or is this activity still being piloted?

A: As in the past, all grantees are expected to develop redundant communication systems and backup plans for communications when infrastructure dependent systems are down. The National Public Health Radio Network is one option for developing such systems.

Q: What is CDC's intent in including Appendix 13, the Target Capabilities Matrix, and what do the acronyms mean?

A: CDC included the matrix to ensure grantees were aware of the variety of other funding sources available for accomplishing the Target Capabilities. Having this information may assist you in leveraging some of these funding sources in your jurisdiction. The acronyms are as follows:

PHEPCA = Public Health Emergency Preparedness Cooperative Agreement

BTCDP = Bioterrorism Training and Curriculum Development Program

NBHPP = National Bioterrorism Hospital Preparedness Program

EMPG = Emergency Management Performance Grants

CCP = Citizen Corps Program

MMRS = Metropolitan Medical Response System

LETPP = Law Enforcement Terrorism Prevention Program

UASI = Urban Area Security Initiative

SHSP = State Homeland Security Program

Performance Measures, Evaluation and Reporting

Q: What is meant by "phasing-in" the 23 performance measures?

A: Grantees will report on a subset of the 23 performance measures that are comparable in intent or question to the 2005 performance measures. Response to the remaining performance measures will be collected with the mid-year progress report.

Q: Can CDC provide additional guidance on the development of an evaluation plan as noted on page 26 of the guidance and Appendix 10?

A: Recipients have been collecting and reporting information on tasks and activities related to capacity and performance measures relating to capability. CDC is asking states to semi-annually use the Evaluation Framework (Appendix 10) to identify opportunities for improvements in planning, activities, linkages, processes and capabilities. Recipients are referred to MIS Assessment Tools Section for "Evaluation Planning." It is expected that each applicant will identify at least one evaluation project that will contribute to the continuous improvement of the overall preparedness project. For example, if a project is unable to meet a given performance measure, CDC would expect the project to identify reasons for the shortfall and identify and test changes for continuous improvement. On a broader scale, exercises are used as opportunities to test preparedness plans. In the After Action Report, what problems were identified, what opportunities need to be considered for improvement and does the plan itself need to be modified?

Q: Is it possible that the Technical Reporting, Progress Reports and Performance Measures reporting schedules might be streamlined?

A: CDC is reviewing the technical reporting requirements for the Public Health Emergency Preparedness cooperative agreement and the pandemic influenza supplements. We will make every attempt to structure progress reports to minimize the burden. If you have ideas about ways to improve the process, please convey them to your project officer.

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Q: Should the evaluation plan cover CRI and Pandemic Influenza activities, or just those funded under the base?

A: The evaluation plan should cover both CRI and activities funded under the base. Evaluation for Pandemic Influenza activities will be covered under Part II of the flu guidance.

Laboratories

Q: Please describe the status of funding for Level 1 Chemical Laboratories. Will there be an appendix dedicated to Chemical Laboratories?

A: The funding for Level One Chemical Laboratories is the same as last year. Appendix 15, which describes critical tasks for Level One and Level Two Chemical Laboratories was distributed as an amendment to the guidance document on June 7.

Q: Please address the performance measure for PulseNet Laboratories. APHL supported 96 hours turn around time for business hours only.

A: This measure will be changed to reflect the 96 hour turn around time during business hours only.

General CRI Questions

Q: What is the Cities Readiness Initiative (CRI)?

A: The Cities Readiness Initiative is a program to aid cities in increasing their capacity to deliver medicines and medical supplies during a large-scale public health emergency such as a bioterrorism attack or a nuclear accident. This initiative focuses on a very specific element of preparedness – the ability to distribute medicine to a population in a very short time. CRI is a collaborative, multi-jurisdictional effort between local, state, county, and federal authorities that transcends jurisdictional boundaries. This collaborative effort will enhance the ability of cities to provide medication and medical supplies to their populations within a timeframe that will make an appreciable health difference in the event of a bioterrorism attack.

Q: What are the specific risks for the citizens in my city/locality?

A: No specific risks at this time. Past events, however, have taught us that the risk of terrorism—including bioterrorism—being perpetrated against Americans, is real. And the ability to quickly deliver countermeasures to large populations is a real, identified gap.

Q: What is the states' role in this activity? I thought states were responsible for their own cities.

A: The states will work with the local and federal entities and ensure that they are a part of the integrated planning for preparedness as described in the National Incident Management System. Furthermore, the states will serve as the conduit for the necessary funding for those cities that are not direct grantees.

Q: What was the rationale for expanding the CRI? What evaluation data was this in response to? Why was it done at the expense of the core program?

A: The CRI is in alignment with Homeland Presidential Security Directive- 8, the National Preparedness Goal and is directly related to one of the top four National Priorities "Strengthen Medical Surge and Mass Prophylaxis Capabilities" by establishing emergency-ready public health and healthcare entities across the Nation.

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The Public Health Emergency Preparedness Cooperative Agreement funding is to be used for terrorism preparedness and emergency response. Thus under that concept this funding is still being used for that purpose and CRI is an integral part of the core program.

Evaluation data from each year's new CRI jurisdictions have shown the majority of jurisdictions to be unprepared for a catastrophic mass prophylaxis event (66% of Group I /MSA and 80% of Group II/Planning Cities). During the course of CRI the majority of the jurisdictions have shown improvement in their preparedness planning.

Q: What are the reporting responsibilities in the following situations?

- **A county in my state is included in the MSA of a city in a neighboring state.**
- **A CRI city straddles my state and a bordering state.**

A: States are only responsible for the jurisdictions within their state borders. If your state has jurisdiction included in the MSA of a CRI city in a bordering state, you are responsible for assessing the jurisdictions within your state's borders.

Q: When will the executive briefing satellite broadcast occur?

A: The CRI Executive Brief is scheduled to air October 19, 2006.

Q: What are the expectations for CRI? What happens if my city doesn't meet the established expectations set by the CRI guidelines?

A: The goal of CRI is to improve readiness among the targeted cities. The DSNS and State team will conduct baseline preparedness assessments and develop a gap analysis; the gap analysis will be the basis for expected activities for the fiscal year. The CRI assessments are based on the 14 DSNS critical capacities. For further guidance, refer to "Receiving, Distributing, and Dispensing Strategic National Stockpile Assets: A Guide for Preparedness", available through the DSNS Extranet or your DSNS Subject Matter Expert.

Please note: As a result of lessons learned and the evolving nature of the medical assets maintained by the DSNS, the guidance document "Receiving, Distributing, and Dispensing Strategic National Stockpile Assets: A Guide for Preparedness" is a "living" document that is updated periodically. The current version of the Guide can be downloaded from the DSNS extranet site.

Q: What sort of assistance can we expect from CDC?

A: CDC will provide, through the Division of Strategic National Stockpile, both technical assistance on the planning process and the CRI assessment process. Based on the gap analysis, DSNS will help to identify needed resources and training opportunities. The DSNS satellite broadcast series on Mass Prophylaxis provides the venue to share information and lessons learned from federal, state and local perspectives.

Q: CRI mentions oral prophylaxis *and* antibiotics. DSNS seems to limit most discussions to anthrax during the introduction of the CRI. Should states assume that we are to consider other scenarios that require oral antibiotics and not just anthrax and begin to focus our attention on prophylaxis campaign planning for antivirals and other countermeasures for class A agents?

A: The basic premise of CRI planning scenario is still aerosolized anthrax (also the worst case scenario); however plans could have applicability to other agents or emerging infections. If planning activities are based on the worst case scenario it's much easier to scale down.

Please note: Federally provided flu antivirals are not to be used in a mass prophylaxis campaign. Due to the limited availability, flu antivirals are for treatment of symptomatic persons.

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Q: The CRI language seems to give states the flexibility to shape the MSA as they see fit. Can states redefine the current MSA data/structure?

A: States can add counties within the MSA but they can not delete. The population center included in the MSA must be included in CRI. The flexibility is with regard to planning structure - the intent is to build on existing planning structure. In other words, all of the jurisdictions within the MSA must do CRI planning; however, they don't need to develop a CRI specific plan for the MSA. Jurisdictions within the MSA should coordinate to ensure consistent health communication messaging and dissemination of public information.

Q: Several state officials have expressed concerns about coordination and implementation issues between city/counties and states. How will these issues be handled?

A: In general, with the exception of the three directly funded cities, our awards are to the state. State health officials are expected to play a significant role in terms of working with cities and counties to create necessary organizational structures. The political jurisdictions are quite varied and different, but support from all jurisdictions is critical in order to achieve the best public health solution.

CRI Funding

Q: What was the formula for the FY06 CRI funding?

A: MSAs that were previously funded were kept at the same level. Former planning jurisdictions were funded based on their MSA population at a \$0.34 per capita rate. The 15 new planning MSAs were given a base funding of \$200,000.

Q: Several metropolitan areas have raised concern over how funds and authority should be distributed in cities/target areas that spread into multiple counties. How will these funding and authority issues be handled?

A: The cooperative agreement itself requires that the funds go to the states, except for Washington DC, Chicago, New York City, and Los Angeles, which are directly funded. The fact that the funds will flow through the regular cooperative agreement gives our state colleagues the opportunity to help shape CRI into a specific multi-jurisdictional solution that makes sense for each area. The target cities are the anchor, based on the population concerns of consequences and risk, but planning of the initiative needs to take into account all of the jurisdictional players to achieve the best public health solution.

Q: Regarding the "majority of funding" going to the CRI area, under what circumstances and how much may a state hold back? Can it be solely "overhead" or does it need to be justified to be held back?

A: Per pg. 64 of the guidance, "States will have a coordinating role and must participate in the CRI activities with local jurisdictions. States should budget funds so that they can perform those functions." "States must provide detailed descriptions of the funding going to local areas for CRI in their budget." Suggested items for States' budgets might include: % of state staff salary dedicated to CRI, supporting supplies/equipment for the state staff person(s), travel expenses to collaborate with CRI city (ies), and other costs related to collaborative State/City activities.

CRI Assessment

Q: Will each assessment result be made public? If so, how?

A: The assessment results are not intended as documents for public release. However, reports will be developed and shared with CDC, DHHS, and may be made available to those with oversight over our program activities, e.g., the Office of Inspector General, the Government Accounting Office, or Congress. The Program Preparedness Branch of the Division of SNS will take the lead on developing the CRI reports.

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The reports will provide an update of the status of the CRI including the progress of the initiative, the number of cities assessed, and a summary of findings to date in aggregate format.

A second category of reports will be the individual assessment/site visit reports for each of the planning jurisdictions. This information will be shared with the appropriate state and local personnel as well as have limited distribution within CDC.

Any sensitive information included in either of these reports that could increase vulnerability would not be made public.

Q: Will Project Areas be using the same assessment tool currently utilized by the DSNS?

A: The assessment tools currently used by the DSNS to assess state and local planning efforts are being revised by RAND. The revised tools will be available for use by DSNS and our state and local partners by September 1, 2006.

Q: Can Project Areas modify assessment tools originally developed by the CDC?

Project Areas are welcome to add elements to the assessment tool; however, for purposes of consistency elements may not be deleted. If additional elements are added they will not be incorporated into assessment rating.

Q: What kind of assessment training will be provided to the states?

A: DSNS Program Service Consultants/Subject Matter Experts (SMEs) will provide an overview of the assessment tool and will guide state staff through the assessment process by conducting joint assessments of 25% of the existing planning jurisdictions (i.e. City, County, Region) within each MSA/CRI jurisdiction. SMEs will be available to our state partners to provide additional technical assistance; and based on availability, may be able to support additional assessments.

Q: What is the expectation regarding performance measure reporting for the MSAs?

A: Each of the public health agencies in the MSA are expected to report on each of the performance measures listed as "local".

Postal Service Option for Distribution

Q: Why will US Postal Service be a major mechanism of distribution of SNS medicines and materials?

A: The USPS is the only organization in the country that already has in place the mechanisms that enable it to get to every residence in a single day, in an arbitrarily large geographic area. It has the necessary logistic capabilities of trucks and other things to help move material around the country in a systematic way. Using the USPS to distribute mass prophylaxis is not automatic, but one of many tools that may be considered in a catastrophic public health event.

This mechanism of distribution is only available to the jurisdictions funded prior to this year's cooperative agreement.

Q: Do states still need to submit their postal Strategic Security Plan for the FY05 grant year requirement or is it fully suspended due to the suspension/pause in the USPS postal option for FY06 grant year?

A: Yes, postal planning must still occur; per the Cooperative Agreement. The second phase of security planning "tactical security planning" is on hold.

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Pandemic Influenza Guidance

Q: When will the \$225M and the \$25M supplements for pandemic influenza be posted, and will the timeline (45 days to apply, 45 days for review) be impacted?

A: We expect to circulate the Pandemic Influenza Guidance for approval beginning June 12. Because of the high level of interest among our colleagues here and at HHS, review and comment is expected to take at least 3 days. As a result, we are hopeful that the guidance will be released by Friday, June 16th. We will make every attempt to allow you 45 days to respond, with another 45 days to process the applications. Pandemic Influenza funding will supplement your PHEP Cooperative Agreement and align with that budget year. Consequently, these funds will have to be obligated by August 30, 2007.

Additional Resources

Attached are some web sites with information regarding safe needle devices, manufacturers, device evaluations, and the NIOSH topic page on blood borne pathogens that you may find useful as resources for your Strategic National Stockpile efforts.

<http://www.cdc.gov/nip/dev/jetinject.htm>

<http://www.napssi.org/>

<http://www.healthsystem.virginia.edu/internet/epinet/safetydevice.cfm>

<http://www.cdc.gov/mmwr/preview/mmwrhtml/00045648.htm>

<http://www.cdc.gov/niosh/topics/bbp/>

The answers to these questions were developed on June 9, 2006.

For more information, visit www.bt.cdc.gov/planning/coopagreement ,
or call CDC at 800-CDC-INFO (English and Spanish) or 888-232-6348 (TTY).

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