



September 21, 2007

Dear Colleagues:

The Department of Health and Human Services' (HHS) Centers for Disease Control and Prevention (CDC) announces the availability of Budget Period 8 funding for continuation of the Public Health Emergency Preparedness (PHEP) Cooperative Agreement. Funds are intended to upgrade state and local public health jurisdictions' preparedness and response to bioterrorism, outbreaks of infectious disease, and other public health threats and emergencies. The purpose of this guidance document (Part 2 of the Interim Progress Report) is to assist the 62 awardees in developing continuation submissions for Budget Period 8. Detailed instructions for the preparation of submissions are provided in Appendix 1. Budget Period 8 began on August 31, 2007 and ends August 9, 2008. Note that this is an 11 month and one week period. This shortened budget period should be reflected in both your proposed work plans and your budget.

This guidance also includes activities that must be integrated with those funded by the Pandemic Influenza Supplement to the Public Health Emergency Preparedness Cooperative Agreement (see Appendix 1).

Impact of the Pandemic and All-Hazards Preparedness Act

Enacted in December 2006, the Pandemic and All-Hazards Preparedness Act (PAHPA) is designed to improve the nation's public health and medical preparedness and response capabilities for all emergencies, whether natural or man-made, with public health consequences. The legislation establishes overarching preparedness goals for essential federal, state and local public health and medical capabilities to increase accountability and provide incentives to promote regional coordination. These goals will be specifically detailed in a National Health Security Strategy to be prepared by the Secretary of the Department of Health and Human Services every 4 years as a foundation for furthering national preparedness.

The PAHPA requires specific activities from the PHEP awardees within Budget Period 8, which are detailed in the requirements section of Appendix 1. Awardees must, in addition, use the upcoming year to prepare to participate in the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP). Revised ESAR-VHP Compliance Requirements have been issued by the Assistant Secretary for Preparedness and Response. Awardees will be expected to participate in ESAR-VHP. CDC will include the Compliance Requirements for ESAR-VHP in the Program Announcement for Fiscal Year 2008 funding. Starting in Fiscal Year 2009, eligibility for these funds requires participation in ESAR-VHP.

In addition, the PAHPA contains provisions that will affect the fiscal management of the program, from both an awardee and a CDC perspective. These include:

- Guidelines for funds to be withheld from awardees who fail to meet benchmarks and performance measures or submit plans for responding to pandemic influenza (use of Fiscal Year 2008 benchmark, performance and other data will impact Fiscal Year 2009 awards);
- Guidelines regarding the waiver or reduction of withholdings;
- Revised auditing requirements for all awardees;
- Guidelines for the repayment of funds not expended in accordance with statutory or Departmental guidelines; and
- Guidelines for the maximum percentage amount of an award that may be carried over to the succeeding fiscal year.

Awardees should also be aware of the following language in the PAHPA, which establishes the intent that PHEP funding be matched by non-federal contributions.

State Matching Funds: In the case of any state or consortium of two or more states, the Secretary may not award a cooperative agreement under this section unless the state or consortium of states agree that, with respect to the amount of the cooperative agreement awarded by the Secretary, the state or consortium of states will make available (directly or through donations from public or private entities) non-federal contributions in an amount equal to:

- (i) for the first fiscal year of the cooperative agreement, not less than 5 percent of such costs (\$1 for each \$20 of Federal funds provided in the cooperative agreement); and
- (ii) for any second fiscal year of the cooperative agreement, and for any subsequent fiscal year of such cooperative agreement, not less than 10 percent of such costs (\$1 for each \$10 of Federal funds provided in the cooperative agreement).

Determination of Amount of Non-Federal Contributions: As determined by the Secretary, non-federal contributions required...(above)... may be provided directly or through donations from public or private entities and may be in cash or in kind, fairly evaluated, including plant, equipment or services. 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 the amount of such non-Federal contributions.

The Secretary of Health and Human Services intends to implement this provision in Fiscal Year 2008.

The PAHPA stipulates that one new program, Real-Time Disease Detection, be initiated from the amount allocated for improvements in state and local capacity (see Appendix 7).

As a result of the many changes and new requirements established in the PAHPA, CDC will conclude the Cooperative Agreements funded under Program Announcement AA154 at the close of Budget Period 8. A new Program Announcement will be written to support pandemic and all-

hazards preparedness and response activities according to the requirements stated in the PAHPA. Financial closeout instructions can be found in Appendix 2.

Integration with Other CDC Programs and National and State Partners

Increased attention to the public health and medical needs of at-risk individuals during public health emergencies is reflected in the language in the reauthorization of this program through the PAHPA. Awardees are encouraged to work with partners who bring insight about the needs of particular communities and connections to those communities to ensure the broadest impact of preparedness planning. These partners include other CDC- and HHS-funded programs, such as chronic disease prevention and control programs, maternal and child health programs, and programs designed to enhance access to services for those with various disabilities. In addition, other governmental units, specifically the State Office for Aging or its equivalent, should be engaged in planning, exercising and evaluation to improve preparedness among the elderly and those who serve them. Non-profit agencies, such as the American Red Cross and Salvation Army, may also be strong preparedness partners.

Integration with Local Partners

Language in the reauthorization of this program through the PAHPA strengthens the government's commitment to the principle that preparedness response is a local activity. Local health departments are to be engaged in and approve both the awardee's preparedness plan and the distribution of funding associated with it. CDC interprets this to include tribes located wholly or in part within the jurisdiction. In addition, public comment about the plan and its implementation must be sought, including a mechanism such as an advisory committee or similar to solicit and address comments from the public and stakeholders. This new emphasis on widespread local engagement is reflected in the required activities of the Budget Period 8 submission guidance.

Guiding Principles for Integrating Preparedness Assistance from the Department of Homeland Security and the U.S. Department of Health and Human Services

In June 2005, the Department of Homeland Security (DHS) and the U.S. Department of Health and Human Services (HHS) established a Joint Grant Program Steering Committee to facilitate the integration of preparedness activities across state and local preparedness programs managed by both Departments. A product of the Joint Grant Program Steering Committee was the development of a list of "allowable costs" as they pertain to preparedness programs. Please review this list found at the following URL: http://www.ojp.usdoj.gov/odp/grants_hsgp.htm.

In the Fiscal Year 2006 program guidance's, both DHS and HHS included common language urging the integration of preparedness activities across disciplines and agencies and also requiring a capabilities-based planning framework that leverages resources from DHS, HHS, and other federal and state partners.

In Fiscal Year 2007, awardees shall continue to implement this planning framework, using the Senior Advisory Committees established to coordinate federal preparedness programs, including those supported by the DHS's National Preparedness Directorate, formally Grants and Training, and HHS. Examples of activities that could be addressed through collaboration at the state and local level among public safety, emergency management, health and medical communities, and non-governmental entities are:

- Developing clear public health emergency plans that delineate who will do what during each stage of a response;
- Identifying the specific competencies needed to complete the tasks associated with the operational plan;
- Implementing effective training programs that specifically support the competencies related to the public health emergency plan;
- Conducting joint exercises to meet multiple requirements from various grant programs;
- Engaging at-risk populations and/or those who represent them in preparedness planning and exercise activities; and
- Conducting joint training for local decision-makers (including government administrators, health and medical professionals, and emergency managers) on issues of joint concern, such as pandemic flu preparedness or risk communication.

DHS and HHS awardees are strongly encouraged to design, conduct, and evaluate exercises collaboratively and in accordance with the Homeland Security Exercise and Evaluation Program (HSEEP). This includes collaborating in the annual Training and Exercise Plan Workshop to coordinate exercises that satisfy the requirements of DHS and HHS grants and cooperative agreements. It also includes entry of all DHS and HHS sponsored drills and exercises in the National Exercise Schedule System.

Joint exercises under DHS and HHS preparedness assistance programs may become a requirement in future grant cycles. Consequently, recipients should begin working together in the joint design and execution of exercises in anticipation of future requirements. The establishment and achievement of joint exercise activities will also begin to address recommendations outlined in the *Federal Response to Hurricane Katrina: Lessons Learned* report, which can be found at <http://www.whitehouse.gov/reports/katrina-lessons-learned/>.

DHS and HHS will continue to take steps to increase collaboration and coordination at the federal level while supporting the enhancement of capabilities at the state and local levels.

Protecting Critical Infrastructure

Protecting the critical infrastructure and key resources of the United States is essential to the Nation's security, economic vitality, and way of life. Mandated by Homeland Security Presidential Directive-7 and published in June 2006, the final National Infrastructure Protection Plan Base Plan sets forth a national model to protect critical assets, systems, networks, and functions in each of the 13 critical infrastructures and 4 key resources by establishing an unprecedented partnership model among private sector and government partners. The protection of the critical infrastructure and key resources is, therefore, an essential component of the homeland security mission to make America safer, more secure, and more resilient from terrorist attacks and other natural and man-made disasters.

The National Infrastructure Protection Plan completes the continuum of readiness by adding the critical infrastructure and key resources protection to the efforts of the National Preparedness Goal, National Response Plan, and National Incident Management System (NIMS). The Sector Partnership model serves each of these readiness levels, solidifying and coordinating all readiness relationships and efforts within a sector. All levels of the readiness continuum are

ideally served by six broad category approaches: identifying the roles and responsibilities, building partnerships and information sharing, utilizing a risk framework, data use and protection, leveraging ongoing emergency preparedness activities, and integrating federal protection and preparedness activities. Awardees are urged to begin this collaboration by focusing on identifying roles and responsibilities related to the critical infrastructure and key resources.

For those interested in further information on the National Infrastructure Protection Plan and the critical infrastructure and key resources Protection, refer to the Federal Emergency Management Agency Incident Command System course on the National Infrastructure Protection Plan (IS-860), which is available for free online. The direct link to the course is:

<http://www.training.fema.gov/EMIWEB/is/is860.asp>

Availability of Funds

The programs listed below have been specifically funded to emphasize their importance to improving national preparedness. In addition, strengthening medical surge and mass prophylaxis capabilities is among the eight national (and health) priorities. Approximately \$896.7 million is available for Budget Period 8, distributed as follows (see Appendix 3 for detailed funding chart):

\$616,779,743	Base plus population funds available to all awardees
\$57,316,782	Cities Readiness Initiative (CRI) funds available to select awardees
\$35,000,000	Real-Time Disease Detection funds available to all awardees
\$7,200,000	Level 1 Surge Capacity Chemical Laboratory funds available to select awardees (There are some changes in the distribution of the funding as a result of the decision to focus on maintaining infrastructure in the five previously funded Level 1 Laboratories while supporting growth in several of the remaining Level 1 Laboratories. See Appendix 4 for additional details.)
\$5,440,000	Early Warning Infectious Disease Surveillance (EWIDS) funds available to select awardees (See Appendix 10 for additional details.)
\$175,000,000	Pandemic Influenza Supplement Phase III funds available to all awardees

Submission Instructions and Requirements

Continuation submissions (Part 2 of the Interim Progress Report) are due to CDC on **October 24, 2007**. Both the Principal Investigator and Business Office Official must sign the completed Part 2 Interim Progress Report. All submissions are due no later than close of business on October 24, 2007 in the Preparedness Emergency Response System For Oversight, Reporting and Management Services (PERFORMS) database maintained by CDC's Division of State and Local Readiness. The direct link to PERFORMS is <https://sdn.cdc.gov>. Part 2 Interim Progress Reports must be submitted on time, as late or incomplete submissions may result in a delay in the award and/or reduction in funds. CDC will only accept requests for a deadline extension on rare occasions, after adequate justification has been provided.

Any programmatic questions regarding your submission should be directed to the appropriate Program Services Branch contact (Appendix 5). Should you have any grants management questions, including questions related to your budget, please contact the Grants Management

Specialist for your region (Appendix 6). You may direct questions about this guidance to PSB@DSL.R.cdc.gov.

Application Review

CDC's Procurement and Grants Office and the Division of State and Local Readiness will review Part 2 of the Interim Progress Reports for completeness. The Procurements and Grants Office will provide an analysis of the financial/business documentation, and the Division of State and Local Readiness, along with Subject Matter Experts, will provide an analysis of the technical/programmatic documentation. Subject Matter Experts and Project Officers will assess the extent to which requirements are addressed, along with the rationale, completeness and acceptability of work plans.

Project Officers, Grants Management Specialists and awardees will jointly discuss proposed budget exceptions in advance of the processing of a Notice of Grant Award. This step is intended to decrease the number of restrictions and items for which additional information is needed. CDC may withhold or reduce an award due to delinquent reports, failure to show satisfactory progress, inadequate stewardship of federal funds, or failure to meet the terms and conditions of the award. In addition, CDC may use unobligated dollars from previous years to comprise the Budget Period 8 award.

Sincerely,



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Attachments

- Appendix 1: Instructions for Preparing the Budget Period 8 Submission
- Appendix 2: Cooperative Agreement AA154 Closeout Requirements
- Appendix 3: Fiscal Year 2007 Funding
- Appendix 4: Level 1 Surge Capacity Chemical Laboratory Funding
- Appendix 5: Division of State and Local Readiness Project Officers
- Appendix 6: Procurement and Grants Office Grants Management Specialists
- Appendix 7: Real-Time Disease Detection Instructions
- Appendix 8: Work Plan Elements and Definitions
- Appendix 9: Select Target Capabilities and Critical Tasks
- Appendix 10: U.S. Border States Early Warning Infectious Disease Surveillance (EWIDS)
- Appendix 11: Project Area Objectives by Level
- Appendix 12: Overarching Exercise Objectives by Priority Area
- Appendix 13: Exercise Strategy and Schedule Sample

- Implement an accountability system to ensure satisfactory annual improvement. (NOTE: During Budget Period 8, accountability will be demonstrated through performance data reporting and routine monitoring and reporting of progress towards the achievement of outputs described in the work plan for that period.)

7. Report on your plans and capabilities to receive, distribute and dispense statewide mass prophylaxis which includes your Cities Readiness Initiative (CRI) jurisdictions. Each awardee that receives specific funding to support the participation of at least one city or metropolitan area in CRI must follow the guidance for Table One – Existing CRI Recipients¹ included in Appendix 3: Cities Readiness Initiative; included in the Guidance for Budget Year 8.

Additionally please provide the following information in narrative form:

- Describe what your objectives are related to your plans and capabilities to receive, distribute and dispense statewide mass prophylaxis which includes your CRI jurisdictions during Budget Period 8. Include barriers that you need to overcome, dates of collaborative planning meetings and a progressive training and exercise schedule that includes seminars, workshops, tabletop exercises, games, drills, functional and full scale exercises.
 - Describe how you have or will transition from the development of a mass prophylaxis strategic plan to the development of an operational plan; include your available tactical capabilities and acquisition plans to acquire the resources necessary to execute your mass prophylaxis campaign. Include development and resolution timelines.
 - Describe an operational drill or functional exercise that you will conduct during the funding period and how you will use the results of the exercise evaluation/corrective action plans to improve your operational plans to receive, distribute and dispense mass prophylaxis.
8. Describe plans to pursue real-time disease detection. Each of the 62 PHEP awardees has been awarded a portion of \$35 million authorized through the PAHPA to improve real-time disease detection (RTDD). These funds are to be used as described below, with objectives accomplished through a sub-award mechanism. Awardee expenses in support of these activities may be included in the budget. Awardees and sub-recipients are reminded that federal funds can be used to augment but not supplant federal, state, and local funds currently used for the same activity.

Recent discussions and publications have used the term “real time” to describe the rapid assimilation or gathering and availability of information for use in event mitigation, curative action decision-making, or case definition or diagnosis efforts. Previous applications of real time efforts and technology have been subject to user interpretations of interval of data entry, the accessible nature of the information, the static versus dynamic aspects of the system, user entry versus automation, and the continuity of data flow.

¹For Budget Period 8 all CRI metropolitan statistical areas are considered to be Table One – Existing CRI Recipients

Substantial federal effort and resources have been dedicated to describing program objectives. These objectives facilitate the goal of real time acquisition and use of information or data markers. These objectives included surveillance, logistical measures, accountability, material and resource availability and use, and information tracking.

For the purpose of meeting the intent of this funded program and to provide a clear and informative aid to the officials and personnel implementing measures to meet these objectives, any use of the term “real time” should be described as an application in which information or data are immediately collected and received without any or virtually no time delay. Events that occur in real time (i.e., occurring virtually at that particular moment) are dynamic -- not static -- and available immediately and continuously.

In your narrative, describe your plans to achieve the objectives listed under A and/or B.

A. Poison Control Center Partnerships

All 62 PHEP awardees are required to carry out objectives through a Poison Control Center or professional organizations in the field of poison control.

- Collaborate with a poison control center or professional organization in the field of poison control to improve the early detection, surveillance, and investigative capabilities of poison control centers for chemical, biological, radiological and nuclear events, which may include:
 - Establishing systems to collect and submit near real-time poison center data relevant to rapid disease and detection of a chemical, radiological, or biological “event” electronically for review and analysis by a professional organization in the field of poison control and rapid reporting of suspicious events back to the relevant state health departments and the CDC;
 - Establishing priority health conditions and syndromes and points of contact at state health departments, the American Association of Poison Control Centers (AAPCC), and CDC;
 - Developing protocols to investigate reports of priority health conditions and syndromes;
 - Planning to provide surge capacity in the event of chemical, biological, radiological or nuclear threat or exposure; or
 - Expanding existing telecommunication equipment to enhance the available number of workstations at each regional poison control center.
- Improve the capabilities of poison control centers to provide information to health care providers and the public with regard to chemical, biological, radiological, or nuclear threats or exposures, in consultation with the appropriate state, local, and tribal public health entities.

Funding will support the acquisition (hire or contract) of staff, equipment, supplies, and training for awardees and subcontractors.

Every state and territory is served by a professional organization in the field of poison control, a state Poison Control Center, or a Regional Poison Control Center. For example, the Oregon Poison Control Center is a regional center that serves the citizens of Oregon, Alaska, and Guam.

Those awardees that do not have a resident Poison Control Center in their state or local jurisdiction are required to fulfill the intent of the award by distributing funds to and collaborating with a state or regional Poison Control Center or a professional organization in the field of poison control that serves their respective state or territory.

Please see the following links for additional information about the program as well as a directory of Poison Control and Prevention Centers.

<http://newsroom.hrsa.gov/releases/2007/PromotePoisonControl.htm>

<http://www.aapcc.org/findyourcenter.htm>

B. Hospital, Clinical Laboratory or University partnerships

In addition to the Poison Control Center Partnerships outlined above, each directly-funded locality (Chicago, District of Columbia, Los Angeles County and New York City) will also be required to carry out the following objectives through hospitals, clinical laboratories or universities.

In your narrative, describe your plans to achieve these objectives:

- Carry out a pilot demonstration project to purchase and implement the use of advanced diagnostic medical equipment.
- Distribute funds to a hospital, clinical laboratory, or university to obtain and validate advanced disease diagnostic technologies in order to explore emerging technologies (e.g., Mass Tag PCR) to analyze real-time clinical specimens for infectious pathogens or syndromes of public health or bioterrorism significance (e.g., bioterrorism agents, pandemic influenza, diarrheal or foodborne diseases, febrile neurological diseases).
- Assure that information obtained in these high throughput clinical centers (i.e., hospitals) are received and analyzed by the state/local health departments and tribal public health entities via their surveillance systems.

In addition, include narratives that present:

- Descriptions of how these enhancements will be incorporated into operations during a large scale infectious disease outbreak;
- Descriptions of how existing infectious disease surveillance systems will be adapted to incorporate data from these participating clinical entities; If applicable, an explanation of how the proposal builds on existing practices or technologies in an effort to more efficiently use available funds; and
- Descriptions of the evaluation and logic model to be used in the evaluation of the practices and technologies.

Funding will support the acquisition (hire or contract) of staff, equipment, supplies, and training for awardees and subcontractors. Additional details regarding expected activities can be found in Appendix 7.

9. Early Warning Infectious Disease Surveillance (EWIDS): HHS' Assistant Secretary for Preparedness and Response (ASPR), continues to provide supplemental funds for the purpose of developing and enhancing cross-border early warning infectious disease surveillance efforts for selected states, those sharing a common land-border with México, and a land- or Great Lakes maritime-border with Canada, to facilitate early detection and situational awareness for infectious disease threats outside the U.S. which could impact U.S. health security.

The aim of the U.S. Border States EWIDS project continues to be to enhance coordination among neighboring states along the U.S. - México border and the U.S. - Canada borders to:

1. Improve early warning epidemiological surveillance capabilities at the state/province, local and tribal level;
2. Strengthen capacity for cross-border detection, reporting and prompt investigation of infectious disease outbreaks;
3. Explore mechanisms to create interoperable systems to share surveillance (including laboratory) data; and
4. Develop the public health workforce to undertake these activities.

In your narrative, describe the EWIDS activities you plan for Budget Period 8. Additional information regarding expected activities can be found in Appendix 10.

10. Ten awardees will receive funding to support Level 1 Surge Capacity Chemical Laboratory personnel, equipment, and/or activities. If you are a recipient of these funds according to Appendix 3, please answer the follow questions.
 - What are your plans to address objectives related to chemical emergency response surge capacity; including staffing and equipping the lab, training, and proficiency testing the staff, and participation in local and national exercises?
 - How will you increase your lab capabilities and capacities consistent with the Laboratory Network for Chemical Terrorism (LRN-C) program objectives, including: addition of new high throughput sample preparation techniques, new high-throughput sample analysis techniques/methods, and analytical capability for new threat agents?
11. CDC supports a network of Centers for Public Health Preparedness (CPHP) to develop, deliver and evaluate competency-based training and education programs based on identified needs of state and local public health agencies for building workforce preparedness and response capabilities. If you have indicated in Part 1 of your Interim Progress Report that you have not yet worked with the CPHPs, describe your plans to establish such a relationship in order to increase the number, type and distribution of health professionals who are prepared to respond to a public health emergency.

12. Provide evidence that at least a majority, if not all, of local health departments and American Indian/Alaska Native tribes within your borders approves or concurs with the approaches and priorities described in this application. CDC requires that the process used by the applicant to engage local health departments and American Indian/Alaska Native tribal governments or tribal organizations located within their boundaries to reach concurrence for the proposed use of non-earmarked cooperative agreement funds, including those for pandemic influenza preparedness, be documented in the Interim Progress Report. (Non-earmarked cooperative agreement funds are those funds not designated for the Cities Readiness Initiative program, the Early Warning Infectious Disease Surveillance program, or currently established Level 1 Chemical Laboratories.) Your description of these processes should have been included in Part 1, Section 1, Item 2 and Item 6, where applicable.

In this Part 2 submission of your Interim Progress Report, evidence must be demonstrated separately for local health officials and tribal entities. Documentation for local health department concurrence may be accomplished by:

- Completing a list in PERFORMS (<https://sdn.cdc.gov>) noting the consensus of a majority of local health officials whose collective jurisdictions encompass a majority of the state's population; or
- Attaching in PERFORMS (<https://sdn.cdc.gov>) the statement of the President of the State Association of County and City Health Officials (SACCHO) that a majority of local health officials whose collective jurisdictions encompass a majority of the state's population agree with the SACCHO's decision.

In addition, state applicants will be required to provide signed letters of concurrence upon request.

Documentation for tribal concurrence may be accomplished by:

- Attaching in PERFORMS (<https://sdn.cdc.gov>) a letter of concurrence from the Indian Health Board representing the tribes within your jurisdiction; or
- Attaching individual letters of concurrence from the American Indian/Alaska Native tribes within the jurisdiction; or
- Attaching a Word document describing the reasons for any lack of concurrence and the steps the state has taken to address them.

Section 2: Awardee-Determined Priority Projects

In order to move your level of preparedness ahead, you must accomplish a variety of tasks and activities. As a result of the work you have done over the past 6 years, it is possible that many of these tasks and activities have been essentially accomplished, and are more in need of routine testing/exercising than concentrated effort. In recognition of this reality, CDC is asking you to build your submission around the priority projects on which you will focus during Budget Period 8.

In the past, CDC has required awardees to specifically indicate whether they were engaged in each of the health and medical critical tasks established by Subject Matter Experts. This activity-centered approach yielded little understanding of challenges, needs, and successes of the

awardees, and gave the impression that each of these tasks was equally important to all jurisdictions. In recognition of the maturation of the Public Health Emergency Preparedness program and the understandable differences in needs, resources, and threats among awardees, CDC has designed a new approach that emphasizes awardee-determined priority projects.

A “priority project” is defined for this purpose as a collection of actions that are linked to a common goal and expected long-term outcomes. Priority projects may be designed to address gaps, to remediate problems, or to focus effort and resources on areas in need of significant immediate improvement. Determining priority projects does not mean awardees will discontinue their other activities. Awardees will, however, describe only those projects that state and local partners have identified as priorities for Budget Period 8. CDC is not requiring a specific number of priority projects. We recommend awardees limit the number of priority projects based on their capacity and resources for the year.

Your priority projects for Budget Period 8 are expected to build upon and complement Budget Period 7 activities and the successes you have described in Part 1 of your Interim Progress Report. Unless you have specified in Part 1 the need to carry forward an activity/project because of significant obstacles or revisions, do not include those that have already been described in Part 1 of your Interim Progress Report.

The Target Capabilities and Critical Tasks are part of the National Preparedness Goal and also are associated with the CDC’s nine Preparedness Goals, as shown in Appendix 9. They serve as a basis for planning how to achieve preparedness goals, and, in practice, often support more than one of the goals. Awardees are required to associate proposed priority projects and outputs for Budget Period 8 with Preparedness Goals and, if applicable, the designation may include the associated Target Capabilities and critical tasks. A single priority project may be linked to multiple Preparedness Goals, Target Capabilities and critical tasks. It is not necessary for every Preparedness Goal, Target Capability or critical task to be addressed by your priority projects.

You will find the template to be used to complete this component of your Interim Progress Report in PERFORMS (<https://sdn.cdc.gov>). Complete each section thoroughly and concisely. As you describe each project, follow the template to ensure that you include all information. Numerous dropdown menus have been provided to ease the submission of information that may be similar across awardees.

B. Pandemic Influenza Supplement Activities and Submission Instructions

Part 2 of the Interim Progress Report for the continuation proposal of the Public Health Emergency Preparedness (PHEP) Cooperative Agreement also includes your Pandemic Influenza Supplement submission for Budget Period 8. Your submission will be comprised of required priority projects through which the awardee, along with local public health and other

partners, will improve and exercise preparedness and response capabilities specifically for an influenza pandemic.

Section 1: Pandemic Influenza Requirements

Awardees are required to:

1. Describe any ongoing pandemic influenza-related priority projects that will be conducted in Budget Period 8, using the work plan template in PERFORMS (<https://sdn.cdc.gov>) (see Appendix 8). In order to move ahead in your preparedness for a pandemic, you must accomplish a variety of tasks and activities. Many of these tasks and activities have been accomplished as a result of your work over the past 2-3 years; they are likely to encompass the 24 thematic areas previously identified by the Federal Government as a framework for creating state pandemic influenza operational plans. CDC recognizes that there may be pandemic influenza-related priority projects and activities that are necessary for you to sustain pandemic planning efforts (ongoing activities); there may also be activities related to capabilities that are priorities that are incomplete from Budget Period 7 (unfinished activities). Budget Period 8 priority projects should first complete the unfinished activities previously identified in Budget Period 7 that are still defined as a priority by the jurisdiction. Development of your budget and justification should reflect the pandemic influenza-related activities necessary to sustain your progress to date.

Workplans must also include specific pandemic influenza planning, implementation, and evaluation of activities to be conducted at the local health department/community level. In addition, be sure to describe how you coordinate with the Hospital Preparedness Program, emergency management, education, critical infrastructure, labor/human resources/private business industry, public safety, and agriculture/food safety as you describe your partners and the “who” and “how” of your priority projects.

2. Conduct a minimum of one new awardee-determined priority project. After describing unfinished projects that remain priorities, awardees must present one (and may present more) project which they and their partners have determined to be of the highest priority in moving pandemic preparedness forward. Awardees are strongly encouraged to support planning activities with the other sectors mentioned above.

In recognition of items 1 and 2 above, CDC anticipates that up to 50 percent of your pandemic influenza supplement funding will support your ongoing efforts from Budget Period 7 and one or more additional priority project(s) of your choice. This is an effort to have you focus the attention and energy of your staff and partners on those areas that you deem most in need of improvement during this budget period. Your budget and justification should reflect resources needed for ongoing activities and new priority projects. Your submission narrative may be limited to the work plan for your priority project(s) if there are no incomplete activities from Budget Period 7.

Section 2: Operational Plans and Exercise Planning

In Appendix 11, you will find a list of activities categorized within three specific levels – Level 1, Level 2, and Level 3 – for each of the six priority thematic areas of the state operational plans that were submitted to the CDC in April 2007 (Mass Vaccination, Continuity of Operations (COOP), Surveillance/Laboratory, Communications, Antiviral Drug Distribution, and Community Containment). The levels are summarized as follows:

- Level 1 – Operational plan developed to incorporate the requirements of each priority area; discussion-based exercise strategy to be utilized to update plan based on After Action Reports/lessons learned from exercises.
- Level 2 – Transition from discussion-based exercises to operational-based exercises utilizing a more complex discussion-based exercise strategy to update the plans based on After Action reports/Improvement Plans/lessons learned from exercises.
- Level 3 – Operational-based exercise strategy based upon documentation of completed corrective action plans from prior discussion-based or operational-based exercise to ensure that any full-scale exercise execution will be based on the updated results.

Perform the following activities using the remaining pandemic influenza supplement funding:

1. Based upon the results of the CDC’s April 2007 assessment of your pandemic influenza operational plans in the six priority thematic areas, CDC may have categorized one or more areas as having “no or inadequate information” or “many major gaps.” For each of the priority thematic areas that fall into one of these two categories, update your existing pandemic influenza operational plan to contain the required missing Level 1 elements as listed in Appendix 11. Submit the updated plans to CDC for review by **December 15, 2007**.
2. Create HSEEP-compliant, capability-based planning, training, and exercise cycles that address a minimum of two of the priority areas that have been categorized as having “few major gaps” or “no major gaps” as determined by CDC, and, if applicable, one of the areas categorized as having “no or inadequate information” or “many major gaps.” After reviewing the CDC-identified pandemic preparedness priorities from the April 2007 assessment, awardees are to select which capabilities, CDC-defined overarching objectives, and critical tasks they wish to validate and develop through a planning, training, and exercise cycle during this budget period. CDC has provided overarching objectives and critical tasks for each priority thematic area in Appendix 12; the critical tasks are items that must be addressed in your exercise activities.

CDC will permit awardees to select which level of exercise to pursue. Awardees will need to create an exercise strategy and schedule (see Appendix 13 for template) to move the designated areas from Level 1 to Level 2 OR from Level 2 to Level 3. Priority areas that are categorized as having “no or inadequate information” or “many major gaps,” however, must begin in Level 1. Priority areas that are in the “few major gaps” or “no major gaps” level can begin in Level 1 if there has not been a tabletop or other discussion-based exercise conducted on that priority during Budget Period 7; otherwise, awardees are permitted to begin their exercise strategy at Level 2.

CDC will notify awardees if a pandemic influenza exercise will be planned in the last quarter of Budget Period 8 that encompasses one or more of the six public health pandemic influenza

priority areas. Awardees with “no major gaps” in a particular priority area that plan to exercise in that area in the last quarter of the Budget Period will be eligible to conduct a joint exercise with CDC. If you would need to utilize cooperative agreement supplement funding to support your participation in a joint exercise with CDC, you may designate a line item entitled “funding for CDC exercise.”

Your exercise strategy must be submitted to your Division of State and Local Readiness Project Officer for review and approval prior to conducting the exercise activities, particularly if a full-scale exercise is planned during this project year. Exercise strategies must build on previous work and reflect HSEEP principles. If this is not the case, CDC will restrict funding until these conditions are met. Awardees will need to demonstrate completed Corrective Action Plan activities in a particular thematic area from tabletop, drills, or functional exercises prior to permission to conduct a full-scale exercise. Where possible, activities should be combined with scheduled exercises by Homeland Security, hospitals, emergency management or other officials to minimize burden on exercise planners and participants. CDC requires all state and local public health exercises to be entered into a CDC-secure page on the Lessons Learned Information System (www.llis.gov) or into the National Exercise Scheduler (NEXS). Information related to how state and local health departments can register for this CDC-secure page will be provided within 1 week of the release of this guidance document. The Lessons Learned Information System also includes hyperlinks to a wide variety of useful resources, such as the National Preparedness Goal, Homeland Security Exercise Evaluation Program, and other federal guidelines and preparedness documents.

Section 3: Assessment and Evaluation

CDC’s assessment of awardee progress at each level of the exercise process will include:

1. Documentation of a planning, training, exercise cycle strategy and schedule. Awardees’ exercise strategy must include buy-in from the appropriate jurisdictions/agencies, and/or senior officials, a project management timeline, activity milestones, an exercise planning team, and identified dates for planning conferences per the Department of Homeland Security Exercise and Evaluation Program (HSEEP). The exercise schedule must include planned state and local public health exercise and be posted to the CDC-secure page at www.llis.gov at a minimum or the NEXS when possible.
2. Documentation of HSEEP-compliant After Action Report / Improvement Plan / Corrective Action Program for each seminar, tabletop, functional, or full-scale exercise conducted. After Action Reports for seminars must also include awardee-developed post-tests that document attendees achieved knowledge retention of the seminar topics. After Action Reports for discussion-based tabletops and all operational exercises must include the provision of a formal exercise evaluation, integrated analysis, and the top 5 corrective actions as prioritized by the awardee that can be completed in 180 days after the exercise in the improvement plan.
3. Documentation that Improvement Plan items have been addressed through subsequent exercises and After Action Reports. CDC will assess the awardee’s progress in line with Performance Measure 9B, Time to Re-evaluate Responses, following completion of corrective actions identified in an After Action Report. Since awardees are required as a

performance measure to submit at least two After Action Reports per reporting period, it is recommended that at least two of the After Action Reports per budget period be linked as part of the awardee's exercise strategy.

For example, if an awardee submitted two After Action Reports related to a discussion-based exercise (e.g. tabletop exercise) followed by an operational exercise (e.g. drill), the following comparisons could apply:

- 5 = number of corrective actions identified by the awardee in an After Action Report for the tabletop exercise
- 3 = number of corrective actions implemented within the 180 day reporting period as identified in the After Action Report from a drill within that reporting period
- 3 / 5 = 60 percent

CDC recognizes that the execution of both discussion and operational exercises on the same thematic topic within 180 days may not be feasible for all awardees based upon the variations in state and local exercise resources; however, awardees may create creative planning, training, and exercise strategies this year that involve multiple discussion-based HSEEP building blocks for this part of the progress assessment if this is pertinent to your jurisdiction.

Since awardees are required as a performance measure to submit data on at least two After Action Reports per budget period, it is recommended that at least two exercises be linked as part of the awardees' exercise strategy.

4. Documentation of an objective third-party peer data collection process to assure that relevant subject matter expertise in public health preparedness is utilized to conduct the data collection and evaluation processes in line with HSEEP standards. Evaluation of a jurisdiction's exercise elements is to be supported by utilizing peer data collectors from neighboring or other states who have the corresponding subject matter experience/expertise and have been trained in the HSEEP protocols.

This corps of data evaluators can and should, if available, consist of membership from public health, hospitals/health care, emergency management, and academia (this component can be filled by coordination with the Center for Public Health Preparedness). Evaluators should have experience and subject-matter expertise in the area they are assigned to observe. For example, if the jurisdiction's exercise scope is mass vaccination, the evaluators should be public health staff or persons with public health department subject matter expertise/operational experience in the area of mass vaccination.

Awardees must provide a list of their state exercise evaluation corps along with their Part 2 submissions. CDC will make this list of personnel available to all awardees through a CDC-secure page on www.llis.gov. Awardees should contact neighboring or other states to obtain data evaluators for their respective exercises.

C. Detailed Line Item Budget and Justification

Submit a detailed line item budget and justification of the funding amount requested to support your program activities for Budget Period 8. Direct Assistance will be included in this section,

and your Direct Assistance budget should reflect the items you requested on your Direct Assistance Request Form. If you did not submit a Direct Assistance Request Form by June 1, 2007, Direct Assistance will not be available to you. Develop your budgets separately by each funding source (PHEP, Pandemic Influenza, Level 1 Surge Capacity Chemical Laboratory, Early Warning Infectious Disease Surveillance, Cities Readiness Initiative, and Real-Time Disease Detection). A matrix to guide awardees in allocating expenses across the various federal preparedness programs can be found at http://www.ojp.usdoj.gov/odp/grants_hsgp.htm.

PERFORMS (<https://sdn.cdc.gov>) will guide you to develop separate budgets based on funding source.

Due to the issuance of Notices of Grant Awards before August 31, 2007, the processing of your budget request will be handled as if it were a budget change request. CDC's Procurement and Grants Office and the Division of State and Local Readiness Project Officers will identify a time for a conversation with you about your budget prior to the creation of your approved amended Notice of Grant Award.

Participation in CDC-sponsored training, workshops and meetings is essential to the effective implementation of the PHEP. Therefore, awardees should include travel for appropriate staff to attend the Preparedness Summit in 2008 for 4 days in Atlanta, Georgia and one 2-day Regional Meeting to be held in a central location in the Mid-Atlantic, South/Midwest, Northwestern and Southwestern regions of the United States, as well as an additional trip to Atlanta for 2 staff for 4 days to attend the Evaluation 101 course currently being designed. For those receiving Level 1 Surge Capacity Chemical Laboratory funding, include travel for at least two staff to Atlanta for 5 days to be trained in Level 1 Surge Capacity Chemical Laboratory techniques, equipment and procedures.

The following information must be submitted for all newly-requested contracts as well as for revisions to any existing contract:

- Name(s) of contractor(s)
- Scope of Work
- Method of selection (competitive or sole source); procurement by noncompetitive proposals may be used only when the award of a contract is infeasible under small purchase procedures, sealed bids or competitive proposals and is justified under criteria in 45 Code of Federal Regulations Part 92.36.
- Period of performance
- Method of accountability
- Itemized budget with narrative justification

Awardees should be aware that pandemic influenza supplement funding may be used in the following circumstances:

- Pandemic influenza supplement funding may be utilized for travel and related expenses for staff from local or state health departments to be trained in HSEEP.

- Awardees/jurisdictions may use a portion of this funding or seek other sources of funding (e.g., DHS) to select and train a core of evaluators/data collectors in HSEEP evaluation principles and protocols if the jurisdiction does not already have public health, hospitals/health care, emergency management, and academic personnel who have HSEEP expertise. HSEEP train-the-trainer design and evaluation programs are available by contacting the awardee's state emergency management agency/state administrative authority. This process is to ensure compliance with the recommendations of *Federal Response to Hurricane Katrina: Lessons Learned*, which recommends that joint exercises be conducted between organizations.
- Pandemic influenza supplement funding may be utilized for travel of groups or corps of state-based peers from local or state health departments who have been trained in HSEEP to assist neighboring or other states in their exercise activities.
- In addition to building internal capacities to conduct and evaluate exercises, awardees may select outside contractor organizations to support their pandemic influenza exercise programs. It is strongly encouraged that awardees select contractors who have exercise personnel with documented public health operational experience on their staff.

Additional budget preparation guidance is available at:

<http://www.cdc.gov/od/pgo/funding/Budget%20Guidelines%2011.03.06.doc>

Appendix 2

Cooperative Agreement AA154 Closeout Requirements

Submit the following required reports to CDC within 90 days after the project completion date as specified in terms and conditions of the award/agreement and 45 Code of Federal Regulations (CFR) Part 74 and 92:

- **Final Performance/Progress Report** – the narrative of the final report should include information to fulfill any specific reporting requirements in the Notice of Award, a summary statement of progress toward the achievement of the originally stated goals, and a list of the results considered significant (whether positive or negative).
- **Final Financial Status Report (SF 269 or 269A)** – the final report should not show any unliquidated obligations and must indicate the exact balance of the unobligated funds. The final Financial Status Report (FSR) should agree with the final expenditures reported to HHS, Payment Management System (PMS). If not, the recipient will be required to update the reports (SF 272 and FSR 269) so they agree.
- **Equipment Inventory List** – an inventory list should include the description of the item, manufacturer serial and/or identification number, acquisition date and cost, and percentage of federal funds used in the acquisition of the item. When equipment acquired with CDC funds is no longer needed on the grant, the equipment may be used for other activities in accordance with the following standards: Equipment with a fair market value of \$5,000 or more may be retained for other uses provided compensation is made to CDC. These requirements do not apply to equipment which was purchased with non-federal funds. Equipment no longer need shall be disposed following instructions requested from and provided by CDC/Procurement and Grants Office. If no equipment was acquired under this grant/cooperative agreement, a negative report is required.
- **Final Invention Statement** – a final Invention Statement is required. If no inventions were conceived under this assistance award, a negative report is required. This Statement may be included in a cover letter.

**Appendix 3
Fiscal Year 2007 Funding**

Awardee	Total Base plus Population* Funding	FY 2007 Cities Readiness Initiative (CRI) Funding	FY 2007 Level 1 Chemical Lab Capacity Funding	FY07 Real-Time Disease Detection Funding	FY07 Early Warning Infectious Disease Surveillance (EWIDS) Funding	FY 2007 Pandemic Influenza Funding	FY 07 Total Allocation
Alabama	\$9,619,061	\$200,000		\$409,377		\$2,723,424	\$12,951,862
Alaska	\$4,714,137	\$200,000		\$85,863	\$15,000	\$823,752	\$5,838,752
American Samoa	\$384,057			\$35,537		\$128,236	\$547,830
Arizona	\$11,625,317	\$1,559,294		\$524,147	\$575,691	\$3,397,350	\$17,681,799
Arkansas	\$7,036,017	\$236,352		\$261,613		\$1,855,748	\$9,389,730
California	\$41,044,030	\$6,042,605	\$1,253,127	\$2,207,070	\$1,476,742	\$13,279,456	\$65,303,030
<i>Chicago</i>	\$9,156,684	\$2,150,000		\$2,500,000		\$1,896,357	\$15,703,041
Colorado	\$9,774,988	\$1,040,857		\$418,297		\$2,775,801	\$14,009,943
Connecticut	\$8,097,817	\$691,902		\$322,353		\$2,212,419	\$11,324,491
Delaware	\$4,633,953	\$265,242		\$100,805		\$911,494	\$5,911,494
District of Columbia	\$5,799,492	\$830,000		\$2,500,000		\$768,635	\$9,898,127
Florida	\$28,835,271	\$2,845,063	\$100,400	\$1,508,657		\$9,178,384	\$42,467,775
Georgia	\$16,175,618	\$1,270,346		\$784,451		\$4,925,852	\$23,156,267
Guam	\$544,797			\$44,732		\$182,230	\$771,759
Hawaii	\$4,851,896	\$307,790		\$136,667		\$1,122,075	\$6,418,428
Idaho	\$5,075,400	\$200,000		\$149,453	\$15,000	\$1,197,152	\$6,637,005
Illinois	\$17,378,879	\$998,379		\$853,284	\$15,000	\$5,330,042	\$24,575,584
Indiana	\$12,108,452	\$731,112		\$551,785	\$15,000	\$3,559,641	\$16,965,990
Iowa	\$7,307,849	\$247,153		\$277,162		\$1,947,059	\$9,779,223
Kansas	\$6,985,963	\$465,100		\$258,749		\$1,838,934	\$9,548,746
Kentucky	\$9,060,813	\$467,118		\$377,442		\$2,535,902	\$12,441,275
<i>Los Angeles County</i>	\$19,428,760	\$3,436,517		\$2,500,000		\$5,346,873	\$30,712,150

Awardee	Total Base plus Population* Funding	FY 2007 Cities Readiness Initiative (CRI) Funding	FY 2007 Level 1 Chemical Lab Capacity Funding	FY07 Real-Time Disease Detection Funding	FY07 Early Warning Infectious Disease Surveillance (EWIDS) Funding	FY 2007 Pandemic Influenza Funding	FY 07 Total Allocation
Louisiana	\$9,569,424	\$560,509		\$406,538		\$2,706,750	\$13,243,221
Maine	\$4,919,151	\$200,000		\$140,515	\$122,283	\$1,144,666	\$6,526,615
Marshall Islands	\$385,786			\$35,635		\$128,816	\$550,237
Maryland	\$11,133,145	\$1,186,275		\$495,992		\$3,232,023	\$16,047,435
Massachusetts	\$12,292,553	\$1,462,811	\$100,400	\$562,317		\$3,621,483	\$18,039,564
Michigan	\$17,697,985	\$1,482,503	\$1,195,196	\$871,539	\$308,096	\$5,437,233	\$26,992,552
Micronesia	\$456,995			\$39,709		\$152,737	\$649,441
Minnesota	\$10,454,090	\$1,060,505	\$565,400	\$457,146	\$50,512	\$3,003,920	\$15,591,573
Mississippi	\$7,242,140	\$281,717		\$273,403		\$1,924,987	\$9,722,247
Missouri	\$11,423,481	\$1,300,711		\$512,601		\$3,329,550	\$16,566,343
Montana	\$4,691,540	\$200,000		\$108,461	\$26,487	\$956,446	\$5,982,934
Nebraska	\$5,554,193	\$235,370		\$176,843		\$1,357,985	\$7,324,391
Nevada	\$6,506,895	\$924,204		\$231,343		\$1,678,009	\$9,340,451
New Hampshire	\$4,902,356	\$251,569		\$139,554	\$15,000	\$1,139,025	\$6,447,504
New Jersey	\$15,660,578	\$1,169,318		\$754,988		\$4,752,843	\$22,337,727
New Mexico	\$5,800,489	\$271,300	\$911,283	\$190,932	\$75,922	\$1,440,719	\$8,690,645
New York	\$19,193,350	\$1,203,275	\$1,181,779	\$957,083	\$399,589	\$5,939,545	\$28,874,621
<i>New York City</i>	\$16,769,122	\$5,100,000		\$2,500,000		\$4,453,467	\$28,822,589
North Carolina	\$15,610,209	\$207,858		\$752,106		\$4,735,924	\$21,306,097
North Dakota	\$4,716,379	\$200,000		\$83,621	\$28,972	\$810,589	\$5,839,561
Northern Mariana Islands	\$416,705			\$37,404		\$139,203	\$593,312
Ohio	\$19,648,617	\$2,098,508		\$983,127	\$15,000	\$6,092,474	\$28,837,726
Oklahoma	\$8,152,403	\$393,316		\$325,476		\$2,230,755	\$11,101,950

Awardee	Total Base plus Population* Funding	FY 2007 Cities Readiness Initiative (CRI) Funding	FY 2007 Level 1 Chemical Lab Capacity Funding	FY07 Real-Time Disease Detection Funding	FY07 Early Warning Infectious Disease Surveillance (EWIDS) Funding	FY 2007 Pandemic Influenza Funding	FY 07 Total Allocation
Oregon	\$8,287,711	\$571,687		\$333,216		\$2,276,207	\$11,468,821
Palau	\$329,485			\$32,415		\$109,904	\$471,804
Pennsylvania	\$21,050,868	\$2,614,150		\$1,063,344	\$15,000	\$6,563,508	\$31,306,870
Puerto Rico	\$8,681,267			\$355,730		\$2,408,407	\$11,445,404
Rhode Island	\$4,562,892	\$365,904		\$120,135		\$1,024,995	\$6,073,926
South Carolina	\$9,179,430	\$308,696	\$100,400	\$384,228		\$2,575,746	\$12,548,500
South Dakota	\$4,704,810	\$200,000		\$95,190		\$878,521	\$5,878,521
Tennessee	\$11,659,687	\$823,492		\$526,113		\$3,408,895	\$16,418,187
Texas	\$36,198,312	\$4,413,698		\$1,929,838	\$2,029,033	\$11,651,720	\$56,222,601
Utah	\$6,586,447	\$351,725		\$235,894		\$1,704,731	\$8,878,797
Vermont	\$4,717,511	\$200,000		\$82,489	\$39,717	\$803,941	\$5,843,658
Virgin Islands (US)	\$457,871			\$39,759		\$153,031	\$650,661
Virginia	\$13,989,826	\$1,241,270	\$1,218,615	\$659,411		\$4,191,617	\$21,300,739
Washington	\$12,131,377	\$1,296,773		\$553,096	\$186,956	\$3,567,341	\$17,735,543
West Virginia	\$5,638,523	\$205,861		\$181,667		\$1,386,312	\$7,412,363
Wisconsin	\$11,039,928	\$548,947	\$573,400	\$490,659	\$15,000	\$3,200,711	\$15,868,645
Wyoming	\$4,726,961	\$200,000		\$73,039		\$748,448	\$5,748,448
TOTAL FY 2007 PHEP FUNDING	\$616,779,743	\$57,316,782	\$7,200,000	\$35,000,000	\$5,440,000	\$175,000,000	\$896,736,525

*Data used from Fiscal Year 2005 Census information

Appendix 4
Level 1 Surge Capacity Chemical Laboratory Funding

The purpose of this section is to provide budgeting guidance to the ten Level 1 laboratories that will provide surge capacity to CDC in the event of a chemical release. This budgeting guidance focuses only on the use of funds that have been specifically allocated since 2003 to maintain chemical laboratory surge capacity. These funds have totaled \$7.2 million each year since 2003 and have been distributed to each of our surge laboratories. The application of these funds is to help meet the Coordinating Office for Terrorism Preparedness and Emergency Responses' sub-objective 3.5 (Laboratory Testing Capacity), specifically, "By 2011 decrease by 50% identified gaps in testing capacity of CDC laboratories and CDC managed networks for identifying agency-specific priority agents, toxins, and toxic substances."

Existing Level 1 Laboratories (CA, MI, NM, NY, and VA)

Budgets submitted for surge capacity funding will not include any new equipment/instrumentation that exceeds \$75,000. Each state should budget for the following:

1. Maintaining existing staff
2. Maintaining/extending necessary maintenance agreements for current instrumentation
3. Maintaining necessary supplies, reagents, and proficiency-testing program subscriptions
4. Travel budgets should include the following:
 - a. Attendance at two Level 1 meetings (locations to be determined)
 - b. Method transfer training at CDC for a minimum of two personnel
 - c. Attendance at LRN-C related conferences
 - d. Professional development conferences and training

Specifically, existing Level 1 laboratories will not submit budget requests for surge capacity funds that exceed the following levels:

California	–	\$1,253,127
Michigan	–	\$1,195,196
New Mexico	–	\$ 911,283
New York	–	\$1,181,779
Virginia	–	\$1,218,615

The amounts listed above represent a 20 percent reduction in surge capacity funds provided last year. The remaining surge-capacity funds will be used to bring new Level 1 laboratories up to analytical parity. This process will be performed incrementally so as to minimally impact the existing Level 1 surge capacity laboratories. In addition, during this time of transition, awardees will have the flexibility to support Level 2 activities using the supplemental funds intended for chemical laboratory surge capacity.

New Level 1 Laboratories (FL, MA, MN, SC, and WI)

Surge-capacity funding will be used to bring new Level 1 laboratories to analytical parity with existing Level 1 laboratories. This process is anticipated to take 3 years. Budgets submitted for new Level 1 laboratories should not include analytical instrumentation other than what is identified below. Each state should budget for the following:

1. Funding one PhD-level analytical chemist, or equivalent, dedicated to surge capacity activities
2. Purchasing necessary supplies, reagents, and proficiency-testing program subscriptions for level-one methods
3. Travel budgets should include the following:
 - a. Attendance at two Level 1 meetings (locations to be determined)
 - b. Method transfer training at CDC for a minimum of two personnel
 - c. Attendance at LRN-C related conferences
 - d. Professional development conferences and training

Specifically, new Level 1 laboratories will not submit budget requests for surge-capacity funds that exceed the following levels:

Florida	–	\$100,400
Massachusetts	–	\$100,400
Minnesota	–	\$565,400 (This amount includes the purchase of an Atmospheric Pressure Ionization (API) 4000 with a Liquid Chromatography front end.)
South Carolina	–	\$100,400
Wisconsin	–	\$573,400 (This amount includes the purchase of an API 4000 with a Nanomate front end.)

State	Surge-Capacity Amount
California	\$1,253,127
Michigan	\$1,195,196
New Mexico	\$ 911283
New York	\$1,181,779
Virginia	\$1,218,615
Florida	\$100,400
Massachusetts	\$100,400
Minnesota	\$565,400
South Carolina	\$100,400
Wisconsin	\$573,400
Total	\$7,200,000

Appendix 5
Division of State and Local Readiness
Project Officers

Projects	Contact	Telephone	E-mail
Maryland, Virginia, District of Columbia, Hawaii	John Scott	(404) 639-7435	jps5@cdc.gov
Ohio, Guam	Monica Farmer	(404) 639-0533	mwf7@cdc.gov
New Jersey, New York, New York City, Georgia	Keesler King	(404) 639-7423	knk8@cdc.gov
North Carolina, Puerto Rico, South Carolina, Virgin Islands	Mark Green	(678) 643-3488	mlg5@cdc.gov
Commonwealth of Northern Mariana Islands (CNMI), Palau	Monica Farmer	(404) 639-0533	mwf7@cdc.gov
Connecticut, Massachusetts, Maine, New Hampshire, Vermont, Rhode Island, Federated States of Micronesia (FSM)	Jean Popiak	(404) 639-7438	lzp9@cdc.gov
Florida, Louisiana	Karen Willis Galloway	(404) 639-7451	klw5@cdc.gov
Iowa, Kansas, Missouri, Nebraska, Kentucky, Arizona, Nevada, Marshall Islands	Andy Hopkins	(404) 639-7408	amh7@cdc.gov
New Mexico, Pennsylvania	Mark Biagoni	(404) 639-4731	gld5@cdc.gov
Colorado, North Dakota, South Dakota, Utah, Alabama, Montana, American Samoa,	Greg Smith	(404) 639-7703	gqs0@cdc.gov
Alaska, Oregon, Washington	Monica Farmer	(404) 639-0533	mwf7@cdc.gov
Chicago, Illinois, Indiana, Michigan, Minnesota, Wisconsin, Texas	Kevin Griffy	(404) 639-7744	kwg2@cdc.gov
California, Los Angeles County	Monica Farmer	(404) 639-0533	mwf7@cdc.gov
Mississippi, Arkansas, Oklahoma	Keesler King	(404) 639-7423	knk8@cdc.gov
Delaware, Tennessee, Idaho	Terrance Jones	(404) 639-7804	tjones3@cdc.gov
Wyoming, West Virginia	Karen Willis Galloway	(404) 639-7451	klw5@cdc.gov

**Appendix 6
Procurement and Grants Office
Grants Management Specialists**

Grant #	Awardee Name	Grants Management Specialist
516966	Illinois	Angela Webb
516983	Ohio	Phone: (770) 488-2784
517008	Chicago	Email: aqw6@cdc.gov
517018	Michigan	
517024	Indiana	
617001	Texas	
617005	Louisiana	
916012	Los Angeles County	
916969	Hawaii	
917016	California	

Grant #	Awardee Name	Grants Management Specialist
117009	Rhode Island	Kaleema McLean
316980	Delaware	Phone: (770) 488-2742
416968	Tennessee	Email: fya3@cdc.gov
516981	Minnesota	

Grant #	Awardee Name	Grants Management Specialist
116970	Vermont	Pamela Baker
116972	Maine	Phone: (770) 488-2689
117011	New Hampshire	Email: fxz7@cdc.gov
217004	New Jersey	
316998	West Virginia	
317014	Virginia	
317023	Maryland	
517002	Wisconsin	
616974	Arkansas	
616982	Oklahoma	
616999	New Mexico	

Grant #	Awardee Name	Grants Management Specialist
116996	Connecticut	Sharon Robertson
116997	Massachusetts	Phone: (770) 488-2748
216988	New York	Email: sqr2@cdc.gov
221298	New York City	
221823	Virgin Islands	
221876	Puerto Rico	
316831	District of Columbia	
316967	Pennsylvania	
416979	North Carolina	
417006	Florida	
417013	Georgia	

Grant #	Awardee Name	Grants Management Specialist
16977	Alaska	Glynnis Taylor
17007	Oregon	Phone: (770) 488-2752
17010	Washington	Email: gld1@cdc.gov
20290	Idaho	
416976	South Carolina	
416978	Alabama	
417015	Kentucky	
419986	Mississippi	
716833	Iowa	
716971	Missouri	
716975	Nebraska	
716985	Kansas	
816827	Colorado	
816832	Montana	
816965	Utah	
816973	South Dakota	
816984	Wyoming	
817000	North Dakota	
916964	Nevada	
916987	Arizona	
917003	Guam	
921818	N. Mariana Islands	
921819	Marshall Islands	
921820	Palau	
921821	Micronesia	
921822	American Samoa	

Appendix 7

Real-Time Disease Detection Instructions

For Directly-Funded Localities:

Specifically, awardees should pursue strategies including:

- New technologies/new uses for existing technologies/improvements to existing technologies – point of contact assays, higher throughput testing, mass screening;
- Surge capacity cross-training program; and/or
- Network development through improved collaboration, reporting, referral and/or consultation mechanisms (e.g., Laboratory Information Management System, proficiency testing program, BioSense, NIAID Research Centers for Excellence in Biodefense (RCEs)).

Submissions must include the following lists; PERFORMS (<https://sdn.cdc.gov>) will direct you about attaching these documents.

- List of agents or syndromes of public health importance of primary concern to the recipients;
- List of clinical, hospital, and/or research university collaborators who agree to participate in the project (with signed concurrence letters available upon request) and where this project will take place;
- List of project Principal Investigators from each collaborating clinic/hospital/university;
- List of members of a local steering committee consisting of members from the collaborating institutions as well as representatives from the project area's Public Health Emergency Preparedness program and public health laboratory;
- List of equipment, supplies, personnel, and primary responsibilities in, for, and of each collaborating clinic/hospital/university; and
- List of advanced diagnostic medical equipment to be purchased and procedures or methods that will be used to better characterize infectious disease threats presenting to participating facilities in real time.

Measures:

Ongoing financial support beyond this year is dependent on many factors. This first year's investment should focus on enhancing the capacity of clinical entities to better characterize infectious disease threats to the population. In the event that continuing support is available, capability, performance, or competency measures will be established. For Budget Period 8, capacity measures of interest will include:

- The identification of pathogens of interest that will be better characterized (i.e., specificity, speed) as a result of this project;
- The number of facilities, staff, training, purchases of equipment and supplies acquired to allow for enhanced identification of pathogens of interest; and
- Evidence of the linkage of diagnostic findings from the selected clinical entities to existing or enhanced local/state surveillance systems.

During Budget Period 8, CDC activities in support of this project will include:

- Convening a stakeholders meeting with representatives from the funded cities, their collaborating institutions, CDC and other subject matter professionals, and other collaborators (e.g., the Regional Centers of Excellence) to discuss protocols or procedures which may be of value to the funded cities. No single protocol will be written as each locality will designate the pathogens or syndromes of highest priority to that locale and, as a result, the instruments purchased may vary.
- Providing technical expertise and advice on linking laboratory and surveillance systems and working directly with awardees to facilitate multi-directional data exchange between state, local, clinical, hospital or university labs.
- In concert with other partners (e.g., DHS, RCEs), convening a working meeting during the course of the project to discuss progress to meeting the objectives of this project.
- When applicable, Laboratory Response Network services for confirmatory testing of established pathogens or for referral to other CDC subject matter expert labs as available.
- Upon request, collaborating on peer-reviewed journal articles with funded localities to better describe lessons learned from the use of these advanced technologies.

Appendix 8
Work Plan Elements and Definitions

Label	Long Description
Priority Project Name	A brief name to identify the priority project
What	The specific purpose of the project. What problem(s) or opportunities will it address?
Why	<ul style="list-style-type: none"> · Why are you addressing this particular problem or opportunity? · Why is this project the best option at this time? · Why does this issue/problem deserve your attention now? · What are the factors & history driving this project? · What are the project assumptions? · What are the benefits of this project? · How does this project support the national program goals?
How	<ul style="list-style-type: none"> · What strategy(ies) will you utilize for this project? · What is the capacity of the awardee to deal with this issue/problem?
When	The timelines against which you will measure progress.
Where	The area/jurisdiction in which the project will be conducted.
Partner Type	Select one or more partners that you will be collaborating with to accomplish this priority project.
Audience Type	The audience the project is designed to affect.
Who is Responsible?	<p>Please include:</p> <ul style="list-style-type: none"> · The position within your program with lead responsibility. · The community partners working with you, their specific roles/contributions and the way in which they are held accountable.
Focus	The funding source(s) for this project.
Theme	Cross-cutting areas that this project serves.
Select Related Performance Measure(s)?	Indicate if the project is related to any PHEP defined performance measures.
Pan Flu Thematic Area(s)	There have been 24 thematic areas in pandemic influenza that have been defined by a federal interagency workgroup. Each priority project, if possible, should be linked to one or more of these thematic areas of pandemic influenza preparedness. Select the thematic area(s) that best correspond to your priority project description.
Ongoing or New?	Indicate that the priority project is ongoing if this project is necessary for you to sustain pandemic planning efforts (ongoing activities) or capabilities that are priority items that may be incomplete from Budget Period 7. Otherwise, indicate that the priority project is new.

Project Output	<p>The deliverables (products/services) you expect to achieve by the end of the budget year. The deliverable can be measured as a quantity or a quality. Quantity measures how much product/service is delivered (e.g. number of public health responders vaccinated). Quality measures how well the product/service is delivered. Completeness and Conformance are two ways to measure the quality of the output.</p> <p>The definition of Completeness is having all the necessary, parts, elements or steps in place. For example, has the awardee responded to all of the necessary information elements with their application submission as required in the Guidance?</p> <p>The definition of Conformance is how well the product or service meets specifications or standards. For example, does an agency's Emergency Operations Center meet National Incident Management System (NIMS) incident command structure requirements to perform core functions?</p>
Type	The type of measure used to define this output: Number, Time (duration), and Ratio.
Output Target	Targets are the quantifiable or otherwise measurable characteristics that tell CDC the results you expect to achieve by the end of the fiscal year. Targets are reported as either a number or percentage.
Current Value	Status of output on Reported As Of Date.
Unit Measured	How the outputs will be measured. For example, Days/Hours/Minutes, Percentages, or Numbers.
Reported As Of Date	Date the current value was measured.

Appendix 9
Selected Target Capabilities and Critical Tasks

CDC Preparedness Goal 1: PREVENT

Increase the use and development of interventions known to prevent human illness from chemical, biological, radiological agents, and naturally occurring health threats.

1A. Target Capability: Planning

Required Critical Tasks:

- 1) Maintain a Senior Advisory Committee (SAC) to integrate preparedness efforts across the jurisdiction and leverage funding streams
- 2) Support incident response operations according to all-hazards plan that includes identification and planning for populations with special needs
- 3) Improve regional, jurisdictional, and state all-hazard plans (including those related to pandemic influenza) to support response operations in accordance with NIMS and the National Response Plan
 - a) Increase participation in jurisdiction-wide self-assessment using the National Incident Management System Compliance Assessment Support Tool (NIMCAST)
 - b) Assure agency's Emergency Operations Center meets NIMS incident command structure requirements to perform core functions: coordination, communications, resource dispatch and tracking and information collection, analysis and dissemination
- 4) Increase the number of public health responders who are protected through Personal Protective Equipment (PPE), vaccination or prophylaxis
 - a) Have or have access to a system that maintains and tracks vaccination or prophylaxis status of public health responders in compliance with PHIN Preparedness Functional Area *Countermeasure and Response Administration*
- 5) Increase and improve mutual aid agreements, as needed, to support NIMS-compliant public health response (e.g., local, regional, and Emergency Management Assistance Compact (EMAC))
 - a) Increase all-hazard incident management capability by conducting regional, jurisdictional and state training for NIMS and the Incident Command System (ICS)
 - b) Address legal and policy issues regarding ability to execute or fulfill EMAC requests (mutual aid versus mutual support)
- 6) Provide support for continuity of public health operations at regional, state, tribal, local government, and agency level

CDC Preparedness Goal 2: DETECT AND REPORT

Decrease the time needed to classify health events as terrorism or naturally occurring in partnership with other agencies.

2A. Target Capability: Information Gathering and Recognition of Indicators and Warning

Required Critical Tasks:

- 1) Increase the use of disease surveillance and early event detection systems
 - a) Select conditions that require immediate reporting to the public health agency (at a minimum, Category A agents)
 - b) Develop and maintain systems to receive reports 24/7/365
 - c) Have or have access to electronic applications in compliance with PHIN Preparedness Functional Area *Early Event Detection* to support:
 - Receipt of case or suspect case disease reports 24/7/365
 - Reportable diseases surveillance
 - Call triage of urgent reports to knowledgeable public health professionals
 - Receipt of secondary use health-related data and monitoring of aberrations to normal data patterns
 - d) Develop and maintain protocols for the utilization of early event detection devices located in your community (e.g., BioWatch)
 - e) Assess timeliness and completeness of disease surveillance systems annually
- 2) Increase sharing of health and intelligence information within and between regions and states with federal, local, and tribal agencies
 - a) Improve information sharing on suspected or confirmed cases of immediately notifiable conditions, including foodborne illness, among public health epidemiologists, clinicians, laboratory personnel, environmental health specialists, public health nurses, and staff of food safety programs
 - b) Identify key public health staff that need secret or top secret security clearances and mechanisms within the jurisdiction to obtain needed clearances to ensure access to sensitive information about the nature of health threats and intelligence information
- 3) Decrease the time needed to disseminate timely and accurate national strategic and health threat intelligence
 - a) Maintain continuous participation in CDC's Epidemic Information Exchange Program (Epi-X)
 - b) Participate in the Electronic Foodborne Outbreak Reporting System (EFORS) by entering reports of foodborne outbreak investigations and monitor the quality and completeness of reports and the time from onset of illnesses to report entry
 - c) Perform real-time subtyping of PulseNet tracked foodborne disease agents. Submit the subtyping data and associated critical information (isolate identification, source of isolate, phenotype characteristics of the isolate, serotype, etc) electronically to the national PulseNet database within 72 to 96 hours of receiving the isolate in the laboratory.

- d) Have or have access to information systems for 24/7/365 notification/alerting of the public health emergency response system that can reach at least 90% of key stakeholders and is compliant with PHIN Preparedness Functional Area *Partner Communications and Alerting*

2B. Target Capability: Planning

Required Critical Tasks:

- 1) Prioritize the hazards identified in the jurisdiction hazard/vulnerability assessment for potential impact on human health with special consideration for lethality of agents and large population exposures in order to mitigate or plan for identified hazards
- 2) Decrease the time to intervention by the identification and determination of potential hazards and threats, including quality of mapping, modeling, and forecasting
- 3) Decrease human health threats associated with identified community risks and vulnerabilities (i.e., chemical plants, hazardous waste plants, retail establishments with chemical/pesticide supplies)
- 4) Through partners increase the capability to monitor movement of releases and formulate public health response and interventions based on dispersion and characteristics over time

CDC Preparedness Goal 3: DETECT AND REPORT

Decrease the time needed to detect and report chemical, biological, and radiological agents in tissue, food, or environmental samples that cause threats to the public's health.

3A. Target Capability: Public Health Laboratory Testing

Required Critical Tasks:

- 1) Increase and maintain relevant laboratory support for identification of biological, chemical, radiological and nuclear agents in clinical (human and animal), environmental, and food specimens
 - a) Develop and maintain a database of all sentinel (biological)/Level 3 (chemical) labs in the jurisdiction using the CDC-endorsed definition that includes:
 - Name
 - contact information
 - BioSafety Level
 - whether they are a health alert network partner
 - certification status
 - capability to rule-out Category A and B bioterrorism agents per state-developed proficiency testing or College of American Pathologists (CAP) bioterrorism module proficiency testing
 - names and contact information for in-state and out-of-state reference labs used by each of the jurisdiction's sentinel/Level 3 labs
 - b) Test the competency of a chemical terrorism laboratory coordinator and bioterrorism laboratory coordinator to advise on proper collection, packaging,

- labeling, shipping, and chain of custody of blood, urine and other clinical specimens
- c) Test the ability of sentinel/Level 3 labs to send specimens to a confirmatory Laboratory Response Network (LRN) laboratory on nights, weekends, and holidays
 - d) Package, label, ship, coordinate routing, and maintain chain-of-custody of clinical, environmental, and food specimens/samples to laboratories that can test for agents used in biological and chemical terrorism
 - e) Continue to develop or enhance operational plans and protocols that include:
 - specimen/samples transport and handling
 - worker safety
 - appropriate BioSafety Level (BSL) working conditions for each threat agent
 - staffing and training of personnel
 - quality control and assurance
 - adherence to laboratory methods and protocols
 - proficiency testing to include routine practicing of LRN validated assays as well as participation in the LRN's proficiency testing program electronically through the LRN website
 - threat assessment in collaboration with local law enforcement and Federal Bureau of Investigations (FBI) to include screening for radiological, explosive and chemical risk of samples
 - intake and testing prioritization
 - secure storage of critical agents
 - appropriate levels of supplies and equipment needed to respond to bioterrorism events with a strong emphasis on surge capacities needed to effectively respond to a bioterrorism incident.
 - f) Ensure the availability of at least one operational BioSafety Level Three (BSL-3) facility in your jurisdiction for testing for biological agents. If not immediately possible, BSL-3 practices, as outlined in the CDC-NIH publication "Biosafety in Microbiological and Biomedical Laboratories, 4th Edition" (BMBL), should be used (see www.cdc.gov/od/ohs) or formal arrangements ((i.e., Memorandum of Understanding (MOU)) should be established with a neighboring jurisdiction to provide this capacity
 - g) Ensure that laboratory registration, operations, safety, and security are consistent with both the minimum requirements set forth in Select Agent Regulation (42 CFR 73) and the US Patriot Act of 2001 (P.L. 107-56) and subsequent updates
 - h) Ensure at least one public health laboratory in your jurisdiction has the appropriate instrumentation and appropriately trained staff to perform CDC-developed and validated real-time rapid assays for nucleic acid amplification (Polymerase Chain Reaction, PCR) and antigen detection (Time-Resolved Fluorescence, TRF)
 - i) Ensure the capacity for LRN-validated testing and reporting of Variola major, Vaccinia and Varicella viruses in human and environmental samples either in the public health laboratory or through agreements with other LRN laboratories
- 2) Increase the exchange of laboratory testing orders and results
 - a) Monitor compliance with public health agency (or public health agency lab) policy on timeliness of reporting results from confirmatory LRN lab back to sending

- sentinel/Level Three lab (i.e., feedback and linking of results to relevant public health data) with a copy to CDC as appropriate
- b) Comply with PHIN Preparedness Functional Areas *Connecting Laboratory Systems and Outbreak Management* to enable: a) the linkage of laboratory orders and results from sentinel/Level Three and confirmatory LRN labs to relevant public health (epi) data and b) maintenance of chain of custody

CDC Preparedness Goal 4: DETECT AND REPORT

Improve the timeliness and accuracy of communications regarding threats to the public's health.

4A. Target Capability: Health Intelligence Analysis and Production

Required Critical Tasks:

- 1) Increase source and scope of health information
- 2) Increase speed of evaluating, integrating, analyzing, and interpreting health data to detect aberrations in normal data patterns
- 3) Improve integration of existing health information systems, analysis, and distribution of information compliant with PHIN Preparedness Functional Area *Early Event Detection*, including those systems used for identification and tracking of zoonotic diseases
- 4) Improve effectiveness of health intelligence and surveillance activities
- 5) Improve reporting of suspicious symptoms, illnesses, or circumstances to the public health agency.
 - a) Maintain a system for 24/7/365 reporting of cases, suspect cases, or unusual events compliant with PHIN Preparedness Functional Area *Early Event Detection*
 - b) Increase number of local sites using BioSense for early event detection

CDC Preparedness Goal 5: INVESTIGATE

Decrease the time to identify causes, risk factors, and appropriate interventions for those affected by threats to the public's health.

5A. Target Capability: Epidemiological Surveillance and Investigation

Required Critical Tasks:

- 1) Increase the use of efficient surveillance and information systems to facilitate early detection and mitigation of disease
- 2) Conduct epidemiological investigations and surveys as surveillance reports warrant
- 3) Coordinate and direct public health surveillance and testing, immunizations, prophylaxis, isolation or quarantine for biological, chemical, nuclear, radiological, agricultural, and food threats
- 4) Have or have access to information systems for outbreak management that capture data related to cases, contacts, investigations, exposures, relationships and other relevant parameters compliant with PHIN preparedness functional area *Outbreak Management*

CDC Preparedness Goal 6: CONTROL

Decrease the time needed to provide countermeasures and health guidance to those affected by threats to the public's health.

6A. Target Capability: Communications

Required Critical Tasks:

- 1) Decrease the time needed to communicate internal incident response information
 - a) Develop and maintain a system to collect, manage, and coordinate information about the event and response activities including assignment of tasks, resource allocation, status of task performance, and barriers to task completion
- 2) Establish and maintain response communications network
- 3) Implement communications interoperability plans and protocols
- 4) Ensure communications capability using a redundant system that does not rely on the same communications infrastructure as the primary system
- 5) Increase the number of public health experts to support Incident Command (IC) or Unified Command (UC)
- 6) Increase the use of tools to provide telecommunication and information technology to support public health response
 - a) Ensure that the public health agency has "essential service" designation from their telephone provider and cellular telephone provider
 - b) Ensure that the public health agency has priority restoration designation from their telephone provider
 - c) Ensure that the public health agency's public information line can simultaneously handle calls from at least 1% of the jurisdiction's households (e.g., play a recorded message to callers, transfer callers to a voice mail box or answering service)
- 7) Have or have access to a system for 24/7/365 notification/alerting of the public health emergency response system that can reach at least 90% of key stakeholders and is compliant with PHIN Preparedness Functional Area *Partner Communications and Alerting*

6B. Target Capability: Emergency Public Information and Warning

Required Critical Tasks:

- 1) Decrease time needed to provide specific incident information to the affected public, including populations with special needs such as non-English speaking persons, migrant workers, as well as those with disabilities, medical conditions, or other special health care needs, requiring attention
 - a) Advise public to be alert for clinical symptoms consistent with attack agent
 - b) Disseminate health and safety information to the public
 - c) Ensure that the Agency's public information line can simultaneously handle calls from at least 1% of the jurisdiction's households
- 2) Improve the coordination, management and dissemination of public information
- 3) Decrease the time and increase the coordination between responders in issuing messages to those that are experiencing psychosocial consequences to an event

- 4) Increase the frequency of emergency media briefings in conjunction with response partners via the jurisdiction's Joint Information Center (JIC), if applicable
- 5) Decrease time needed to issue public warnings, instructions, and information updates in conjunction with response partners
- 6) Decrease time needed to disseminate domestic and international travel advisories
- 7) Decrease the time needed to provide accurate and relevant public health and medical information to clinicians and other responders

6C. Target Capabilities: Responder Safety and Health

Required Critical Tasks:

- 1) Increase the availability of worker crisis counseling and mental health and substance abuse behavioral health support
- 2) Increase compliance with public health personnel health and safety requirements
 - a) Provide Personal Protection Equipment (PPE) based upon hazard analysis and risk assessment
 - b) Develop management guidelines and incident health and safety plans for public health responders (e.g.; heat stress, rest cycles, PPE)
 - c) Provide technical advice on worker health and safety for IC and UC
- 3) Increase the number of public health responders that receive hazardous material training

6D. Target Capability: Isolation and Quarantine

Required Critical Tasks:

- 1) Assure legal authority to isolate and/or quarantine individuals, groups, facilities, animals and food products
- 2) Coordinate quarantine activation and enforcement with public safety and law enforcement, including federal authorities with jurisdiction.
- 3) Improve monitoring of adverse treatment reactions among those who have received medical countermeasures and have been isolated or quarantined
- 4) Coordinate public health and medical services among those who have been isolated or quarantined
- 5) Improve comprehensive stress management strategies, programs, and crisis response teams among those who have been isolated or quarantined
- 6) Direct and control public information releases about those who have been isolated or quarantined
- 7) Decrease time needed to disseminate health and safety information to the public regarding risk and protective actions
- 8) Have or have access to information systems to collect, manage, and coordinate information about isolation and quarantine, compliant with Public Health Information Network (PHIN) Preparedness Functional Area *Countermeasure and Response Administration*

6E. Target Capability: Mass Prophylaxis

Required Critical Tasks:

- 1) Decrease the time needed to dispense mass therapeutics and/or vaccines
 - a) Implement local, (tribal, where appropriate), regional and state prophylaxis protocols and plans
 - b) Achieve and maintain the Strategic National Stockpile (SNS) preparedness functions described in the current version of the Strategic National Stockpile guide for planners
 - c) Ensure that smallpox vaccination can be administered to all known or suspected contacts of cases within 3 days and, if indicated, to the entire jurisdiction within 10 days
 - d) Have or have access to information systems to collect, manage, and coordinate information about the administration of countermeasures, including isolation and quarantine, compliant with PHIN Preparedness Functional Area *Countermeasure and Response Administration*
- 2) Decrease time to provide prophylactic protection and/or immunizations to all responders, including non-governmental personnel supporting relief efforts
- 3) Decrease the time needed to release information to the public regarding dispensing of medical countermeasures via the jurisdiction's JIC (if JIC activation is needed)

6F. Target Capability: Medical Surge

Required Critical Tasks:

- 1) Improve tracking of cases, exposures, adverse events, and patient disposition
 - a) Have or have access to information systems that provides these capabilities compliant with PHIN Preparedness Functional Area *Outbreak Management*
- 2) Decrease the time needed to execute medical and public health mutual aid agreements
- 3) Improve coordination of public health and medical services
 - a) Ensure epidemiology response capacity consistent with hospital preparedness guidelines for surge capacity
 - b) Participate in the development of plans, procedures, and protocols to identify and manage local, tribal, and regional public health and hospital surge capacity
- 4) Increase the proficiency of volunteers and staff performing collateral duties in performing epidemiology investigation and mass prophylaxis support tasks
- 5) Increase the number of physicians and other providers with experience and/or skills in the diagnosis and treatment of infectious, chemical, or radiological diseases or conditions possibly resulting from a terrorism-associated event who may serve as consultants during a public health emergency

6G. Target Capability: Mass Care

Required Critical Tasks:

- 1) Develop plans, policies, and procedures for the provision of mass care services to general populations and companion animals in coordination with all responsible agencies

- 2) Develop processes and criteria for conducting an assessment (cultural, dietary, medical) of the general population registering at the shelter to determine suitability for the shelter, identify issues to be addressed within the shelter, and the transference of individuals and caregivers/family members, to medical needs shelters if appropriate
- 3) Develop plans, policies, and procedures to coordinate delivery of mass care services to medical shelters

6H. Target Capability: Citizen Evacuation and Shelter-In-Place

Required Critical Tasks:

- 1) Develop plans and procedures to identify in advance populations requiring assistance during evacuation/shelter-in-place
- 2) Develop plans and procedures for coordinating with other agencies to meet basic needs during evacuation
- 3) Develop plans and procedures to get resources to those who have sheltered in place (Long term—3 days or more)

CDC Preparedness Goal 7: RECOVER

Decrease the time needed to restore health services and environmental safety to pre-event levels.

7A. Target Capability: Environmental Health

Required Critical Tasks:

- 1) Conduct post-event planning and operations to restore general public health services
- 2) Decrease the time needed to issue interim guidance on risk and protective actions by monitoring air, water, food, and soil quality, vector control, and environmental decontamination, in conjunction with response partners

CDC Preparedness Goal 8: RECOVER

Increase the long-term follow-up provided to those affected by threats to the public's health.

8A. Target Capability: Economic and Community Recovery

Required Critical Tasks:

- 1) Develop and coordinate plans for long-term tracking of those affected by the event
- 2) Improve systems to support long-term tracking of cases, exposures, and adverse event reports
- 3) Increase the availability of information resources and messages to foster community's return to self-sufficiency

CDC Preparedness Goal 9: IMPROVE

Decrease the time needed to implement recommendations from after-action reports following threats to the public's health.

9A. Target Capability: Planning

Required Critical Tasks:

- 1) Exercise plans to test horizontal and vertical integration with response partners at the federal, state, tribal, and local level
- 2) Decrease the time needed to identify deficiencies in personnel, training, equipment, and organizational structure, for areas requiring corrective actions
- 3) Decrease the time needed to implement corrective actions
- 4) Decrease the time needed to re-test areas requiring corrective action

Appendix 10

U.S. Border States Early Warning Infectious Disease Surveillance (EWIDS)

EWIDS awardees are encouraged to continue working towards achieving cross-border early warning and detection of infectious disease health threats and events, and overall situational awareness of infectious and emerging disease activity, within the broader context of the Pandemic and All-Hazards Preparedness Act (PAHPA), the Security and Prosperity Partnership of North America (SPP), and the World Health Organization's revised 2005 International Health Regulations (IHRs).

Regional border state public health leadership should strive to collaborate with regional HHS resources, (e.g. Regional Health Directors, Administrators, and Emergency Coordinators) and, where appropriate, with other border health and public health epidemiology, laboratory and health alert, and education and training preparedness programs, such as the Centers for Disease Control and Prevention's funded Centers for Public Health Preparedness, FoodNet, PulseNet, Laboratory Response Network, Epi-X, Public Health Information Network, Health Alert Network, Border Infectious Disease Surveillance Project, and CDC Quarantine Stations located at land-based border crossings. Where appropriate, EWIDS activities should also begin collaborating or continue to collaborate with homeland security initiatives [e.g., near border Urban Area Security Initiative (UASI) and Metropolitan Medical Response System (MMRS) jurisdictions] and state-based U.S. Customs and Border Protection personnel at port of entry facilities. In a jurisdiction that shares tribal, military installation or international borders, the public health agency may use cooperative agreement funds to jointly participate in all hazard planning meetings; exchange health alert messages and epidemic epidemiological data; provide mutual aid; and conduct collaborative drills and exercises.

In accordance with their authorizing legislation, U.S. Border States EWIDS funds are intended strictly for the support of surveillance and epidemiology-related activities to address bioterrorism and other outbreaks of infectious diseases with the potential for catastrophic consequences (including pandemic influenza). U.S. Border States EWIDS funds are not to be used to support non-infectious disease surveillance or broader border activities in terrorism preparedness. Consequently, these funds may not be used to finance any chemical, radiological, nuclear or other emergency preparedness activities. EWIDS funds cannot be used to supplant surveillance and/or epidemiological activities already supported by other funding sources. However, U.S. Border States EWIDS funds can be used to enhance coordination and integration with other existing cross-border infectious disease surveillance and epidemiology activities including, but not limited to, pandemic influenza preparedness and response.

In your narrative, you must describe how you will address any of the following critical tasks; you are not required to address all of them.

CDC Preparedness Goal 2: PREVENT

Decrease the time needed to classify health events as terrorism or naturally occurring in partnership with other agencies.

2A Target Capability: Intelligence/Information Sharing and Dissemination

- 1) If not already undertaken, collaborate with Canada or Mexico (as appropriate) to design, develop, and adopt a bi-national surveillance needs assessment tool to be used by public health officials on both sides of the border to identify gaps in the capacity of border jurisdictions to respond to bioterrorism event or infectious disease outbreak. Specific needs assessment studies should focus on availability of expertise, personnel and other resources to carry out epidemiology and surveillance activities essential to cross-border epidemiological investigations and response needs.
- 2) Work with states and provinces across the international border to develop and agree on a list of notifiable conditions and distinguish between select conditions that require immediate reporting to the public health agency (at a minimum, CDC Category A agents) and conditions for which a delay in reporting is acceptable. For those where a delay is acceptable, describe time frames for notification.
- 3) Develop or improve infectious disease surveillance in a uniform manner along and across the international border by establishing a network of hospitals, clinics, epidemiologists and laboratories to conduct active sentinel surveillance for emerging infectious diseases and syndromes such as SARS, West Nile Virus, and fever and rash syndromes
- 4) Continue to develop and evaluate sentinel/syndromic surveillance programs in border hospitals and clinics to rapidly detect (a) influenza-like illness (ILI) and distinguish possible bioterrorism-caused illness from other causes of ILI and (b) severe acute vesicular rash syndromes resembling smallpox and other febrile exanthemas to distinguish possible bioterrorism-caused illness from other causes and assist in case definition through specific clinical entry criteria and differential diagnosis.
- 5) Continue to engage federally recognized tribes along the international border in your state in cross-border infectious disease surveillance activities through mutual aid compacts, memoranda of understanding, and/or agreements. Where appropriate, include local binational health councils and/or Indian Tribes/Native American organizations in bioterrorism surveillance activities.
- 6) Assess the timeliness and completeness of your reportable disease surveillance system at least once a year for detecting and reporting outbreaks of infectious diseases in the border region.
- 7) Formulate, develop and, when feasible, test a bi-national 24/7 infectious disease reporting plan that extends its coverage area to jurisdictions on both sides of the border. State, provincial and/or priority local/tribal public health agencies develop/implement a cross-border early event detection system that:
 - receive immediately notifiable condition and emergent public health threat reports 24/7/365;
 - immediately notify the agency-designated public health professional 24/7/365;
 - have the agency-designated public health professional promptly respond to immediately notifiable condition or emergency public health threat reports 24/7/365; and

- receive reportable disease reports 24/7/365.
- 8) Conduct joint, cross-border assessments of information technology capabilities essential to infectious disease surveillance.
 - 9) Collaborate with public health officials in border jurisdictions to identify how infectious disease outbreak information can be most rapidly and effectively shared across the border. Together, border jurisdictions should explore the interoperability of information technology systems, i.e., the ability of different types of computers, networks, operating systems, and applications to work together effectively. Jurisdictions on both sides of the border should work towards ensuring the connectivity and interoperability, both vertically and horizontally, of their surveillance and epidemiology relevant information technology (IT) systems.
 - 10) Working with jurisdictions across the border, establish a secure, Web-based communications system that provides for rapid and accurate reporting and discussion of disease outbreaks and other acute health events that might suggest bioterrorism. Include provision for routine communications (e.g., Web, e-mail) and contingency plans for communication systems' failure and alert capacity for emergency notification (e.g., phone, pager) of key staff of counterpart agency across the border.
 - 11) Work with states, tribes and provinces along the international border to help train personnel regarding notifiable diseases, conditions, syndromes and their clinical presentations, and reporting requirements and procedures, including those conditions and syndromes that could indicate a bioterrorist event.
 - 12) Conduct joint infectious disease surveillance exercises involving a broad range of appropriate participants from both sides of the international border. This exercise should involve not only border health departments but, where feasible, local hospitals, tribal and Public Health Service health facilities, hospital laboratories, major community health care institutions, emergency response agencies, and public safety agencies in order to respond in a coordinated manner.

CDC Preparedness Goal 3: DETECT/REPORT

Decrease the time needed to detect and report chemical, biological, radiological agents in tissue, food, or environmental samples that cause threats to the public's health.

3A Target Capability: Public Health Laboratory Testing

- 1) If not already undertaken, survey and assess the surveillance and laboratory capacity on each side of the international border including those of any tribes located within states that share an international border and the connectivity among these laboratories with a view towards (a) identifying and addressing needs or gaps with respect to their consistency or uniformity of testing standards, notification protocols, and laboratory-based surveillance data exchange practices and (b) developing bi-national, regional laboratory response capabilities.
- 2) Improve cross-border, electronic sharing of laboratory information with public health officials and other partners in neighboring jurisdictions (to facilitate the rapid formulation of an appropriate response to and control of the outbreak). Specific objectives are for jurisdictions on both sides of the international border to: (1) coordinate availability of and access to laboratories with appropriate expertise

- 24/7/365, and (2) test clinical specimens, food samples, and environmental samples for biological agents that could be used for terrorism.
- 3) Develop and maintain a database of all sentinel/clinical labs in awardee's border region that includes name, contact information, Bio-Safety Level, certification status, and whether they are part of an information-sharing network. The database should also include the names and contact information for reference labs used by the sentinel/clinical labs in the border region.
 - 4) In coordination with local public health agencies on both sides of the border, apply information technology to develop or enhance electronic disease surveillance, including electronic disease reporting from clinical and public health laboratories and linkage of laboratory results to case report information.
 - 5) Partner with Schools of Public Health and/or CDC's Centers for Public Health Preparedness to develop binational training activities to enable border health professionals in the U.S., Canada and Mexico to receive introductory or advanced training jointly with their U.S. counterparts in surveillance, epidemiology, laboratory methods and information technologies that are relevant to the detection, reporting and investigation of infectious disease outbreaks.
 - 6) In coordination with relevant programs (i.e. FoodNet and PulseNet) and other agencies, conduct joint cross-border assessments of active public health surveillance and diagnostic capacities to improve outbreak-associated foodborne and agro-terrorism response capabilities and collaborate on how relevant active food microbiology surveillance information can be effectively shared across the border.

CDC Preparedness Goal 5: INVESTIGATE

Decrease the time to identify causes, risk factors, and appropriate interventions for those affected by threats to the public's health.

5A Target Capability: Epidemiological Surveillance and Investigation

- 1) Develop the capability to undertake joint epidemiological investigations of infectious disease outbreaks along the international border. Such capability should include the ability to jointly:
 - assess the seriousness of the threat and rapidly mobilize in response to an emergency
 - investigate to identify causes, risk factors, and appropriate interventions
 - coordinate the tracking of victims, cases, contacts, exposures, prophylaxes, treatments, and patient disposition.
 - contribute information directly to the public, including special populations, that explains and informs about risk and appropriate courses of action.
- 2) Continue to convene binational surveillance and epidemiology planning workshops to discuss and plan cross-border surveillance and/or epidemiology related activities. Such activities should, where feasible, involve a collaborative and regional approach with neighboring US border states, appropriate tribal nations as well as Mexico or Canada (as appropriate).

- 3) Conduct capable field epidemiologic investigations, rapid needs assessments, exposure assessments, and response.

Appendix 11
Priority Area Objectives by Level

MASS VACCINATION

Level 1	Level 2	Level 3
<p>Agencies have a written plan that includes and documents the following minimum elements of a mass vaccination plan:</p> <ul style="list-style-type: none"> a) Identification and utilization of an ICS/IMS system for a mass vaccination event involving both preparedness and immunization offices; b) Processes to estimate the project area’s weekly allocation of vaccine based on vaccine availability c) Vaccine transport using cold-chain custody d) Vaccine security plans e) Staffing to support vaccination clinics and conduct just-in-time training f) Instructions about second doses of vaccine g) Inclusion of tribal populations in vaccine allocation plans h) Cross-border coordination of vaccination plans for tribal communities that cross project area boundaries i) Address the needs of the physically disabled and at-risk populations j) Identify and implement plans to vaccinating homebound persons k) Identify and disseminate vaccination-related information via different means and languages to reach all segments of the population, including to those less likely to seek vaccination l) Determine how data will be collected at the administration sites and how data will be transmitted from administration sites, to 	<p>Conduct individual and team training of agency personnel <u>based on gap identification from tabletop exercises in 2006</u> to ensure staff knowledge and integration of skills necessary to implement mass vaccination plans and carry out essential functions (seminar/knowledge retention)</p> <p>Assess intra/inter-agency gaps in state/local mass vaccination coordination plans, procedures, and protocols around the critical tasks via a tabletop exercise. Staff should be able to articulate roles, responsibilities, and decision-making processes around prioritization, distribution, administration, data collection/information transfer</p>	<p>Ensure personnel are sufficiently trained to carry out agency essential functions related to mass vaccination by conducting drills of individual subcomponents of the overall mass vaccination plan, such as vaccine transport, plans to vaccinate homebound persons, and countermeasure/response administration (CRA) data transmission between vaccination sites to local/state health departments and to CDC.</p> <p>Ensure that subcomponent gaps of the state’s mass vaccination allocation, distribution, and vaccine administration systems are tested by means of a jointly (state/local) planned full-scale exercise involving simultaneous activation of the following critical tasks:</p> <ul style="list-style-type: none"> • Prioritization of limited amounts of pandemic vaccine; • Intrastate distribution of limited vaccine to local vaccine ship-to-sites • CRA data collection and data transfer between vaccination sites, local/state health departments, and to CDC

<p>local and state health departments, and to CDC.</p> <ul style="list-style-type: none"> m) Determine policies for reporting adverse events. n) Develop a plan to ensure timely reporting of adverse events when the number of reports is large <p>Conduct (or demonstrate by producing documentation of a HSEEP-compliant after-action report (AAR) if that activity was already completed during 2006) seminars that include <u>knowledge retention question/answer components</u> on the critical tasks under each objective to assess intra-agency personnel's familiarity with the mass vaccination plans at the state and local levels</p> <p>Validate the ability of staff to demonstrate an understanding of their role in the agency's mass vaccination plan via an initial tabletop exercise using the CDC-derived overarching goals/objectives</p>		
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CONTINUITY OF OPERATIONS (COOP)

Level 1	Level 2	Level 3
<p>At a minimum, agencies should document the following elements of a continuity of operations (COOP) plan:</p> <ul style="list-style-type: none"> a) Essential functions and other critical activities b) Identification and preparation of alternate operating facilities for continuity operations c) Vital records, databases and systems and where/how they are stored; d) Orders of succession for key organizational leadership positions e) Delegation of authorities f) Decision process for determining appropriate actions in implementing COOP plans and procedures g) Responsibilities of the individuals who have COOP roles (leadership, planners, COOP personnel); h) Interoperable communications systems and contact numbers; i) COOP personnel and other employee contact lists j) Human capital issues such as telecommuting/telework, humanitarian assistance/support k) Process to reconstitute/resume routine public health functions <p>Conduct (or demonstrate by producing documentation of an HSEEP-compliant AAR if that activity was already completed during 2006) seminars that include <u>knowledge retention question/answer components</u> on the critical tasks under each objective to assess intra-agency personnel's familiarity with the alert, notification, and COOP enactment procedures (training/education seminar/knowledge retention after seminar completion)</p> <p>Validate the ability of staff to demonstrate</p>	<p>Conduct individual and team training of agency COOP personnel based on gap identification from initial tabletop exercises in 2006 to ensure staff knowledge and integration of skills necessary to implement COOP plans and carry out essential functions (seminar/knowledge retention)</p> <p>Assess intra/inter-agency gaps in COOP activation plans, procedures, and protocols via a tabletop exercise staff to articulate roles, responsibilities, decision-making processes)</p>	<p>Ensure COOP personnel are sufficiently trained to carry out agency essential functions in a COOP situation by conducting drills of individual subcomponents of an overall COOP plan (examples to include, but not be limited to, validation of employee contact lists via notification drills; validation the ability of staff to access COOP-defined essential operations from remote locations; validation of the agency's ability to coordinate centrally remote activities at the EOC or other location; and validation of plans for utility, water, and transportation)</p> <p>Ensure that gaps identified in the previous COOP assessment on alert, notification, and deployment procedures and systems are tested by means of a jointly (state/local) planned full-scale exercise involving simultaneous activation of the following:</p> <ul style="list-style-type: none"> • Deployment of designated personnel and equipment to the alternate operating facilities to ensure a public health agency's ability to perform essential functions and operations during a COOP situation • Simultaneous operation of COOP plans with other partner agencies (transportation, utility companies, public safety, school closing, social services, etc) • Utilization of intra-agency equipment to ensure both internal and external interoperability

understanding of their role in the agency's COOP and assess intra/inter-agency gaps in COOP activation plans, procedures, and protocols via an initial tabletop exercise using the CDC-derived overarching goals/objectives		
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SURVEILLANCE/LABORATORY

Level 1	Level 2	Level 3
<p>At a minimum, agencies should document the following elements of a surveillance/laboratory plan:</p> <ol style="list-style-type: none"> a) Conducting year-round surveillance for seasonal influenza (e.g. virologic and outpatient visits) b) Methods for notification of healthcare providers c) A method for healthcare providers to obtain the appropriate testing and contact the state health department to report cases meeting the criteria for pandemic influenza testing d) A statewide electronic death reporting system e) Electronic monitoring of pneumonia and influenza hospitalizations f) Methods for estimating or counting influenza-associated deaths g) Information sharing between Health Departments, Hospitals, Medical Examiners, Vital Statistic Offices, other stakeholders (e.g. DoD) h) Obtain, track and report numbers and rates daily between local and state health departments to the CDC the numbers of newly hospitalized persons with influenza, numbers of newly isolated and quarantined persons, influenza-related hospitalizations, and pandemic-associated deaths i) Laboratory capacity to: test for influenza viruses year-round, to perform PCR or IF testing, protocols for safe specimen collection and testing, how and to whom a potential case of novel influenza should be reported, mechanisms for submitting specimens to referral laboratories, protocols for proper handling and shipment of specimens, notifying and reporting anything novel, exchange specimen-level data electronically, healthcare 	<p>Conduct individual and team training of agency personnel <u>based on gap identification from initial tabletop exercises in 2006</u> to ensure staff knowledge and integration of skills necessary to implement surveillance plans and carry out essential functions (seminar/knowledge retention)</p> <p>Assess intra/inter-agency gaps in surveillance and laboratory plans, procedures, and protocols via a tabletop exercise to articulate roles, responsibilities, decision-making processes)</p>	<p>Ensure personnel are sufficiently trained to carry out agency essential functions related to influenza surveillance and laboratory activities by conducting drills of individual subcomponents of the overall surveillance and laboratory plans</p> <p>Ensure that subcomponent gaps of the state's surveillance and laboratory systems are tested by means of a jointly (state/local) planned functional exercise involving simultaneous activation of the following:</p> <ul style="list-style-type: none"> • Notification of healthcare providers • Electronic monitoring of pneumonia and influenza hospitalizations estimating or counting influenza-associated deaths • Information sharing between Health Departments, Hospitals, Medical Examiners, Vital Statistic Offices, other stakeholders • Daily tracking and reporting of numbers and rates of newly hospitalized persons with influenza, newly isolated and quarantined persons, influenza-related hospitalizations, and pandemic-associated deaths between local and state health departments and to the CDC • Protocols/mechanisms for submitting specimens to referral laboratories, proper handling and shipment of specimens, how and to whom a potential case of novel influenza should be reported, electronic exchange of specimen-level data

<p>facilities, other clinical laboratories, state public health, CDC, call-down procedures for laboratory staff, locations for additional laboratory facilities</p> <p>Conduct (or demonstrate by producing documentation of an HSEEP-compliant AAR if that activity was already completed during 2006) seminars that include <u>knowledge retention question/answer components</u> on the critical tasks under each objective to assess intra-agency personnel's familiarity with the surveillance and laboratory plans at the state and local levels; (training/education seminar/knowledge retention after seminar completion)</p> <p>Validate the ability of staff to demonstrate an understanding of their role in the agency's surveillance and laboratory plans via an initial tabletop exercise using the CDC-derived overarching goals/objectives.</p>		
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COMMUNICATIONS

Level 1	Level 2	Level 3
<p>At a minimum, agencies should document the following elements of a communications plan:</p> <ul style="list-style-type: none"> a) Two-way communications through the state Emergency Operations Center between (1) state partners (e.g., emergency management) and (2) regional multi-agency coordination centers (regional healthcare coalitions, local public health, local emergency management, EMS, etc) b) Redundant communications in the event that primary communications are unavailable c) Access to information systems that are PHIN compliant at the state AND local levels d) A crisis communication and emergency risk plan that addresses all phases of an influenza pandemic e) Training processes for Public Information (PI) staff f) Designated line and staff responsibilities for the PI staff g) Information verification and clearance/approval protocols h) Regional and/or local media contact list i) Contact numbers/addresses for emergency personnel j) Procedures to join the Joint Information Center if activated k) Identification of vehicles for information dissemination to public, stakeholders, partners (e.g., e-mail, fax, brochures, press releases) l) Contact lists of additional persons outside the state health department who can be available as subject matter advisors m) Support materials for public health issues that are unique to an influenza pandemic, such as issues of isolation, social distancing, and public health law n) Hotlines and other community resources to respond to local questions from the public and professional groups o) Development and dissemination of culturally- 	<p>Conduct individual and team training of agency personnel <u>based on gap identification from initial tabletop exercises in 2006</u> to ensure staff knowledge and integration of skills necessary to implement communication plans and carry out essential functions (seminar/knowledge retention)</p> <p>Assess intra/inter-agency gaps in communications plans, procedures, and protocols via a tabletop exercise to articulate roles, responsibilities, decision-making processes)</p>	<p>Ensure personnel are sufficiently trained to carry out agency essential functions by conducting drills of individual subcomponents of the overall communications plans</p> <p>Ensure that subcomponent gaps of the state’s communications systems are tested by means of a jointly (state/local) planned functional exercise involving simultaneous activation of the following:</p> <ul style="list-style-type: none"> • Communication equipment between local and state health department EOCs • Redundant communication systems • Crisis/risk communications • Joint Information Center activation • Activation of hotlines/community resources to respond to local questions regarding quarantined persons • Dissemination of culturally-appropriate and language-specific essential written information to the public utilizing trusted leaders/liaisons in communities for information dissemination

<p>appropriate and language-specific essential written information to the public that utilizes trusted leaders/liaisons in communities for information dissemination</p> <ul style="list-style-type: none"> p) List of spokespersons to work with the media q) A process to disseminate materials to the media r) Ethnic/language-specific media, mainstream media, at-risk populations <p>Conduct (or demonstrate by producing documentation of an HSEEP-compliant AAR if that activity was already completed during 2006) seminars that include <u>knowledge retention question/answer components</u> on the critical tasks under each objective to assess intra-agency personnel's familiarity with to assess intra-agency personnel's familiarity with communication plans at the state and local levels (training/education seminar/knowledge retention after seminar completion)</p> <p>Validate the ability of staff to demonstrate an understanding of their role in the agency's communication plans via an initial tabletop exercise using the CDC-derived overarching goals/objectives</p>		
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COMMUNITY CONTAINMENT

Level 1	Level 2	Level 3
<p>At a minimum, agencies should document the following elements of a community containment plan:</p> <p>a) Isolation and treatment of ill persons</p> <ul style="list-style-type: none"> • Strategy with community hospitals to advise non-acute patients to remain home • Processes for rapid remote identification of possible cases (e.g., hotlines) • Tools for triage for both professionals and the general public regarding follow-up (monitoring) of known or suspected cases • Efforts regarding availability and distribution of medications, vaccine and other subsistence items to households in isolation or quarantine <p>b) Quarantine of household contacts of ill persons</p> <ul style="list-style-type: none"> • Plans to work with household contacts for a known or suspected case to establish a voluntary quarantine • Plans to communicate processes for voluntary quarantine to the public • Plans to assure the availability and distribution of medications, vaccine, and other subsistence items to households in isolation or quarantine <p>c) Dismissal of school and closure of child care programs</p> <ul style="list-style-type: none"> • Systems for notifying parents re: dismissal of students from classes or childcare, communication during dismissal • Systems for distributing educational material for students/families regarding preventing transmission and social distancing 	<p>Conduct individual and team training of agency personnel <u>based on gap identification from tabletop exercises in 2006</u> to ensure staff knowledge and integration of skills necessary to implement communication plans and carry out essential functions (seminar/knowledge retention)</p> <p>Assess intra/inter-agency gaps in community containment plans, procedures, and protocols via a tabletop exercise to articulate roles, responsibilities, decision-making processes)</p>	<p>Ensure personnel are sufficiently trained to carry out agency essential functions by conducting drills of individual subcomponents of the overall community mitigation plan</p> <p>Ensure that subcomponent gaps of the state’s community mitigation systems are tested by means of a jointly (state/local) planned functional exercise involving simultaneous activation of the following:</p> <ul style="list-style-type: none"> • Processes with community hospitals as to how to advise non-acute patients to remain home • Processes for rapid remote identification of possible cases (e.g., hotlines) • Tools for triage for both professionals and the general public regarding follow-up (monitoring) of known or suspected cases • Distribution of medications, vaccine and other subsistence items to households in isolation or quarantine • Communication to household contacts to a known or suspected case who are in voluntary quarantine • Communication of the processes for voluntary quarantine to the public • Systems for notifying parents re: dismissal of students from classes or childcare, as well as

<ul style="list-style-type: none"> • Authorities, processes, and triggers for dismissal and reopening • Incident command structure for local/state operations • Plans for extramural activities that may be conducted on the school grounds and that may continue or be relocated or discontinued <p>d) Community social distancing</p> <ul style="list-style-type: none"> • Plans and guidance for cancelling large public gatherings • Distribution plans for informational materials for workplace and community • Plans for businesses to address increased absenteeism due to illness, school closure, or voluntary home quarantine • Plans with business, education, faith-based communities, and others that have been identified as playing a role during a pandemic <p>Conduct (or demonstrate by producing documentation of an HSEEP-compliant AAR if that activity was already completed during 2006) seminars that include <u>knowledge retention question/answer components</u> on the critical tasks under each objective to assess intra-agency personnel’s familiarity with community containment plans at the state and local levels (include a pre/post process to assess education seminar/knowledge retention after seminar completion)</p> <p>Validate the ability of staff to demonstrate an understanding of their role in the agency’s communication plans via an initial tabletop exercise using the CDC-derived overarching goals/objectives,</p>		<ul style="list-style-type: none"> • communication during dismissal • Distribution of educational material for students/families, as well as instruction on prevention of transmission and social distancing • Authorities, processes, and triggers for dismissal and reopening • Incident command structure for local/state operations • Plans for extramural activities that may be conducted on the school grounds and that may continue, be re-located or discontinued • Plans and guidance for cancelling large public gatherings • Distribution plans for informational materials for workplace and community • Plans for businesses to address increased absenteeism due to illness, school closure, or voluntary home quarantine • Plans with business, education, faith based communities and others that have been identified as playing a role during a pandemic
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ANTIVIRAL DRUG DISTRIBUTION

Level 1	Level 2	Level 3
<p>At a minimum, agencies should document the following elements of an Antiviral Distribution plan and include references to lessons learned from tabletop exercises conducted in 2006:</p> <ul style="list-style-type: none"> a) A central warehouse [Receipt/Store/Stage (RSS) facility] location has been selected for the receipt of antiviral drugs, personal protection equipment and other ancillary medical supplies from SNS b) A contract, memorandum of agreement (MOA) or other appropriate documentation is in place that guarantees the availability of the selected RSS c) The RSS management team and back-up personnel have been identified d) The RSS management team and back-up personnel have job action sheets for their specific functions, and a training plan is in place e) The RSS staff/volunteers and back-up personnel have been identified f) Call down rosters for 24/7 operations for all RSS Managers and staff/volunteers are documented, reviewed and tested for accuracy g) An inventory of material handling equipment that's available at the RSS is documented along with a list of materials/supplies that need to be procured and/or delivered at the time of activation h) An inventory of office equipment that's available at the RSS is documented along with a list of materials/supplies that need to be procured and/or delivered at the time of activation i) Plan for a primary and back-up inventory management system (IMS) is in place 	<p>Conduct individual and team training of agency personnel <u>based on gap identification from tabletop exercises in 2006</u> to ensure staff knowledge and integration of skills necessary to implement communication plans and carry out essential functions (seminar/knowledge retention)</p> <p>Validate the RSS Antiviral Distribution Location by the DSNS Consultant if not already done</p> <p>Assess intra/inter-agency gaps in antiviral distribution plans, procedures, and protocols via a modified functional exercise to articulate roles, responsibilities, decision-making processes)</p>	<p>Ensure personnel are sufficiently trained to carry out agency essential functions by conducting drills of individual subcomponents of the overall antiviral distribution plan</p> <p>Ensure that subcomponent gaps of the state's antiviral distribution plan are tested by means of a jointly (state/local) planned functional exercise involving simultaneous activation of the following:</p> <ul style="list-style-type: none"> • An allocation methodology and plan is in place. • Activation of the RSS protocols • Activation of Security Protocols • Tracking/Monitoring of Antiviral Drugs Distributed

<ul style="list-style-type: none"> j) IMS staff has been identified and a training plan is in place k) An allocation methodology and plan is in place l) Recipient locations have been identified (e.g. hospitals, skilled nursing facilities, community health centers, and other treatment facilities) and documented m) The plan to train recipient locations on the antiviral distribution activation procedures is in place n) Procedures are documented for recipient locations to request additional supplies o) A Distribution Manager and back-up(s) have been identified and a training plan is in place p) Procedures to monitor chain of custody are in place q) Primary agency/Organization/Backup Organization has been assigned to distribute antiviral drugs personal protection equipment (N95 masks, etc.) and other ancillary medical supplies. A contract, memorandum of agreement (MOA) or other appropriate documentation is in place that guarantees the availability of the selected resource r) Just-in-time training materials have been developed for the distribution functions s) State-level Security Coordinator has been identified to coordinate overall security issues t) State security support agencies have been identified and oriented to security issues/needs u) Security plans are in place for RSS and recipient locations v) Staff badging/credentialing system for all response personnel is in place w) Plans and protocols are in place to 		
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<p style="text-align: center;">administer antiviral drugs to priority groups</p> <p>Plans and protocols are in place for antiviral drugs that may need to be administered under Investigational New Drug (IND) or Emergency Use Authorization Plans should include procedures for the receipt on the IND protocol consent forms to be received and mass copied for distribution.</p> <p>A plan to track outcomes and adverse events following treatment with antiviral drugs is in place. Information systems are available that support monitoring of adverse reactions that comply with the Public Health Information Network functional requirements for Countermeasure/Response Administration.</p>		
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Appendix 12 Overarching Exercise Objectives by Priority Area

Overarching Mass Vaccination Exercise Objectives

- Ensure that offices responsible for emergency preparedness and immunization at the State and local levels both define roles and responsibilities in regard to pandemic vaccination
 - *Critical Tasks:*
 - *Identification and utilization of an ICS/IMS system for mass vaccination event that involves coordination between state/local offices of public health preparedness and immunization*
- Identify vaccine allocation, distribution, and administration issues related to limited vaccine availability during an influenza pandemic
 - *Critical Tasks:*
 - *Estimate the project area's weekly allocation of vaccine based on vaccine availability*
 - *Transport vaccine using cold-chain custody*
 - *Identify and execute vaccine security plans*
 - *Identify staffing to support vaccination clinics and conduct just-in-time training*
 - *Disseminate instructions about second doses of vaccine*
 - *Include tribal populations in vaccine allocation plans*
 - *Conduct cross-border coordination of vaccination plans for tribal communities that cross project area boundaries*
 - *Address the needs of the physically disabled and special needs populations*
 - *Identify and implement plans to vaccinating homebound persons*
 - *Identify and disseminate vaccination-related information via different means and languages to reach all segments of the population, including to those less likely to seek vaccination*
 - *Determine how data will be collected at the administration sites and how data will be transmitted from administration sites, to local and state health departments, and to CDC*
 - *Determine policies for reporting adverse events.*
 - *Develop a plan to ensure timely reporting of adverse events when the number of reports is large*
- Validate identified procedures to select target/priority groups for vaccination during periods of limited vaccine availability
 - *Critical Tasks:*
 - *In cases where priority groups will be vaccinated by groups other than public health, identification of roles and responsibilities*
 - *Identification and implementation of protocols for verification of priority group membership*

Overarching COOP Exercise Objectives

- (Target audience: state/local agencies) Identify and perform critical/essential public health functions during a pandemic influenza outbreak
 - *Critical Tasks:*
 - *Articulate and implement orders of succession for key organizational leadership positions*
 - *Articulate and implement decision processes for determining appropriate actions in implementing COOP plans and procedures*
- (Target audience: state/local agencies) Integrate non-essential personnel into essential agency roles during a pandemic COOP activation
 - *Critical Tasks:*
 - *Activation of responsibilities of the individuals who have COOP roles (leadership, planners, COOP personnel)*
 - *Identification of personnel and back-up personnel, by position, needed to continue essential services and functions, including delegations of authority in the face of workforce reduction*
 - *Sustain essential services and functions with a work force reduction up to 40%, under conditions of limited access to facilities, and broad-based implementation of social distancing policies*
 - *Coordination of planning with contractors, suppliers, shippers, state agencies and other businesses that support or are supported by state/local essential functions*
 - *Identification and implementation of functions that can be continued from designated operating facilities or alternative operating facilities*
 - *Activation of plans to account for personnel and their status*
 - *Activation of plans to monitor who is sick and who got better*
- (Target audience: state/local agencies) Resume routine public health functions between pandemic phases and after a pandemic has ended

Overarching Surveillance/Lab Exercise Objectives

- Validate existing processes at the state and local health department levels to obtain, investigate, and report early cases of pandemic influenza
 - *Critical Tasks*
 - *Mass notification of healthcare providers at the state/local level regarding the state's plans for testing of suspected pandemic cases*
 - *Activation of surveillance/reporting procedures for providers to report cases meeting the criteria for pandemic influenza testing*
 - *Activation of laboratory capacity to test for influenza viruses year-round, to perform PCR or IF testing, to safely perform specimen collection and testing, mechanisms for submitting specimens to referral laboratories*
- Validate existing processes for monitoring severe disease during a pandemic
 - *Critical Tasks*
 - *Utilization of a statewide electronic death reporting system*
 - *Electronic monitoring of pneumonia and influenza hospitalizations*
 - *Activation of methods for estimating or counting influenza-associated deaths*
- Validate existing procedures to exchange specimen-level data electronically
 - *Critical Tasks*
 - *Coordinate information sharing between Health Departments, Hospitals, Medical Examiners, Vital Statistic Offices, other stakeholders (e.g. DoD)*
 - *Ability to obtain, track and report, between local/state health departments to the CDC, daily numbers and rates of the numbers of newly hospitalized persons with influenza, numbers of newly isolated and quarantined persons, influenza-related hospitalizations, and pandemic-associated deaths*
- Validate existing call-down procedures for laboratory staff to report to work
 - *Critical Tasks*
 - *Activation of call-down procedures for laboratory staff, locations for additional laboratory facilities*

Overarching Community Mitigation Exercise Objectives

- Identify potential gaps in existing plans, procedures and protocols for school, business, and public event closure during an influenza pandemic
 - *Critical Tasks*
 - *Activation of systems for notifying parents re: dismissal of students from classes or childcare, as well as communication during dismissal*
 - *Activation of distribution of educational material for students/families, as well as instruction on prevention of transmission and social distancing*
 - *Activation of authorities, processes, and triggers for dismissal and reopening*
 - *Activation of plans and guidance for cancelling large public gatherings*
 - *Activation of distribution plans for informational materials for workplace and community*
 - *Activation of plans for businesses to address increased absenteeism due to illness, school closure, or voluntary home quarantine*
 - *Activation of partnerships with business, education, faith based communities and others that have been identified as playing a role during a pandemic*
 - *Activation of plans for extramural activities that may be conducted on the school grounds and that may continue, be re-located or discontinued*
- Validate the ability of state/local agencies to ensure provisions of essential services and supplies to persons in isolation and quarantine, keeping in mind the special needs of children
 - *Critical Tasks:*
 - *Incident command structure for local/state operations*
 - *Validate the ability to provide mental health services to persons in isolation or quarantine*
- Validate the ability of state/local agencies to identify locations and deploy staff to manage influenza cases and contacts in isolation or quarantine situations
 - *Critical Tasks:*
 - *processes with community hospitals as to how to advise non-acute patients to remain home*
 - *processes for rapid remote identification of possible cases (e.g., hotlines)*
 - *tools for triage for both professionals and the general public regarding follow-up (monitoring) of known or suspected cases*
 - *distribution of medications, vaccine and other subsistence items to households in isolation or quarantine*
 - *communication to household contacts to a known or suspected case who are in voluntary quarantine*
 - *communication of the processes for voluntary quarantine to the public*

Overarching Communication Exercise Objectives

- Validate the ability of state/local agencies to utilize redundant communications systems between intrastate partners and regional multi-agency coordination centers
 - *Critical Tasks*
 - *Activation of communication equipment between local and state health department EOCs, including activation of redundant communication systems*
- Validate existing crisis communication and emergency risk plans to communicate protective actions to the public during an influenza pandemic
 - *Critical Tasks*
 - *Activation of prepared message-maps on pandemic influenza*
 - *JIC activation*
 - *Activation of hotlines/community resources to respond to local questions regarding quarantined persons*
 - *Validate existing internal staff protocols to educate the media, public, partners and stakeholders of agency actions during an influenza pandemic*
- Validate the ability of existing protocols and processes to reach special needs populations with culturally-appropriate and language specific protective actions against pandemic influenza
 - *Critical Tasks*
 - *Dissemination of culturally-appropriate and language-specific essential written information to the public utilizing trusted leaders/liaisons in communities for information dissemination*

Overarching Antiviral Distribution Objectives

- Increase understanding regarding the roles and responsibilities of all participating agencies related specifically to SNS Medical Countermeasures Distribution during an outbreak of pandemic influenza
 - *Critical Tasks*
 - *Ensure that SLTT Project Areas coordinate antiviral distribution plans with military installations and tribal entities in their jurisdiction*
- Identify and capture potential gaps in existing plans, policies, procedures, and protocols
 - *Critical Tasks*
 - *Establishment of a primary and back-up plan at the state/Project Area for Inventory Management of received supplies*
 - *Plans and protocols in place at the Project Area/state to administer antiviral drugs to previously identified priority groups*
 - *Plans and protocols to track/monitor antiviral medications distributed*
 - *Establishment of a distribution plan for SNS medical countermeasures that includes:*
 - *Delivery Locations & Routes*
 - *Delivery Schedule/Frequency*
 - *Location Points of Contact and Location delivery points*
 - *Documentation of Security Plans the Project Area/state for transportation of SNS materials leaving the RSS*
 - *Identification of an RSS facility that is adequate for the receipt and distribution of allocated antiviral drugs, PPE, additional items, to include ventilators*
 - *Creation of a pre-determined allocation table for SNS medical countermeasures*
- Identify and capture potential gaps in coordination between agencies
 - *Critical Tasks:*
 - *Designation of state/Project Area agency(ies) to provide guidance to receiving facilities on Material Handling Equipment (MHE)*
 - *Documentation of training for Hospitals and other recipient locations on the communication and request procedures for SNS Medical Countermeasures related to Pandemic Influenza*

More information on the Target Capabilities, the National Preparedness Framework and other resource documents, please log in to: www.llis.gov

Appendix 13 Exercise Strategy and Schedule Sample

Sample Exercise Work Plan Level 2

1. Identify priorities and goals
2. Identify associated capabilities relevant to priorities
3. Schedule training and exercises that support identified priorities and capabilities

Priority 1 - Mass Vaccination; Goal 1 - Enhance jurisdiction's capability for distributing and administering pandemic vaccine, including tracking pandemic influenza vaccine doses administered document a system for collecting and submitting the CDC-defined minimum set of data elements to CDC's Countermeasure and Response Application (CRA) using one of the CDC-identified options.

Priority 2 – COOP; Goal 1 - Validate and improve jurisdiction's capability to identify and perform critical/essential public health functions during a pandemic influenza outbreak

Priority 3 - Community Containment; Goal 1 – Enhance jurisdiction's capability to monitor persons with influenza like illness or pandemic influenza and to provide recommended community strategies dependent upon CDC's pandemic influenza severity index

- The following is a beginning list of capabilities associated with the Mass Vaccination Priority:
 - Mass prophylaxis
 - Emergency Public Information and Warning
 - Allocation and Distributing Pandemic Vaccine (“Pandemic Influenza Vaccination: A Guide for State, Local, Tribal and Territorial Planners”)
- The following is a beginning list of capabilities associated with the COOP Priority:
 - Economic Impact and Recovery
 - Emergency Operations Systems Management
- The following is a beginning list of capabilities associated with the Community Mitigation Priority:
 - Emergency Public Information and Warning

Action Steps in scheduling training and exercises that support identified priorities and capabilities:

- *adjustments to Jurisdiction X's written plans in the areas of mass vaccination, COOP, and community containment as recommended by the results of the April 16th assessment, to include procurement of any needed equipment or contractual planning assistance to support this activity (**planning phase**)*
- *conduction of seminars on the contents of these plans to be delivered to local and state public health staff and applicable community partners; each seminar would contain a series of pre/post event knowledge retention question/answer components (**training**)*
- *an initial tabletop exercise, addressing CDC-determined critical tasks, to validate the ability of staff to demonstrate the understanding of their role in the agencies' mass vaccination, COOP, and community containment plans and to (**exercise**) training*

following that initial tabletop exercise to address any gaps identified regarding CDC-determined critical tasks (**training and plan revision**)

The exercise schedule will be as follows:

JURISDICTION (facility, agency, local, regional, state) Jurisdiction X	[Current Year]											
	Qtr 1			Qtr 2			Qtr 3			Qtr 4		
	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG
State Public Health and Local Public Health	planning and staffing, equipment purchase selections	planning and plan revisions in mass vaccination, COOP, and community mitigation	seminar with state and local public health staff on mass vax topics	seminar with state and local public health staff and community partners on community mitigation	training on COOP for state public health staff	table-top exercise		training based upon gaps identified from table-top exercise	plan revision based upon corrective actions	planning begins for next discussion or operational exercise activities		

For further assistance, HSEEP program materials can be found at www.hseep.dhs.gov