



Public Health Emergency Preparedness (PHEP) Operational Readiness Review Guidance

Budget Period 1
July 1, 2017–June 30, 2018

November 2017





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INTRODUCTION

The Centers for Disease Control and Prevention’s (CDC) Office of Public Health Preparedness and Response Division of State and Local Readiness administers the Public Health Emergency Preparedness (PHEP) cooperative agreement program. The operational readiness review (ORR) is a rigorous, evidence-based assessment that evaluates planning and operational functions of the PHEP program. The ORR primarily focuses on evaluating a jurisdiction’s ability to execute a large response requiring medical countermeasure (MCM) distribution and dispensing. The intended outcome of this assessment is to identify strengths and challenges facing preparedness programs across the nation and to identify opportunities for improvement and further technical support.

The review focuses on how countermeasures and mitigation are strengthened by managing access to and administration of pharmaceutical and non-pharmaceutical interventions; ensuring the safety and health of responders; and operationalizing response plans to facilitate the earliest possible identification, investigation, and response of an incident. Ultimately, validation of continuity of emergency operations throughout the surge of an emergency or incident must occur.

By 2022, all Public Health Emergency Preparedness (PHEP) recipients and local planning jurisdictions should be able to implement timely:

- intervention and control measures
- communication of situational awareness and risk information
- coordination and support for response activities with healthcare and other partners

This document provides specific guidance on how to 1) complete a self-assessment and 2) complete a review using the new ORR system. All 62 PHEP recipients, as well as Cities Readiness Initiative (CRI) local planning jurisdictions, are required to participate in an ORR. State recipients are not only responsible for ensuring their own planning and operational function but also for supporting their local counterparts, in addition to monitoring, tracking, and evaluating local activities.

OVERVIEW

The ORR is divided into three modules: 1) descriptive/demographic, 2) planning, and 3) operations. Each module collects information via specific forms. Guidance about the content collected in each form is located in the specific *form chapters* of this document.

Descriptive/Demographic Forms

The forms below must be submitted or updated as indicated to complete the demographic form section. The descriptive/demographic forms must be submitted before an ORR site visit is conducted.

Form	Submission Cycle*	State	DFL	TFAS	CRI
Critical Contact Sheet	every 6 months	✓	✓	✓	
Receipt, Stage, and Store (RSS) Site Survey	every 12 months	✓	✓	✓	
Jurisdictional Data Sheet (JDS)	every 12 months	✓	✓	✓	✓
Point of Dispensing (POD)	every 12 months	✓ (state-run open PODs only)	✓	✓	✓

*Note. Descriptive/demographic forms must be submitted or updated as indicated; due date cycles are based on (either 6 or 12 months, as indicated in table above) the date of the original form submission.

Planning Forms

The forms below must be submitted or updated as indicated to complete the planning form section. The planning forms must be submitted before an ORR site visit is conducted.

Form	Submission Cycle*	State	DFL	TFAS	CRI
Dispensing	every 12 months	✓	✓	✓	✓
Distribution	every 12 months	✓	✓	✓	✓

*Note. Planning forms must be submitted or updated as indicated; due date cycles are based on 12-month intervals (as indicated in table above) from the date of the original form submission.

Operational Forms

The forms below must be submitted or updated as indicated to document operational performance.

Form	Submission Cycle*	State	DFL	TFAS	CRI
Facility Setup Drill	Once a budget period		✓	At least once every 5 years	✓
Staff Notification and Assembly Drill	Once a budget period	✓ (formerly PM 3.1)	✓	At least once every 5 years	✓

Form	Submission Cycle*	State	DFL	TFAS	CRI
Site Activation Drill	Once a budget period		✓	At least once every 5 years	✓
Successful IMATS/Information Data Exchange (IDE) <ul style="list-style-type: none"> information is populated directly from SNS reports; no data entry required 	Once a budget period	✓	✓	✓**	
Training and Exercise Planning Form <ul style="list-style-type: none"> to document Training and Exercise Plan Workshop (TEPW) information 	Once a budget period	✓	✓	At least once every 5 years	
Training and Exercise Planning Form <ul style="list-style-type: none"> to document Multi-year Training and Exercise Plan (MYTEP) 	Once a budget period	✓	✓	At least once every 5 years	✓
PHEP/Functional/Full-scale Exercise or Incident <ul style="list-style-type: none"> to document PHEP exercise to document Emergency Operations Center (EOC) Staff Notification/Assembly 	Per incident/exercise, minimum of once a budget period	✓	✓	At least once every 5 years	
PHEP/Functional/Full-scale Exercise or Incident <ul style="list-style-type: none"> to document joint HPP/PHEP functional or full-scale exercise 	Once a project period (every 5 years)	✓	✓	only Puerto Rico	Optional
Dispensing Full-scale Exercise (FSE)/Incident	Once a project period (every 5 years)	***	✓	FE or FSE for dispensing or distribution	✓
Distribution Full-Scale Exercise (FSE)/Incident	Once a project period (every 5 years)	✓	✓	FE or FSE for dispensing or distribution	
After Action Report (AAR) and Improvement Plan (IP)	Once a project period (every 5 years)	✓	✓	✓(only incidents)	✓
Dispensing Throughput Drill <ul style="list-style-type: none"> only used to document if mass vaccination was conducted in lieu of pill dispensing 	Once a project period (every 5 years)	Optional	✓	✓	✓
Tabletop Exercise (TTX) <ul style="list-style-type: none"> to document any TTX including community reception and fiscal/administrative focused exercises 	Once a project period (every 5 years)	Optional	Optional	Optional	Optional

*Note. Operational forms above must be submitted or updated as indicated; due date cycles are based on an annual budget period cycle (at least one submission annually between July 1–June 30).

**Note. To document compliance, American Samoa, Commonwealth of Northern Mariana Islands, Federated States of Micronesia, Guam, Republic of Palau, Republic of the Marshall Islands, and U.S. Virgin Islands may continue to submit an Excel spreadsheet (if IMATS or IDE is unavailable) to respond to CDC inventory request. Puerto Rico must submit through IMATS or another IDE.

***Note. Required for states with dispensing responsibilities.

DOCUMENT ORGANIZATION

The chapters in this document generally follow the structure below.

Example of reporting requirements table

Completed By	Submission Timeline
<input type="checkbox"/> States	<input type="checkbox"/> Annual requirement
<input type="checkbox"/> Directly funded localities	<input type="checkbox"/> Five-year requirement
<input type="checkbox"/> Territories or freely associated states	
<input type="checkbox"/> CRI local planning jurisdictions	
Form Key Terms (refer to Appendix B):	

“**Completed By**” column indicates who (by type of jurisdiction) is responsible for completing and submitting the form.

“**Submission Timeline**” column indicates when forms are due.

- **Annual Requirement**
 - Descriptive/demographic forms must be submitted or updated at 6 or 12 months intervals (depending on the form); intervals are based on the date of the original form submission.
 - Planning forms must be submitted or updated at 12-month intervals from the date of the original form submission.
 - Annual operational forms must be submitted at least once between July 1–June 30 of each budget period.
- **Five-year requirement**
 - Full-scale exercise operational forms are only required at least once during the 5-year project period (July 1, 2017–June 30, 2022).

Why is this information collected?

This briefly describes why the content is requested for each form.

What do I need to know about this form?

This includes tips and detail about certain questions that will help the user complete the self-assessment; this section also provides tips for how the reviewer will evaluate submitted evidence.

What impacts achieving established status?

This describes any nuanced requirements that will contribute to eligibility for achieving an “established” status.

IMPLEMENTATION

Preparing for an ORR Site Visit Conducted by CDC

This chapter provides recommendations for how a jurisdiction should prepare for an ORR site visit conducted by CDC. CDC will schedule approximately 50% of recipient ORR site visits in budget period (BP) 1 (July 1, 2017–June 30, 2018) and the other half in BP2 (July 1, 2018–June 30, 2019). The MCM specialists (both regional and Atlanta-based), in coordination with PHEP specialists and team leads, will determine which jurisdictions are prioritized for site visits in BP1 based on program needs and status levels. Typically, your Atlanta-based MCM specialist will be in contact to schedule the ORR site visit, and the regional MCM specialist will actively engage in a support role.

A significant amount of time will be necessary to prepare for the ORR site visit. We encourage you to plan accordingly and negotiate a date that is reasonable to accommodate all stakeholder's needs. CDC will send an email with the selected site visit date, reminder to submit relevant documentation, and request to confirm acceptance of the scheduled date and time for the ORR site visit.

- **Do not wait until the last minute to prepare for the site visit!** Schedule sufficient time to collect, enter, review, and submit the data for each required form. Your timeline should account for any internal review process that must occur before submission to CDC. Keep in mind that the new ORR online system is available 24 hours a day, 7 days a week (except if otherwise notified).

All ORR forms must be submitted via the ORR online system, and CDC highly encourages all supporting documentation be uploaded in the ORR online system. You may upload files individually or in batches using the supporting documentation tab. Use a ZIP file if the documentation is >25MB. However, you may discuss with your MCM specialist if you need to use an alternative method to submit supporting documentation. For example, you may choose to grant your CDC reviewer access to documents stored on your own internal electronic system rather than upload them to the ORR system. You might also need to mail a compact disc (CD) or other digital media type if reliable internet access is not available (particularly for U.S. territories and freely associated states).

A site visit should be rescheduled if there are unforeseen circumstances such as a national or state emergency declaration or if all parties mutually agree to reschedule the visit. If completed forms and adequate documentation are not submitted within the designated period, CDC reviewers can cancel the site visit. Failure to complete and submit required forms may result in national status reports displaying your status as early and non-compliant with reporting requirements. This includes sites that submit either incomplete or none of the required forms in the time allotted (20 business days prior to a site visit or by the end of BP1 if not due for a site visit).

Agenda Development

Prior to the site visit, an agenda will be developed in conjunction with you that outlines the purpose, goals, and objectives of the meeting. It is recommended that the review progress from demographic, planning, to operational forms to best facilitate a logical flow for the site visit discussion.

You will be responsible for identifying speakers and participants in advance of the site visit and should confirm that your MCM stakeholders can attend the meeting; accommodations for individuals with limited

availability should be built into the agenda. The figure below lists stakeholders typically involved in MCM planning and response activities. Additional partners not listed can also be invited to participate if deemed important to the MCM response for your site.

Suggested list of stakeholders to invite to participate in the site visit.

<ul style="list-style-type: none"> • CRI coordinator • Dispensing lead • Distribution lead • Federal partners <ul style="list-style-type: none"> ○ HHS regional emergency coordinators ○ United States Marshals Service ○ HPP field project officers (FPOs) ○ Federal executive board partners • Health officer • Hospital Preparedness Program coordinator • Inventory control lead • Law enforcement or security lead 	<ul style="list-style-type: none"> • MCM coordinator • Military installation liaison(s) • National Guard (if applicable) • PHEP director • Private sector partners or agencies • Public health, Public information officer(s) • Receipt, stage, store (RSS) lead • State/local emergency management representative • Tactical communications lead • Training lead • Tribal partners • Volunteer coordinator(s)
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Form Submission (via ORR online system)

All jurisdictions must submit the required forms described in the overview chapter in BP1 (no later than, June 30, 2018) regardless of whether your jurisdiction is scheduled for a site visit from CDC in BP1.

- Submit forms as completed. It is not necessary to submit all required forms at one time. Reviewers will need time to read and synthesize the information and can do so once the first form and supporting documents are submitted.

Jurisdictions selected to receive a site visit in BP1 must complete and submit, at minimum, the forms in the following table prior to the visit. However, all forms required for BP1 must ultimately be completed and submitted by the end of BP1 (June 30, 2018).

Jurisdictions not selected to receive a site visit in BP1 must complete and submit, at minimum, the forms in the following table to serve as their self-assessment for the year. These forms will not be validated by CDC.

- **Complete and submit all required forms and upload supporting documents no later than 20 business days prior the site visit.**

Minimum forms that must be completed and submitted prior to a scheduled site visit.

Form	State	DFL	Territory	CRI
Critical Contact Sheet	✓	✓	✓	
Jurisdictional Data Sheet (JDS)	✓	✓	✓	✓
Point of Dispensing (POD)	✓*	✓	✓	✓
Distribution Planning	✓	✓	✓	✓
Dispensing Planning	✓	✓	✓	✓
Training and Exercise Planning	✓	✓	✓	✓

*Note. POD form is completed by states if applicable (state maintains plans for PODs).

Review and Validation

CDC reviewers will validate submitted forms for accuracy and evidence of sufficient information by reading all supporting documentation provided. Demographic and operational forms receive a form level approval whereas planning forms are evaluated element by element. Reviewers will select from standardized response options for the planning forms to promote consistency across reviews.

Standardized reviewer options are generally defined as indicated below. Refer to the planning forms chapter for specific information about how each distribution and dispensing element review is defined.

- **Concur** means sufficient evidence is given and no additional comments are required.
- **Insufficient evidence** means more information is needed and reviewer comments will include what additional data are required.
- **No evidence** means nothing relevant to the element was provided and reviewer comments will include requests for data to meet minimal standards for established.
- **Contradictory evidence** means the reviewer found inconsistent information and comments will include requests for clarification.

A reviewer can identify a **data input error** for any item in the planning section; this will promote data integrity (documenting why data is changed) and allows the recipient to easily recognize and correct the error.

Site Visit Flow

At the beginning of the ORR site visit, CDC will reiterate the purpose, goals, and objectives for the meeting that were agreed upon prior to the site visit. CDC recommends the meeting commence with an overview of the agenda and introductions. During the site visit, CDC will facilitate discussions between MCM program staff and partners to verify plans and operational implementation. CDC will address any identified issues, document program progress towards achieving established status for ORR elements, and discuss monitoring of action plan activities. Challenges and barriers associated with those topics will also be noted.

Exit Meeting

The exit discussion is the opportunity for all stakeholders, including recipient's leadership, to hear feedback from CDC about important observations including program strengths, opportunities for improvement, and new or pending action plan recommendations. Any action items, including requests for additional documentation, will be documented by CDC prior to departing the site visit and the recipient must adequately respond no later than five (5) business days from the ORR site visit date. Technical assistance may be requested by the recipient or discussed by CDC. All site visit stakeholders can offer areas where technical assistance might be needed. In response, the MCM and PHEP specialists will either provide requested assistance to the jurisdiction or make a plan to triage issues to the appropriate subject matter expert (SME).

Conducting Local CRI ORR Site Visits

The purpose of this section is to provide recommendations to state MCM coordinators (or staff responsible) on how to conduct an ORR for a local CRI jurisdiction. CDC recommends that you schedule approximately 50% of the local CRI site visits in BP1 (July 1, 2017–June 30, 2018) and the other half in BP2 (July 1, 2018–June 30, 2019) for consistency with CDC protocols.

CDC recommends determining which CRI jurisdictions receive site visits in BP1 based on program needs and prior status levels. The following questions might help prioritize which jurisdictions to visit.

- Were there recent changes in personnel, lack of resources, or incomplete drills and exercises that would warrant concern or require technical assistance?
- Has the jurisdiction experienced challenges with meeting key benchmarks, performance measures, or target metrics?
- Do the jurisdiction's MCM action plans indicate progress?

A significant amount of time will be necessary to prepare for CRI reviews and site visits. Your regional MCM specialist is available to support and provide technical assistance for this process. We encourage you to negotiate dates that are reasonable to accommodate all stakeholder's needs (including your review time). CDC recommends about 20 business days per CRI will be required to review all forms and supporting documentation. We recommend you send an email with the selected site visit date, reminder to submit relevant documentation, and request to confirm acceptance of the scheduled date and time for the ORR site visit.

- **Do not wait until the last minute to prepare for the site visit!** Schedule sufficient time to allow CRIs to collect, enter, and submit the data for each required form. The timeline should account for your review process. Keep in mind that the new ORR online system is available 24 hours a day, 7 days a week (except if otherwise notified).

While **all ORR forms must be submitted via the ORR online system**, an alternative method to submit supporting documentation can be used. CDC highly encourages all relevant documentation be uploaded to the ORR online system. CRIs may upload files individually or in batches using the supporting documentation tab. Use a ZIP file if the documentation is >25MB. For example, you might choose to review a document stored on your internal systems rather than upload the files to the ORR system. You might also allow CRIs to send you a CD or other digital media type.

A site visit should be rescheduled if there are unforeseen circumstances such as a national or state emergency declaration or if all parties mutually agree to reschedule the visit. If completed forms and adequate documentation are not submitted within the designated period, CDC recommends you cancel the site visit. Failure of CRIs to complete and submit required forms may result in national status reports displaying their status as early and non-compliant with reporting requirements.

Agenda Development

Prior to the site visit, develop an agenda in collaboration with the CRI that outlines the purpose, goals, and objectives of the meeting. CDC recommends that the review progress from demographic, planning, to operational forms to best facilitate a logical flow for the site visit discussion.

The CRI jurisdiction is responsible for identifying speakers and participants in advance of the site visit and their staff should confirm that all relevant MCM stakeholders can attend the meeting; accommodations for individuals with limited availability should be built into the agenda. The figure below lists stakeholders typically involved in MCM planning and response activities. Additional partners not listed can also be invited to participate if deemed important to the MCM response for the CRI jurisdiction.

Suggested list of stakeholders to invite to participate in the site visit.

<ul style="list-style-type: none"> • CRI coordinator • Dispensing lead • Distribution lead • Federal partners <ul style="list-style-type: none"> ○ CDC (MCM specialist, regional MCM specialist, PHEP specialist) ○ HHS regional emergency coordinators ○ United States Marshals Service ○ HPP field project officers (FPOs) ○ Federal executive board partners • Health officer • Hospital Preparedness Program coordinator • Inventory control lead • Law enforcement or security lead 	<ul style="list-style-type: none"> • MCM coordinator • Military installation liaison(s) • National Guard (if applicable) • PHEP director • Private sector partners or agencies • Public health, Public information officer(s) • Receipt, stage, store (RSS) lead • State/local emergency management representative • Tactical communications lead • Training lead • Tribal partners • Volunteer coordinator(s)
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Form Submission (via ORR online system)

CDC recommends CRIs selected to receive a site visit in BP1, complete and submit, at minimum, the forms in the following table 20 business days prior to the site visit. However, **all operational forms required for CRIs, regardless of whether they receive a site visit, must ultimately be completed and submitted by the end of the BP1 (June 30, 2018)**.

Minimum forms that must be completed and submitted prior to a scheduled site visit.

Form	State	DFL	Territory	CRI
Critical Contact Sheet	✓	✓	✓	
Jurisdictional Data Sheet (JDS)	✓	✓	✓	✓
Point of Dispensing (POD)	✓*	✓	✓	✓
Distribution Planning	✓	✓	✓	✓
Dispensing Planning	✓	✓	✓	✓
Training and Exercise Planning	✓	✓	✓	✓

*Note. POD form is completed by states if applicable (state maintains plans for PODs).

- CRIs can submit forms as completed. It is not necessary to submit all required forms at one time. Reviewers will need time to read and synthesize the information and can do so once the first form and supporting documentation are submitted.

Review and Validation

Review submitted forms for accuracy and evidence of sufficient information by reading all supporting documentation provided. The regional MCM specialist can provide consultation, clarify any outstanding questions, and assist with supporting document review. Demographic and operational forms receive a form level approval whereas planning forms are evaluated element by element. Reviewers select from standardized response options for the planning forms to promote consistency across reviews.

Standardized reviewer options are generally defined as indicated below. **Refer to the planning forms chapter for specific information about how each distribution and dispensing element review is defined.**

- **Concur** means sufficient evidence is given and no additional comments are required.
- **Insufficient evidence** means more information is needed and reviewer comments will include what additional data are required.
- **No evidence** means nothing relevant to the element was provided and reviewer comments will include requests for data to meet minimal standards for established.
- **Contradictory evidence** means the reviewer found inconsistent information and comments will include requests for clarification.

A reviewer can identify a **data input error** for any item in the planning section; this will promote data integrity (documenting why data is changed) and allows the recipient to easily recognize and correct the error.

Site Visit Flow

At the beginning of the ORR site visit, reiterate the purpose, goals, and objectives for the meeting that were agreed upon prior to the site visit. CDC recommends the meeting commence with an overview of the agenda and introductions. During the site visit, facilitate discussions between CRI stakeholders to verify plans and operational implementation. Address any identified issues, document program progress towards achieving established status for ORR elements, and discuss monitoring of action plan activities. Challenges and barriers associated with those topics will also be noted.

Exit Meeting

The exit discussion is the opportunity for all stakeholders, including CRI jurisdiction leadership, to hear feedback from you about important observations including program strengths, opportunities for improvement, and new or pending action plan recommendations. Any action items, including requests for additional documentation, should be documented prior to departing the site visit and CDC recommends an adequate response is requested no later than five (5) business days from the ORR site visit date. All site visit stakeholders can offer areas where technical assistance might be needed.

At-a-Glance CRI Site Visit Facilitation

1. Opening remarks and introductions
 - a. Set expectations on meeting purpose
 - i. Reiterate the goals, objectives, and purpose of the ORR site visit
 - ii. Discuss the flow and allotted duration of the meeting
 - iii. Establish an environment of collaboration and trust

- b. Review the agenda
 - i. Start and end meeting on time
 - 1. Starting on time will set a positive tone
 - 2. Do not to shortchange important discussions
 - ii. Refer to the agenda frequently and be cognizant to make full use of allotted time
 - c. Introductions
 - i. Learn name and role in response of each attendee
 - ii. Acknowledge and thank participants for their work
2. Facilitate program discussion and note observations
 - a. Frame conversations and observations positively and openly
 - b. Ask insightful questions to increase understanding about planning and operational readiness
 - c. Maintain flexibility and discuss new topics as needed (balance with overall agenda)
 3. Verify plans and operational implementation
 - a. Reiterate the ORR is designed to measure ability of a CRI jurisdiction to execute plans in response to an incident, event, or exercise
 - b. Note progress and any challenges/barriers presented by the jurisdiction
 4. Identify follow-up action items
 - a. Identify any additional documents that are required
 - b. Request relevant supplemental materials no later than five (5) business days from the ORR site visit
 5. Technical assistance (areas needing improvement)
 - a. Address any identified requests
 - b. Identify areas throughout site visit
 - i. Encourage all participants to contribute to the discussion
 - ii. Triage to appropriate SME (including CDC regional MCM specialist) or note for follow-up action
 - c. Discuss technical assistance identified or requested during the site visit
 6. Exit meeting
 - a. Organize your observations and recommendations
 - b. Provide feedback
 - c. Ensure attendees have a clear understanding of any follow-up actions required
 7. Site visit promising practices
 - a. Allow adequate time between scheduled site visits
 - i. Don't compromise the quality of an individual review by compressing your timeline
 - b. Reinforce the importance of key staff and partner attendance at the site visit
 - i. Local CRI jurisdictions are the SMEs on their relevant elements
 - c. Capitalize on your regional MCM specialists who can:
 - i. Assist with training of the ORR online system for the CRI coordinator
 - ii. Consult on clarifying questionable evidence
 - iii. Recommend appropriate technical assistance based on outcome of the site visit
 - d. Query On-TRAC peer-to-peer for additional resources

ORR STATUS

Status determination is hard coded into the online system and is calculated from the self-assessment responses and reviewer input. In the current online version (released September 18, 2017, version 1.0), each section (demographic, planning, and operational) will display a preliminary status once all forms for each respective section are submitted. An “adjudicated” status will populate after the ORR is conducted and the reviewer submits responses. All jurisdictions and CRIs are expected to achieve “established” status by 2022. There are several generalizable rules that contribute to status determination.

Deadlines

To be eligible for “established” status, all requirements with specific deadlines must be met. If information is submitted late, the site becomes eligible for an “intermediate” status. If information is overdue or submitted more than two times the deadline (e.g., annual form requirement is not updated until 25 months) then the eligibility status drops to “early.”

Essential Elements

Within the planning forms, multiple criteria must be addressed to be considered eligible for “established” status. The *form chapters* of this document detail the specific criteria as relevant for each form. If the particular criteria is not met, then eligibility status drops to “early.”

Advanced

Eligibility for “advanced” status is obtained when the site goes above and beyond the criteria for established by completing optional exercises and submitting a Training and Exercise Planning Workshop (TEPW) and Multi-year Training and Exercise Plan (MYTEP) with 3 or more planning years. Optional exercises include a community reception tabletop and a fiscal/administrative tabletop exercise (or any higher exercise level for either). To evaluate training plans, reviewers will need to ensure evidence for improvements identified in annual After Action Reports (AAR) and improvement plans (IP) are appropriately addressed and updated in training documents and plans for future exercises.

DESCRIPTIVE/DEMOGRAPHIC FORMS CHAPTER

Critical Contact Sheet (CCS)

Completed By	Submission Timeframe
<input checked="" type="checkbox"/> States	<input checked="" type="checkbox"/> Annual requirement
<input checked="" type="checkbox"/> Directly funded localities	<input type="checkbox"/> Five-year requirement
<input checked="" type="checkbox"/> Territories or freely associated states	
<input type="checkbox"/> CRI local planning jurisdictions	
<p>Form Key Terms (refer to Appendix B): Department Operations Center (DOC), Continuity of Operations (COOP), Emergency Management Agency (EMA), Emergency Operations Center (EOC), materiel, preparedness, public health emergency, Public Health Emergency Preparedness (PHEP) cooperative agreement, rapid dispensing model (or non-medical model), receiving, staging, and storing (RSS) facility, Strategic National Stockpile (SNS)</p>	

Why is this information collected?

The CCS is used to maintain accurate, up-to-date information on essential personnel. For example, CDC’s Division of Strategic National Stockpile can consult this information when a request to ship materiel is received.

What do I need to know about this form?

Form question	Form Hint
Primary CDC PHEP Specialist	Provide the name of the current primary CDC PHEP specialist assigned to you.
Back-up CDC PHEP Specialist or Team Lead	Provide the name of the current back-up CDC PHEP specialist or team lead assigned to you.
CDC MCM Specialist	Provide the name of the current CDC MCM specialist assigned to you.
CDC Regional MCM Specialist	Provide the name of the current regional CDC MCM specialist assigned to you.
US Marshal	Provide the name of the current US Marshal assigned to you.
Back-up US Marshal	Provide the name of the current back-up US Marshal assigned to you.
Department of Health EOC	Provide the general contact number for the health department.
Department of Health EOC: 24/7 phone number	Provide the current contact number for the health agency EOC/DOC.
Department of Health EOC: Primary contact name	Provide the name for the current primary health department contact; if this is dependent on type of incident/event, provide the position title that will be responsible. Contact information for the on-call duty officer, after-hours service, or dispatch is acceptable.



Form question	Form Hint
Department of Health EOC: Primary phone number	Provide the EOC contact number for the health department.
COOP EOC: Primary contact name	Provide the name of the current COOP primary contact; if this is dependent on type of incident/event, provide the position title that will be responsible.
Emergency Management Agency EOC: Primary contact name	Provide the name of the current primary emergency management agency contact. If this is dependent on type of incident/event, provide the position title that will be responsible.
Health Commissioner/Secretary of Health/SHO/Ministry of Health	Provide the name of the lead health officer/health commissioner for the jurisdiction.
CHEMPACK Coordinator	Select “yes” if the CHEMPACK coordinator is the same as the MCM coordinator. If CHEMPACK coordinator is someone different, provide his/her information.
Law enforcement agencies responsible for MCM security: Security contact name	Provide the name of the current law enforcement agency primary contact. If this is dependent on type of incident/event, provide the position title that will be responsible.
Law enforcement agencies responsible for MCM security: Primary phone number	Provide the primary law enforcement agency current number. The agency phone number or non-emergency dispatch number should be entered if a position title (rather than person) is listed as the security contact.
Back-up law enforcement agency responsible for MCM security: Security contact name	Provide the name of the current back-up law enforcement agency/department contact.
Distribution (RSS) Lead/Supervisor/Chief: Name	Provide the name of the current public health department personnel that serves as the distribution planning lead. A contractor is not an acceptable entry.
Back-up Distribution Lead: Name	Provide the name of the current public health department personnel that serves as the distribution planning lead back-up. A contractor is not an acceptable entry.

What impacts achieving established status?

To be eligible for this status, you must update and submit the CCS every six months.



Jurisdictional Data Sheet (JDS), State

Completed By	Submission Timeframe
<input checked="" type="checkbox"/> States	<input checked="" type="checkbox"/> Annual requirement
<input type="checkbox"/> Directly funded localities	<input type="checkbox"/> Five-year requirement
<input type="checkbox"/> Territories or freely associated states	
<input type="checkbox"/> CRI local planning jurisdictions	
<p>Form Key Terms (refer to Appendix B): backup point of dispensing (POD), centralized governance, Cities Readiness Initiative (CRI), closed point of dispensing (closed POD or CPOD), command staff or incident management lead roles, critical infrastructure personnel, decentralized governance, distribution assets, Emergency Management Agency (EMA), materiel, open point of dispensing (open POD), public health emergency, Public Health Emergency Preparedness (PHEP) cooperative agreement, responder</p>	

Why is this information collected?

The JDS is used to gather information about the jurisdictions population and staffing to support MCM distribution and dispensing.

What do I need to know about this form?

Form question	Form Hint
State population	Population will be auto-populated from Census Bureau data (https://factfinder.census.gov/bkmk/table/1.0/en/ACS/15_5YR/B01003/0100000US.04000). If adjustments to the population estimate are necessary to account for commuters, tourists, or other impacts, insert a modified population. Provide reasons and source(s) used to update the population in the comments.
Number of county/city/tribal local health departments	Provide the number of all health departments (not just CRI areas) within your state.
Number of county/city/tribal local health departments required to develop local mass prophylaxis plans	Provide the number of all health departments (planning jurisdictions) required to develop mass prophylaxis plans. This number should not be greater than the number of county/city/tribal local health departments referenced above.
Number of local CRI planning jurisdictions	Provide all CRI MSA planning jurisdictions within your state. If your CRI MSA overlaps your state borders, include only the CRI planning jurisdictions that is within your state.



Form question	Form Hint
Number of non-CRI planning jurisdictions	Provide the number of all non-CRI MSAs (as defined by OMB) planning jurisdictions within the state borders.
Total sites that receive materiel directly from the RSS	Given an anthrax planning scenario, provide the total number of sites that receive materiel directly from the RSS and serve as a regional or local distribution sites (RDS/LDS/receiving site).
Total number of designated primary open (public) point of dispensing (PODs) statewide	Provide the total number of public PODs that would open to give prophylaxis to the entire population. Do not include backup PODs in this number.
Distribution assets identified in the state plan for use in primary and any additional RSS sites	Select the agencies/organizations (government, military, private business) that will provide personnel and assets to support RSS distribution.
EOC and Command Staff	Given an anthrax-planning scenario, provide the public health staffing number for the EOC and command staff. The number should represent a 24-hour staffing operation. If the same person fills multiple positions, only count the staff person one time in the total. If public health staff will serve as liaisons to other agencies (e.g., Emergency Management Agency) include them in the total.
Current RSS Staff	Given an anthrax-planning scenario, provide the current staff total available to conduct RSS functions (security, logistics, material handling, inventory management, etc.). EOC staff located at the RSS should be included in the EOC staff totals, not the RSS staff total.
Needed RSS Staff	Given an anthrax planning scenario, provide the total staff needed to run the RSS (security, logistics, material handling, inventory management, etc.).
State dispenses directly to public health responders and/or critical infrastructure personnel (CIP)	Select “no” if state employees are only used to augment local dispensing staff. Also, select “no” if state staff only receive MCM assets from local PODS.

What impacts achieving established status?

To be eligible for this status, you must update and submit the JDS every 12 months.



Jurisdictional Data Sheet (JDS), Directly Funded Locality (DFL)

Completed By	Submission Timeframe
<input type="checkbox"/> States	<input checked="" type="checkbox"/> Annual requirement
<input checked="" type="checkbox"/> Directly funded localities	<input type="checkbox"/> Five-year requirement
<input type="checkbox"/> Territories or freely associated states	
<input type="checkbox"/> CRI local planning jurisdictions	
<p>Form Key Terms (refer to Appendix B): academic institutions, alternate dispensing methods, backup point of dispensing (POD), Cities Readiness Initiative (CRI), closed point of dispensing (closed POD or CPOD), command staff or incident management lead roles, community-based agencies, distribution assets, critical infrastructure personnel, Emergency Management Agency (EMA), head of household (HoH), materiel, military installations, open point of dispensing (open POD), operational plans, preparedness, public health emergency, Public Health Emergency Preparedness (PHEP) cooperative agreement, regimens per hour (RPH), throughput</p>	

Why is this information collected?

The JDS is used to gather information about the jurisdictions population and staffing to support MCM distribution and dispensing.

What do I need to know about this form?

Form question	Form Hint
POD name	Designate a name for the POD that includes whether it is open or closed (e.g., Open POD Columbus Tustin Activity Center, Closed POD Walgreens30032). The name will be required on relevant operational forms that require POD exercise or in the event of an incident.
Total sites that receive materiel directly from the RSS	Given either a worst-case scenario or the actual incident/event, provide the total number of sites that receive materiel directly from the RSS and are used as a regional or local distribution sites (RDS or LDS). If there are no intermediate sites within your DFL, enter 0.
Total number of designated primary Open (Public) Point of Dispensing (PODs) DFL-wide	Provide the total number of public PODs that would open to give prophylaxis to the entire population. Do not include backup PODs in this number.
Distribution assets identified in the DFL plan for use in primary and any additional RSS sites	Select the agencies/organizations (government, military, private business) that will provide personnel and assets to support RSS distribution.



Form question	Form Hint
EOC and Command Staff	Given an anthrax-planning scenario, provide the number of public health staffing for the EOC and command staff. The number should represent a 24-hour staffing operation. If the same person fills multiple positions, only count the staff person one time in the total. If public health staff will serve as liaisons to other agencies (e.g., Emergency Management Agency) include them in the total.
Current RSS Staff	Given an anthrax-planning scenario, provide the current staff total available to conduct RSS functions (security, logistics, material handling, inventory management, etc.). EOC staff located at the RSS should be included in the EOC staff totals, not the RSS staff total.
Needed RSS Staff	Given an anthrax-planning scenario, provide the total staff needed to run the RSS (security, logistics, material handling, inventory management, etc.).
DFL dispenses directly to public health responders and/or critical infrastructure personnel (CIP)	Select “no” if DFL-level staff only receive MCM assets from open PODS.
Jurisdiction population	Enter population from Census Bureau data (https://factfinder.census.gov/bkmk/table/1.0/en/ACS/15_5YR/B01003/0100000US.05000.004). If adjustments to the population estimate are necessary to account for commuters, tourists, or other impacts, insert a modified population. Provide reasons and source(s) used to update the population in the comments.
Closed PODs Section	This section will collect information about types of CPOD including healthcare entities, businesses, government agencies, military installations, academic institutions, and community based agencies.
Closed PODs: Population served by closed PODs (CPODs)	Provide the total number of people the type of CPOD is intended to serve; estimate should include family and friends that will receive medications from this location.
Closed PODs: Number of CPODs with written operations plans	Of the CPODs with agreements, provide the number of CPODs with written operational plans in each category. For example, if one agreement includes 5 CPODs, enter 5.
Closed PODs: Number of plans reviewed	Of the CPODs with written operational plans in each category, enter the number of CPOD plans that underwent any review by the CRI planning jurisdiction, state, or other agency.
Closed PODs: Number of CPODs exercised	Provide number of CPODs (if any) in each category that were exercised at any level (drill, FSE, or incident).
Closed PODs: Number of agreements in place with dispensing sites using alternate dispensing methods	Provide a total number for any other MCM dispensing sites used to reach any individuals within the population who cannot access designated open or CPODs.



Form question	Form Hint
Open PODs: Total population per hour to process	Auto-calculated value, based on the following formula: $\frac{\text{Remaining population to be covered by Open PODs}}{\text{Hours available to complete dispensing operations}}$
Open PODs: Maximum regimens dispensed to each HOH	Provide most realistic estimate. However, if unlimited, enter 000.
Open PODs: Estimated number of regimens dispensed to each HoH	Provide an estimated number of regimens to be dispensed based on the following formula: $\frac{\text{Approximate \# of persons in the jurisdiction}}{\text{\# of households in the jurisdiction}}$
Open PODs: Calculated throughput if HoH available	This is auto-calculated based on information entered in prior questions regarding head of household and RPH calculations.
Open PODs: Actual number of Open (Public) PODs needed to meet the throughput	This is auto-calculated based on information entered in prior questions regarding head of household and RPH calculations.
Open PODs Roll-Up: Estimated throughput	This is auto-calculated based on information entered in prior questions.

What impacts achieving established status?

To be eligible for this status, you must update and submit the JDS every 12 months.



Jurisdictional Data Sheet (JDS), CRI

Completed By	Submission Timeframe
<input type="checkbox"/> States	<input checked="" type="checkbox"/> Annual requirement
<input type="checkbox"/> Directly funded localities	<input type="checkbox"/> Five-year requirement
<input type="checkbox"/> Territories or freely associated states	
<input checked="" type="checkbox"/> CRI local planning jurisdictions	
<p>Form Key Terms (refer to Appendix B): academic institutions, alternate dispensing methods, Cities Readiness Initiative (CRI), closed point of dispensing (closed POD or CPOD), community-based agencies, head of household (HoH), military installations, open point of dispensing (open POD), operational plans, preparedness, regimens per hour (RPH), throughput</p>	

Why is this information collected?

The JDS is used to gather information about the jurisdictions population and staffing to support MCM dispensing.

What do I need to know about this form?

Form question	Form Hint
POD name	Designate a name for the POD that includes whether it is open or closed (e.g., Open POD Columbus Tustin Activity Center, Closed POD Walgreens30032). The name will be required on relevant operational forms that require POD exercise or in the event of an incident.
Local population	Enter population from Census Bureau data (https://factfinder.census.gov/bkmk/table/1.0/en/ACS/15_5YR/B01003/0100000US.05000.004). If adjustments to the population estimate are necessary to account for commuters, tourists, or other impacts, insert a modified population. Provide reasons and source(s) used to update the population in the comments.
Closed PODs Section	This section will collect information about types of CPOD including healthcare entities, businesses, government agencies, military installations, academic institutions, and community based agencies.
Closed PODs: Population served by closed PODs (CPODs)	Provide the total number of people the type of CPOD serves; estimate should include family and friends that will receive medications from this location.
Closed PODs: Number of CPODs with written operations plans	Of the CPODs with agreements, provide the number of CPODs with written operations plans in each category. For example, if one agreement includes 5 CPODs, enter 5.



Form question	Form Hint
Closed PODs: Number of plans reviewed	Of the CPODs with written operational plans in each category, enter the number of CPOD plans that underwent any review by the CRI planning jurisdiction, state, or other agency.
Closed PODs: Number of CPODs exercised	Provide number of CPODS (if any) in each category that were exercised at any level (drill, FSE, or incident).
Number of POD agreements with federally recognized tribal nations	Provide all dispensing types (closed PODs, open PODs, and alternate modes of dispensing) planned for persons who work or live on the reservation.
Population served by PODs within recognized tribal nations	Provide best estimate of total tribal nation population served by all dispensing types.
Number of PODs with written operations plans (tribal nations)	Of the tribal nation PODs with agreements, provide the number with written operational plans in each category. For example, if one agreement includes 2 PODs, enter 2.
Number of PODs exercised (tribal nations)	Provide number of tribal nation PODS (if any) that were exercised at any level (drill, FSE, or incident).
Alternate Dispensing Methods: Number of agreements in place with dispensing sites using alternate dispensing methods	Provide a total number for any other MCM dispensing sites used to reach any individuals within the population who cannot access designated open or closed PODs.
Total population per hour to process	Auto-calculated value, based on the following formula: $\frac{\text{Remaining population to be covered by Open PODs}}{\text{Hours available to complete dispensing operations}}$
Estimated number of regimens dispensed to each HoH	Provide an estimated number of regimens to be dispensed based on the following formula: $\frac{\text{Approximate \# of persons in the jurisdiction}}{\text{\# of households in the jurisdiction}}$
Open PODs: Maximum regimens dispensed to each HOH	Provide most realistic estimate. However, if unlimited, enter 000.
Open PODs: Calculated throughput if HoH available	This is auto-calculated based on information entered in prior questions regarding head of household and RPH calculations.
Open PODs: Actual number of Open (Public) PODs needed to meet the throughput	This is auto-calculated based on information entered in prior questions regarding head of household and RPH calculations.
Open PODs Roll-Up: Estimated throughput	This is auto-calculated based on information entered in prior questions.

What impacts achieving established status?

To be eligible for this status, you must update and submit the JDS every 12 months.



Jurisdictional Data Sheet (JDS), Territory or Freely Associated States (TFAS)

Completed By	Submission Timeframe
<input type="checkbox"/> States	<input checked="" type="checkbox"/> Annual requirement
<input type="checkbox"/> Directly funded localities	<input type="checkbox"/> Five-year requirement
<input checked="" type="checkbox"/> Territories or freely associated states	
<input type="checkbox"/> CRI local planning jurisdictions	
<p>Form Key Terms (refer to Appendix B): academic institutions, alternate dispensing methods, backup point of dispensing (POD), Cities Readiness Initiative (CRI), closed point of dispensing (closed POD or CPOD), command staff or incident management lead roles, community-based agencies, distribution assets, EMA, head of household (HoH), materiel, military installations, open point of dispensing (open POD), operational plans, preparedness, public health emergency, Public Health Emergency Preparedness (PHEP) cooperative agreement, regimens per hour (RPH), throughput</p>	

Why is this information collected?

The JDS is used to gather information about the jurisdictions population and staffing to support MCM distribution and dispensing.

What do I need to know about this form?

Form question	Form Hint
POD name	Designate a name for the POD that includes whether it is open or closed (e.g., Open POD Columbus Tustin Activity Center, Closed POD Walgreens30032). The name will be required on relevant operational forms that require POD exercise or in the event of an incident.
Local population	Enter population from Census Bureau (http://data.worldbank.org/indicator/SP.POP.TOTL). If adjustments to the population estimate are necessary to account for commuters, tourists, or other impacts, insert a modified population. Provide reasons and source(s) used to update the population in the comments.
Total number of health departments	Provide the total number of health departments, include national, state, island, and municipal health departments.
Total number of health departments required to develop local mass prophylaxis plans	Provide the number of all health departments required to develop mass prophylaxis plans. This number should not be greater than the number of health departments referenced above.
Total planning jurisdictions	Provide the number of all planning jurisdictions required to develop mass prophylaxis plans.



Form question	Form Hint
Total sites that receive materiel directly from the RSS	Given either a worst case scenario or the actual incident/event, provide the total number of sites that receive materiel directly from the RSS and are used as a regional or local distribution sites (RDS or LDS). If there are no intermediate sites within your TFAS, enter 0.
Total number of designated primary Open (Public) Point of Dispensing (PODs)	Provide the total number of public PODs that would open to give prophylaxis to the entire population. Do not include backup PODs in this number.
Distribution assets identified in the TFAS plan for use in primary and any additional RSS sites	Select the agencies/organizations (government, military, private business) that will provide personnel and assets to support RSS distribution.
EOC and Command Staff	Given an anthrax-planning scenario, provide the public health staffing number for the EOC and command staff. The number should represent a 24-hour staffing operation. If the same person fills multiple positions, only count the staff person one time in the total. If public health staff will serve as liaisons to other agencies (e.g., Emergency Management Agency) include them in the total. If no public health staffing is used, enter 000.
Current RSS Staff	Given an anthrax-planning scenario, provide the current staff total available to conduct RSS functions (security, logistics, material handling, inventory management, etc.). EOC staff located at the RSS should be included in the EOC staff totals, not the RSS staff total.
Needed RSS Staff	Given an anthrax planning scenario, provide the total staff needed to run the RSS (security, logistics, material handling, inventory management, etc.).
TFAS dispenses directly to public health responders and/or critical infrastructure personnel (CIP)	Select "no" if TFAS-level staff only receive MCM assets from open PODs.
Total population	Enter population estimates. TFAS are not included in the US census data, so provide the standard reference point in comments.
Closed PODs Section	This section will collect information about types of CPOD including healthcare entities, businesses, government agencies, military installations, academic institutions, and community based agencies.
Closed PODs: Population served by closed PODs (CPODs)	Provide the total number of people the type of CPOD is intended to serve; estimate should include family and friends that will receive medications from this location.
Closed PODs: Number of CPODs with written operations plans	Of the CPODs with agreements, provide the number of CPODs with written operations plans in each category. For example, if one agreement includes 5 CPODs, enter 5.
Closed PODs: Number of plans reviewed	Of the CPODs with written operations plans in each category, enter the number of CPOD plans that underwent any review by the health department or emergency management agency.



Form question	Form Hint
Closed PODs: Number of CPODs exercised	Provide number of CPODs (if any) in each category that were exercised at any level (drill, FSE, or incident).
Closed PODs: Number of agreements in place with dispensing sites using alternate dispensing methods	Provide a total number for any other MCM dispensing sites used to reach any individuals within the population who cannot access designated open or CPODs.
Total population per hour to process	Auto-calculated value, based on the following formula: <u>Remaining population to be covered by Open PODs</u> Hours available to complete dispensing operations
Open PODs: Estimated number of regimens dispensed to each HoH	Provide an estimated number of regimens to be dispensed based on the following formula: <u>Approximate # of persons in the jurisdiction</u> # of households in the jurisdiction
Open PODs: Calculated throughput if HOH available	This is auto-calculated based on information entered in prior questions regarding head of household and RPH calculations.
Open PODs: Actual number of open (public) PODs needed to meet the throughput	This is auto-calculated based on information entered in prior questions regarding head of household and RPH calculations.
Open PODs Roll-Up: Estimated throughput	This is auto-calculated based on information entered in prior questions.

What impacts achieving established status?

To be eligible for this status, you must update and submit the JDS every 12 months.



Point of Dispensing (POD)

Completed By	Submission Timeframe
<input checked="" type="checkbox"/> States (state-run open PODs only)	<input checked="" type="checkbox"/> Annual requirement
<input checked="" type="checkbox"/> Directly funded localities	<input type="checkbox"/> Five-year requirement
<input checked="" type="checkbox"/> Territories or freely associated	
<input checked="" type="checkbox"/> CRI local planning jurisdictions	
<p>Form Key Terms (refer to Appendix B): alternate dispensing methods, backup point of dispensing (POD), Cities Readiness Initiative (CRI), closed point of dispensing (closed POD or CPOD), core staff, head of household (HoH), hybrid point of dispensing (POD), Inventory Management and Tracking System (IMATS), medical model (clinical) POD, preparedness, open point of dispensing (open POD), primary point of dispensing (POD), public health emergency, Public Health Emergency Preparedness (PHEP) cooperative agreement, rapid dispensing model (or non-medical model), regimens per hour (RPH), technical assistance, throughput</p>	

Why is this information collected?

The POD form is used to maintain accurate, up-to-date information about open POD location, population served, and staffing necessary to support dispensing activities. The information can be used to identify staffing shortages and opportunities for technical assistance.

What do I need to know about this form?

Form question	Form Hint
POD name	Designate a name for the POD that includes whether it is open or closed (e.g., Open POD Columbus Tustin Activity Center, Closed POD Walgreens30032). The name will be required on relevant operational forms that require POD exercise or in the event of an incident.
Maximum number of dispensing stations in the POD design	Given an anthrax planning scenario, provide the maximum number of stations this POD could set up for antibiotic dispensing.
Latitude (optional)	May use this link: http://www.latlong.net
Longitude (optional)	May use this link: http://www.latlong.net
Population served by the POD	Provide the total number of people expected in each geographic area who will receive their regimens from PODs. To the degree possible, calculate the total number of people within each geographic area who will receive prophylaxis (taking into consideration residential, worker, and visitor population estimates), and subtract the population to be served via alternate dispensing strategies.



Form question	Form Hint
Estimated population who will visit the POD	Provide an estimate of the number of people from each geographic unit of analysis anticipated to visit a POD. If a HoH model is planned, estimate the average number of regimens the HoH will receive.
Required POD person per hour to meet the 48-hour goal	Provide the throughput number using this formula: $\frac{\text{Estimated population who will visit the POD}}{(48 \text{ hour target time}) - (\text{distribution time})}$
Antibiotic Dispensing Operation: Staffing Section	Complete if applicable to this POD staffing plans.
Total needed core staff	Provide the minimum number of staff needed to allow the POD to function.
Total current core staff	Provide the total number of staff available (actual staff in place) and ready to participate. If this number cannot be provided (e.g., given a security contract), enter 000.
Core Management/Lead Staff	POD management lead staff includes manager, operations chief, logistics chief, etc. Core staff that require pre-incident training should be included in this calculation.
Additional Management/Lead Staff	Provide any additional positions deemed necessary for this POD's operations.
Core Medical Health Department Staff	Provide type and number of medical staff from any part of the health department that are available to support clinical POD operations.

What impacts achieving established status?

To be eligible for this status, if you have multiple open PODs within your jurisdiction you must update and submit the POD form for at least two open PODs every 12 months. For small jurisdictions that have only one open POD that serves your entire jurisdiction, submit the POD planning form for the single open POD.



Receipt, Stage, and Store (RSS) Site Survey

Completed By	Submission Timeframe
<input checked="" type="checkbox"/> States	<input checked="" type="checkbox"/> Annual requirement
<input checked="" type="checkbox"/> Directly funded localities	<input type="checkbox"/> Five-year requirement
<input checked="" type="checkbox"/> Territories or freely associated states (Puerto Rico requires survey for primary and additional RSS site; other TFASs require only primary RSS survey)	
<input type="checkbox"/> CRI local planning jurisdictions (may use for RDS/LDS sites)	
<p>Form Key Terms (refer to Appendix B): After Action Report (AAR), alert, cross-docking, fire suppression system, medical countermeasures (MCMs), preparedness, public health emergency, Public Health Emergency Preparedness (PHEP) cooperative agreement, rapid dispensing model (or non-medical model), receipt, stage, and store (RSS) facility, request, resources, Strategic National Stockpile (SNS), VOIP</p>	

Why is this information collected?

The RSS site survey provides situational awareness about potential MCM storage facilities; it is used to validate whether a site is appropriate to receive, store, and distribute MCM assets. Type of information collected on the RSS include physical facility and surrounding area detail, security considerations, staffing information, and environmental controls including cold chain management.

What do I need to know about this form?

Form question	Form Hint
Date of visit (to include CDC and USMS)	Conduct a RSS site visit (at minimum) every 3 years.
Facility onsite inspection performed by	Provide names of the key persons (CDC MCM specialist, USMS senior inspector, jurisdiction representative, security representative, and facility representative) present at the onsite inspection. CDC MCM specialist and US Marshal are required to validate site visit. Documentation of other attendees can be uploaded as supplemental evidence (optional).
Contact person(s) during facility business hours	Provide the name and number for how to reach the primary contact during routine business hours (regardless of whether the site is open for MCM operations).
Secondary phone number	Provide numerical information. Do not enter text like “same as above” – instead, copy and paste potentially redundant information. Doing so will allow the system to create comprehensive directories.



Form question	Form Hint
Alternate contact person(s) during facility business hours	Provide the name and number for how to reach the alternate contact during routine business hours (regardless of whether the site is open for MCM operations).
Facility accessibility information	RSS facilities should have clear, unrestricted access to major highways and roadways. Provide information about access to all major roads or highways from the RSS facility, including access from any distribution or dispensing facilities.
Facility physical address	Provide street address, city, state, and zip code; and any descriptive information about major crossroads, highway exit name/number, landmarks, etc. This must be provided for a site to be validated.
Facility accessible during adverse weather conditions	Select “no” if the facility will potentially be adversely impacted by weather conditions such as flooding, snow/unplowed roads, etc.
Facility is ready to receive product within 3 hours of notification or verified incident	Select “yes” if given an optimal scenario the RSS could be activated and setup for operations in 3 hours or less. This contributes to situational awareness about how many RSS sites are available to achieve distribution goals. Evidence of operationalizing RSS activation and setup should be included in AARs and ORR.
Facility has concrete driveway	Select “yes” if driveway is concrete (or equivalent surface like asphalt). Select “no” if driveway is gravel, dirt, or equivalent.
Facility has cross-docking	Select “yes” if the facility has ability for trucks to transfer assets from truck to truck without picking and re-palletizing the material.
Nearest major airport that can receive federal MCM assets (able to land and off-load a wide-body cargo aircraft)	Provide name of major airport or landing site (e.g., military installation/runway) where federal assets will be received. Include approximate distance from RSS site, approximate travel time, and any other pertinent details for receiving federal assets.
Dimensions/square footage of facility	Provide descriptive information about the site. Include any physical characteristics critical to operations. Adequate preparation requires that jurisdictions identify enough space to accomplish receiving, storage, and staging tasks. Jurisdictions with small spaces should develop strategies to assure fluid operations or identify larger space for potential alternate RSS site.
Total square footage	Provide numerical value. Recommended space is approximately 30,000 to 50,000 square feet for RSS operations.
Brief description of physical characteristics	This is a required accommodation and must include enough detail for the reviewer to have a good understanding about the site.
Facility has hard surface floors	This is a required accommodation and “no” responses will require negotiations with the reviewer.



Form question	Form Hint
Flooring surface supports modern material handling equipment	This is a required accommodation and “no” responses will require negotiations with the reviewer.
Facility clean and free from infestation by insects, rodents, birds, or vermin, chemical and mechanical hazards to include any storage of petroleum products	Select “yes” if petroleum products are stored in accordance with federal, state and local regulations. This is a required accommodation and “no” responses will require negotiations with the reviewer.
Fire safety plan in place	This is a required accommodation and “no” responses will require negotiations with the reviewer.
Number of loading docks available at the facility for MCM operations	Numerical field entry. Recommendation is for 2 docks available for receiving and 3 for shipping. Enter “0” if no loading docks are available; sites with no loading docks will have to describe how material is loaded and unloaded to assure reviewer is satisfied that the site can adequately function. Resource: <i>Receiving, Distributing, and Dispensing Strategic National Stockpile Assets: A Guide for Preparedness, Version 11.</i>
Loading docks are 48” to 52” high	This is a required accommodation and “no” responses will require negotiations with the reviewer.
Facility has dock levelers available	This is a required accommodation and “no” responses will require negotiations with the reviewer.
Number of <i>automated</i> dock levelers	This is a required accommodation and “no” responses will require negotiations with the reviewer.
Number of <i>mechanical</i> dock levelers	This is a required accommodation and “no” responses will require negotiations with the reviewer.
Number of dock plates available at the facility	This is a required accommodation and “no” responses will require negotiations with the reviewer.
Number of dock doors	This is a required accommodation and “no” responses will require negotiations with the reviewer.
Dock door dimensions height ≥8 feet	Select “door height >8 feet...” if the site meets the standard height of 100 inches wide x 14 feet high. A minimum height of 8 feet, width of 8.5 feet is a required accommodation and responses with “door height <8 feet...” will require negotiations with the reviewer.
Receiving and staging area floor free of holes, doorstops, or other obstructions	This is a required accommodation and “no” responses will require negotiations with the reviewer.
Driveway to docks can accommodate a 53-foot trailer and 11-foot tractor with turning radius ≥95 feet	This is a required accommodation and “no” responses will require negotiations with the reviewer.
Multiple trucks have a secure area to wait until offload of MCM assets at the RSS site	This is a required accommodation and “no” responses will require negotiations with the reviewer.
Loading docks and receiving area have adequate lighting	This is a required accommodation and “no” responses will require negotiations with the reviewer.



Form question	Form Hint
Number of forklifts available for use onsite	Available forklifts should match velocity needed to achieve maximum facility output. If proper loading docks with levelers are present, a minimal number of forklifts can be used. However, if loading docks are not present, two 3000–5000 pound capacity forklifts must be available to off-load federal MCM assets from the vehicles. In addition, 2 forklifts will be needed to stage and load repackaged assets onto trucks.
Adequate fuel and battery resources available for forklifts	Units that run on propane will require a tank of fuel every 8 to 12 hours. Electric units will require a charging station and battery recharge every 8 to 12 hours. Safety Note: Gasoline-powered forklifts are not recommended for indoor use due to the danger of carbon monoxide build up. In addition, individuals must be trained and certified to operate forklifts as required by Occupational Health and Safety Administration (OSHA).
Number of pallet jacks available for use onsite	In general, RSS operations will need a minimum of six pallet jacks – three to support picking material, one for use in the quality control area, and two for staging, loading, and unloading assets onto trucks if forklifts are not available.
Number of available dollies or hand trucks available offsite	Numeric value, enter how many can be obtained (if not currently available).
If storing product long term, facility offers temperature-controlled storage for pharmaceuticals which generally range between 68° F to 77° F (20°C to 25°C)	This is a required accommodation and “no” responses will require negotiations with the reviewer.
If storing product long term, facility has a working and tested temperature monitoring/logging device or service to monitor and record the temperature	This is a required accommodation and “no” responses will require negotiations with the reviewer.
Facility has a working and tested alarm and notification system to notify personnel if the temperature falls out of range (exceeds 104° F (40°C)) for more than 4 hours	This is a required accommodation and “no” responses will require negotiations with the reviewer.
Cold Chain Management (Storage) Section	Refer to the CDC guidance related cold chain management.
Facility offers on-site refrigerated and frozen storage areas for cold chain managed items such as vaccines	This is a required accommodation and “no” responses will require negotiations with the reviewer.
Refrigerated storage area can maintain a controlled temperature between 35° F and 46° F (2° and 8°C)	This is a required accommodation and “no” responses will require negotiations with the reviewer.
Frozen storage area can maintain a controlled temperature of 5° F to -13° F (-15° C to -25° C)	This is a required accommodation and “no” responses will require negotiations with the reviewer.



Form question	Form Hint
Cold storage unit temperatures are read twice each day.	This is a required accommodation and “no” responses will require negotiations with the reviewer. If facility is not operational until opened as a RSS site, temperatures should be read twice a day during RSS operations using calibrated thermometers with certificates of traceability and certification.
Facility maintains a log of cold storage temperature readings	This is a required accommodation and “no” responses will require negotiations with the reviewer.
Functional and tested alarm and notification system available to alert personnel if storage temperatures deviate outside of the specified norms	<p>Due to the sensitive nature of some MCM products (e.g., vaccines) and the need to ensure product efficacy, temperatures must be maintained. If no alarm and notification system is available, plan should include process for monitoring and logging the temperature of the storage containers in which the product is kept. This is a required accommodation and “no” responses will require negotiations with the reviewer.</p> <p>Resource: Cold Chain Management in <i>Receiving, Distributing, and Dispensing Strategic National Stockpile Assets: A Guide for Preparedness, Version 11</i>. (see Appendix E)</p>
If no alarm and notification system is in place, someone is available to manually check temperature on an hourly basis	This is a required accommodation and “no” responses will require negotiations with the reviewer.
Plan or survey includes description of cold chain storage (e.g., use of gel packs, endurotherm, refrigeration vehicles)	Reference survey or plan should be available for review upon request.
Describe contingency plan for providing cold storage for pharmaceuticals (medical countermeasures) if the capability does not exist at this facility	<p>Required if cold storage for pharmaceuticals does not exist at the facility. This is a required accommodation and “no” responses will require negotiations with the reviewer.</p> <p>Resource: Cold Chain Management in <i>Receiving, Distributing, and Dispensing Strategic National Stockpile Assets: A Guide for Preparedness, Version 11</i>. (see Appendix E)</p>
Based on state or local law enforcement security assessment, this facility is capable of securely receiving, storing, and staging federal MCM assets	Security assessment from state or local law enforcement required every 3 years as part of certification. This is a required accommodation and “no” responses will require negotiations with the reviewer.
Facility located in a designated high crime area in comparison to other areas: Describe and provide source of information	State or local law enforcement security assessment can provide area designation, if no other source is available.
All exterior doors equipped with cylinder locks, deadbolts, or solid locks and high security hasps	Hasps are used for mounting padlocks to a variety of surfaces to control access and protect the padlock from additional attack on sensitive areas.
Facility has a locked area inside the building to store controlled substances: Size of the door for this area	Largest push package container is 43x62x80 inches. Door should accommodate this size.



Form question	Form Hint
Interior has sufficient lighting to perform work required and maintain a safe workplace per OSHA standards	OSHA standards: physical plants, shops, machining areas, equipment and work rooms is 10 candle-feet, and office areas require at least 30 candle-feet of illumination; Title 29 of the Code of Federal Regulations at section 1926.56 sets out the units, or candle-feet, of light required for various types of work. This is a required accommodation and “no” responses will require negotiations with the reviewer.
Facility has eating and break areas	This is a required accommodation and “no” responses will require negotiations with the reviewer.
Facility has drinking water fountains or access to potable water	This is a required accommodation and “no” responses will require negotiations with the reviewer.

What impacts achieving established status?

To be eligible for this status, states, DFLs, and Puerto Rico must update and submit the RSS Site Survey for a primary site and additional RSS every 12 months. All other territories and freely associated states must update and submit the RSS Site Survey only for a primary site (no additional/secondary site) every 12 months. A site visit and certification of the RSS must be conducted every 3 years.



PLANNING FORMS CHAPTER



Distribution Planning

Completed By	Submission Timeframe
<input checked="" type="checkbox"/> States	<input checked="" type="checkbox"/> Annual requirement
<input checked="" type="checkbox"/> Directly funded localities	<input type="checkbox"/> Five-year requirement
<input checked="" type="checkbox"/> Territories or freely associated states	
<input checked="" type="checkbox"/> CRI local planning jurisdictions	
<p>Form Key Terms (refer to Appendix B): all-hazard incidents, chain of custody, Cities Readiness Initiative (CRI), closed point of dispensing (closed POD or CPOD), command staff or incident management lead roles, delivery schedule, demobilize, durable medical equipment, economically disadvantaged, emergency operations coordination, event, incident, interagency agreement (IAA), intergovernmental agreement (IGA), intermediary/intermediate distribution sites, Inventory Management System (IMS), materiel, medical countermeasures (MCMs), memorandum of agreement (MOA), memorandum of understanding (MOU), public health emergency operations plan (PHEOP), preparedness, promulgated plan, public health emergency, Public Health Emergency Preparedness (PHEP) cooperative agreement, receiving, staging, and storing (RSS) facility, regional distribution site (RDS)/local distribution site (LDS), request, resources, scalability, standard operating procedure (SOP), subject matter expert (SME), vendor</p>	

Why is this information collected?

The distribution planning form provides insight about procedures for handling medical materiel management and distribution. While the primary questions address those components, additional questions from Capability 3: Emergency Operations Coordination are included for related situational awareness. Questions not specific to handling medical materiel management and distribution should be answered based on overall PHEP planning and as applicable to strengthen the MCM plans.



What do I need to know about this form?

Form question (and hint)	Reviewer Criteria
<p>Date of most recent preparedness plans review/update</p>	<p>Concur/Sufficient Evidence All-hazards plans that include MCM distribution and dispensing are acceptable. The document must identify the signatory authority. Any plan (draft or final) signed by the PHEP director within two years of the date of the review is acceptable.</p> <p>Insufficient Evidence All-hazards plans do not include a MCM distribution and dispensing component, or the date is outside of the two-year timeframe.</p> <p>No Evidence No plan is provided.</p> <p>Contradictory Evidence The date on the plan is different from date uploaded in the system.</p>
<p>Plans include strategies to coordinate with subject matter experts (SMEs) to inform incident management decision making</p>	<p>Concur/Sufficient Evidence Written plans should include a well-defined process for identifying and consulting appropriate SMEs to develop a response strategy for a particular incident. A decision matrix that describes the functional roles needed to activate the EOC and process for consulting SMEs is also acceptable evidence.</p> <p>Insufficient Evidence Some but not all required evidence is provided.</p> <p>No Evidence None of the following evidence is provided: decision matrix, points of contact for relevant SMEs, process for contacting SMEs.</p> <p>Contradictory Evidence Multiple pieces of evidence lack consistent information or reference to a relevant documents is not available (e.g., content differs between the PHEOP and SNS plans).</p>



Form question (and hint)	Reviewer Criteria
<p>Subject matter experts involved in developing plans include</p> <ul style="list-style-type: none"> Plans should also include MCM subject matter experts. 	<p>Concur/Sufficient Evidence All-hazards plans that include MCM distribution and dispensing are acceptable; involvement of appropriate SMEs can be assumed if the plan follows CDC guidance and follows a logical progression.</p> <p>Insufficient Evidence The plan does not follow CDC guidance or a logical progression.</p> <p>No Evidence No plan is provided.</p> <p>Contradictory Evidence Evidence suggests that a SME was not consulted or included in drafting submitted All-hazards plans.</p>
<p>Standard operating procedures include: full activation procedures, notification procedures, partial activation procedures, staff authorized to activate EOC</p>	<p>Concur/Sufficient Evidence Full/Partial activation procedures: Evidence should include triggers, pre-event indicators, EOC activation levels, activation processes, minimum staffing requirements, logistics, process for demobilization, and a plan for sustained operations.</p> <p>Notification procedures: Evidence should include a description of notification process including system(s) used, and how often contact information is updated.</p> <p>Staff authorized to activate EOC: Evidence should include functional role(s) or position(s) (as defined by the jurisdiction) with the authority to stand up the EOC.</p> <p>Insufficient Evidence Some but not all required evidence is provided.</p> <p>No Evidence No plan is provided.</p> <p>Contradictory Evidence Multiple pieces of evidence lack consistent information or reference to a relevant documents is not available (e.g., content differs between the PHEOP and SNS plans).</p>



Form question (and hint)	Reviewer Criteria
<p>Identified incident command staff include: Incident Commander; Finance/Administration Section Chief; Liaison Officer; Logistics Section Chief; Operations Section Chief; Planning Section Chief; Public Information Officer; Safety Officer; Other</p> <ul style="list-style-type: none"> In the other category, please specify MCM specific roles beyond the command and general staff level. 	<p>Concur/Sufficient Evidence Job action sheet or other documents must outline requirements and duties; roles and responsibilities; and required qualifications and/or skillset. Rosters or staffing matrices that indicate sufficient staff to fill primary and back-up positions for a 24-hour operational period should be provided.</p> <p>Insufficient Evidence Only the name and role are provided. Excludes responsibilities of the position or qualifications and/or skillset required to successfully perform the role.</p> <p>No Evidence No job action sheets or other documentation are provided.</p> <p>Contradictory Evidence Multiple job action sheets that do not align.</p>



Form question (and hint)	Reviewer Criteria
<p>Transportation agreements include: Primary transport, Back-up transport; Operators; Types of drivers/specially licensed operators; Vehicles: load capacity, number available, type; Vendor agreements with MOUs; Procedures to maintain cold chain management; Jurisdiction’s response time for initial transportation requirements</p> <ul style="list-style-type: none"> • CRI planning jurisdictions with responsibility for RDS/LDS transportation strategy are required to provide transportation agreements. Evidence must also include an explanation about how agreements are satisfied. • For operators, provide estimated number of available drivers for the largest planned incident/event. If there are agreements with other agencies companies for transportation (UPS, DOT, etc.), that determine number of vehicles based on scale of incident, enter 000 and specify in the “other” category. Other/specify is appropriate for evidence of agreements external to your agency/department (Department of Transportation, private business, etc.). • For number of available vehicles, provide estimate of how many vehicles will be available largest planned incident/event. • Regarding vendor agreements with MOUs, some jurisdictions will rely exclusively on the services of a vendor for their transport capability while others will rely on a combination of public and private resources. • Response time for transport refers to the expected time for vendors to provide needed transportation assets based on scale of incident. 	<p>Concur/Sufficient Evidence</p> <p>Primary and back-up transport: Signed MOAs, MOUs, IGAs, IAAs, contracts, or a promulgated plan indicating how transportation will be procured (e.g., through ESF-1. Draft documents are also acceptable. The documents should identify roles and responsibilities of primary and back-up transport agencies, and relevant partners should acknowledge their roles and responsibilities.</p> <p>Operators: Evidence should include the number in the driver pool, or the jurisdiction's planning estimates</p> <p>Vehicles</p> <ul style="list-style-type: none"> • load capacity: evidence should include the capacities for identified vehicles • number available: evidence should include the number in a vehicle pool, or the number the jurisdiction will request • type: evidence should include the types of vehicles available, or the types the jurisdiction will request <p>Vendor agreements with MOUs: Written acknowledgement, in the form of a MOU or other documentation is acceptable.</p> <p>Procedures to maintain cold chain management: Evidence should include standard protocols (e.g., use of refrigerator delivery vehicles, product packaging, bill of lading) during transport.</p> <p>Jurisdiction’s response time for initial transportation requirements: Evidence should include the expected time for vendors to provide needed transportation assets based on type/scale of incident and for the arrival of assets.</p> <p>Insufficient Evidence</p> <p>Some but not all required evidence is provided.</p> <p>No Evidence</p> <p>No transportation plan/agreement is provided.</p> <p>Contradictory Evidence</p> <p>Transportation agreements or promulgated planning documents do not align.</p>



Form question (and hint)	Reviewer Criteria
<p>RSS staff identified: Distribution lead, primary, Distribution lead, back-up, Logistics, primary, Logistics, back-up, Receiving site lead, primary, Receiving site lead, back-up, Security coordinator, primary, Security coordinator, back-up, Current DEA registrant (identified or access to), Other RSS staff</p> <ul style="list-style-type: none"> In “other” category, recipient should indicate if any of these positions are located at the Health EOC. Current drug enforcement agency (DEA) registrant includes the DEA registrant or other individuals authorized to sign for MCMs. 	<p>Concur/Sufficient Evidence Job action sheet or other documents must outline requirements and duties; roles and responsibilities; and required qualifications and/or skillset.</p> <p>Insufficient Evidence Only the name and role are provided. Excludes responsibilities of the position or qualifications and/or skillset required to successfully perform the role.</p> <p>No Evidence No job action sheets or other documentation are provided.</p> <p>Contradictory Evidence Multiple job action sheets that do not align.</p>
<p>RDS/LDS staff identified: Distribution lead, primary, Distribution lead, back-up, Logistics, primary, Logistics, back-up, Receiving site lead, primary, Receiving site lead, back-up, Security coordinator, primary, Security coordinator, back-up, Current DEA registrant, Other RDS/LDS staff</p> <ul style="list-style-type: none"> In “other” category, recipient should indicate if any of these positions are located at the Health EOC. Current DEA registrant includes the DEA registrant or other individuals authorized to sign for MCMs. 	<p>Concur/Sufficient Evidence Job action sheet or other documents must outline requirements and duties; roles and responsibilities; and required qualifications and/or skillset.</p> <p>Insufficient Evidence Only the name and role are provided. Excludes responsibilities of the position or qualifications and/or skillset required to successfully perform the role.</p> <p>No Evidence No job action sheets or other documentation are provided.</p> <p>Contradictory Evidence Multiple job action sheets that do not align.</p>



Form question (and hint)	Reviewer Criteria
<p>Plans include the following elements for requesting medical materiel: Assessment of local inventory/medical countermeasure caches, Decision process, Identification of local pharmaceutical and/or medical-supply wholesalers, Process for requesting medical countermeasures</p>	<p>Concur/Sufficient Evidence Assessment of local inventory/medical countermeasure caches: Evidence should include procedures to assess local, regional, and state inventory levels, and inventory/MCM caches available for the response.</p> <p>Decision process: Evidence should include appropriate jurisdictionally defined procedures to initiate request MCM.</p> <p>Identification of local pharmaceutical and/or medical-supply wholesalers: Evidence should include procedures to identify sites/wholesalers that may have inventory for use in a response.</p> <p>Process for requesting medical countermeasures: Evidence should include appropriate jurisdictionally defined procedures to request MCM from local, state, regional, federal entities etc. (as applicable to the jurisdiction).</p> <p>Insufficient Evidence Some but not all required evidence is provided.</p> <p>No Evidence No plan is provided.</p> <p>Contradictory Evidence Multiple pieces of evidence lack consistent information or reference to a relevant documents is not available (e.g., content differs between the PHEOP and SNS plans).</p>



Form question (and hint)	Reviewer Criteria
<p>Locals providing inventory level elements to state or federal authorities (state only)</p> <ul style="list-style-type: none"> • Number of locals that can provide inventory information to the state via IMATS or another electronic IMS. • If a local jurisdiction uses hard copies, the state must choose "Some jurisdictions use IMS" answer option. 	<p>Concur/Sufficient Evidence Protocol to use IMATS and/or another information data exchange (IDE)-compliant IMS to collect inventory data from local entities and consolidate that information to send to CDC is necessary. A plan that describes how inventory data is sent from the local level, to the state, to the CDC is sufficient. Excel is the minimum acceptable documentation.</p> <p>Insufficient Evidence A plan/protocol does not adequately describe how inventory data is sent from the local level to the state to CDC.</p> <p>No Evidence No inventory management plan/protocol is provided.</p> <p>Contradictory Evidence Planning documents describe different inventory management procedures, or planning documents reference outdated and current inventory management procedures.</p>
<p>Security plans for primary RSS include: Security lead during PH emergency response, Evacuation plans, Exterior physical security of locations, Interior physical security of location, Security breach plans</p> <ul style="list-style-type: none"> • US Marshals Service (USMS) Inspectors are the SMEs who can verify RSS site specific security plans and can provide feedback to MCM specialists and law enforcement. • "Not applicable" only applies to CRI local planning jurisdictions who do not have the responsibility for establishing and maintaining an RDS/LDS. Required for CRI planning jurisdictions that do establish and maintain an RDS/LDS. • If security plans are created and maintained by law enforcement partners, a trusted agent can verbally affirm to the reviewer that the exterior security for location, interior security for location, security breach procedures, and/or security command/management plan are clearly defined. 	<p>Concur/Sufficient Evidence Exterior security for location: Evidence should include specialized unit needs, canine explosive ordinance disposal, unit barriers, additional lighting, staging areas for people in vehicles, identification of entrances and exits, and external crowd control.</p> <p>Interior security for location: Evidence should include a security sweep before facility use, access controls in the facility, badging, internal crowd control, and establishing law enforcement officer posts.</p> <p>Scalability: Evidence should include how POD security is established based on threat levels, and judgement and availability of law enforcement officers.</p> <p>Security breach procedures: Evidence should include evacuation or safety plans to enable people to shelter in place.</p> <p>Insufficient Evidence Some but not all required evidence is provided.</p> <p>No Evidence No documentation provided.</p> <p>Contradictory Evidence Multiple documents do not align.</p>



Form question (and hint)	Reviewer Criteria
<p>Transportation security plans include: Crossing jurisdictional lines, Crossing governmental sovereignty, MCM arriving at RSS, MCM transported from RSS to RDS/LDS/receiving site, (e.g., POD), MCM transported from RDS/LDS to POD</p> <ul style="list-style-type: none"> • “Not applicable” only applies to CRI local planning jurisdictions who do not have the responsibility of developing and executing a distribution transportation strategy. 	<p>Concur/Sufficient Evidence Evidence must include protocols for crossing jurisdictional lines, crossing governmental sovereignty, MCM arriving at RSS, MCM transported from RSS to RDS/LDS/receiving site (e.g., POD), and MCM transported from RDS/LDS to POD. Security contract with police or private security that includes all elements is acceptable evidence. If such a contract exists, but is not available for review, verification from a trusted agent is acceptable.</p> <p>Insufficient Evidence Some but not all required evidence is provided.</p> <p>No Evidence No transportation security plan is provided.</p> <p>Contradictory Evidence Transportation security procedures differ across planning documents (e.g., SNS Base Plan and a security annex).</p>



Form question (and hint)	Reviewer Criteria
<p>Allocation and distribution elements include: Chain of custody, Cold chain, Delivery locations, Delivery schedule, Transportation method(s), Transportation routes, Receipt from intermediary site</p> <ul style="list-style-type: none"> • “Not applicable” only applies to CRI local planning jurisdictions who do not have the responsibility of setting up and activating an RDS/LDS. • In regards to transportation routes, knowledge of the whereabouts and security of medical materiel is always the responsibility of the jurisdiction. 	<p>Concur/Sufficient Evidence</p> <p>Chain of custody: Evidence should include chain of custody process and forms.</p> <p>Cold chain: Evidence should describe the process necessary to monitor and maintain appropriate temperature at fixed locations and during transport, available freezer or refrigeration capabilities, and/or processes to acquire these assets. Documents should reference relevant elements from RSS site surveys.</p> <p>List of delivery locations: Evidence should include RDS, LDS, open and closed PODs, and hospitals, etc.</p> <p>Delivery schedule: Evidence should include allocation tables, routes, load plans, a delivery schedule, and a decision-making process to handle factors that could affect the delivery schedule (e.g., road closures, alternative routes).</p> <p>Transportation methods: Evidence should include a list of methods.</p> <p>Transportation routes: Evidence should include route planning or a process to address real-time conditions, and how the jurisdiction will maintain knowledge of the whereabouts and security of medical materiel at all times.</p> <p>Receipt from Intermediary site: Evidence should specify a process to receive acknowledgement from the RDS/LDS (e.g., e-mail, phone).</p> <p>Insufficient Evidence</p> <p>Some but not all required evidence is provided.</p> <p>No Evidence</p> <p>No plan is provided.</p> <p>Contradictory Evidence</p> <p>Procedures differ across planning documents.</p>



Form question (and hint)	Reviewer Criteria
<p>Recovery and demobilization elements include: Recovery of durable medical equipment, Recovery of materiel</p> <ul style="list-style-type: none"> • “Not applicable” only applies to CRI local planning jurisdictions who do not have the responsibility of developing and executing a transportation strategy. 	<p>Concur/Sufficient Evidence Recovery of durable medical equipment and material: Evidence should identify responsible personnel, describe the process, and outline assets needed (i.e., vehicles) for recovery of durable medical equipment and MCM. Evidence should also include where durable medical equipment and MCM will be taken/stored (e.g., back to RSS).</p> <p>Insufficient Evidence Recovery procedures for either durable medical equipment/materiel are missing or are not thoroughly described.</p> <p>No Evidence Recovery procedures are not provided.</p> <p>Contradictory Evidence Recovery procedures differ across planning documents.</p>

What impacts achieving established status?

To be eligible for this status, standard operation procedures, at minimum, must include full activation procedures, notification procedures, partial activation procedures, and staff authorized to activate the EOC.

In addition, the incident commander, finance/administration section chief, logistics section chief, operations section chief, planning section chief, and public information officer must be identified and clearly defined in the evidence to be eligible for the status. Multiple positions can be filled by the same person, but each position should be defined separately in the planning evidence.

Transportation agreements, at minimum, must describe primary transport, back-up transport, operators, types of drivers/specially licensed operators, load capacity for vehicles, number of available vehicles, types of vehicles, vendor agreements with MOUs, procedures to maintain cold chain management, and jurisdiction’s response time for initial transportation requirements to be eligible for this status.

For RSS staff, the primary and back-up distribution lead, primary logistics position, primary receiving site lead, primary security coordinator, and current DEA registrant (or individual(s) authorized to sign for MCMs) must be identified and clearly defined in the evidence to be eligible for the status.

Similarly for RDS/LDS staff, the primary distribution lead, primary logistics position, primary receiving site lead, primary security coordinator, and current DEA registrant (or individual(s) authorized to sign for MCMs) must be identified and clearly defined in the evidence to be eligible for the status.

Also, plans for requesting medical materiel must outline the assessment of local inventory/medical countermeasure caches, the decision process for acquiring medical materiel, identification of local pharmaceutical and/or medical-supply wholesalers, and process for requesting medical countermeasures to be eligible for the status.



Security plans for the primary RSS, at minimum, must clearly delineate a security lead during a public health emergency response, evacuation plans, exterior physical security of locations, interior physical security of location, and security breach plans to be eligible for the status.

Additionally, transportation security plans must clearly explain the process for crossing jurisdictional lines, crossing governmental sovereignty (if applicable), MCM arriving at RSS, MCM transported from RSS to RDS/LDS/POD, and MCM transported from RDS/LDS to POD to be eligible for the status.

Allocation and distribution plans must clearly define chain of custody, cold chain, delivery locations, delivery schedule, transportation method(s), transportation routes, and receipt from intermediary site(s) to be eligible for the status.

Lastly, recovery and demobilization plans must clearly describe the recovery of durable medical equipment and materiel to be eligible for the status.

To be eligible for this status, you must update and submit the distribution planning form every 12 months.



Dispensing Planning

Completed By	Submission Timeframe
<input checked="" type="checkbox"/> States	<input checked="" type="checkbox"/> Annual requirement
<input checked="" type="checkbox"/> Directly funded localities	<input type="checkbox"/> Five-year requirement
<input checked="" type="checkbox"/> Territories or freely associated states	
<input checked="" type="checkbox"/> CRI local planning jurisdictions	
<p>Form Key Terms (refer to Appendix B): alert, all-hazard incidents, at-risk populations, Cities Readiness Initiative (CRI), command staff or incident management lead roles, community preparedness, critical infrastructure personnel, dispensing modalities, economically disadvantaged, emergency management, Emergency Public Information and Warning, event, functional needs, Hazard Vulnerability Analyses (HVA), incident, Inventory Management and Tracking System (IMATS), Jurisdictional Risk Assessment (JRA), materiel, Medical Reserve Corps (MRC), memorandum of agreement (MOA), memorandum of understanding (MOU), preparedness, public health emergency, Public Health Emergency Preparedness (PHEP) cooperative agreement, rapid dispensing model (or non-medical model), request, resources, responder, scalability, Threat and Hazard Identification and Risk Assessment (THIRA), volunteer, volunteer management, vulnerable populations</p>	

Why is this information collected?

The dispensing planning form provides insight about procedures for handling medical materiel management and dispensing. While the primary questions address those components, additional questions from other related capabilities inform situational awareness and include: Capability 1: Community Preparedness; Capability 4: Emergency Public Information and Warning; Capability 14: Responder Safety and Health; and Capability 15: Volunteer Management. Questions from additional capabilities should be answered based on overall PHEP planning and as applicable to strengthen MCM plans.



What do I need to know about this form?

Form question (and hint)	Reviewer Criteria
<p>Date of most recently conducted jurisdictional risk assessment (JRA) or equivalent</p>	<p>Concur/Sufficient Evidence Any risk assessment that also includes a health component is acceptable. Evidence must include MCM coordinator/PHEP director signature or acknowledgement. Evidence must be within 5 year range and specific to that jurisdiction.</p> <p>Insufficient Evidence JRA or equivalent does not include an MCM coordinator/PHEP director signature. The evidence is older than 5 years. The evidence did not include a health component or the evidence is not specific to that jurisdiction.</p> <p>No Evidence No plan is provided or no assessment was conducted.</p> <p>Contradictory Evidence The date on the JRA (or equivalent) is different from the date in the system.</p>
<p>Hazards identified in the assessment</p> <ul style="list-style-type: none"> Select identified risks from the most recent jurisdictional risk assessment or equivalent. 	<p>Concur/Sufficient Evidence Acceptable documentation includes a plan that lists all hazards and applicable MCM hazards (at a minimum, influenza) completed within 5 years. MCM coordinator/PHEP director’s signature or acknowledgement must also be provided. If no plan nor assessment is indicated, indicate concurrence by selecting “no evidence” as described below.</p> <p>Insufficient Evidence Some but not all required evidence is provided.</p> <p>No Evidence No plan is provided or no assessment was conducted.</p> <p>Contradictory Evidence Multiple documents do not align.</p>



Form question (and hint)	Reviewer Criteria
<p>Select a vulnerable population partner</p> <ul style="list-style-type: none"> Vulnerable populations are those groups that will potentially be disproportionately impacted by an incident/event. It is recommended (but not required) that vulnerable population stakeholders be engaged during or as a result of the JRA (or equivalent) process to ensure appropriate planning considerations are in place. <u>DFLs/TFAS/CRIs</u>: Five broad vulnerable populations are called-out in the ORR and include persons potentially disproportionately impacted due to: economic disadvantage, communication barriers because of language or literacy, medical issues and/or disability, elderly persons, and infants and children under age 18. It is recommended (but not required) that a stakeholder from each category be engaged during or as a result of the JRA. <p>Resource:</p> <ul style="list-style-type: none"> <i>CDC Public Health Workbook: To Define, Locate, and Reach Special, Vulnerable, and At-risk Populations in an Emergency</i> https://emergency.cdc.gov/workbook/pdf/ph_workbookfinal.pdf 	<p>Concur/Sufficient Evidence Acceptable evidence that vulnerable population stakeholders are engaged include: signed MOUs and MOAs (preferred); e-mails; meeting sign-in sheets, agendas, notes, etc.</p> <p>Insufficient Evidence Some but not all required evidence is provided.</p> <p>No Evidence No plan is provided.</p> <p>Contradictory Evidence Multiple documents do not align.</p>
<p>States</p> <p>Did this vulnerable population partner participate or provide input into planning for emergency information and warning for vulnerable populations they represent?</p>	<p>Concur/Sufficient Evidence Evidence of engagement may include meeting notes or sign-in sheets.</p> <p>Insufficient Evidence Previously selected stakeholders are not included. No evidence of engagement in plans (e.g., only a list of agencies).</p> <p>No Evidence No documentation provided.</p> <p>Contradictory Evidence Multiple documents do not align.</p>



Form question (and hint)	Reviewer Criteria
<p>DFLs/TFAS/CRIs</p> <p>Estimate the number of people planned for with functional and/or access needs (including transportation) due to: economic disadvantage, communication barriers because of language and literacy, medical issues and/or disability, and age (elderly persons and infants and children under age 18)</p> <ul style="list-style-type: none"> A number for each category must be provided <p>Resources:</p> <ul style="list-style-type: none"> <i>CDC Public Health Workbook: To Define, Locate, and Reach Special, Vulnerable, and At-risk Populations in an Emergency</i> https://emergency.cdc.gov/workbook/pdf/ph_workbookfinal.pdf ATSDR social vulnerability index <ul style="list-style-type: none"> https://svi.cdc.gov/ HHS Empower <ul style="list-style-type: none"> http://nacchopreparedness.org/the-hhs-empower-initiative-emergency-preparedness-tools-addressing-the-needs-of-energy-dependent-at-risk-populations-2/ 	<p>Concur/Sufficient Evidence A number, source for the number, and evidence of the process for determining the number must be provided.</p> <p>Insufficient Evidence Some but not all required evidence is provided.</p> <p>No Evidence No plan is provided.</p> <p>Contradictory Evidence Multiple documents do not align.</p>
<p>Plans describe roles and responsibilities of public information staff and stakeholders</p> <ul style="list-style-type: none"> Public information and communication personnel regularly inform, educate, and communicate with the public during an incident. 	<p>Concur/Sufficient Evidence Job action sheet or other documents must outline requirements and duties; roles and responsibilities; and required qualifications and/or skillset.</p> <p>Insufficient Evidence Only the name and role are provided. Excludes responsibilities of the position or qualifications and/or skillset required to successfully perform the role.</p> <p>No Evidence No job action sheets or other documentation are provided.</p> <p>Contradictory Evidence Multiple job action sheets that do not align.</p>



Form question (and hint)	Reviewer Criteria
<p>Required training plans for the PIO include</p> <ul style="list-style-type: none"> FEMA course IS-250, <i>A New Approach to Emergency Communication and Information Distribution</i> must be specified in evidence as a required responsibility for the public information officer. 	<p>Concur/Sufficient Evidence Evidence should demonstrate the IS-250 training requirement in the PIO position description. Certificates of IS-250 training are also acceptable.</p> <p>Insufficient Evidence Some but not all required evidence is provided.</p> <p>No Evidence No plan is provided.</p> <p>Contradictory Evidence Multiple documents do not align.</p>
<p>Plans include a process for dissemination of warning information through various channels</p> <ul style="list-style-type: none"> <i>CDC Public Health Workbook: To Define, Locate, and Reach Special, Vulnerable, and At-risk Populations in an Emergency</i> is intended to provide public health and emergency preparedness planners with better ways to communicate health and emergency information to at-risk individuals with access and functional needs for all-hazards events through step-by-step instructions, resources guides and templates. A step-by-step guide is available to assist you in creating a community outreach information network (COIN) in your communities to gather trusted community leaders and a network of people who can help with emergency planning and give information to at-risk populations during an emergency. 	<p>Concur/Sufficient Evidence Methods to issue alerts, warnings, and notifications and development of message templates based on planning risk scenarios must be clearly defined in evidence. PIO may provide a list of contacts and a press release form. Evidence can also be a jurisdiction-specific COIN.</p> <p>Insufficient Evidence Evidence of some processes, but not all.</p> <p>No Evidence No documentation provided.</p> <p>Contradictory Evidence Multiple documents do not align.</p>
<p>Plans include process for real-time translation of information specific to vulnerable populations (select all that apply)</p> <ul style="list-style-type: none"> The process for dissemination of information to populations disproportionately impacted by planning risk scenarios must be clearly defined in evidence. Language and literacy stakeholders should be engaged to ensure development and dissemination of culturally and linguistically appropriate messages. 	<p>Concur/Sufficient Evidence Evidence should include translators, language lines, printing services, and/or mailing lists for specific groups (medical, high pollution warning, allergens, asthma, etc.). Evidence should not include prefabricated messages.</p> <p>Insufficient Evidence Some but not all required evidence is provided.</p> <p>No Evidence No plan is provided.</p> <p>Contradictory Evidence Multiple documents do not align.</p>



Form question (and hint)	Reviewer Criteria
<p>Evidence of a public health responder and/or critical infrastructure personnel (CIP) plan for anthrax dispensing campaign (select all that apply)</p> <ul style="list-style-type: none"> Only applicable if state has the responsibility of dispensing MCMs to public health responders, or runs any open PODs at the state level (not including statewide responsibility for recipients with centralized governance structure). 	<p>Concur/Sufficient Evidence Evidence should include a flow diagram or communication plan. Plans should specify the public health responders who will receive MCMs and how many. If dispensing will occur at a POD, plans should describe agreement and POD staffing. The source and cache of MCMs should also be identified. Plans should also indicate if a jurisdiction is responsible for dispensing.</p> <p>Insufficient Evidence Some but not all required evidence is provided.</p> <p>No Evidence No plan is provided.</p> <p>Contradictory Evidence Multiple documents do not align.</p>
<p>DFLs/TFAS/CRIs</p> <p>Evidence of a public health responder and/or critical infrastructure personnel (CIP) plan for anthrax dispensing campaign (select all that apply)</p> <ul style="list-style-type: none"> Plans must describe populations served and methods to obtain staff necessary to meet dispensing needs. 	<p>Concur/Sufficient Evidence Evidence should include a flow diagram and/or communication plan. Plans should specify which public health responders will receive MCMs, and how many will receive MCMs. If dispensing will occur at a POD, plans should describe who will staff the POD. The source and cache of MCMs should also be identified. Plans should also indicate if a jurisdiction is responsible for dispensing. Plans should support information represented on the JDS regarding the number of PODs and POD staff.</p> <p>Insufficient Evidence Lack of POD plans. Gaps in plans as related to staffing.</p> <p>No Evidence No documentation provided.</p> <p>Contradictory Evidence Multiple documents do not align.</p>



Form question (and hint)	Reviewer Criteria
<p>Communication platform for notification of responders (select all that apply)</p>	<p>Concur/Sufficient Evidence Plans should include primary forms of communication, cycle of maintenance and testing, cycle of updating rosters, evidence of updating rosters, and reminders for updates every 6 months.</p> <p>Insufficient Evidence Some but not all required evidence is provided.</p> <p>No Evidence No plan is provided.</p> <p>Contradictory Evidence Multiple documents do not align.</p>
<p>Last date communication platform was updated or tested (whichever is more recent)</p>	<p>A date picker (calendar pop-up) will appear; for ham radio, satellite phone, or two-way VHF/UHF/700/800/900 MHz communications, select the most recent date a system test was completed. For all other platforms, select the most recent date distribution lists/contact information was updated.</p>
<p>DFLs/TFAS/CRIs</p> <p>The process to request assistance from the state for MCM assets when a federal disaster is declared in the state is available</p>	<p>Concur/Sufficient Evidence Signed plan or SOP should include the justification required for the request, specific method to gain the request, and who must authorize the process. Additional information about the status about the Biowatch actionable result (BAR), index case, or any information prompting request, assessment of need, and what is required to initiate the state request should be included.</p> <p>Insufficient Evidence Some but not all required evidence is provided.</p> <p>No Evidence No documentation provided.</p> <p>Contradictory Evidence Multiple documents do not align.</p>



Form question (and hint)	Reviewer Criteria
<p>The process to request assistance from the state for MCM assets in the absence of federal disaster declaration is available</p>	<p>Concur/Sufficient Evidence Signed plan or SOP should include the justification required for the request, specific method to gain the request, and who must authorize the process. Additional information about the status about the Biowatch actionable result (BAR), index case, or any information prompting request, assessment of need, and what is required to initiate the state request should be included. Plans should highlight how the process differs when a federal disaster is declared.</p> <p>Insufficient Evidence Some but not all required evidence is provided.</p> <p>No Evidence No plan is provided.</p> <p>Contradictory Evidence Multiple documents do not align.</p>
<p>The process to request assistance from the state for MCM assets for an isolated, individual, or time-critical case is available</p>	<p>Concur/Sufficient Evidence The process for requesting assistance for one or more individuals must be clearly defined in evidence. Signed plan or SOP should include the justification required for the request, specific method to gain the request, and who must authorize the process. Additional information about the status about the Biowatch actionable result (BAR), index case, or any information prompting request, assessment of need, and what is required to initiate the state request should be included. Plans should also include the process for expediting requests due to the time sensitivity of the isolated incident.</p> <p>Insufficient Evidence Some but not all required evidence is provided.</p> <p>No Evidence No plan is provided.</p> <p>Contradictory Evidence Multiple documents do not align.</p>



Form question (and hint)	Reviewer Criteria
<p>The process to request assistance from the state for MCM assets in coordination with tribal government(s) is available</p> <ul style="list-style-type: none"> This needs to be in place to address how the federally recognized tribes will make requests. Requests may occur at the local, state, or federal level. 	<p>Concur/Sufficient Evidence Process should be clearly defined and understandable in evidence.</p> <p>Insufficient Evidence Some but not all required evidence is provided.</p> <p>No Evidence No plan is provided.</p> <p>Contradictory Evidence Multiple documents do not align.</p>
<p>Plans for POD security address: evacuation procedures, exterior security for location, interior security for location, scalability, security breach procedures, security command/management plan</p> <ul style="list-style-type: none"> If security plans are created and maintained by law enforcement partners, a trusted agent can verbally affirm to the reviewer that the exterior security for location, interior security for location, security breach procedures, and/or security command/management plan are clearly defined. 	<p>Concur/Sufficient Evidence</p> <p>Exterior security for location: Evidence should include specialized unit needs, canine explosive ordinance disposal, unit barriers, additional lighting, staging areas for people in vehicles, identification of entrances and exits, and external crowd control.</p> <p>Interior security for location: Evidence should include a security sweep before facility use, access controls in the facility, internal crowd control, and establishing law enforcement officer posts.</p> <p>Scalability: Evidence should include how POD security is established based on threat levels, judgement of the law enforcement, and availability of the law enforcement officers.</p> <p>Security breach procedures: Evidence should include evacuation or safety plans to enable people to shelter in place.</p> <p>Insufficient Evidence Some but not all required evidence is provided (for the particular requirement).</p> <p>No Evidence No documentation provided.</p> <p>Contradictory Evidence Multiple documents do not align.</p>



Form question (and hint)	Reviewer Criteria
<p>Process or protocols for PODs address: adverse event reporting for dispensed drugs; providing information on adverse events; record/log of drugs dispensed; reporting data to state/federal entities; screening for the purpose of triaging</p>	<p>Concur/Sufficient Evidence Adverse event reporting for dispensed drugs: Evidence should include instructions on how reports should be sent from local to state jurisdictions and from state to federal agencies.</p> <p>Providing information on adverse events: Evidence should include provision of health information upon entering or leaving the POD. Provision of a package insert (similar to the prescription information sheet from drug store) is acceptable.</p> <p>Record/log of drugs dispensed: Evidence should include a process for how to record the number and type of drug dispensed.</p> <p>Reporting inventory specification data to state/federal entities: Evidence should include Inventory Data Exchange (IDE) specification standards.</p> <p>Screening for the purpose of triaging: Evidence should include a clear process for screening and triaging visitors to the POD.</p> <p>Insufficient Evidence Some but not all required evidence is provided.</p> <p>No Evidence No plan is provided.</p> <p>Contradictory Evidence Multiple documents do not align.</p>
<p>Process to identify all public health responders (including any first responders and critical infrastructure personnel if applicable) who will be used in an incident or event is available</p> <ul style="list-style-type: none"> An incident, including an MCM incident with dispensing campaign may have adverse effects on responders, including medical or mental health issues related to stress of the incident. Process to mitigate potential risks (stress, mental health, physical injury, etc.) for public health responders must be clearly defined in evidence. 	<p>Concur/Sufficient Evidence Evidence should include specific agency/partnership and numbers for responders.</p> <p>Insufficient Evidence Some but not all required evidence is provided.</p> <p>No Evidence No documentation provided.</p> <p>Contradictory Evidence Multiple documents do not align.</p>



Form question (and hint)	Reviewer Criteria
<p>Process to ensure that mission-critical responders receive initial prophylaxis during an MCM incident is available</p>	<p>Concur/Sufficient Evidence Process for initial prophylaxis to mission-critical public health responders (for at least a 48 hour dispensing campaign) must be clearly defined in evidence and include who (by functional role) and in what priority prophylaxis will be provided. State recipients with no direct dispensing role, should still have evidence about how state public health responders will receive prophylaxis (e.g., local jurisdictions will provide prophylaxis to state-level responders).</p> <p>Insufficient Evidence Some but not all required evidence is provided.</p> <p>No Evidence No plan is provided.</p> <p>Contradictory Evidence Multiple documents do not align.</p>
<p>Procedures to notify volunteers are available</p>	<p>Concur/Sufficient Evidence Evidence should include who will be notified, method of notification, triggers for notification, and where they will be required to assemble. Primary and back up process should be clearly defined in the evidence.</p> <p>Insufficient Evidence Some but not all required evidence is provided.</p> <p>No Evidence No plan is provided.</p> <p>Contradictory Evidence Multiple documents do not align.</p>
<p>Systems used to notify volunteers required to complete a dispensing and/or distribution campaign (select all that apply)</p>	<p>Concur/Sufficient Evidence Plans should include primary forms of communication, cycle of maintenance and testing, process and cycle for updating rosters, evidence of updating rosters, and reminders for updates every six months.</p> <p>Insufficient Evidence Some but not all required evidence is provided.</p> <p>No Evidence No documentation provided.</p> <p>Contradictory Evidence Multiple documents do not align.</p>



Form question (and hint)	Reviewer Criteria
Last date notification system was updated or tested (whichever is more recent)	A date picker (calendar pop-up) will appear. For ham radio, satellite phone, or two-way VHF/UHF/700/800/900 MHz communications, select the most recent date a system test was completed. For all other platforms, select the most recent date distribution lists/contact information was updated.

What impacts achieving established status?

To be eligible for this status, the JRA or equivalent must be conducted at least every 5 years; CRIs are encouraged to participate in a risk assessment and must provide documentation that demonstrates input into the risk assessment or equivalent process.

A minimum of five vulnerable population stakeholders are required to be included for established status eligibility for all sites including Puerto Rico; however, only three vulnerable population stakeholders are required for other territories and freely associated states.

A primary and back-up PIO, as well as Joint Information Center (JIC) personnel, must be identified and clearly defined in the evidence to be eligible for the status. The PIO’s required training plan must specify the FEMA course IS-250 training.

In addition, the process for dissemination of warning information through various channels must clearly describe methods to issue alerts, warnings, and notifications and the development of message templates based on planning risk scenarios to be eligible for this status.

The process for real-time translation of information specific to a response must address language and literacy barriers to be eligible for this status.

A primary and back-up communication platform for the notification of responders, as well as volunteers, required to complete a dispensing/distribution campaign must be included in the plans as well. Distribution lists for each platform must be updated every six months or less. A system test must be completed, at minimum, every 6 months for sites using ham radio, satellite phone, or two-way VHF/UHF/700/800/900 MHz communications.

Additionally, the plans for DFLs, CRI planning jurisdictions, and territories and freely associated states must clearly outline a process to request assistance from the state or federal government (where applicable) for MCM assets for the following three scenarios to be eligible for this status: when a federal disaster is declared, in the absence of federal disaster declaration, and for an isolated, individual, or time-critical case.

Plans for POD security must address, at minimum, evacuation procedures, exterior security for location, interior security for location, scalability, security breach procedures, and a security command/management plan to be eligible for this status.

Lastly, POD protocols must describe screening for the purpose of triaging. Protocols must also provide information on adverse events and adverse event reporting. Protocols must also delineate how to record and log dispensed MCMs and report information to state/federal entities.



To be eligible for this status, you must update and submit the dispensing planning form every 12 months.



OPERATIONAL FORMS CHAPTER



Facility Setup Drill

Completed By	Submission Timeframe
<input type="checkbox"/> States	<input checked="" type="checkbox"/> Annual requirement
<input checked="" type="checkbox"/> Directly funded localities	<input type="checkbox"/> Five-year requirement
<input checked="" type="checkbox"/> Territories or freely associated states (at least one time in 5 years; exercise different PODs if completed more than once in 5 years)	
<input checked="" type="checkbox"/> CRI local planning jurisdictions	

Form Key Terms (refer to Appendix B): CBRNE, Cities Readiness Initiative (CRI), drill, facility setup, full notification, materiel, no notification (none), partial notification, preparedness, public health emergency, Public Health Emergency Preparedness (PHEP) cooperative agreement, rapid dispensing model (or non-medical model), receiving, staging, and storing (RSS) facility

Why is this information collected?

The facility setup drill provides information on operational ability to standup a site with the necessary materiel, layout, and supplies for timely distribution and dispensing. The drill information should be completed for each facility setup.

What do I need to know about this form?

Form question	Form Hint
Site(s) setup (select all that apply)	Select the type of facility that participated in the drill. It is strongly encouraged that different types of sites are exercised each year. Different PODs should also be set up each year.
Facility Setup Total setup time (in minutes)	Auto-calculated value, based on the following formula: $(\text{Setup end date/time}) - (\text{Setup start date/time})$
Total Number of RSSs	Number of RSS sites should match number of RSS Site Surveys completed.
Name of RSS	RSS name should match the RSS site survey.
Total number of planned primary PODs within jurisdiction	Provide number of PODs; this number should match the number entered on the POD planning sheets.
Name of POD	POD name should match the information entered on the descriptive POD form.

What impacts achieving established status?

To be eligible for this status and meet the PHEP program requirement, you must conduct and submit the facility setup drill every budget period (July 1–June 30).



Staff Notification and Assembly Drill

Completed By	Submission Timeframe
<input checked="" type="checkbox"/> States (required for staff assembly, formerly PM 3. 1)	<input checked="" type="checkbox"/> Annual requirement
<input checked="" type="checkbox"/> Directly funded localities	<input type="checkbox"/> Five-year requirement
<input checked="" type="checkbox"/> Territories or freely associated states (at least one time in 5 years; exercise different staff and assembly sites if completed more than once in 5 years)	
<input checked="" type="checkbox"/> CRI local planning jurisdictions	
<p>Form Key Terms (refer to Appendix B): CBRNE, Cities Readiness Initiative (CRI), command staff or incident management lead roles, core staff, drill, full notification, no notification (none), partial notification, preparedness, public health emergency, Public Health Emergency Preparedness (PHEP) cooperative agreement, rapid dispensing model (or non-medical model), RSS facility, regional distribution site (RDS)/ local distribution site (LDS), responder, staff assembly, staff notification, volunteer</p>	

Why is this information collected?

The staff notification and assembly drill provides information on operational function specific to staff notification and assembly procedures for various facilities including EOCs, RSSs, RDSs/LDSs, and PODs. The drill measures the accuracy of staff rosters, timeliness of staff confirmations to the notification, and staff ability to report for duty within a designated timeframe. Communication methods and processes are also measured. The drill information should be completed for each site notified.

What do I need to know about this form?

Form question	Form Hint
Site(s) notified (select all that apply)	Select the type of facility that participated in the drill. It is strongly encouraged that different types of sites are exercised each year. Different PODs should also be notified each year.
Staffing categories: management/lead staff, security staff, general health department staff, volunteer staff	Complete if applicable to the POD staffing plans.
Incident management roles (or equivalent lead roles) activated	Incident Commander; Finance/Administration Section Chief; Logistics Section Chief; Operations Section Chief; Planning Section Chief; and Public Information Officer should be identified (one person may fill multiple roles).
Total number of staff who acknowledged notification	If staff responded outside of the specified event day/time, do not include them in the total number.



Form question	Form Hint
Acknowledgement completion time	Auto-calculated value, based on the following formula: (Date/time last person acknowledged) – (Date/time first person notified)
Acknowledgement percentage	Auto-calculated value, based on the following formula: $\frac{\text{Total \# staff who acknowledged}}{\text{Total \# staff contacted}} \times 100$
Assembly completion time	Auto-calculated value, based on the following formula: (Date/time last staff member arrived at facility) – (Date/time first staff member notified)
Assembly percentage	Auto-calculated value, based on the following formula: $\frac{\text{Total \# staff assembled}}{\text{Total \# staff notified}} \times 100$
Number of security available	Provide the number of security staff available to participate. If this number cannot be provided given the security contract, enter 000.
Total number of RSS Sites	Number of RSS sites should match number of RSS Site Surveys completed.
Name of RSS	RSS name should match the RSS site survey.
Total number of planned primary PODs within jurisdiction	Provide total number of PODs; this number should match the number entered on the POD planning sheets.
Name of POD	POD name should match the information entered on the descriptive POD form.

What impacts achieving established status?

To be eligible for this status and meet the PHEP program requirement, you must conduct and submit the site activation drill every budget period (July 1–June 30).

States must conduct and submit the staff notification and assembly every budget period (July 1–June 30). This is reported on the applicable functional or full-scale exercise operational form unless your EOC is not activated as the result of an incident. In that case, states must report, at minimum, one no notice, immediate assembly for EOC incident command staff via this form to fulfill the performance measure requirement for “staff assembly” (formerly PM 3.1).



Site Activation Drill

Completed By	Submission Timeframe
<input type="checkbox"/> States	<input checked="" type="checkbox"/> Annual requirement
<input checked="" type="checkbox"/> Directly funded localities	<input type="checkbox"/> Five-year requirement
<input checked="" type="checkbox"/> Territories or freely associated states (at least one time in 5 years; exercise different sites if completed more than once in 5 years)	
<input checked="" type="checkbox"/> CRI local planning jurisdictions	
<p>Form Key Terms (refer to Appendix B): CBRNE, Cities Readiness Initiative (CRI), drill, full notification, no notification (none), partial notification, preparedness, public health emergency, Public Health Emergency Preparedness (PHEP) cooperative agreement, rapid dispensing model (or non-medical model), RSS facility, regional distribution site (RDS)/ local distribution site (LDS), responder, site activation, site availability</p>	

Why is this information collected?

The site activation drill provides information on operational function for procedures to open and activate various types of distribution and dispensing facilities. The drill measures the accuracy of site rosters, timeliness of site confirmations to the notification, and site function within a designated timeframe. Communication methods and processes are also measured. The drill information should be completed for each site notified.

What do I need to know about this form?

Form question	Form Hint
Site(s) activated (select all that apply)	Select the type of facility that participated in the drill. It is strongly encouraged that different types of sites are exercised each year. Different PODs should also be set up each year.
Total number of <sites> that acknowledged notification	If site responded outside of the specified event day/time, do not include them in the total number.
Acknowledgement completion time	Auto-calculated value, based on the following formula: (Date/time last site acknowledged) – (Date/time first site notified)
Acknowledgement percentage	Auto-calculated value, based on the following formula: $\frac{\text{Total \# sites who acknowledged}}{\text{Total \# sites notified}} \times 100$
Availability percentage	Auto-calculated value, based on the following formula: $\frac{\text{Total \# sites made available}}{\text{Total \# sites notified}} \times 100$
Availability completion time	Auto-calculated value, based on the following formula: (Date/time site made available) – (Date/time site notified)
Total Number of RSSs	Include number of RSSs for which RSS Site Surveys were completed.



Form question	Form Hint
Name of RSS	RSS name should match the RSS site survey
Total number of PODs	Provide number of PODs; this number should match the number entered on the POD planning sheets.
Name of POD	POD name should match the information entered on the descriptive POD form.

What impacts achieving established status?

To be eligible for this status and meet the PHEP program requirement, you must conduct and submit the site activation drill every budget period (July 1–June 30).



Dispensing Throughput Drill

Completed By	Submission Timeframe
<input type="checkbox"/> States	<input type="checkbox"/> Annual requirement
<input checked="" type="checkbox"/> Directly funded localities	<input checked="" type="checkbox"/> Five-year requirement (only if dispensing FSE was conducted for mass vaccination)
<input checked="" type="checkbox"/> Territories or freely associated states	
<input checked="" type="checkbox"/> CRI local planning jurisdictions	
Form Key Terms (refer to Appendix B): advance notice, full notification, regimens per hour (RPH), partial notification	

Why is this information collected?

The dispensing throughput drill tests dispensing procedures for pills and verifies estimates of regimens (or courses) and persons per hour in a given POD. Submission of this form is only required if the dispensing FSE was conducted using a mass vaccination model (not pills).

What do I need to know about this form?

Form question	Form Hint
Start date/time End date/time	A date picker (calendar pop-up) will appear for date/time fields. Select the appropriate information for the exercise or incident/event. For exercises, it is understood that the start/end date might be the same. When using the date picker, the time will auto-populate as the time data is entered; simply click the time to edit to the relevant start/end time for the exercise or incident/event.
Extent of advance notification	Select type of notification (full, partial, none) described in the exercise objectives.
Reporting throughput section	At minimum, 1 POD per CRI should exercise dispensing procedures. Throughput should be provided for each different size POD tested. Throughput should be entered from calculations outside of the system. External systems must be able to estimate the following: <ul style="list-style-type: none"> • # of regimens dispensed to HoH • traditional/assisted or express dispensing information • total time for each individual to start and complete dispensing activities • regimens per hour (required data entry) • persons per hour (required data entry) • average completion time (required data entry)
Total people/vehicles participating in POD Throughput	A minimum of 50 people (or vehicles if a drive through POD) must be submitted to calculate throughput.



What impacts achieving established status?

This form is only required once in a project period (July 1, 2017–June 30, 2022) if only one dispensing FSE is reported and was conducted as a mass vaccination exercise/incident. If more than one dispensing FSE is reported and at least one measured pill throughput then this form is not required (pill throughput will be captured via the Dispensing FSE/Incident form).



Tabletop Exercise (TTX)

Completed By	Submission Timeframe
<input type="checkbox"/> States	<input type="checkbox"/> Annual requirement
<input type="checkbox"/> Directly funded localities	<input type="checkbox"/> Five-year requirement
<input type="checkbox"/> Territories or freely associated states (Incidents Only)	
<input type="checkbox"/> CRI local planning jurisdictions	
<p>Form Key Terms (refer to Appendix B): CBRNE, event, functional needs, incident, preparedness, public health emergency, Public Health Emergency Preparedness (PHEP) cooperative agreement, rapid dispensing model (or non-medical model)</p>	

Why is this information collected?

A tabletop exercise (TTX) is a discussion-based exercise intended to generate discussion of various issues regarding a hypothetical, simulated emergency; the TTX form standardizes the information collected from a TTX. TTXs are optional but can increase participants' general awareness while validating plans and procedures. Participants can also assess the type of systems needed to prevent, protect against, mitigate negative effects, and recover from a defined incident. TTXs can also help identify strengths and areas for improvement in preparedness plans. Involving vulnerable population stakeholders in TTX (if relevant to the exercise) will satisfy the annual PHEP requirement to engage those partners.

What do I need to know about this form?

Form question	Form Hint
Start date/time End date/time	A date picker (calendar pop-up) will appear for date/time fields. When using the date picker, the time will auto-populate as the time data is entered; simply click the time to edit to the relevant start/end time for the exercise or incident/event.
Event Type	If the exercise includes community reception centers for those potentially exposed to radioactive material, select CBRNE and type "Community Reception Center" as "other."
Fiscal or other administrative processes and procedures included in exercise (select all that apply)	<p>Completing an administrative and fiscal preparedness TTX are recommended but not required.</p> <p>Grant allocation and hiring surge questions to inform exercise objectives are available in the Performs Resource Library (see <i>2017-2022 HPP-PHEP Supplemental Guidelines (CDC-RFA-1701-01)</i>).</p>
List jurisdictions that participated	Provide any regional, district, ward, parish, local or federal partners that participated. There are no requirements for inclusion.



Form question	Form Hint
Vulnerable population partner(s) that participated	Vulnerable populations are those groups that will potentially be disproportionately impacted by an incident/event. It is recommended (but not required) that vulnerable population stakeholders be engaged during TTX process to ensure appropriate planning considerations are in place.

What impacts achieving established status?

The TTX is optional but recommended. Once “established” is achieved for all modules (demographic, planning, and operations), conducting both a) community reception and b) fiscal/administrative TTX will begin to meet the criteria for achieving “advanced” status. Documented engagement with vulnerable population stakeholders (either through a TTX, PHEP functional, FSE, or incident, or dispensing FSE form) will satisfy the annual PHEP requirement. To receive credit for annual PHEP exercise requirement involving vulnerable population stakeholders, you must also submit the PHEP/Functional/Full-scale Exercise or Incident form with the general information and vulnerable population section completed (at minimum).



Distribution Full-scale Exercise (FSE)/Incident

Completed By	Submission Timeframe
<input checked="" type="checkbox"/> States	<input type="checkbox"/> Annual requirement
<input checked="" type="checkbox"/> Directly funded localities	<input checked="" type="checkbox"/> Five-year requirement
<input checked="" type="checkbox"/> Territories or freely associated states must complete either a distribution or dispensing FE/FSE once every 5 years; the FE/FSE satisfies the annual drill requirement the year it is conducted and submitted.	
<input type="checkbox"/> CRI local planning jurisdictions	
<p>Form Key Terms (refer to Appendix B): CBRNE, closed point of dispensing (closed POD or CPOD), command staff or incident management lead roles, core staff, demobilize, Department Operations Center (DOC), Emergency Management Agency (EMA), event, facility setup, full notification, incident, materiel, no notification (none), partial notification, preparedness, public health emergency, Public Health Emergency Preparedness (PHEP) cooperative agreement, rapid dispensing model (or non-medical model), RSS facility, regional distribution site (RDS)/ local distribution site (LDS), request, responder, site activation, site availability, staff assembly, staff notification, volunteer</p>	

Why is this information collected?

The distribution FSE/incident form provides information on operational function specific to staff notification and assembly procedures for EOCs and RSSs. The exercise measures the accuracy of staff rosters, timeliness of staff confirmations to the notification, and staff ability to report for duty within a designated timeframe. The form also provides information on operational function specific to site activation and availability procedures for EOCs to measure the accuracy of site rosters, timeliness of site confirmations to the notification, and site ability to clear a facility for subsequent site setup in a designated timeframe. The exercise also assesses the ability for a complete, timely RSS setup with the necessary materiel, layout, and supplies. Partnerships outlined in written agreements are also verified through the inclusion of the receiving sites and transportation assets tested during the MCM distribution exercise or incident/event. Lastly, time required for MCM asset and material request, processing, and distribution as well as security plans for transport are verified through either the exercise or incident/event.

What do I need to know about this form?

Form question	Form Hint
Type	Select whether you are reporting a FSE or actual incident/event.
Start date/time End date/time	A date picker (calendar pop-up) will appear for date/time fields. Select the appropriate information for the exercise or incident/event. For exercises, it is understood that the start/end date might be the same. When using the date picker, the time will auto-populate as the time data is entered; simply click the time to edit to the relevant start/end time for the exercise or incident/event.



Form question	Form Hint
Event Type	If the exercise includes community reception centers for those potentially exposed to radioactive material, select CBRNE and type "Community Reception Center" as "other."
Site activation start date/time Site activation end date/time	Site activation may occur at the same time as the start of the activity or it can differ (depending on the scenario). Provide the date/time start even if the same as the date/time start of the activity.
Site Activation: Communication platforms used for notification	Select relevant communication platforms used or tested; this should align with planning documentation.
Call notification process	Select type of notification (automated, manual, hybrid); this should align with planning documentation.
Number of EOC sites included in site activation	Record every EOC activation for all exercises and incidents/events; this includes virtual EOC activations. All EOC activations that public health supports (regardless of type of EOC) should be reported.
Site Activation: Total number of sites that acknowledged notification	If site responded outside of the specified event day/time, do not include them in the total number.
Site Activation: Acknowledgement completion time	Auto-calculated value, based on the following formula: (Date/time last site acknowledged) – (Date/time first site notified)
Site Activation: Acknowledgement percentage	Auto-calculated value, based on the following formula: $\frac{\text{Total \# sites who acknowledged}}{\text{Total \# sites notified}} \times 100$
Site Activation: Availability completion time	Auto-calculated value, based on the following formula: (Date/time site made available) – (Date/time site notified)
EOC staff notification start date/time EOC staff notification end date/time	Staff notification may occur at the same time as the start of the activity or it can differ (depending on the scenario). Provide the date/time start even if the same as the date/time start of the activity.
Incident management roles (or equivalent lead roles) activated	Incident Commander, Finance/Administration Section Chief, Logistics Section Chief, Operations Section Chief, Planning Section Chief, and Public Information Officer should be activated to satisfy PHEP Performance Measure 3.1 requirements (one person may fill multiple roles).
Target time for assembly (in minutes)	Target time for assembly during an incident should be <60 minutes to satisfy PHEP Performance Measure 3.1 requirements.
Name of RSS	RSS name should match the RSS site survey.
Staff notification/assembly: Total number of staff who acknowledged notification	If staff responded outside of the specified event day/time, do not include them in the total number.
Staff notification/assembly: Acknowledgement completion time	Auto-calculated value, based on the following formula: (Date/time last person acknowledged) – (Date/time first person notified)
Staff notification/assembly: Acknowledgement percentage	Auto-calculated value, based on the following formula: $\frac{\text{Total \# staff who acknowledged}}{\text{Total \# staff contacted}} \times 100$



Form question	Form Hint
Staff notification/assembly: Assembly percentage	Auto-calculated value, based on the following formula: $\frac{\text{Total \# staff assembled} \times 100}{\text{Total \# staff notified}}$
Staff notification/assembly: Assembly completion time (in minutes)	Auto-calculated value, based on the following formula: (Date/time last staff member arrived at facility) – (Date/time first staff member notified)
RSS Staff Notification: Number of security available	Provide the number of security staff available to participate. If this number cannot be provided given the security agreement, enter 000.
Staffing Categories: General health department staff, Volunteer staff	Complete if applicable to the RSS staffing plans. General health department staff refers to other RSS staff that does not include RSS management, security, or volunteers.
RSS Total set up time (in minutes)	Auto-calculated value, based on the following formula: (RSS setup end date/time) – (RSS setup start date/time)
Number of Sites receiving distributions from RSS	Provide the total number of sites that receive materiel directly from the RSS (RDS, LDS, etc.). If there are no intermediate sites within your state, enter 0.
Transportation assets section	Transportation assets need to be exercised or used in an incident at least once every 5-years to test capacity and availability.
Number of transportation assets mobilized to meet the incident need	Provide total number of vehicles utilized for distribution to PODs and intermediate distribution sites. Numbers should match information reported in the distribution planning form and should align with planning documentation.
Types of transportation assets mobilized to meet the incident need	Describe type of vehicles utilized for distribution to PODs and intermediate distribution sites. Types should match information reported in the distribution planning form and should align with planning documentation.
Backup transportation utilized	If backup transportation utilized, briefly describe the inject used to exercise backup transport, or situation requiring use of back up transport during an incident.
Procedures to maintain cold chain management included	Cold chain management capability needs to be exercised or used in an incident at least once every 5-years to test capacity and availability.
Describe how cold chain management was exercised	Provide description of how cold chain management was tested; this should align with planning documentation.



Form question	Form Hint
RSS Estimate of Warehouse Processing Time Section: Material Processing start date/time	<p>Processing includes MCM allocation, sorting, prioritizing, and picking.</p> <p>A date picker (calendar pop-up) will appear for date/time fields. Select the appropriate information for the exercise or incident/event. When using the date picker, the time will auto-populate as the time data is entered; simply click the time to edit to the relevant start/end time for the exercise or incident/event.</p> <p>Start date/time should be the time assets arrive at the RSS and should match the actual date/time of arrival for federal shipment (in the “request for federal MCM assets” section).</p>
Material processing end date/time	<p>A date picker (calendar pop-up) will appear for date/time fields. Select the appropriate information for the exercise or incident/event. When using the date picker, the time will auto-populate as the time data is entered; simply click the time to edit to the relevant start/end time for the exercise or incident/event.</p> <p>End date/time should be when the first shipment leaves the RSS for distribution and match the date/time first MCM leaves RSS (in the “total time for distribution” section).</p>

What impacts achieving established status?

To be eligible for this status and meet the PHEP program requirement you must submit the distribution FSE form, at minimum, once every 5 years. This will also satisfy the 3.1 PHEP Performance Measure requirement (formerly reported in PERFORMS) for actual incidents that require MCM and for which a no notice, partial or full activation of the EOC was required. The PHEP functional, FSE, or incident form should be used (instead) to report information about all non-MCM related EOC activations, but it will not satisfy the MCM distribution exercise requirement. However, if no actual incident occurred, the 3.1 performance measure can be fulfilled by conducting a no-notice drill using the staff notification and assembly drill form.



Dispensing Full-scale Exercise (FSE)/Incident

Completed By	Submission Timeframe
<input type="checkbox"/> States (required for states with dispensing responsibilities)	<input type="checkbox"/> Annual requirement
<input checked="" type="checkbox"/> Directly funded localities	<input checked="" type="checkbox"/> Five-year requirement (The dispensing FSE subsumes annual facility setup and staff notification/assembly drill requirements the year the FSE is conducted; however, site activation must still be entered independently, in the site activation drill form.)
<input checked="" type="checkbox"/> Territories or freely associated states must complete either a distribution or dispensing FE/FSE once every 5 years; the FE/FSE satisfies the annual drill requirement the year it is conducted and submitted.	
<input checked="" type="checkbox"/> CRI local planning jurisdictions	
<p>Form Key Terms (refer to Appendix B): After Action report (AAR), CBRNE, Cities Readiness Initiative (CRI), core staff, Emergency Management Agency (EMA), event, facility setup, full notification, functional needs, head of household (HoH), incident, no notification (none), partial notification, preparedness, primary point of dispensing (POD), public health emergency, Public Health Emergency Preparedness (PHEP) cooperative agreement, rapid dispensing model (or non-medical model), regimens per hour (RPH), request, responder, staff assembly, staff notification, subject matter expert (SME), throughput, volunteer</p>	

Why is this information collected?

The dispensing FSE/incident form provides information on operational function specific to staff notification and assembly procedures for PODs. The exercise measures the accuracy of staff rosters, timeliness of staff confirmations to the notification, and staff ability to report for duty within a designated timeframe. The exercise also assesses the ability for a complete, timely POD setup with the necessary materiel, layout, and supplies for the general population as well as vulnerable populations. In addition, the exercise tests dispensing procedures and verifies estimates of regimens and persons per hour. Lastly, the exercise tests timeliness for developing and releasing public health messages to the public (including vulnerable populations).



What do I need to know about this form?

Form question	Form Hint
Type	Select whether you are reporting a FSE or actual incident/event.
Start date/time End date/time	A date picker (calendar pop-up) will appear for date/time fields. Select the appropriate information for the exercise or incident/event. For exercises, it is understood that the start/end date might be the same. When using the date picker, the time will auto-populate as the time data is entered; simply click the time to edit to the relevant start/end time for the exercise or incident/event.
Event Type	If the exercise includes community reception centers for those potentially exposed to radioactive material, select CBRNE and type "Community Reception Center" as "other."
EOC staff received initial prophylaxis as part of exercise (or incident, if applicable)	Select "yes" if any type of EOC (public health EOC/DOC, EMA EOC, etc.) staff is given initial prophylaxis.
SMEs involved	If the activity is an exercise, select all SMEs that were included in the planning or participated in the exercise. If the activity is an incident/event, select all SMEs that were consulted or involved. The exercise forms, associated AAR forms, and supporting evidence should be reviewed to confirm reported information.
POD Name	POD name should match the information entered on the descriptive POD form. Submit no more than 5 PODs per exercise or incident/event.
Total number of planned primary PODs within jurisdiction	Provide number of PODs; this number should match the number entered on the POD planning sheets.
POD staff notification start date/time POD staff notification end date/time	Staff notification may occur at the same time as the start of the activity or it can differ (depending on the scenario). Provide the date/time start even if the same as the date/time start of the activity.
Staff notification/assembly: Extent of advance notification	Select type of notification (full, partial, none) described in the exercise objectives.
Staff notification/assembly: Communication platform/s used for notification	Select relevant communication platforms used or tested; this should align with planning documentation.
Staff notification/assembly: Call notification process	Select type of notification (automated, manual, hybrid); this should align with planning documentation.
Staff notification/assembly: Automated system type	Select either concurrent or sequential; this should align with planning documentation.
Staff notification/assembly staffing categories: Management/Lead staff, Security staff, General health department staff, Volunteer staff	Complete if applicable to the POD staffing plans.
Staff notification/assembly: Current first shift core POD management/lead staff	Include number of staff participating in the activity. If multiple PODs are activated at different times based on the scale of the incident, provide numbers for each notification. If PODs are activated individually, provide numbers per POD. If a particular type of staff was not needed, enter 000.



Form question	Form Hint
Staff notification/assembly: Total number of staff who acknowledged notification	If staff responded outside of the specified event day/time, do not include them in the total number.
Staff notification/assembly: Acknowledgement completion time	Auto-calculated value, based on the following formula: (Date/time last person acknowledged) – (Date/time first person notified)
Staff notification/assembly: Acknowledgement percentage	Auto-calculated value, based on the following formula: $\frac{\text{Total \# staff who acknowledged}}{\text{Total \# staff contacted}} \times 100$
Staff notification/assembly: Assembly completion time (in minutes)	Auto-calculated value, based on the following formula: (Date/time last staff member arrived at facility) – (Date/time first staff member notified)
Staff notification/assembly: Assembly percentage	Auto-calculated value, based on the following formula: $\frac{\text{Total \# staff physically assembled}}{\text{Total \# staff notified}} \times 100$
POD Staff Notification: Number of security available	Provide the number of security staff available to participate. If this number cannot be provided given the security contract, enter 000.
Messages about POD locations and hours of operation were disseminated during the incident/event	Select “yes” if public health messages were disseminated during the incident/event and enter date/time that communication was sent. This question is asked for messages directed to both general and vulnerable populations.
Vulnerable population stakeholders included in planning for the exercise (CRI/TFAS/DFL)	In this section information about stakeholders that support planning and communication to vulnerable populations is verified. Exercise and incident/event experiences should align with dispensing planning evidence.
POD setup section	Provide information for up to 5 PODs, including at least 1 for each different size POD exercised (e.g., one standard POD and one mega POD).
POD total setup time (in minutes)	Auto-calculated value, based on the following formula: (POD setup end date/time) – (POD setup start date/time)
Reporting Throughput Section	At minimum, 1 POD per CRI should exercise dispensing procedures. Throughput should be provided for each different size POD tested. Throughput can be entered from calculations outside of the system or the system will calculate throughput if a minimum of 50 samples are entered. External systems must be able to estimate the following: <ul style="list-style-type: none"> • # of regimens dispensed to HoH • traditional/assisted or express dispensing information • total time for each individual to start and complete dispensing activities • regimens per hour (required data entry) • persons per hour (required data entry) • average completion time (required data entry)



Form question	Form Hint
Total people/vehicles participating in POD Throughput	A minimum of 50 people (or vehicles if a drive through POD) must be submitted to calculate throughput.

What impacts achieving established status?

To be eligible for this status and meet the PHEP program requirement you must submit the dispensing FSE form, at minimum, once every 5 years. To receive credit for annual PHEP exercise requirement involving vulnerable population stakeholders, you must also submit the PHEP/Functional/Full-scale Exercise or Incident form with the general information and vulnerable population section completed (at minimum).



PHEP/Functional/Full-scale Exercise or Incident

Completed By	Submission Timeframe
<input checked="" type="checkbox"/> States	<input checked="" type="checkbox"/> Annual requirement
<input checked="" type="checkbox"/> Directly funded localities	<input type="checkbox"/> Five-year requirement
<input checked="" type="checkbox"/> Territories or freely associated states must complete either a PHEP FE/FSE once every 5 years; the FE/FSE satisfies the annual drill requirement the year it is conducted and submitted.	
<input type="checkbox"/> CRI local planning jurisdictions (May use for RDS/LDS sites)	
<p>Form Key Terms (refer to Appendix B): full notification, Healthcare Preparedness Program (HPP), no notification (none), partial notification, public health emergency, Public Health Emergency Preparedness (PHEP) cooperative agreement, rapid dispensing model (or non-medical model), RSS facility, request, responder, site activation, site availability, staff assembly, staff notification</p>	

Why is this information collected?

The PHEP functional, FSE, or incident form provides operational information about EOCs, including staff notification and assembly procedures. Detail about staff roster accuracy, notification, and assembly are collected. Further, EOC procedures including site activation and availability are collected.

Engagement with vulnerable population stakeholders during an activation are collected to satisfy the PHEP program requirement to engage these partners if relevant to the exercise or incident/event. Information provided might also satisfy the joint planning exercise if HPP and state, regional, or federal emergency management are involved in the incident/event.

What do I need to know about this form?

Form question	Form Hint
Type	This form can be used to report information about all non-MCM related EOC activations. Use this form to meet PHEP program reporting requirements for incident-based EOC activations.
Start date/time End date/time	A date picker (calendar pop-up) will appear for date/time fields. Select the appropriate information for the exercise or incident/event. For exercises, it is understood that the start/end date might be the same. When using the date picker, the time will auto-populate as the time data is entered; simply click the time to edit to the relevant start/end time for the exercise or incident/event.
Event Type	If the exercise includes community reception centers for those potentially exposed to radioactive material, select CBRNE and type "Community Reception Center" as "other."



Form question	Form Hint
Fiscal or other administrative processes and procedures included in exercise (select all that apply)	Grant allocation and hiring surge questions to inform exercise objectives are available in the Performs Resource Library (see 2017-2022 HPP-PHEP Supplemental Guidelines [CDC-RFA-1701-01]).
Vulnerable population stakeholders included in planning for the exercise	Vulnerable populations are those groups that will potentially be disproportionately impacted by an incident/event. It is recommended (but not required) that vulnerable population stakeholders be engaged while planning for or during an exercise or incident/event.
EOC site activation drill information communication platform/s used for notification	Select relevant communication platforms used or tested; this should align with planning documentation.
EOC site activation drill information call notification process	Select type of notification (automated, manual, hybrid); this should align with planning documentation.
Emergency Operations Center (EOC) general: Total number of EOCs	Provide total number of EOCs in your jurisdiction (regardless of type of EOC). Examples include, Department Operations Center (DOC), State Operation Center (SOC), EMA EOC, etc.
Emergency Operations Center (EOC) general: Number of EOC sites included in site activation	Provide total number of EOC activated for this exercise or incident/event; this includes virtual EOC activations. All EOC activations that public health supports (regardless of type of EOC) should be reported.
Emergency Operations Center (EOC) general: Total number of sites that acknowledged notification	If site responded outside of the specified event day/time, do not include them in the total number.
Emergency Operations Center (EOC) general: Acknowledgement completion time	Auto-calculated value, based on the following formula: (Date/time last site acknowledged) – (Date/time first site notified)
Emergency Operations Center (EOC) general: Acknowledgement percentage	Auto-calculated value, based on the following formula: $\frac{\text{Total \# sites who acknowledged}}{\text{Total \# sites notified}} \times 100$
Emergency Operations Center (EOC) general: Availability percentage	Auto-calculated value, based on the following formula: $\frac{\text{Total \# sites made available}}{\text{Total \# sites notified}} \times 100$
Site Activation Emergency Operations Center (EOC), per site: Availability completion time	Auto-calculated value, based on the following formula: (Date/time site made available) – (Date/time site notified)
Incident management lead staff: Current EOC incident management lead staff	Provide the total number of EOC incident management staff notified for this exercise or incident/event.



Form question	Form Hint
Incident management lead staff: Incident management roles (or equivalent lead roles) activated (select all that apply)	Incident Commander, Finance/Administration Section Chief, Logistics Section Chief, Operations Section Chief, Planning Section Chief, and Public Information Officer all should be activated to satisfy PHEP Performance Measure 3.1 requirements (one person may fill multiple roles).
Incident management lead staff: Target time for assembly (in minutes)	Target time for assembly during an incident should be <60 minutes to satisfy PHEP Performance Measure 3.1 requirements.
Incident management lead staff: Acknowledgement completion time	Auto-calculated value, based on the following formula: (Date/time last person acknowledged) – (Date/time first person notified)
Incident management lead staff: Acknowledgement percentage	Auto-calculated value, based on the following formula: $\frac{\text{Total \# staff who acknowledged}}{\text{Total \# staff contacted}} \times 100$
Incident management lead staff: Assembly completion time	Auto-calculated value, based on the following formula: (Date/time last staff member arrived at facility) – (Date/time first staff member notified)
Incident management lead staff: Assembly percentage	Auto-calculated value, based on the following formula: $\frac{\text{Total \# staff assembled}}{\text{Total \# staff notified}} \times 100$

What impacts achieving established status?

To receive credit towards “established” status and meet the annual PHEP exercise requirement, the exercise/incident/event must include engagement with vulnerable population stakeholders. This form will also meet the HPP-PHEP-EMA joint exercise requirement and must be submitted, at minimum, once every 5 years. This form must be used to report information about all non-MCM related EOC activations, but it will not satisfy the MCM distribution exercise requirement.

EOC activation and staff assembly during incidents is reported using this form unless MCM dispensing is exercised (in which case use the Dispensing Full-Scale Exercise/Incident form). Reporting EOC activations for all incidents satisfies the program reporting requirements and the performance measure requirements formerly reported as PM 3.1, staff assembly (see also Staff Notification and Assembly Drill form).



After-Action Report (AAR) and Improvement Plan (IP)

Completed By	Submission Timeframe
<input checked="" type="checkbox"/> States	<input type="checkbox"/> Annual requirement
<input checked="" type="checkbox"/> Directly funded localities	<input checked="" type="checkbox"/> Five-year requirement
<input checked="" type="checkbox"/> Territories or freely associated states (Incidents Only)	
<input checked="" type="checkbox"/> CRI local planning jurisdictions	
<p>Form Key Terms (refer to Appendix B): After Action Report (AAR), Cities Readiness Initiative (CRI), improvement plan, incident, medical countermeasures (MCM), preparedness, public health emergency, Public Health Emergency Preparedness (PHEP) cooperative agreement</p>	

Why is this information collected?

The AAR/IP form standardizes the information collected from an After Action Report (AAR) and improvement plan (IP) to evaluate the activity reported. The form **does not** replace the AAR/IP document(s). The form provides critical information required to determine the areas of strength and improvement across the program. The form is not required for drills or tabletop exercises, but should be used for all incidents, functional exercises, and full-scale exercises (not just specific to MCM).

What do I need to know about this form?

Form question	Form Hint
Number of days after incident end date	AAR/IPs should be completed 120 days after incident/event.
Event Type	If the exercise includes community reception centers for those potentially exposed to radioactive material, select CBRNE and type "Community Reception Center" as "other."
Capabilities evaluated (select all that apply)	Select "yes" only for the capabilities that were utilized and/or exercised in the incident/exercise reported.
List any functions addressed; describe in 1-2 sentences	Include preparedness capability and function number and briefly describe the objectives addressed by the exercise, incident, or event. Include four evaluation ratings outlined by HSEEP.
Key strengths identified	Include preparedness capability and function number.
Areas for improvement identified	Include preparedness capability and function number and provide detail about identified areas of improvement. Include four evaluation ratings outlined by HSEEP.



What impacts achieving established status?

To be eligible for this status, you must update and submit AAR/IP form as relevant to a given event/incident and, at minimum, an improvement plans (IP) once every five years. To evaluate training plans, reviewers will need to ensure evidence for improvements identified in annual After Action Reports (AAR) and IP are appropriately addressed and updated in training documents and plans for future exercises.

What impacts achieving established status?

To be eligible for this status, you must update and submit an AAR/IP form for each required functional and full-scale exercise and as relevant for events/incidents. Only one AAR/IP form is required if the dispensing and distribution FSEs and the PHEP FE/FSE are conducted as one exercise. Otherwise, each exercise requires an AAR/IP form be submitted (for a total of 3 AAR/IP forms). To evaluate training plans, reviewers will need to ensure evidence for improvements identified in the relevant AAR/IP is appropriately addressed and updated in training documents and plans for future exercises.



Training and Exercise Planning

Training and Exercise Planning Workshop (TEPW)

Completed By	Submission Timeframe
<input checked="" type="checkbox"/> States	<input checked="" type="checkbox"/> Annual requirement (States, DFLs)
<input checked="" type="checkbox"/> Directly funded localities	<input checked="" type="checkbox"/> Five-year requirement (TFAS)
<input checked="" type="checkbox"/> Territories or freely associated states	
<input type="checkbox"/> CRI local planning jurisdictions	
<p>Form Key Terms (refer to Appendix B): After Action Report (AAR), preparedness, public health emergency, Public Health Emergency Preparedness (PHEP) cooperative agreement, public health emergency preparedness capabilities</p>	

Multi-year Training and Exercise Plan (MYTEP)

Completed By	Submission Timeframe
<input checked="" type="checkbox"/> States	<input checked="" type="checkbox"/> Annual requirement
<input checked="" type="checkbox"/> Directly funded localities	<input type="checkbox"/> Five-year requirement
<input checked="" type="checkbox"/> Territories or freely associated states	
<input checked="" type="checkbox"/> CRI local planning jurisdictions	
<p>Form Key Terms (refer to Appendix B): Cities Readiness Initiative (CRI), public health emergency preparedness capabilities</p>	

Why is this information collected?

The training and exercise form standardizes the collection of areas for improvement identified in the TEPW and allows for monitoring of exercise program priorities used to develop the MYTEP; it can also inform technical assistance activities. The information collected outlines the plans to address specific threats and hazards, identified areas for improvement, and preparedness capabilities. The form **does not** replace the MYTEP document.

What do I need to know about this form?

Form question	Form Hint
Area(s) for improvement identified - List in priority (include capability and, if applicable, function for each)	Include a minimum of five descriptions of improvement (up to 250 characters) in order of priority with preparedness capability, function number, and Homeland Security Exercise and Evaluation Program (HSEEP) ratings definitions as applicable.



Form question	Form Hint
Methodology and tracking section	Provide information about how training and exercises are selected and monitored with respect to progression and improvement as indicated in HSEEP guidelines. Refer to https://preptoolkit.fema.gov/web/hseep-resources . Upload timeline or spreadsheet with planned exercises, if available.
Number of trainings planned in current budget period	Include all trainings, not just MCM-specific trainings.
Number of trainings planned in future budget periods	Include all trainings, not just MCM-specific trainings.
Changes in priorities from last year's MYTEP	Describe any significant changes from planned priorities; these should include shifts because of budgetary constraints, actual incidents, etc. Information should support why improvement plans are altered and how continued improvement is supported.
Changes in exercise schedule from previous MYTEP	Briefly describe the reasons for any changes (both planned and unplanned) to the exercise schedule including those due to priorities described in previous question. There should be updates to the MYTEP each year whether or not priorities differed.

What impacts achieving established status?

To be eligible for this status and meet the PHEP program requirement, states and DFLs must conduct a TEPW every budget period (July 1–June 30). Territories and freely associated states must conduct a TEPW, at minimum, once every five-years. To be eligible for this status and meet the PHEP program requirement, the MYTEP must also be updated every budget period (July 1–June 30) for states, DFLs, territories, and CRI local planning jurisdictions and include at least one year of additional training and exercise planning (minimum of 2 years must be included to be eligible for established).



APPENDICES



APPENDIX A: COMPARISON OF ORR ELEMENTS FROM 2015–2016 (BP4) TO 2017–2018 (BP1)

BP4 ORR Capability 1 – Community Preparedness

Function 1 – Determine risks to the health of the jurisdiction

BP4 Planning Element	BP4 Operational Element	BP1 Planning Element	BP1 Operational Element
<p>1a. MCM planning elements include the following based on risk assessments: 1) definition of risk, 2) mapped locations of at-risk populations, 3) evidence of community involvement, 4) assessment of loss or disruption of essential services (i.e., water, sanitation, healthcare services, and public health agency infrastructure).</p>	<p>NONE</p>	<p>Dispensing Planning Determine risks to the health of the jurisdiction</p> <ul style="list-style-type: none"> • Date of most recently conducted jurisdictional risk assessment (JRA) or equivalent • Hazards identified in the assessment • Estimate the number of people planned for with functional and/or access needs (including transportation) due to economic disadvantage, communication barriers because of language or literacy, medical issues and/or disability, and age (elderly persons and infants and children under age 18) • Select a vulnerable population partner 	<p>Dispensing FSE/Incident Information collection and intelligence:</p> <ul style="list-style-type: none"> • SMEs involved <p>Jurisdictional risk assessment (JRA, THIRA, or equivalent with public health included as a focus)</p>

Function 2 – Build community partnerships to support health preparedness

BP4 Planning Element	BP4 Operational Element	BP1 Planning Element	BP1 Operational Element
2a. Plans address partner engagement and document written acknowledgment of response roles for the following partners: 1) private sector, 2) local, 3) state, and 4) regional.	2a Ops. Jurisdiction can provide evidence of how the roles and responsibilities of these partners have been used within the last five years.	<p>Dispensing Planning</p> <p>Determine risks to the health of the jurisdiction</p> <ul style="list-style-type: none"> • Select a vulnerable population partner • Did this vulnerable population partner participate in or provide information for the current JRA/HVA? 	<p>Dispensing FSE/Incident</p> <p>Vulnerable population stakeholders included in planning for the exercise</p>

Function 3 – Engage with community organizations to foster public health, medical and mental/behavioral health social networks

BP4 Planning Element	BP4 Operational Element	BP1 Planning Element	BP1 Operational Element
3a. Plan addresses engagement with community partners, to include medical and mental/behavioral health agencies to promote an understanding of and connection to MCM activities.	NONE	Will be considered for a future ORR iteration	Will be considered for a future ORR iteration

Function 4 – Coordinate training or guidance to address community engagement in preparedness efforts

BP4 Planning Element	BP4 Operational Element	BP1 Planning Element	BP1 Operational Element
4a. Provide MCM-related public health preparedness and response training or guidance to community partners, including groups representing at-risk populations, to assist them in educating their own constituency groups regarding emergency preparedness and response plans.	NONE	Will be considered for a future ORR iteration	Will be considered for a future ORR iteration

BP4 ORR Capability 3 – Emergency Operations Coordination

Function 1 – Conduct preliminary assessment to determine need for public activation

BP4 Planning Element	BP4 Operational Element	BP1 Planning Element	BP1 Operational Element
1a. Plans describe strategies to coordinate with appropriate epidemiology, laboratory, medical, chemical, biological, and radiological subject matter experts (SMEs) to inform MCM decision-making. Plans should include the following elements: 1) analyze data, 2) assess emergency conditions, and 3) determine the activation levels based on the complexity of the event or incident required to support an MCM response.	1a Ops. Participation of appropriate subject matter experts to inform MCM decision-making has been exercised within the last five years.	<p>Dispensing Planning Activate the emergency public information system</p> <ul style="list-style-type: none"> Plans describe roles and responsibilities of public information staff and stakeholders <p>Distribution Planning</p> <ul style="list-style-type: none"> Plans include strategies to coordinate with subject matter experts to inform incident management decision making Subject matter experts involved in developing plans 	<p>Staff Notification and Assembly Drill EOC staff notification and assembly</p> <ul style="list-style-type: none"> Acknowledgement completion time Acknowledgement percentage Assembly completion time <p>Distribution FSE/Incident EOC staff notification and assembly</p> <ul style="list-style-type: none"> Acknowledgement completion time Acknowledgement percentage Assembly completion time
1b. Plans document a process depicting what/when actions would be initiated for 1) pre-event indicators, 2) notifications, 3) activations, 4) logistics, 5) operations, 6) sustained operations, or 7) demobilization.	NONE	<p>Distribution Planning Standard Operating Procedures include:</p> <ul style="list-style-type: none"> Full activation procedures Notification procedures Partial activation procedures Staff authorized to activate EOC <p>Recover Medical Materiel and Demobilize</p> <ul style="list-style-type: none"> Recovery of durable medical equipment Recovery of materiel 	<p>Distribution FSE/Incident</p>

Function 1 – Conduct preliminary assessment to determine need for public activation (continued)

BP4 Planning Element	BP4 Operational Element	BP1 Planning Element	BP1 Operational Element
<p>1c. Plans identify the redundant communication platforms that are in place to ensure communications remain available should primary communication systems become unavailable</p>	<p>1c Ops. Quarterly testing of redundant communications platforms is conducted and documented.</p>	<p>Dispensing Planning</p> <ul style="list-style-type: none"> • Primary communication platform used for notification of responders • Procedures to notify volunteers are available. • Primary system used to notify volunteers • Last update of system notification 	<p>Staff Notification and Assembly Drill</p> <p>EOC staff notification and assembly</p> <ul style="list-style-type: none"> • Communication platform/s used for notification <p>Distribution FSE/Incident</p> <p>EOC staff notification and assembly</p> <ul style="list-style-type: none"> • Communication platform/s used for notification

Function 2 – Activate public health emergency operations

BP4 Planning Element	BP4 Operational Element	BP1 Planning Element	BP1 Operational Element
<p>2a. Plans identify staff with the subject matter expertise to fulfill required incident command and emergency management roles in emergency operations centers (EOCs) as required during an MCM response.</p>	<p>2a Ops. Incident command and emergency management staff have exercised required EOC roles during an MCM incident during the last five years.</p>	<p>Distribution Planning</p> <p>Activate public health emergency operations</p> <ul style="list-style-type: none"> • Identified incident command staff 	<p>Distribution FSE/Incident</p> <ul style="list-style-type: none"> • EOC site activation and • EOC staff notification and assembly

Function 2 – Activate public health emergency operations (continued)

BP4 Planning Element	BP4 Operational Element	BP1 Planning Element	BP1 Operational Element
<p>2b. Plans 1) identify sites or virtual structure to serve as the unified health command (Health EOC), and 2) document procedures for setting up the Health EOC.</p>	<p>2b Ops. Site activation (via staff assembly) of Health EOC or virtual structure supporting unified health command during an MCM incident at least every two years.</p> <p>NOTE: For recipients, this element refers to PHEP Performance Measure 3.1</p>	<p>Will be considered for a future ORR iteration</p>	<p>Staff Notification and Assembly Drill EOC staff notification and assembly</p> <ul style="list-style-type: none"> • Acknowledgement completion time • Acknowledgement percentage • Assembly completion time <p>Site Activation Drill EOC Site Activation</p> <ul style="list-style-type: none"> • Acknowledgement completion time • Acknowledgement percentage • Availability completion time • Availability percentage <p>Distribution FSE/Incident EOC staff notification and assembly</p> <ul style="list-style-type: none"> • Acknowledgement completion time • Acknowledgement percentage • Assembly completion time <p>EOC Site activation</p> <ul style="list-style-type: none"> • Acknowledgement completion time • Acknowledgement percentage • Availability completion time <p>PHEP/Functional/FSE or Incident EOC staff notification and assembly</p> <ul style="list-style-type: none"> • Acknowledgement completion time • Acknowledgement percentage • Assembly completion time <p>EOC Site activation</p> <ul style="list-style-type: none"> • Acknowledgement completion time • Acknowledgement percentage • Availability completion time

Function 3 – Develop incident response strategy

BP4 Planning Element	BP4 Operational Element	BP1 Planning Element	BP1 Operational Element
3a. Plans document processes for completing the following elements required to support an MCM response: 1) incident action plan, 2) situation reports, and 3) finance/administration logs.	NONE	Will be considered for a future ORR iteration	NA

Function 4 – Manage and sustain public health response

BP4 Planning Element	BP4 Operational Element	BP1 Planning Element	BP1 Operational Element
4a. Plans address continuity strategies in the event that primary systems are unavailable during an MCM response, including: 1) activation triggers, 2) loss of facilities (RSS, RDS, PODs, etc.), 3) loss of personnel, 4) orders of succession, and 5) devolution.	4a Ops. Continuity plans, as they apply to an MCM response, have been exercised within the last five years.	RSS site survey	Will be considered for a future ORR iteration

Function 5 – Demobilize and evaluate public health emergency operations

BP4 Planning Element	BP4 Operational Element	BP1 Planning Element	BP1 Operational Element
5a. Plans describe strategies to demobilize assets and personnel during an MCM incident. This includes the following elements: 1) development of processes with support agencies for collection and transport of assets and personnel, and 2) signed written agreements to support demobilization.	NONE	Distribution Planning <ul style="list-style-type: none"> • Recovery of durable medical equipment • Recovery of materiel 	NA

Function 5 – Demobilize and evaluate public health emergency operations (continued)

BP4 Planning Element	BP4 Operational Element	BP1 Planning Element	BP1 Operational Element
5b. Plans identify a sufficient number of staff (as defined by the jurisdiction) are trained in the Homeland Security Exercise and Evaluation Program (HSEEP) to develop After Action Reports (AAR) and improvement plans (IP).	NONE	Distribution Planning Activate public health emergency operations <ul style="list-style-type: none"> • Staff (by functional role/name) authorized to activate EOC 	NA
5c. Plans identify processes and responsibilities for 1) developing a multi-year training and exercise plan (MYTEP), 2) conducting a hot wash, and 3) implementing IPs that incorporate MCM activities.	5c Ops. Annual training and exercise plan (TEP) workshop is conducted and a MYTEP is produced that incorporates MCM, and completion of required documentation demonstrating that the IP has been implemented and exercise components have been retested and re-evaluated accordingly.	MYTEP Form <ul style="list-style-type: none"> • Methodology and tracking section of MYTEP • AAR inclusion for FE, FSE, and incidents as applicable 	MYTEP Form <ul style="list-style-type: none"> • Training and Exercise Planning Workshop information • AAR inclusion for FE, FSE, and incidents as applicable

BP4 ORR Capability 4 – Emergency Public Information and Warning

Function 1 – Activate the emergency public information system

BP4 Planning Element	BP4 Operational Element	BP1 Planning Element	BP1 Operational Element
1a. Plans document public information and communication primary and back-up personnel who are trained in MCM responsibilities and current contact lists exist for these individuals.	NONE	Dispensing Planning <ul style="list-style-type: none"> • Plans describe roles and responsibilities of PI staff • Required training is documented • Plans include a process for dissemination of warning information through various channels Critical Contact Sheet <ul style="list-style-type: none"> • PIO • Backup PIO 	NA

Function 2 – Determine the need for a joint public information system

BP4 Planning Element	BP4 Operational Element	BP1 Planning Element	BP1 Operational Element
2a. Plans include processes for the establishment of scalable joint information operations with MCM components, including 1) trigger points, and 2) decision criteria.	2a Ops. Joint information operations (scaled to the public information demands) have been exercised within the last five years.	Will be considered for a future ORR iteration	Will be considered for a future ORR iteration

Function 3 – Establish and participate in information system operations

BP4 Planning Element	BP4 Operational Element	BP1 Planning Element	BP1 Operational Element
3a. Plans include procedures for 1) media notification (including an updated contact list) and credentialing, 2) press advisories and briefings, and 3) media monitoring and validation (including social media).	NONE	Will be considered for a future ORR iteration	NA
3b. Public health public information officer (PIO) responsibilities are documented in the job aid for the PIO or other MCM-designated staff and include the following elements: 1) coordinating information with the lead PIO and/or joint information center (JIC), 2) serving as the point-of-contact for the media, and 3) controlling public information messages and materials.	NONE	Dispensing Planning <ul style="list-style-type: none"> • Plans describe roles and responsibilities of PI staff 	NA

Function 4 – Establish avenues for public interaction and information exchange

BP4 Planning Element	BP4 Operational Element	BP1 Planning Element	BP1 Operational Element
<p>4a. Plans include methods for the public to contact the health department with MCM-related questions and concerns through 1) phone (i.e., call centers and/or help desks), 2) social media, 3) web chat, 4) e-mail, or 5) other communication platforms.</p>	<p>4a Ops. The jurisdiction can provide evidence of participation in an exercise or real incident within the last five years that demonstrates all applicable methods (referenced in the planning element) to address MCM-related questions/concerns from the public.</p>	<p>Will be considered for a future ORR iteration</p>	<p>Will be considered for a future ORR iteration</p>

Function 5 – Issue public information alerts, warnings, and notifications

BP4 Planning Element	BP4 Operational Element	BP1 Planning Element	BP1 Operational Element
<p>5a. Plans include procedures for 1) information verification; 2) message development, approval, and clearance; and 3) message dissemination to the public, as they relate to an MCM mission.</p>	<p>5a Ops. The jurisdiction can provide evidence of participation in an exercise or real incident within the last five years in which public messages that incorporate MCM elements are created and disseminated.</p>	<p>Dispensing Planning Activate the emergency public information system</p> <ul style="list-style-type: none"> Plans include a process for dissemination of warning information through various channels 	<p>Dispensing FSE/Incident Public information messaging</p> <ul style="list-style-type: none"> General population messages about POD location and hours of operation were developed Vulnerable population messages about POD location and hours of operation were developed Messages were developed prior to the incident with POD locations and hours of operation

Function 5 – Issue public information alerts, warnings, and notifications (continued)

BP4 Planning Element	BP4 Operational Element	BP1 Planning Element	BP1 Operational Element
<p>5b. Plans include a process for the pre-incident and real-time translation of information specific to an MCM response to address the following populations of the jurisdiction: 1) non-English speaking, 2) hearing impaired, 3) visually impaired, and 4) limited language proficiency populations.</p>	<p>5b Ops. The jurisdiction can provide evidence of participation in an exercise or real incident within the last five years where MCM materials were translated or adapted for applicable at-risk populations.</p>	<p>Dispensing Planning Activate the emergency public information system</p> <ul style="list-style-type: none"> Plans include process for real-time translation of information specific to a response to address 	<p>Dispensing FSE/Incident Public information messaging</p> <ul style="list-style-type: none"> Vulnerable population messages about POD location and hours of operation were developed Select a vulnerable population partner Did this vulnerable population partner participate or provide input into planning for emergency information and warning for vulnerable populations they represent?

BP4 ORR Capability 6 – Information Sharing

Function 1 – Identify stakeholders to be incorporated into information flow

BP4 Planning Element	BP4 Operational Element	BP1 Planning Element	BP1 Operational Element
<p>1a. Identify stakeholders to be incorporated into information flow</p>	<p>1a. Plans include procedures that 1) identify all stakeholders who would be involved in an MCM incident (including public health, medical, law enforcement and other disciplines), 2) outline communications pathways between and among these stakeholders, and 3) show evidence that current contact lists exist that include multiple contact mechanisms/devices for identified stakeholders.</p>	<p>1a Ops. Percentage of local partners that reported requested essential elements of information (EEI) to the public health/medical lead within the required timeframe (recipient defined) during an MCM incident within the last two years. NOTE: This element refers to HPP-PHEP Performance Measure 6. 1. This element does not apply to local jurisdictions.</p>	<p>Will be considered for a future ORR iteration</p>

Function 2 – Identify rules and data elements for information sharing

BP4 Planning Element	BP4 Operational Element	BP1 Planning Element	BP1 Operational Element
2a. Plans document minimum requirements for information sharing during an MCM incident, including 1) when information should be shared, 2) who is authorized to receive and/or share information, 3) what types of information can be shared, 4) information use and re-release parameters, and 5) protection of information (including legal considerations).	NONE	Will be considered for a future ORR iteration	NA

Function 3 – Exchange information to determine a common operating picture

BP4 Planning Element	BP4 Operational Element	BP1 Planning Element	BP1 Operational Element
3a. Plans include 1) procedures for sharing MCM-related information to enable a common operating picture, and 2) evidence of access to a platform to share this information,	3a Ops. Procedures (as referenced in the planning element) for sharing MCM-related information have been exercised within the last five years.	Will be considered for a future ORR iteration	Will be considered for a future ORR iteration

BP4 ORR Capability 8 – Medical Countermeasure Dispensing POD

Function 1 – Identify and initiate medical countermeasure dispensing

BP4 Planning Element	BP4 Operational Element	BP1 Planning Element	BP1 Operational Element
<p>1a. Guidance/plans document dispensing strategies (according to a tiered priority or alternate modality) to include: 1) open (public) PODs, 2) Closed PODs, and 3) Populations with Access and Function Needs.</p>	<p>1a Ops. Tiered priority or alternate dispensing modalities (as referenced in the planning element) have been exercised within the last five years.</p>	<p>POD Form Includes primary open PODs at a minimum</p> <p>Local, State, CRI, TFAS Jurisdictional Data Sheet Includes pertinent closed POD and alternate modes of dispensing for the jurisdiction</p> <p>Dispensing Planning Plans include process for real-time translation of information specific to a response to address populations at-risk</p>	<p>Dispensing FSE Includes open PODs, closed PODs for first responders at state level, and populations with access and functional needs</p>
<p>1b. Guidance/plans document the capability to 1) initiate a dispensing campaign (i.e., initial 10-day prophylaxis regimen for anthrax) and 2) sustain dispensing campaign follow-on needs (i.e., additional 50-day regimen of prophylaxis for anthrax).</p>	<p>1b Ops. The capability to initiate a dispensing campaign and transition to sustained dispensing operations has been tested within the last five years.</p>	<p>Dispensing Planning Identify and initiate MCM dispensing</p> <ul style="list-style-type: none"> • Evidence of plans to complete a 10-day dispensing campaign for state public health responders within a 48 hour operational window after medical materiel is requested from federal assets is available • Primary communication platform used for notification of responders 	<p>Staff Notification and Assembly Drill POD staff notification and assembly</p> <ul style="list-style-type: none"> • Acknowledgement completion time • Acknowledgement percentage • Assembly completion time • Communication platform/s used for notification <p>Dispensing FSE/Incident POD staff notification and assembly</p> <ul style="list-style-type: none"> • Acknowledgement completion time • Acknowledgement percentage • Assembly completion time • Communication platform/s used for notification

Function 1 – Identify and initiate medical countermeasure dispensing (continued)

BP4 Planning Element	BP4 Operational Element	BP1 Planning Element	BP1 Operational Element
<p>1c. Guidance/plans identify healthcare partners that would participate in MCM activities and include: 1) list of current healthcare partners with appropriate contact information, 2) MOUs (or other signed written agreements) with these organizations, 3) procedures for how these healthcare partners will participate in MCM activities (including asset request procedures), and 4) planning guidance for those partners participating as closed PODs.</p>	<p>1c Ops. Jurisdiction has participated in exercises (tabletop, functional or full-scale) or real incidents with healthcare partners related to closed PODs, MCM asset request procedures, or other MCM activities within the last five years.</p>	<p>Will be considered for a future ORR iteration</p>	<p>Will be considered for a future ORR iteration</p>

Function 2 – Receive medical countermeasures at POD

BP4 Planning Element	BP4 Operational Element	BP1 Planning Element	BP1 Operational Element
<p>2a. Guidance/plans for open (public) PODs include dispensing site surveys that document: 1) required equipment and resources, 2) procedures to acquire these resources, 3) current contact lists for site/facility, and 4) Memorandums of Understanding (MOUs) (or other written agreements).</p>	<p>2a Ops. Dispensing site set-up has been tested (via drills, functional, or full-scale exercises or a real incident) within the last five years for all open (public) PODs within the planning jurisdiction.</p>	<p>Dispensing Planning The process to request assistance from the state for MCM assets when a</p> <ul style="list-style-type: none"> • federal disaster is declared in the state • in the absence of federal disaster declaration • for an isolated, individual, or time-critical case • for MCM Assets in coordination with tribal government(s) 	<p>Facility Setup Drill POD setup</p> <ul style="list-style-type: none"> • Total set up time <p>Site Activation Drill POD Site Activation</p> <ul style="list-style-type: none"> • Acknowledgement Completion time • Acknowledgement percentage • Availability completion time • Availability percentage <p>Distribution FSE/Incident POD setup</p> <ul style="list-style-type: none"> • Total set up time

Function 3 – Activate dispensing modalities

BP4 Planning Element	BP4 Operational Element	BP1 Planning Element	BP1 Operational Element
<p>3a. Guidance/plans for open (public) PODs identify all personnel required to staff dispensing sites, in accordance with planning estimates, and contact lists for these individuals are current.</p>	<p>3a Ops. Quarterly call down drills conducted among pre-assigned core staff needed to staff dispensing sites.</p>	<p>POD Planning Form</p>	<p>Staff Notification and Assembly Drill POD staff notification and assembly</p> <ul style="list-style-type: none"> • Acknowledgement completion time • Acknowledgement percentage • Assembly completion time <p>Dispensing FSE/Incident POD staff notification and assembly</p> <ul style="list-style-type: none"> • Acknowledgement completion time • Acknowledgement percentage • Assembly completion time

Function 4 – Dispense medical countermeasures to identified population

BP4 Planning Element	BP4 Operational Element	BP1 Planning Element	BP1 Operational Element
<p>4a. Guidance/plans address and document operational planning elements necessary to provide MCM to the public at open (public) PODs, including: 1) dispensing flow, 2) screening forms, 3) mechanisms and trigger points to increase throughput, and 4) assisting populations with access and functional needs.</p>	<p>4a Ops. Jurisdiction has tested (drill, functional, full-scale exercise or real incident) all planning elements necessary to provide MCM to the public within the last five years and has calculated throughput capacity for each dispensing site.</p>	<p>Dispensing Planning Process or protocols for PODs address</p> <ul style="list-style-type: none"> • Adverse event reporting for dispensed drugs • Providing information on adverse events • Record/log of drugs dispensed • Reporting data to state/federal entities • Screening for the purpose of triaging 	<p>Dispensing FSE/Incident</p> <ul style="list-style-type: none"> • Dispensing throughput • Materials (e.g., signage, handouts) accommodate communication barriers because of language or literacy • Set-up accommodates persons with mobility issues

Function 4 – Dispense medical countermeasures to identified population (continued)

BP4 Planning Element	BP4 Operational Element	BP1 Planning Element	BP1 Operational Element
4b. Guidance/plans for open (public) PODs include procedures for 1) operating a full medical POD, 2) operating a non-medical POD, and 3) transitioning from one to the other during an MCM incident.	NONE	<p>Dispensing Planning Process or protocols for PODs address</p> <ul style="list-style-type: none"> • Adverse event reporting for dispensed drugs • Providing information on adverse events • Record/log of drugs dispensed • Reporting data to state/federal entities • Screening for the purpose of triaging 	NA

Function 5 – Report adverse events

BP4 Planning Element	BP4 Operational Element	BP1 Planning Element	BP1 Operational Element
5a. Guidance/plans for open (public) PODs evidence that adverse event reporting procedures are included in: 1) dispensing site protocols, 2) job aides, and 3) information sheets provided to the public as they leave the site.	NONE	<p>Dispensing Planning Activate dispensing modalities</p> <ul style="list-style-type: none"> • Adverse event reporting for dispensed drugs 	NA

BP4 ORR Capability 9 – Medical Materiel Management and Distribution

Function 1 – Direct and activate medical materiel management and distribution

BP4 Planning Element	BP4 Operational Element	BP1 Planning Element	BP1 Operational Element
<p>1a. Plans identify receiving locations (receipt, stage and store (RSS) sites/regional distribution sites (RDS)/local distribution sites (LDS)) for medical countermeasures.</p>	<p>1a Ops. Receiving sites have been exercised (functional exercise, full-scale exercise or real incident) according to distribution plans (RSS/RDS/LDS) within the last five years.</p>	<p>RSS Site Survey</p>	<p>Facility Setup Drill RDS setup</p> <ul style="list-style-type: none"> • Total set up time <p>Site Activation Drill RDS site activation</p> <ul style="list-style-type: none"> • Acknowledgement Completion time • Acknowledgement percentage • Availability completion time • Availability percentage <p>Distribution FSE/Incident RDS setup</p> <ul style="list-style-type: none"> • Total set up time • Percentage of RDS exercised RSS estimate of warehouse processing time

Function 1 – Direct and activate medical materiel management and distribution (continued)

BP4 Planning Element	BP4 Operational Element	BP1 Planning Element	BP1 Operational Element
<p>1b. Plans identify primary and back-up transportation assets from public and/or private sources and include a transportation asset list.</p>	<p>1b Ops. Transportation assets have been exercised according to distribution plans within the last five years.</p>	<p>Distribution Planning Transportation agreements include</p> <ul style="list-style-type: none"> • Primary transport • Back-up transport • Operators • Types of drivers/specially licensed operators • Vehicles: load capacity, number available, type • Vendor agreements with MOUs; Procedures to maintain cold chain management • Jurisdiction’s response time for initial transportation requirements 	<p>Distribution FSE/Incident Transportation Assets</p> <ul style="list-style-type: none"> • Number and types of transportation assets mobilized to meet the incident need • Primary transportation utilized • Back up transportation utilized • Number of operators, both drivers and specialist licensed operators used during the activity
<p>1c. Plans identify all personnel needed to staff receiving sites (RSS/RDS/LDS).</p>	<p>1c Ops. Quarterly call-down drills conducted among all personnel needed to staff receiving sites (RSS/RDS/LDS).</p>	<p>Distribution Planning RSS/RDS/LDS staff identified</p> <ul style="list-style-type: none"> • distribution lead, primary • distribution lead, back-up • logistics, primary • logistics, back-up • receiving site lead, primary • receiving site lead, back-up • security coordinator, primary • security coordinator, back-up • current DEA registrant (identified or access to), other staff type 	<p>Staff Notification and Assembly Drill RSS/RDS/LDS staff notification and assembly</p> <ul style="list-style-type: none"> • Acknowledgement completion time • Acknowledgement percentage • Assembly completion time <p>Distribution FSE/Incident RSS staff notification and assembly</p> <ul style="list-style-type: none"> • Acknowledgement completion time • Acknowledgement percentage • Assembly completion time

Function 2 – Acquire medical materiel

BP4 Planning Element	BP4 Operational Element	BP1 Planning Element	BP1 Operational Element
2a. Plans include procedures to request medical materiel from 1) jurisdictional, 2) private, 3) regional, and/or 4) federal partners in alignment with National Incident Management System standards and incident needs.	2a Ops. Processes (as referenced in the planning element) for requesting medical materiel have been exercised within the last five years.	Distribution Planning Plans include the following elements for requesting medical materiel <ul style="list-style-type: none"> • Assessment of local inventory/medical countermeasure caches • Decision process (e.g., trigger indicators, thresholds) • Identification of pharmaceutical and/or medical-supply • Process for requesting medical countermeasures 	Distribution FSE/Incident Request for federal MCM assets <ul style="list-style-type: none"> • Date of MCM asset request • Time of MCM asset request • Estimated time of arrival for federal shipment • Actual time of arrival of federal shipment
2b. Plans include procedures to maintain integrity of medical materiel according to jurisdictional requirements and manufacturer specifications, including 1) cold chain management, 2) tracking by lot number, 3) tracking by expiration date, and 4) chain of custody (controlled and non-controlled substances).	2b Ops. Procedures (as referenced in the planning element) to maintain integrity of medical materiel in accordance with jurisdictional requirements and manufacturer specifications have been exercised within the last five years.	Distribution Planning Allocation and distribution elements include <ul style="list-style-type: none"> • Chain of custody • Cold chain 	Distribution FSE/Incident Transportation assets <ul style="list-style-type: none"> • Procedures to maintain cold chain management included

Function 3 – Maintain updated inventory management and reporting system

BP4 Planning Element	BP4 Operational Element	BP1 Planning Element	BP1 Operational Element
3a. Plans include procedures to operate a primary and back-up inventory management system (IMS) during an MCM incident.	3a Ops. Demonstrate the ability to receive, store, pick, and ship assets from both primary and backup system.	Distribution Planning Maintain updated inventory management and reporting system	Successful IMATS/IDE

Function 3 – Maintain updated inventory management and reporting system (continued)

BP4 Planning Element	BP4 Operational Element	BP1 Planning Element	BP1 Operational Element
3b. Plans outline processes to track and report inventory levels from all entities within a jurisdiction.	3b Ops. Procedures to track and report inventory levels have been exercised within the last five years.	<p>Distribution Planning Plans include the following elements for requesting medical materiel</p> <ul style="list-style-type: none"> • Assessment of local inventory/medical countermeasure caches 	<p>Distribution FSE Number of sites receiving distributions from RSS including RDS/LDS, PODs, hospitals and closed PODs, total times for distribution</p>

Function 4 – Establish and maintain security

BP4 Planning Element	BP4 Operational Element	BP1 Planning Element	BP1 Operational Element
4a. Plans include procedures to identify, acquire, and maintain security measures at all MCM distribution sites (RSS/RDS/LDS).	4a Ops. Security plans for receiving site (RSS, RDS, LDS) have been exercised (tabletop, functional, or full-scale exercise or real incidents) within the last five years.	<p>Distribution Planning Security plans for primary RSS include</p> <ul style="list-style-type: none"> • Security lead during PH emergency response • Evacuation plans • Exterior physical security of locations • Interior physical security of location • Security breach plans <p>Transportation security plans include</p> <ul style="list-style-type: none"> • MCM arriving at RSS • MCM transported from RSS to RDS/LDS/POD • MCM transported from RDS/LDS to POD 	<p>Staff Notification and Assembly Drill RSS/RDS/LDS staff notification and assembly (security staff)</p> <ul style="list-style-type: none"> • Acknowledgement completion time • Acknowledgement percentage • Assembly completion time <p>Distribution FSE/Incident RSS staff notification and assembly (security)</p> <ul style="list-style-type: none"> • Acknowledgement completion time • Acknowledgement percentage • Assembly completion time <p>Establish and maintain security</p> <ul style="list-style-type: none"> • Security plans were exercised in the following distribution phases

Function 4 – Establish and maintain security (continued)

BP4 Planning Element	BP4 Operational Element	BP1 Planning Element	BP1 Operational Element
<p>4b. Plans include procedures to identify, acquire, and maintain security measures at all public MCM dispensing sites (general points of dispensing [PODs]).</p>	<p>4b Ops. Security plans for public dispensing sites (general PODs) have been exercised (tabletop, functional, or full-scale exercises or real incidents) within the last five years.</p>	<p>Distribution Planning Establish and maintain security</p> <ul style="list-style-type: none"> • MCM transported from RDS/LDS to POD <p>Dispensing Planning Plans for POD security address</p> <ul style="list-style-type: none"> • Evacuation procedures, • Exterior security for location, • Interior security for location, • Scalability, • Security breach procedures, • Security command/management plan 	<p>Staff Notification and Assembly Drill POD staff notification and assembly (security)</p> <ul style="list-style-type: none"> • Acknowledgement completion time • Acknowledgement percentage • Assembly completion time <p>Dispensing FSE/Incident POD staff notification and assembly (security)</p> <ul style="list-style-type: none"> • Acknowledgement completion time • Acknowledgement percentage • Assembly completion time <p>Distribution FSE/Incident Security plan for:</p> <ul style="list-style-type: none"> • MCM transported from RDS/LDS to POD
<p>4c. Plans include processes for the security of MCM assets through all applicable distribution phases up to and including arrival distribution end points and an MOU (or similar written agreement) is in place with security partners.</p>	<p>4c Ops. Transportation security plans for the applicable phases referenced in the planning element have been exercised (tabletop, functional, full-scale exercises or real incidents) within the last five years.</p>	<p>Distribution Planning Transportation security plans include</p> <ul style="list-style-type: none"> • Crossing jurisdictional lines • Crossing governmental sovereignty (if applicable) • MCM arriving at RSS • MCM transported from RSS to RDS/LDS/POD • MCM transported from RDS/LDS to POD 	<p>Distribution FSE/Incident Security plan for</p> <ul style="list-style-type: none"> • Crossing jurisdictional lines • Crossing governmental sovereignty (if applicable) • MCM arriving at RSS exercised • MCM transported from RSS to RDS/LDS/POD • MCM transported from RDS/LDS to POD

Function 5 – Distribute medical materiel

BP4 Planning Element	BP4 Operational Element	BP1 Planning Element	BP1 Operational Element
<p>5a. Plans include procedures to determine allocation and distribution strategy, including 1) delivery locations, 2) routes, and 3) delivery schedule/frequency, based on incident needs.</p>	<p>5a Ops. Jurisdiction has demonstrated capacity to transport material from receiving sites (RSS/RDS/LDS) to identified dispensing sites according to planning assumptions (modeling, exercise, or real incident) within the last five years.</p>	<p>Distribution Planning Allocation and distribution elements include</p> <ul style="list-style-type: none"> • Delivery locations • Delivery schedule • Transportation method(s) • Transportation routes • Receipt from intermediary site (if applicable) 	<p>Distribution FSE/Incident Number of Sites receiving distributions from RSS</p> <ul style="list-style-type: none"> • Percent intermediate sites exercised in this event • Total number of PODs that received MCM directly from the RSS in this event • Total number of PODs receiving directly from RSS sites listed in state plans • Percent hospital receiving sites exercised in this event • Percent closed PODs exercised in this event • Total number of sites that receive materiel directly from the RSS • Total time for distribution

Function 6 – Recover medical materiel and demobilize distribution operations

BP4 Planning Element	BP4 Operational Element	BP1 Planning Element	BP1 Operational Element
<p>6a. Plans include procedures to 1) recover material, 2) recover equipment, and 3) dispose of biomedical waste materials according to jurisdictional policies and protocols.</p>	<p>6a Ops. Recovery and waste disposal procedures have been exercised within the last five years.</p>	<p>Distribution Planning Recovery and demobilization elements include</p> <ul style="list-style-type: none"> • Recovery of durable medical equipment • Recovery of materiel 	<p>Will be considered for a future ORR iteration</p>

BP4 ORR Capability 14 – Responder Safety and Health

Function 1 – Identify responder safety and health risks

BP4 Planning Element	BP4 Operational Element	BP1 Planning Element	BP1 Operational Element
<p>1a. Plans include procedures for protecting public health staff and volunteer responders, to include 1) identifying and communicating medical and behavioral health risks, 2) validating health and safety recommendations with subject matter experts, and 3) identifying personal protective equipment (PPE), protective actions, or other mechanisms as they relate to an MCM mission.</p>	<p>1a Ops. All procedures (as referenced in the planning element) for protecting public health staff and volunteer responders have been exercised within the last five years.</p>	<p>Will be considered for a future ORR iteration</p>	<p>Will be considered for a future ORR iteration</p>
<p>1b. Plans: 1) identify all responders (including first responders and critical infrastructure personnel (CIP) that would be used in an MCM incident, 2) describe procedures for priority prophylaxis of identified responders (including first responders/CIS), and 3) describe resources necessary to conduct priority prophylaxis of responders (including first responders/CIS).</p>	<p>1b Ops. Procedures for the prophylaxis of all responders (including first responders/CIS) have been exercised within the last five years.</p>	<p>Dispensing Planning Identify responder safety and health risks</p> <ul style="list-style-type: none"> • Process to identify all public health responders (including any first responders and critical infrastructure personnel if applicable) that will be used in an incident or event is available • Process to ensure that mission-critical responders receive initial prophylaxis during an MCM incident is available 	<p>Dispensing FSE/Incident</p> <ul style="list-style-type: none"> • State public health responders utilized in running PODs • Staff received initial prophylaxis as part of exercise

Function 2 – Identify safety and personal protective needs

BP4 Planning Element	BP4 Operational Element	BP1 Planning Element	BP1 Operational Element
2a. Plans include procedures for 1) training on PPE, 2) PPE fit-testing, 3) medically clearing staff to use PPE, and 4) obtaining additional PPE appropriate for the MCM incident.	NONE	Will be considered for a future ORR iteration	NA

Function 3 – Coordinate with partners to facilitate risk-specific safety and health training

BP4 Planning Element	BP4 Operational Element	BP1 Planning Element	BP1 Operational Element
3a. Plans document procedures for MCM just-in-time training for 1) first responders, 2) critical infrastructure personnel 3) volunteer responders, and 4) staff responders regarding their own safety and health.	NONE	Will be considered for a future ORR iteration	NA

Function 4 – Monitor responder safety and health actions

BP4 Planning Element	BP4 Operational Element	BP1 Planning Element	BP1 Operational Element
4a. Plan includes procedures for 1) monitoring health and safety of all responders, 2) providing medical and behavioral health services to all responders, and 3) modifying health and safety recommendations based on available surveillance, as they relate to an MCM mission.	4a Ops. Procedures for monitoring responder safety and health actions have been exercised within the last five years.	Will be considered for a future ORR iteration	Will be considered for a future ORR iteration

BP4 ORR Capability 15 – Volunteer Management

Function 1 – Coordinate volunteers

BP4 Planning Element	BP4 Operational Element	BP1 Planning Element	BP1 Operational Element
1a. Plans include procedures for 1) pre-incident volunteer recruitment and identification, including a registration system, 2) pre-incident screening and credential verification, and 3) pre-incident training on public health response capabilities as they relate to an MCM mission.	1a Ops. Plans related to volunteer registration systems, pre-incident screening, credentials verification, and pre-incident training have been exercised within the last five years.	Will be considered for a future ORR iteration	Will be considered for a future ORR iteration

Function 2 – Notify volunteers

BP4 Planning Element	BP4 Operational Element	BP1 Planning Element	BP1 Operational Element
<p>2a. Plans include procedures for 1) volunteer notification, with redundant systems and template messages, 2) partner agency notifications for staff support, and 3) credential confirmation at time of incident, as they relate to an MCM mission.</p>	<p>2a Ops. Jurisdiction conducts annual call-down drill of all volunteers required to support an MCM mission.</p>	<p>Dispensing Planning Notify volunteers</p> <ul style="list-style-type: none"> • Procedures to notify volunteers are available in • Primary system used to notify volunteers required to complete a dispensing (and if applicable, distribution) campaign 	<p>Staff Notification and Assembly Drill POD, EOC, RSS, RDS staff notification and assembly</p> <ul style="list-style-type: none"> • Acknowledgement completion time • Acknowledgement percentage • Assembly completion time <p>Distribution FSE/Incident RSS staff notification and assembly (volunteers)</p> <ul style="list-style-type: none"> • Acknowledgement completion time • Acknowledgement percentage • Assembly completion time <p>Dispensing FSE/Incident POD staff notification and assembly (volunteers)</p> <ul style="list-style-type: none"> • Acknowledgement completion time • Acknowledgement percentage • Assembly completion time

Function 3 – Organize, assemble, and dispatch volunteers

BP4 Planning Element	BP4 Operational Element	BP1 Planning Element	BP1 Operational Element
<p>3a a. Plans include procedures for 1) assembling and rotating volunteers, 2) providing volunteer support services (feeding, housing, etc.), and 3) briefing volunteers through job aids, just-in-time training materials, safety instructions, etc.</p>	<p>NONE</p>	<p>Will be considered for a future ORR iteration</p>	<p>NA</p>

Function 3 – Organize, assemble, and dispatch volunteers (continued)

BP4 Planning Element	BP4 Operational Element	BP1 Planning Element	BP1 Operational Element
3b. Plans include a process for 1) badging volunteers, 2) managing spontaneous volunteers, and 3) coordinating with emergency management, or other jurisdictional lead, for support of public health volunteers	NONE	Will be considered for a future ORR iteration	NA

Function 4 – Demobilize volunteers

BP4 Planning Element	BP4 Operational Element	BP1 Planning Element	BP1 Operational Element
4a. Plans include procedures (manual or electronic system) for 1) tracking, 2) out-processing, and 3) providing follow-up services to volunteers.	NONE	Will be considered for a future ORR iteration	NA

APPENDIX B: KEY TERMS

A

Academic institutions

Refers to post high school facilities such as colleges, universities, community colleges, etc.; excludes high schools, middle schools, elementary schools, etc.

Adequate

A system, process, procedure, or quantity that will achieve a defined response objective.

After-action report (AAR)

Summarizes key exercise-related evaluation information including the exercise overview and analysis of objectives and core capabilities; the AAR is usually developed in conjunction with an improvement plan (IP).

Alert

Time-sensitive tactical communication sent to parties potentially impacted by an incident to increase preparedness and response. Alerts can convey 1) urgent information for immediate action, 2) interim information with actions that may be required in the near future, or 3) information that requires minimal or no action by responders. CDC's Health Alert Network is a primary method of sharing cleared information about urgent public health incidents with public information officers; federal, state, territorial, and local public health practitioners; clinicians; and public health laboratories.

All-hazard incidents

Incidents, whether natural or manmade, that warrant action to protect life, property, environment, or public health safety.

Alternate dispensing methods

Alternate modes of dispensing include other methods used to reach individuals who do not use the open or public walk-through PODs. Alternate methods of dispensing may include drive-through or mobile dispensing sites, providing medications via businesses, nursing homes, and assisted living facilities, or door-to-door or direct deliveries to residences, or deliveries to sheltered-in populations (e.g., incarcerated individuals, group homes).

Ante mortem data

Information about a missing or deceased person used for identification. This includes demographic and physical descriptions, medical and dental records, and information regarding the person's last known whereabouts. Ante mortem information is gathered and compared to postmortem information when confirming a victim's identification.

At-risk populations

Population members who may have additional needs before, during, and after an incident in functional areas, including but not limited to maintaining independence, communication, transportation, supervision, and medical care. Individuals in need of additional response assistance may include those who have disabilities; who live in institutionalized settings; who are elderly; who are children; who are from diverse cultures; who have limited English proficiency; who are non-English speaking; or who are transportation disadvantaged (U.S. Department of Health and Human Services definition).

B

Backup Point of dispensing (POD)

Secondary site for POD medical countermeasures.

BioWatch Actionable Result (BAR)

One or more polymerase chain reaction (PCR)-verified positive result(s) from a BioWatch collector that meets the algorithm for one or more specific BioWatch agents. A BAR is one piece of information provided to federal, state, and local decision-makers as they review findings from other collectors and additional relevant information to determine the cause of the BAR and whether there is a public health risk.

C

Category A, B and C agents

Three categories of biological pathogens. Category A agents are high priority organisms and toxins posing the greatest threat to public health. This category of agents causes the highest morbidity and mortality with a likelihood of subsequent public panic. Category B agents are fairly easy to disperse but have lower morbidity and mortality than Category A agents. Category C agents are emerging infectious organisms that could become easily available in the future and used as a weapon.

- Category A agents include anthrax, botulism, plague, smallpox Tularemia, viral hemorrhagic fevers (e.g., Ebola).
- Category B agents included food safety threats (e.g., E. coli, Salmonella), Ricin toxin, staphylococcal enterotoxin B.
- Category C agents include hendra virus encephalitis, hantavirus pulmonary syndrome.

CBRNE

An acronym for a chemical, biological, radiological, nuclear, or explosive threat.

Centralized governance

A health governance structure where the state retains authority over local health units and most decisions related to the budget, issuing public health orders, and the selection of the local health official.

Chain of Custody

Tracking of possession of and responsibility for medical materiel during the distribution process.

Cities Readiness Initiative (CRI)

A CDC-funded program designed to enhance preparedness in the nation's largest population centers, where nearly 60% of the population resides, to respond successfully to large public health emergencies needing life-saving medications and medical supplies.

Closed point of dispensing (closed POD or CPOD)

A point of dispensing site that serves a defined population and is not open to the general public.

Command staff or incident management (IM) lead roles

Refers to the command staff (incident commander, public information officer, safety officer, liaison officer) required to support the command function in an incident as well as general staff (operations section chief, planning section chief, logistics section chief, and finance/administration section chief), or their equivalent titles or roles, in an jurisdictional health department. The level of complexity and characteristics of an incident will direct the activation of certain IM lead roles. Not all lead roles will be activated for a given response. Moreover, in certain scenarios, individual staff members may cover more than one IM role at a time. Finally, it is possible that an agency may include additional personnel in key IM lead roles (e.g., chief science officer, chief medical officer).

Common operating picture

A continuously updated overview of an incident compiled throughout the incident's life cycle; includes data shared between integrated systems for communication, information management, and intelligence, and information sharing. The common operating picture facilitates collaborative planning and assists achieving situational awareness across all engaged entities.

Community-based agencies

Refers to any organization or entity that is primarily based in the community (i.e., American Red Cross, home health).

Community outreach information network (COIN)

A grassroots network of people and trusted leaders who can help with emergency response planning and delivering information to at-risk populations in emergencies.

Community preparedness (Public Health Preparedness Capability 1)

The ability of a community to prepare for, withstand, and recover from public health incidents in both the short and long terms.

Continuity of operations plan (COOP)

Describes the efforts of an agency to ensure that their primary mission essential functions (PMEFs) can be continued throughout, or resumed rapidly after, a disruption of normal activities during a wide range of emergencies, including localized acts of nature, accidents, and technological or man-made emergencies.

Core staff

The minimum number of staff that can be used at a facility and still meet the required operational objectives.

Critical infrastructure

Assets, systems, and networks, whether physical or virtual, so vital to the United States that the incapacitation or destruction of such assets, systems, or networks would have a debilitating impact on security, national economic security, national public health or safety, or any combination of those matters.

Critical infrastructure personnel

Staff required to maintain assets, systems, and networks, whether physical or virtual, so vital to the United States that the incapacitation or destruction of such assets, systems, or networks would have a debilitating impact on security, national economic security, national public health or safety, or any combination of those matters.

Crossdocking

A warehouse term for the transfer of goods from an inbound carrier (truck, railroad car, etc.) to an outbound carrier without the goods or products being stored in the warehouse.

D

DEA registrant

A practitioner (e.g., physician, dentist, veterinarian, scientific investigator, pharmacy, hospital, or other person) licensed, registered, or otherwise permitted, by the United States or the jurisdiction in which he practices or does research, to distribute, dispense, conduct research with respect to, administer, or use in teaching or chemical analysis, a controlled substance in the course of professional practice or research. All registrants are required by the Controlled Substance Act (CSA) to maintain complete and accurate inventories and records of all regulated transactions involving controlled substances and listed chemicals, as well as provide adequate security controls to prevent their diversion.

Decentralized governance

Refers to a health governance structure in which local health units are primarily governed by local authority (also known as home rule).

Delivery schedule

The estimated time to deliver medical materiel to final destination, including estimates for third-party involvement.

Demobilize

Release and return of resources that are no longer required for the support of an incident.

Department operations center (DOC)

The public health emergency operation center that gathers information and shares information with the state operation center (SOC). This is most likely the emergency operations center (EOC) for the agency that serves as the ESF-8 lead.

Deploy

The movement of assets, including personnel, to a specific area.

Designated official

Individuals in the health department who have the authority to take appropriate action on behalf of the agency (e.g., decide to activate incident management roles).

Devolution

The capability to transfer statutory authority and responsibility for essential functions from an organization's primary operating staff and facilities to other organization employees and facilities and to sustain that operational capability for an extended period.

Discussion-Based Exercises

Discussion-based exercises include seminars, workshops, tabletop exercises (TTXs), and games. These types of exercises can be used to familiarize players with, or develop new, plans, policies, agreements, and procedures. Discussion-based exercises focus on strategic, policy-oriented issues. Facilitators and/or presenters usually lead the discussion, keeping participants on track towards meeting exercise objectives.

Dispensing modalities

The strategies or methods that a jurisdiction uses to provide the countermeasures (e.g., POD locations, drive-through pick-up locations, providing medications to private businesses).

Distribution assets

The resources (personnel, equipment, supplies, technology, etc.) needed to transport medical countermeasures materiel during a public health emergency or disaster.

Distribution planning

A systematic process for determining which goods, in what quantity, at which location, and when are required in meeting anticipated demand.

Drill

A coordinated, supervised activity usually employed to validate a specific operation or function in a single agency or organization. Drills can used to provide training on new equipment, develop, or validate new policies or procedures, or practice and maintain current skills.

Durable medical equipment

Equipment that can withstand repeated use, provides therapeutic benefits to a patient in need because of certain medical conditions or illnesses, and can be recovered after an emergency (e.g., ventilators).

E

Economically disadvantaged

Individuals who fall below the poverty level or would not have the financial means to get to a POD during a public health emergency requiring dispensing or administration of medical countermeasures.

Element

An essential part or aspect of each function within a public health preparedness capability.

Emergency

An occurrence that may cause adverse physical, social, psychological, economic or political effects that challenge a jurisdiction's ability to respond rapidly and effectively.

Emergency management

Federal, state, local, and nongovernmental organizations in the area of emergency management, homeland security, and first responders. Examples include the local emergency management agency, relevant tribal entities involved in emergency services or emergency management, the state emergency management agency, federal entities such as Federal Emergency Management Agency (FEMA) and other components of the U.S. Department of Homeland Security, the Medical Reserve Corps (MRC), Citizen Corps groups, Community Emergency Response Teams (CERTs), and others. This sector also includes traditional first responder groups including fire, police, and emergency medical services, as well as local public works agencies and nonprofit utility companies (e.g., city/county utilities, energy, water, and sanitation), and tribal utility authorities that may respond to an incident and/or provide services critical for an effective response.

Leaders from this sector may include emergency managers or their deputies; chiefs and assistant chiefs for divisions such as special operations, hazardous materials and fire suppression; state police, city police, and county sheriffs involved in large planning events; special weapons and tactics supervisors; directors and supervisors of emergency medical services; and senior public works administrators. Please note that to the extent that this sector covers public safety (e.g., police and sheriffs) it implies engagement to ensure incarcerated individuals are appropriately included in relevant public health preparedness efforts.

Emergency management agency (EMA)

A jurisdictional agency that has the responsibility for an emergency management program (EMP). The agency typically has responsibility to ensure the overall preparation, implementation, evaluation, etc. of the program during a disaster.

Emergency Management Assistance Compact (EMAC)

A congressionally ratified organization that provides form and structure to interstate mutual aid. Through EMAC, a disaster-impacted state can request and receive assistance from other member states quickly and efficiently, resolving two key issues: liability and reimbursement.

Emergency operations center (EOC)

The physical location at which the coordination of information and resources to support incident management (on-scene operations) activities normally takes place. An EOC may be a temporary facility or may be located in a more central or permanently established facility, perhaps at a higher level of organization within a jurisdiction. EOCs may be organized by major functional disciplines (e.g., fire, law enforcement, medical services, public health), by jurisdiction (e.g., federal, state, regional, tribal, city, county), or by some combination thereof.

Emergency operations coordination (Public Health Preparedness Capability 3)

The ability to direct and support an event or incident with public health or medical implications by establishing a standardized, scalable system of oversight, organization, and supervision consistent with jurisdictional standards and practices with the National Incident Management System (NIMS).

Emergency operation plan (EOP)

The response plan that an entity (organization, jurisdiction, state, etc.) maintains that describes intended response to any emergency. It provides action guidance for management and emergency response personnel during the response phase.

Emergency public information and warning (Public Health Preparedness Capability 4)

The ability to develop, coordinate, and disseminate information, alerts, warnings, and notification to the public and incident management responders.

Emergency Support Function #8 (ESF-8) – Public Health and Medical Services Annex

Provides the mechanism for coordinated federal assistance to supplement state, tribal, and local resources in response to:

- Public health and medical care needs
- Veterinary and/or animal health issues in coordination with the U.S. Department of Agriculture (USDA)
- Potential or actual incidents of national significance
- A developing potential health and medical situation

Essential elements of information (EEI)

Discrete types of reportable public health or healthcare-related, incident-specific knowledge communicated or received concerning a particular fact or circumstance, preferably reported in a standardized manner or format, which assists in generating situational awareness for decision-making purposes. EEI are often coordinated and agreed upon before an incident (and communicated to local partners) as part of information collection request templates and emergency response playbooks.

Event

A planned, non-emergency activity (e.g., concerts, conventions, parades, sporting events).

F

Facility setup

Ability to quickly set up materiel and spatial layouts.

Fire suppression system

Uses a combination of dry chemicals and/or wet agents to suppress equipment fires.

Formal written agreements

A document between two or more parties that contains specific binding obligations or expectations that each involved party must attain. Examples of formal written agreements include the following:

- Contracts
- EOPs and annexes that describe roles and responsibilities of jurisdictional agencies
- Letters of agreement
- Memoranda of agreement (MOA)
- Memoranda of understanding (MOU)
- Mutual aid agreements
- Any other official document which describes the role of public health and carries with it an expectation that public health will undertake certain fatality management-related activities.

Full notification

Site and staff are told beforehand the time and place of the activity.

Full-scale exercises (FSEs)

FSEs are typically the most complex and resource-intensive type of exercise. They involve multiple agencies, organizations, and jurisdictions and validate many facets of preparedness. FSEs often include many players operating under cooperative systems such as the Incident Command System (ICS) or Unified Command.

In an FSE, events are projected through an exercise scenario with event updates that drive activity at the operational level. FSEs are usually conducted in a real-time, stressful environment that is intended to mirror a real incident. Personnel and resources may be mobilized and deployed to the scene, where actions are performed as if a real incident had occurred. The FSE simulates reality by presenting complex and realistic problems that require critical thinking, rapid problem solving, and effective responses by trained personnel.

Function

The critical element that needs to occur to achieve the capability.

Functional exercises (FEs)

FEs are designed to validate and evaluate capabilities, multiple functions and/or sub-functions, or interdependent groups of functions. FEs are typically focused on exercising plans, policies, procedures, and staff members involved in management, direction, command, and control functions. In FEs, events are projected through an exercise scenario with event updates that drive activity typically at the management level. An FE is conducted in a realistic, real-time environment; however, movement of personnel and equipment is usually simulated.

FE controllers typically use a Master Scenario Events List (MSEL) to ensure participant activity remains within predefined boundaries and ensure exercise objectives are accomplished. Simulators in a Simulation Cell (SimCell) can inject scenario elements to simulate real events.

Functional needs

Defined as communication, medical, independence, supervisory, and transportation needs of at-risk individuals.

G

Games

A game is a simulation of operations that often involves two or more teams, usually in a competitive environment, using rules, data, and procedures designed to depict an actual or hypothetical situation. Games explore the consequences of player decisions and actions. They are useful tools for validating plans and procedures or evaluating resource requirements.

H

Hazard vulnerability analyses (HVA)

A process to identify hazards and associated risks to persons, property, and structures and to improve protection from natural and human-caused hazards.

Head of household (HoH)

A dispensing modality where one person is permitted to pick up medications for other members of their household or other households, allowing jurisdictions to decrease the number of people who are anticipated to come in person to a POD locations. Use of this method allows for rapid dispensing because one person can obtain medical countermeasures for as many as the jurisdiction allows. For example, Mr. Doe picks up eight regimens of medical countermeasures (one regimen for Joe and seven other regimens, one for his spouse, four for his children, and two for his parents).

Health Alert Network (HAN)

A primary method of sharing cleared information about urgent public health incidents with public information officers; federal, state, territorial, and local public health practitioners; clinicians; and public health laboratories.

Healthcare Preparedness Program (HPP) cooperative agreement

Administered by the HHS Office of the Assistant Secretary for Preparedness and Response, the HPP cooperative agreement provides funding and guidance to assist the healthcare sector in preparing for, responding to, and recovering from adverse health effect of emergencies and disasters enabling the health care delivery system to save lives.

Homeland Security Exercise and Evaluation Program (HSEEP)

The Homeland Security Exercise and Evaluation Program (HSEEP) provides a set of guiding principles for exercise programs, as well as a common approach to exercise program management, design and development, conduct, evaluation, and improvement planning. Exercises are a key component of national preparedness—they provide elected and appointed officials and stakeholders from across the whole community with the opportunity to shape planning, assess and validate capabilities, and address areas for improvement.

Human impact

Refers to indicators such as number of fatalities resulting from a particular hazard, injuries requiring emergency medical services transport, outpatient injuries, hospital emergency department visits due to injuries, etc.

Hybrid point of dispensing (hybrid POD)

Refers to a POD that combines medical and nonmedical models.

Hygiene

Behaviors that can improve cleanliness and lead to good health, such as frequent hand washing, face washing, and bathing with soap and water.

I

Immediate

An expectation of performance with no delay. There is an expectation that upon notification, pre-identified staff are to report for duty within the amount of time identified by the jurisdiction.

Improvement plan

A compilation of corrective actions and timelines that convert the AAR recommendations into specific, measurable steps that will result in improved preparedness. The complete IP is included in the final AAR/IP as a table that summarizes next steps. Participating organizations and agencies will use it to execute improvement planning.

Improvement planning

During improvement planning, the corrective actions identified during individual exercises are tracked to completion, ensuring that exercises yield tangible preparedness improvements. An effective corrective action program develops IPs that are dynamic documents, which are continually monitored and implemented as part of the larger system of improving preparedness.

Incident

An occurrence either human caused or by natural phenomena, that requires action to prevent or minimize loss of life or damage to property and/or natural resources.

Information sharing (Public Health Preparedness Capability 6)

The ability to conduct multijurisdictional, multidisciplinary exchange of health-related information and situational awareness data including public health alerts among federal, state, local, territorial, and tribal levels of government, and the private sector.

Interagency agreement (IAA)

A written agreement entered into between two agencies, which specifies the goods and services to be furnished or tasks to be accomplished by one agency (servicing agency) in support of the other (requesting agency). The length and contents of the agreement will depend on the complexity of the services, supplies and/or equipment to be provided and the conditions under which they are provided.

Intergovernmental agreement (IGA)

An arrangement as to a course of action existing or occurring between two or more governments or levels of government.

Intermediary/intermediate distribution sites

Refers to any facility between the initial receiving site and the final delivery location where medical countermeasures are dispensed to the public. These sites could include but are not limited to regional distribution sites (RDS), local distribution sites (LDS), or any other facility noted in the jurisdiction's planning documents.

Inventory Management and Tracking System (IMATS)

A CDC IT platform developed with input from state and local jurisdictions that allows public health agencies to track medical countermeasure inventory down to the local level during an event; monitor reorder thresholds; and support warehouse operations, including receiving, staging, and storing inventory. IMATS also supports data exchange and allows state public health agencies to collect inventory totals from local jurisdictions, aggregate the data, and report to CDC. CDC also allows public health jurisdictions using inventory systems other than IMATS to electronically report data to CDC. IMATS supports synchronizing data from offline deployments.

Inventory management system

A database or software application developed to manage information regarding medical and nonmedical countermeasures.

I

Jurisdictions

Planning areas (e.g., directly funded localities, states, territories, and freely associated states).

Jurisdictional risk assessment (JRA)

A process of assessing the potential loss or disruption of essential services such as clean water, sanitation, or the interruption of healthcare services, public health agency infrastructure within a specified community.

K

Key community partners

An entity, group, agency, club, business, professional association, or individual service provider that public health deems critical, typically according to one or more of the following criteria.

- The entity is expected to provide health or human services (e.g., food, shelter/housing, social services, and mental/behavioral health services) to vulnerable or at-risk populations in the context of a significant disaster or public health emergency.
- The entity is an essential vehicle for community outreach, information dissemination, or similar communications with vulnerable and hard-to-reach populations, as well as the general public, during response or recovery following an incident. Such key organizations may fit within one or more of the 11 community sectors (e.g., the media, community leaders, cultural and faith-based organizations, businesses).
- The entity is or would be an essential primary partner in a jurisdictional disaster or public health emergency response in terms of emergency operations, resource sharing, provision of goods or services, or surge capacity.
- Representation in the Incident Management Structure (e.g., the emergency operations center) or other type of formal integration into an LHD's response to a public health emergency.

Key community partners are often characterized as:

- Having a significant footprint or service area in a community (e.g., hospitals, television/radio stations, food banks, or the local emergency management agency)
- High-volume or throughput in terms of goods or services provided (e.g., high-volume food providers and distributors [businesses]; low-income or publicly funded housing organizations; or shelters)
- Serving hard-to-reach, vulnerable, or at-risk populations (e.g., multi-service community- or faith-based organizations)

- Historically significant institutions, or key figures/icons, within a community, often with significant influence within one or more cultural or affinity groups (e.g., community leaders and cultural and faith-based organizations)
- Providers of narrow or unique, but critical, services to the community (e.g., media outlets, hospitals)

L

Local partners

Local partners are entities or organizations that plan and respond together.

M

Materiel

The equipment, apparatus, or supplies necessary to successfully distribute or dispense medical countermeasures during a public health emergency.

Medical countermeasures (MCM)

Life-saving medicines and medical supplies regulated by the U.S. Food and Drug Administration (FDA) that are used to diagnose, prevent, protect from, or treat conditions associated with CBRNE threats, emerging infectious diseases, or natural disasters. MCMs can include biologic products such as vaccines, blood products, and antibodies; drugs such as antimicrobial or antiviral drugs; devices such as diagnostic tests to identify threat agents, and personal protective equipment (PPE) such as gloves, respirators (face masks), and ventilators.

Medical countermeasure dispensing (Public Health Preparedness Capability 8)

The ability to provide MCMs (including vaccines, antiviral drugs, antibiotics, antitoxin, etc.) in support of treatment or prophylaxis(oral or vaccination) to the identified population in accordance with public health guidelines and/or recommendations.

Medical countermeasure incident

A public health emergency or event that requires rapid deployment of medical countermeasures to mitigate morbidity and or mortality.

Medical materiel management and distribution (Public Health Preparedness Capability 9)

The ability to acquire, maintain (e.g., cold chain storage or other storage protocol), transport, distribute, and track medical materiel during an incident and to recover and account for unused medical materiel, as necessary, after an incident.

Medical model (clinical) POD

A type of dispensing model in which each person receives a personalized medical assessment and education prior to the dispensing or administration of MCMs; the medical model makes several assumptions for dispensing operations, including:

- Each individual is unique; therefore, MCMs are provided on a personalized medical evaluation, even if only of two MCM options are available;
- Constraints may exist for the type of medical staff who can dispense;
- No time constraints exist for conducting medical evaluations or providing MCMs; and
- All medical professionals have the necessary training and licensures to provide medical care based on current, best medical practices

Medical Reserve Corps (MRC)

A national network of local groups of volunteers engaging local communities to strengthen public health, reduce vulnerability, build resilience, and improve preparedness, response, and recovery capabilities.

Mental and behavioral health

An overarching term to encompass behavioral, psychosocial, substance abuse, and psychological health.

Metropolitan Statistical Area (MSA)

An area containing a large population nucleus and adjacent communities that have a high degree of integration with that nucleus. The Office of Management and Budget (OMB) establishes and maintains MSAs solely for statistical purposes. The classification provides a nationally consistent set of delineations for collecting, tabulating, and publishing federal statistics for geographic areas.

Military installations

Facilities (including leased) under the jurisdiction of the Department of Defense including bases, camps, posts, stations, yards, centers, ports, or etc.

Memorandum of Agreement (MOA)

A document describing in detail the specific responsibilities of, and actions to be taken by, each of the parties so that their goals may be accomplished.

Memorandum of Understanding (MOU)

A document that describes a very broad concept of mutual understanding, goals, and plans shared by the parties.

N

National Incident Management System (NIMS)

A systematic, proactive approach to guide departments and agencies at all levels of government, nongovernmental organizations, and the private sector to work together seamlessly and manage incidents involving all threats and hazards—regardless of cause, size, location, or complexity—to reduce loss of life, property, and harm to the environment

No notification (none)

Neither site nor staff is informed beforehand of the time nor place of the activity.

0

Office of Public Health Preparedness and Response (OPHPR)

CDC's office that has primary oversight and responsibility for all programs that comprise CDC's public health preparedness and response portfolio.

Online Technical Resource and Assistance Center (On-TRAC)

A CDC IT system that provides state and local public health departments with a secure, user-friendly platform for requesting technical assistance and accessing tools and resources.

Open point of dispensing (open POD)

A dispensing site that serves the general public and does not have restrictions on who has access to the site; these PODs are open to everyone including residents, visitors, commuters, or anyone else in the affected area during an incident.

Operations-based exercises

Operations-based exercises include drills, functional exercises (FEs), and full-scale exercises (FSEs). These exercises can be used to validate plans, policies, agreements, and procedures; clarify roles and responsibilities; and identify resource gaps. Operations-based exercises are characterized by actual reaction to an exercise scenario, such as initiating communications or mobilizing personnel and resources.

Operational plans

Describe roles and responsibilities, tasks, integration, and actions required of a jurisdiction or its departments and agencies during emergencies. Jurisdictions use plans to provide the goals, roles, and responsibilities that a jurisdiction's departments and agencies are assigned, and to focus on coordinating and integrating the activities of the many response and support organizations within a jurisdiction. They also consider private sector planning efforts as an integral part of community-based planning for ensuring efficient allocation of resources. Department and agency plans do the same thing for the internal elements of those organizations. Operational plans tend to focus more on the broader physical, spatial, and time-related dimensions of an operation; thus, they tend to be more complex and comprehensive, yet less defined, than tactical plans.

Operational readiness

The capability of a jurisdiction to execute their medical countermeasure distribution and dispensing plans during a public health response.

Order of succession

Provisions to delegate authority to a representative at the time of an incident when the legal authority is unable to conduct their duties.

P

Partial notification

Site and/or staff are informed beforehand an activity will occur during a certain time but do not know the exact time or location of the activity.

Personal protective behaviors

Personal behaviors to prevent the transmission of infection, such as coughing into your elbow, cover sneezing, hand washing, keeping your hands away from your face.

Planning jurisdiction

Defined geographic area that develops a planning strategy. For example, several counties may form a regional planning jurisdiction.

Point of dispensing (POD)

A facility where medical countermeasures are dispensed or administered during a public health emergency requiring the use of medical countermeasures.

Pre-identified staff

Personnel who are rostered and trained to fulfill specific roles in an incident. Contact information for public health staff with incident management roles should be maintained and updated frequently.

Pre-incident recovery planning (jurisdictional or community)

Disaster recovery planning describes the establishment of processes and protocols, prior to a disaster, for coordinated post-disaster recovery planning and implementation through engagement between public health and key partners and sectors, including emergency management, healthcare providers, community leaders, media, businesses, service providers for at-risk populations, and more. (Definition adapted from the National Disaster Recovery Framework)

Preparedness

Actions that involve a combination of planning, resources, training, exercising, and organizing to build, sustain, and improve operational capabilities. Preparedness is the process of identifying the personnel, training, and equipment needed for a wide range of potential incidents and developing jurisdiction-specific plans for delivering capabilities.

Primary point of dispensing (primary POD)

The facility designated as the one to open first to issue medical countermeasures during a public health emergency.

Promising Practices

Peer-validated techniques, procedures, and solutions that prove successful and are solidly grounded in actual experience in operation, training, and exercises.

Promulgated plan

A plan that is officially announced, published, or made known to the public.

Public health emergency

An occurrence or imminent threat of an illness or health condition, caused by bioterrorism, epidemic or pandemic disease, or (a) novel and highly fatal infectious agent or biological toxin, that poses a substantial risk of a significant number of human fatalities or incidents or permanent or long-term disability.

Public Health Emergency Preparedness (PHEP) cooperative agreement

A critical source of funding for state, local, and territorial public health departments. Since 2002, the PHEP cooperative agreement has provided funding to public health departments across the nation. This funding helps health departments build and strengthen their abilities to successfully respond to a range of public health threats, including infectious diseases, natural disasters, and biological, chemical, nuclear, and radiological threats. Preparedness activities funded by the PHEP cooperative agreement are specifically for the development of emergency-ready public health departments that are flexible and adaptable.

Public health preparedness capabilities

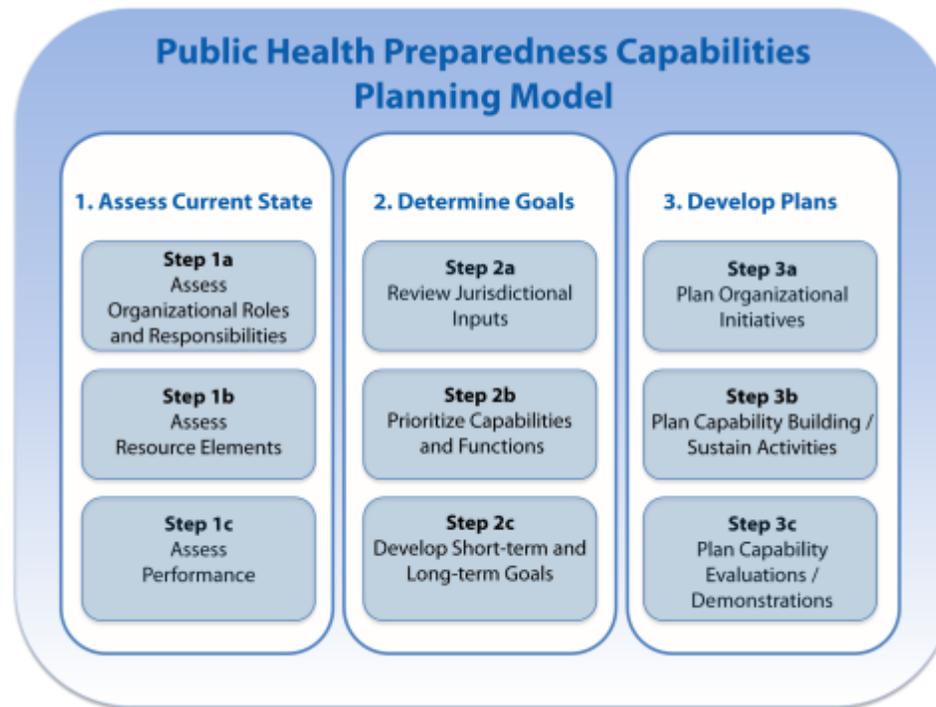
Each of the 15 capabilities includes a definition of the capability and list of the associated functions, tasks, and resource considerations

- The **capability definition** defines the capability as it applies to state, local, tribal, and territorial public health
- The **function** describes the critical elements that need to occur to achieve the capability
- The **task** describes the steps that need to occur to complete the functions
- The **resource elements** section lists the resources a jurisdiction needs to have or have access to (an arrangement with a partner organization, a memorandum of understanding or agreement, equipment, etc.) to successfully perform a function and the associated tasks. Note: CDC also defines some elements as “priority.” Priority elements are considered the most critical of the resources element and a “minimum standards” for state and local preparedness. The remaining resource elements are recommended or suggested activities for considerations by jurisdictions

- The CDC categorizes the resources into three categories:
 - **Planning:** Elements that should be included in existing operational plans, standard operating procedures and/or emergency operations plans. This may include language on suggested legal authorities and at-risk populations
 - **Skills and Training:** the baseline competences and skills necessary for personnel and teams to possess to competently deliver a capability
 - **Equipment and Technology:** The equipment that a jurisdiction should have in their possession (or have access to), and the equipment should be in sufficient quantities to adequately achieve the capability within the jurisdiction

Public health preparedness capabilities planning model

A tool developed by CDC to assist jurisdictions in using the capabilities for planning. The model describes a high level planning process that the state and local public health departments may wish to follow to help determine their preparedness priorities and plan their preparedness activities. The model is not to be a prescriptive methodology but a series of suggested activities for preparedness planning. The diagram below depicts the model’s three main phases and associated steps. Note: the planning model fits into the planning phase of the U.S. Department of Homeland Security Preparedness Cycle.



Public health system

Defined as executing the core functions of public health agencies at all levels of government.

Public information officer

The individual responsible for interfacing with the public, media, other agencies, and stakeholders to provide incident-related information, and updates based on changes in the status of the incident or planned event.

Q

Quarterly

Regular intervals every three months, four times a year.

R

Rapid dispensing model (or nonmedical model)

Refers to a modification of the medical model of dispensing that increases the dispensing throughput. For example, persons might receive a less comprehensive screening form; steps in the dispensing process might be combined or eliminated; head of household might be allowed to pick up MCM regimens for others; trained nonmedical personnel may dispense MCMs under limited supervision from licensed medical professionals.

Receipt, stage, and store (RSS) facility

Acts as the hub of the distribution system of the state or jurisdiction to which Strategic National Stockpile (SNS) assets are deployed.

Regimens per hour (RPH)

The regimens (or courses) of medical countermeasures issued within a certain period of time. For example, regimen per hour is the number of unit regimens (or courses) of medical countermeasure issued within 60 minutes. This is not to be confused with throughput, which focuses on the number of people served at the POD within a certain time people.

Regional distribution site (RDS)/local distribution site (LDS)

A site or facility selected to receive MCMs from the RSS facility for further breakdown and distribution to determined dispensing sites, such as PODs.

Request

A request is a formal application to ask for a specific asset needed in the time of an emergency or incident.

Requested timeframe

Requested timeframe is a defined period of time for receiving requested EEI (e.g., operational period, set time to meet special request, e.g., 1,500 hours).

Resources

Personnel and major assets available for assignment to incident operations.

Responsible entity or entities

A responsible entity or entities refers to an organization at the awardee or sub-awardee level that is accountable for completing the specific activity or performance element associated with one or more PHEP performance measures.

- *Recipient entities* typically include the recipient's central office and, in some states, regional or district (state-operated) offices.
- *Subrecipient entities* usually refer to autonomous regional, district, or local health departments (LHDs). Occasionally this may also refer to local boards of health, coalitions, or other types of organizations.

Responder

Any individual responding to the public health task or mission, dependent on the jurisdiction.

Responder safety and health (Public Health Preparedness Capability 14)

The ability to protect public health agency staff responding to an incident and the ability to support the health and safety needs of hospital and medical facility or other critical stakeholders, if requested.

Response

Immediate actions to save lives, protect property and the environment, and meet basic human needs. Response also includes the execution of emergency plans and actions to support recovery.

S

Scalability

The ability to expand or decrease operations as dictated by the needs of the response.

Seminars

Seminars generally orient participants to, or provide an overview of, authorities, strategies, plans, policies, procedures, protocols, resources, concepts, and ideas. As a discussion-based exercise, seminars can be valuable for entities that are developing or making major changes to existing plans or procedures. Seminars can be similarly helpful when attempting to assess or gain awareness of the capabilities of interagency or inter-jurisdictional operations.

Site activation

The ability to contact and ensure that facilities are available for emergency response functions.

Site availability

The capacity for a facility to be ready to be turned over to the health department to begin their setup operations after receiving the notification for site activation.

Situational awareness

Capturing, analyzing, and interpreting data to inform decision making in a continuous and timely cycle. National health security calls for both routine and incident-related situational awareness. Situational awareness requires not only coordinated information collection to create a common operating picture (COP), but also the ability to process, interpret, and act upon this information. Action, in turn, involves making sense of available information to inform current decisions and making projections about likely future developments. Situational awareness helps identify resource gaps, with the goal of matching available and identifying additional resources to current needs. Ongoing situational awareness provides the foundation for successful detection and mitigation of emerging threats, better use of resources, and better outcomes for the population.

Social connections

Refers to personal (family, friends, neighbors, etc.) and professional (service providers, community leaders, etc.) relationships among community residents.

Staff assembly

The ability of staff to report to their assigned stations in a timely manner. Staff assembly can occur at a physical location (e.g., department or emergency operations center), virtually (e.g., through a web-based interface such as WebEOC), or a combination of both.

Staff notification

The ability to contact and mobilize staff to perform emergency response functions.

Standard operating procedure (SOP)

SOPs or operating manuals are complete reference documents that detail the procedures for performing a single function or a number of interdependent functions. Collectively, practitioners refer to both documents as SOPs. SOPs often describe processes that evolved institutionally over the years or document common practices so that institutional experience is not lost to the organization because of staff turnover. Sometimes they are task specific (e.g., how to activate a siren system or issue an emergency alert system message).

State health official (SHO)

An appointed senior official who plays a critical role in emergency preparedness and response, including making strategic and tactical decisions and communicating with key partners. Visit <http://www.astho.org/Directory/> for a list of state or territorial health officials.

Strategic National Stockpile (SNS)

The nation's supply of medical countermeasures for use in a public health emergency severe enough to exhaust local resources.

Strategic plans

Describe jurisdiction wants to meet its emergency management or homeland security responsibilities over the long-term. These plans are driven by policy from senior officials and establish planning priorities.

Subject matter expert (SME)

An individual recognized as having expert knowledge about and specialized experience in a subject area.

T

Tabletop exercise (TTX)

An exercise typically held in an informal setting intended to generate discussion of various issues regarding a hypothetical, simulate emergency. TTXs can be used to enhance general awareness, validate plans and procedures, rehearse concepts, or types of systems needed to guide the prevention of, protection from, mitigation of, response to, and recovery from a defined incident.

Technical assistance

Advice, assistance, or training pertaining to program development, implementation, maintenance, or evaluation provided by the funding agency.

Three tiers of planning: strategic, operational, tactical

Strategic planning sets the context and expectations for operational planning, while operational planning provides the framework for tactical planning. All three tiers of planning occur at all levels of government.

Third-party logistics (3PL)

A company that works with shippers to manage their logistics.

Threat and Hazard Identification and Risk Assessment (THIRA)

A four-step common risk assessment process that helps the whole community (i.e., individuals, business, faith-based organizations, nonprofit groups, schools, academia, and all levels of government) understand its risks and estimate capability requirements.

Threats

Three category types:

- *Natural threats* such as floods, tornadoes, earthquakes, hurricanes, ice storms, etc.
- *Technical/man-made threats* such as radiological, chemical, biological, mechanical, electrical, etc.
- *Intentional acts* such as terrorism, demonstrations, bomb threats, assaults, theft, computer security

Throughput

The number of people receiving medical countermeasures at a point of dispensing (POD) during a certain period of time. For example, if 6,000 people visit a POD over a 12-hour operational period, then the throughput is 6,000 persons/12 hours = 500 people/hour. This is not to be confused with the term regimen, which is defined as the medical countermeasures issued during a certain period of time.

Tiered approach

A systematic and flexible strategy to ensure the entire population is served through POD models that are implemented according to the individual needs of the jurisdiction or community.

Training and Exercise Planning Workshop (TEPW)

The TEPW establishes the strategy and structure for an exercise program. In addition, it sets the foundation for the planning, conduct, and evaluation of individual exercises. The purpose of the TEPW is to use the guidance provided by elected and appointed officials to identify and set exercise program priorities and develop a multi-year schedule of exercise events and supporting training activities to meet those priorities. This process ensures whole community exercise initiatives are coordinated, prevents duplication of effort, promotes the efficient use of resources, avoids overextending key agencies and personnel, and maximizes the efficacy of training and exercise appropriations. TEPWs are held on a periodic basis (e.g., annual or biennial) depending on the needs of the program and any grant or cooperative agreement requirements.

V

Vendor

An agency or organization that will complete the function or provide service.

Virtual assembly

The use of teleconference and/or Internet-based technology to convene two or more individuals in a real-time exchange of information/ideas/thoughts, etc., to facilitate efficient decision-making. This can include, but is not limited to, teleconferencing, Web-based meetings, and other types of online interactive systems and technologies in which voice and/or visual exchange of information is present. Virtual assembly does not include an active email exchange with all parties or other types of time-delayed communications that do not allow for an immediate feedback/response discussion.

Virtual Initiatives Program

A tabletop exercise (TTX), usually regional, that focuses on enhancing CDC technical assistance and MCM capabilities. The program is led by CDC's Office of Public Health Preparedness and Response, Division of Emergency Operations (OPHPR DEO).

Voice over Internet Protocol (VOIP)

A technology that makes voice calls using a broadband Internet connection instead of a regular (or analog) phone line.

Volunteer

Individuals or groups who donate time or efforts in support of the public health agency's response, including public health, medical and nonmedical personnel.

Volunteer Management (Public Health Preparedness Capability 15)

The ability to coordinate the identification, recruitment, registration, credential verification, training, and engagement of volunteers to support the jurisdictional public health agency's response to incidents of public health significance. Volunteer Management includes coordinating, notifying, dispatching, and demobilizing volunteers to support a public health agency's response to an incident of public health significance. Public health and medical volunteers enable the public health and healthcare systems to surge and meet the elevated needs of an event or incident and therefore coordinated management is crucial.

W

Workshops

Although similar to seminars, workshops differ in two important aspects: participant interaction is increased, and the focus is placed on achieving or building a product. Effective workshops entail the broadest attendance by relevant stakeholders.

Products produced from a workshop can include new standard operating procedures (SOPs), emergency operations plans, continuity of operations plans, or mutual aid agreements. To be effective, workshops should have clearly defined objectives, products, or goals, and should focus on a specific issue.

X

Y

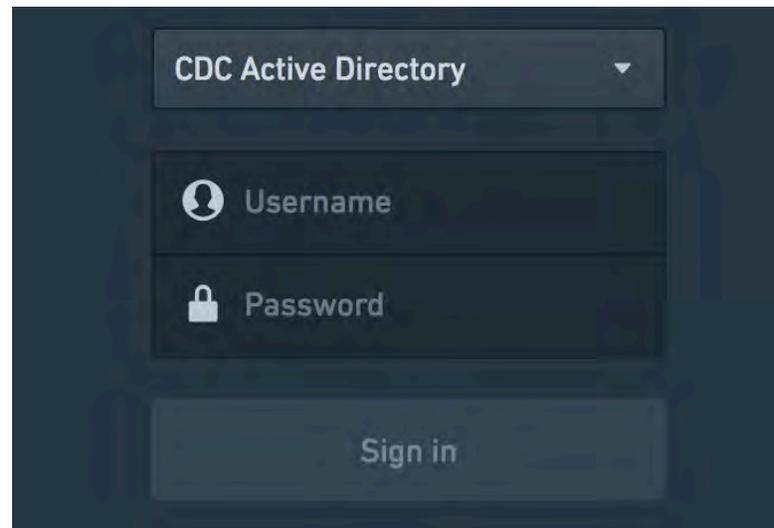
Z

APPENDIX C: ORR SYSTEM FREQUENTLY ASKED QUESTIONS

System Access

I am a CDC user; how do I log in?

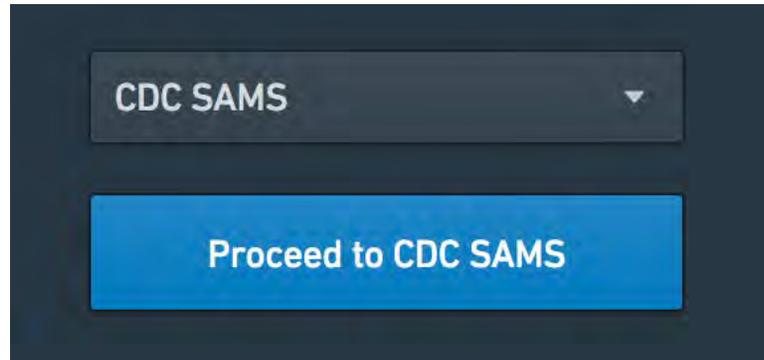
Go to <https://dcipher.cdc.gov>. Select the option “CDC Active Directory” from the drop down menu, and input your CDC user ID and password to access DCIPHER. Note that CDC employees must log in from within the CDC network, the VPN, or Citgo.



The screenshot shows a dark-themed login form. At the top, there is a dropdown menu with the text "CDC Active Directory" and a downward arrow. Below this are two input fields: the first is labeled "Username" with a person icon, and the second is labeled "Password" with a lock icon. At the bottom of the form is a large button labeled "Sign in".

I am a jurisdiction or CRI user; how do I log in?

Go to <https://dcipher.cdc.gov>. Select the option “CDC SAMS” from the drop down menu, and input your SAMS username and password/challenge phrase to access DCIPHER. For more information on SAMS please see the SAMS Access section.



When I log in, I do not see any “Activities” listed on the DCIPHER home page. Do I need to take additional action?

The first time you successfully log into DCIPHER, you will not see any activities listed for your account. This is because the system needs to match your account with the appropriate user permissions. If you log out and log back in to DCIPHER, the permissions updates will have taken place and you will be able to see a button labeled “ORR” on your screen. If you log out and log back in and still do not see any activity options, please contact dcipher-orr@cdc.gov.

SAMS Access

What is SAMS?

Secure Access Management Services (SAMS) is an external authentication system that allows public health partners to interact with CDC applications online behind a secure firewall.

How do I get my invitation to register with SAMS?

Invitations are created and sent by CDC’s program administrator (i.e., the DCIPHER administrator). You will receive an invitation e-mail from sams-no-reply@cdc.gov with the subject “U.S. Centers for Disease Control: SAMS Partner Portal – Invitation to Register”. The invitation will contain instructions on how to begin the SAMS registration process.

How do I get my SAMS user ID and password?

Your SAMS user name will always be your full e-mail address. During the SAMS registration process, you will be assigned a temporary password that you will be required to change during the creation of your SAMS profile.

How long will it be until I can access the DCIPHER ORR platform using SAMS?

The entire SAMS process – from registration to completion of processing – can take up to 1 month, so the DCIPHER team recommends starting this process

as soon as you receive the invitation e-mail.

I have an existing SAMS account. Do I need to take any additional action?

Contact your MCM specialist to inform them of your existing account and the associated contact information. You will not have to go through the SAMS identity proofing process again; however, you still need to be given access to the ORR platform through SAMS.

What if I have forgotten my SAMS user ID and/or password?

Click on the “Forgot SAMS Password?” [link](#) when you reach the SAMS login page. Then follow the prompts to reset your password; or contact the SAMS help desk at (877) 681-2901 or email samshelp@cdc.gov.

I have additional questions about SAMS. Where can I find more information?

For more information about the SAMS process, please reference the SAMS Frequently Asked Questions website, which can be found at <https://auth.cdc.gov/sams/samsfaq.html>.

Data Input

1. How do I edit the information in a form?

To edit a form, first select the form by clicking on the form name. Once highlighted, click “Edit” at the bottom of the form list (to input information or update responses). Note: You may only edit a form when it is in the “Open” review stage.



What does the fraction at the top of a form’s navigation panel represent? What are the numbers next to each sub-section when I’m editing a form?

The fraction at the top of the navigation panel represents the number of questions you have completed out of the total number of questions in the form. The denominator may change over the course of your time editing the form, as questions can be revealed/hidden due to input-triggered conditional display. The fractions next to each sub-section represent the number of questions complete within that particular section out of the total number of questions in that section.

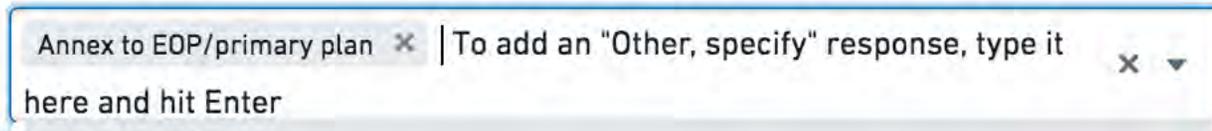


What do we do if a question is unclear?

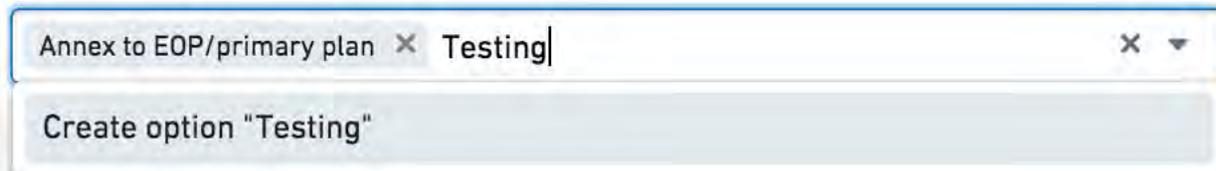
You can leave a comment for your reviewer on the question and they can provide additional information. Comments can be left for a reviewer in the review page of a form. If you are editing a form, you can access the review page by saving the form. If you want to access review page of a form directly from the home page, select the form and click "Review" at the bottom of the form list.

How do I provide an "other" response for a question?

For questions in which the response is chosen by using a dropdown menu, users may create their own response choice if one of the preset options does not suffice. A new option can be added by typing the additional response(s) into the answer field and pressing "Enter" to create the option. Note: There are some questions in which you will be forced to use a preset response. In this case, if you attempt to type in a custom response, the dropdown will say "No results found" and you will be unable to use with the custom text.

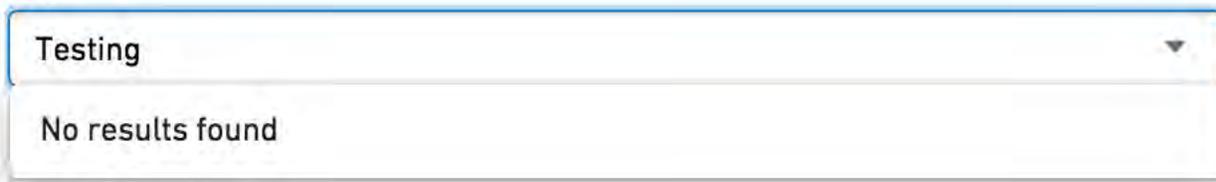


A screenshot of a dropdown menu. The top bar contains the text "Annex to EOP/primary plan" followed by a close icon (x) and a vertical separator line. To the right of the separator is the text "To add an 'Other, specify' response, type it" followed by a close icon (x) and a dropdown arrow (v). Below the top bar, the text "here and hit Enter" is visible.



A screenshot of a dropdown menu. The top bar contains the text "Annex to EOP/primary plan" followed by a close icon (x) and the text "Testing" followed by a close icon (x) and a dropdown arrow (v). Below the top bar, a light blue button with the text "Create option 'Testing'" is visible.

Note: There are some questions in which you will be forced to use a preset response. In this case, if you attempt to type in a custom response, the dropdown will say "No results found" and you will be unable to proceed with the custom text.

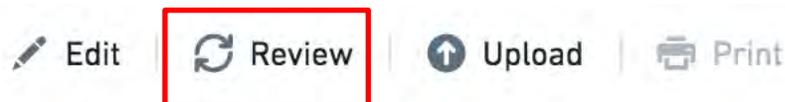


A screenshot of a dropdown menu. The top bar contains the text "Testing" followed by a dropdown arrow (v). Below the top bar, the text "No results found" is visible.

How do I upload an offline version of RSS Site Survey and/or POD Planning Form?

To upload the offline version of either of these forms, select the form name on your home page and then click "Upload". A small pop-up will appear and

prompt you to select the document from your local device and upload it. Note: If you try to upload anything other than the DCIPHER-provided offline form template, the data will not be loaded into the online system. This functionality will be available early in 2018.



How do I update a response from an offline form?

After uploading an offline form into the ORR platform, the data is saved into the online form as if you had input the data online. You will be able to update these responses from within the online platform. You may resubmit an offline form to update your responses; however, the data within the offline form will overwrite any existing data stored in the online system for that particular form.

How do I provide evidence for a question?

Each form has an associated page in which you can upload supporting documents or other files pertinent to your ORR review. This page, named “Supporting Documents”, can be accessed from the review page of a form.

How do I indicate the document/page numbers of evidence for a question?

The document/page number for evidence related to a question can be added on the review page of the form in a comment. If you are editing a form, you can access the review page by saving the form. If you want to access the review page of a form directly from the home page, select the form and click “Review” at the bottom of the form list.

Does the "History" page show comments from everyone in our local group?

The history page contains any saved edits to the form made by anyone with access to the form (i.e., anyone in the local group or the reviewer). Edits to the form include initial responses to a question, any response updates, and comments left on any particular response. All items in the history page are tagged with the date of the update, the user making the update and what the update was.

How do I know if a question is required?

The platform is set up in a way that it hides any question(s) your jurisdiction is not required to address. Therefore, if a question is displayed within a form, you should provide some sort of a response. While you are not forced to respond to every question in order to save, the platform will prevent you from submitting until you have addressed all required fields. A message will appear at the top of the review page to indicate which required fields were left blank.

How do I remove an additional vulnerable population, RSS site, or similar list item that I have accidentally added?

After creating the sub-form, click the “Done” button in the lower right hand corner of the sub-form. There will then be an “x” button on the right hand side of the list item that can be clicked to remove extraneous sub-form. Note: Clicking the “x” button next to a particular sub-form will delete it, regardless of the

content.

Vulnerable population stakeholders included in planning for the exercise	
Appears In	After-school programs such as community recreation centers
Evidence can be found	Annex to planning document MOUs/MOAs
Did this vulnerable population partner participate in or provide information for the current JRA/HVA?	No
Did this vulnerable population partner participate or provide input into planning for emergency information and warning for vulnerable populations they represent?	Yes

 Add

Data Review

How does submission work?

Forms will be submitted, reviewed, and acknowledged on a form-by-form basis. An ORR review is considered final when all required forms are marked acknowledged.

As a reviewer, how can I search for specific jurisdiction?

The Awardee Forms tab (accessible from the home page) allows a reviewer to view, search, and assess review stage for all the forms assigned to a given jurisdiction.



Is there an option for bulk approvals/approval status change?

Most forms do allow an overall form approval versus approval of individual questions. Those forms that require individual question approvals are Distribution Planning and Dispensing Planning. For these two forms, reviewers must assess each item individually.

When a form is approved, what is this indicative of?

Approval indicates that the reviewer agrees with information provided and that the information provided is sufficient.

What if I want to just view, not edit, an acknowledged form?

Select the form of interest and click the "Review" button at the bottom of the form list to view all responses.



Will both the CDC and assigned regional MCM specialists have the ability to view the same jurisdictions and make comments?

Yes, all appropriate parties will be able to review form data and provide comments. While only an official ORR reviewer can approve/disagree with particular responses submitted by their assigned jurisdiction(s), all users associated with a particular jurisdiction can leave comments on a response. CDC administrators will have the ability to view all jurisdictions' forms, and MCM specialists will be able to view all forms for those jurisdictions that they review. All comments, regardless of who wrote them, will be viewable by clicking on the speech bubble icon next to a particular response in the review page.

Are CRI jurisdictions going to have to submit their own self-assessment? If so, does that show up for the state to review?

Yes, states will have reviewer permissions for the CRIs that fall under their jurisdiction. The review process of CRIs by states will be the same as the review process of recipients by CDC.

A form was returned to a recipient with feedback from their ORR reviewer and they have resubmitted it. How do you know what was changed since the most recent submission?

The history tab, accessible from the review page of a form, shows all changes made to a form. Each change is listed with the date/time that the update was made, as well as the name of the individual who made the change.

General Questions

Clicking MCM-ORR icon doesn't take me "home" Is something wrong?

The icon is currently not a hyperlink. You can go back to the main ORR screen by clicking the "Home" button in the upper, left-hand corner of your screen.

Is there an option to remove comments?

Comments cannot be deleted or edited once they have been saved.

Technical Assistance

What browsers can I use to access the platform?

You may access the platform using Internet Explorer (version 11), Google Chrome, Mozilla Firefox, or Microsoft Edge. While the platform is accessible by all of the aforementioned browsers, DCIPHER recommends using Google Chrome or Microsoft Edge for optimal system performance.

What software should I use to input data into offline forms?

For any PDF files that will be uploaded into the system, DCIPHER recommends using Adobe Acrobat Reader. For any workbook/spreadsheet files that will be uploaded into the system, DCIPHER recommends using Microsoft Excel.

I have logged into the platform but I only see a white screen? Is something wrong?

There are a couple steps you should take before reaching out to dcipher-orr@cdc.gov for assistance:

- Ensure you are using one of the accepted web browsers (listed above).
- If you are accessing the platform using Internet Explorer version 11, check to see if your browser is running in Compatibility Mode. You can do this by clicking the settings icon in the top, right hand corner of your browser and clicking "Compatibility View settings". Ensure that the option "Display intranet sites in Compatibility View" is unchecked. If the option is checked, uncheck it and refresh your browser.
- If neither of the options above resolve your problem, contact the DCIPHER team for further assistance.

APPENDIX D: ORR OFFLINE FORMS

PDF versions of the online forms are under development and will be available when finalized.

Direct data entry into the online system is highly encouraged. However, for sites with connectivity issues, the official CDC distributed PDF forms will be the only offline format supported for direct data upload.

APPENDIX E: DOCUMENT CHANGE LOG

November 2017 Version

Page No.	Change(s) Made
5	Changed verbiage for "PHEP/Functional/Full-scale Exercise or Incident" in the "Submission Cycle" column
8	Added third paragraph (Jurisdictions <u>not selected</u> to receive . . .) under "Form Submission (via ORR online system)"
18	Deleted "POD name" row
47–48, 60–61	Edited text under "What impacts achieving established status"
70, 73, 77, 80, 83	Changed verbiage in "Event Type" row
Appendix B	Added HSEEP definitions to Appendix B: Key Terms