Public Health Emergency Preparedness Cooperative Agreement

Follow-Up Questions and Answers: Third Set

General Questions

Q: There have been problems getting federal assistance with secret clearance. Will there be any assistance on the Secret Clearance requirements?

A: It was CDC's intent to facilitate obtaining security clearances by using CDC's Office of Security and Emergency Preparedness. We've met with them and learned that the process and implications are more complex than originally imagined. Issues include on-going commitment to facilitate clearances when staff depart, determining the need for 'secret' compared with 'top secret' clearance, not usurping states (e.g., their governor's office, their state EMA office, state law enforcement agency) to determine who within their state needs security clearances etc. We also learned that some public health officials already have security clearances since the policy in their state included public health officials as part of their overall state preparedness plans as drafted by their governors' offices or state EMAs. So, we've made the task more realistic by asking the states to "identify key public health staff that need secret or top secret security clearances and mechanisms within the jurisdiction to obtain needed clearances…" It is likely that state-generated requirements exist that dictate who—within any given state—should have access to secure information, and public health staff should not proceed with obtaining security clearances in a manner different from other state staff. Some states have already developed arrangements or compacts with other federal agencies (e.g., DHS, FBI) to facilitate this process. In short, we believe that the states should determine who needs clearances, who has clearances, and the process that has been used in their states to incorporate public health officials with other state staff who have had clearances as deemed necessary by the governor or state statute. Cooperative agreement funds may be used to obtain clearances.

Q: Please clarify what is expected regarding the wording that special populations "should participate in all preparedness planning activities and exercises?"

A: There should be special populations or their representatives on the state and local advisory committees. In addition, provisions for special populations should be included in response plans and special population should be engaged in the design and implementation of drills and exercises.

Q: Where is the reference in last year's guidance to the purchase of prophylaxis for public health first responders?

A: The reference is on page 8 of the CRI appendix in the section entitled "Program Budget" and reads as follows:

> Inventory tracking software, vehicles, medications and medical supplies may not be purchased with these funds. Prophylaxis for health department first responders and their families is acceptable with the approval of the Division of State and Local Readiness Project Officer in collaboration with the Division of Strategic National Stockpile Subject Matter Expert.

Q: Can you clarify the intent of the first critical task under outcome 4A: Health Intelligence Analysis and Production?

A: This intent of these tasks as described in the targeted capabilities list is as follows:

Intelligence Analysis and Production is the merging of data and information for the purpose of analyzing, linking, and disseminating timely and actionable intelligence with an emphasis on the larger public safety and homeland security threat picture. This process focuses on the consolidation of analytical products

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among the intelligence analysis units at the Federal, State, local, and tribal levels for tactical, operational, and strategic use. This capability also includes the examination of raw data to identify threat pictures, recognize potentially harmful patterns, or connect suspicious links to discern potential indications or warnings.

Q: Was the content of the call hosted by ASTHO on June 14th the same as the previous week's TA call with CDC?
A: No. Different people may have participated, and different concerns were raised. We have, however, tried to capture all of the questions from each call in the next set of FAQs.

Performance Measures, Evaluation and Reporting

Q: Will the "benchmarks" be used this year, and how?
A: There are no planned changes to the benchmarks. Guidance for reporting will be, as it has in the past, included with the semi-annual and annual reports.

Q: How does CDC plan to phase in performance measures?
A: The following measures will be assessed in the first phase, which will be due approximately 30 days after the application: 1, 5, 15, 16, 17, 22, 23. The entire set of measures will be assessed during the mid-year progress report. This approach is being used to provide grantees with time to set up systems for measurement.

Q: Can the methods for determining performance measures be written in as activities, and if so, where?
A: Where appropriate, the "metrics" to be included in the MIS should have areas to indicate the methods

Q: Is CDC is putting together a template for the evaluation plan?
A: The evaluation plan is NOT being required as part of the application. However, grantees are encouraged to begin thinking about the areas described in appendix 10 and how they evaluate programs to ensure improvement. However, as described under section 9A, grantees are required to exercise plans and we are requiring the submission of the schedule of these exercises at the State and local level (for CRI cities).

Q: On page 19 there is a discrepancy in language related to capacity for public information lines. In TC:6A6c [Communications] capacity is cited as "1% of jurisdiction's *households*" and in TC;6B1c [Emergency Public Information and Warning] capacity is cited as "1% or jurisdiction's *population*". Which is correct?
A: The language citing "1% of jurisdiction's households" (from TC:6A6c [Communications]) is correct and should be inserted in its entirety to replace language in Critical Task 1c in 6B Target Capability: Emergency Public Information and Warning.

> **6A Target Capability: Communications**
> **Critical Task:**
> **6c)** Ensure that the public health agency's public information line can simultaneously handle calls from at least 1% of the jurisdiction's households (e.g., play a recorded message to callers, transfer callers to a voice mail box or answering service)
>
> **Corrected: Target Capability 6B: Emergency Public Information and Warning; Critical Task:**

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1c) Ensure that the public health agency's public information line can simultaneously handle calls from at least 1% of the jurisdiction's households (e.g., play a recorded message to callers, transfer callers to a voice mail box or answering service)

Antivirals

Q: Regarding the purchase of antivirals, and assuming a state commits to ordering a number of courses of Tamiflu by the July 1 deadline:

- **When will these courses actually enter the stockpile?**
- **When will we be required to transfer funds to CDC/HHS to pay for the courses?**
- **Are these courses dedicated to that particular state and unavailable under any circumstances to another state?**
- **When these courses reach their expiration date, who will pay to replace them?**
- **Can the courses of Tamiflu that HHS has allocated to my state be diverted to another state?**
- **Is the 25% subsidy program a one time only program, or will states be able to purchase Tamiflu at future dates at the subsidized rates? Many states have already passed budgets for the next fiscal year without allocating funds for the purchase of antivirals.**

A: CDC is unable to answer these questions at this time, as the decision-making authority on these issues rests with HHS. The Department has informed us that states should submit their non-binding estimates, per the cooperative agreement guidance, to their CDC Project Officer. Once we have contracts with Roche and GSK for subsidized State purchases, we will provide a contact for placing orders - probably an OPHEP contracting officer. We will inform you immediately when we have the additional answers.

Laboratories

Q: Target Capability 3A: CT 1b. It has been our impression that the BT and CT laboratory coordination the CDC is speaking about in this critical task is our own (NYC's). However, in the APHL guidance for this grant my view changed and the CDC may be speaking about the CT and BT coordinator at the Sentinel lab. Which is correct?
A: Under 3A, required critical task 1b, this refers to the ability of the BT/CT Coordinator at a biological LRN reference lab or at a Level 1, 2, or 3 LRN chemical lab (e.g., a grant recipient) to advise others (e.g., sentinel labs) on proper collection, packaging, labeling, shipping, and chain-of-custody procedures.

Q: Metric #9: Does time only have to be measured for the three agents listed (bacillus anthracis, *Francisella tularensis* and *Yersinia pestis*), or all select agents?
A: The three listed agents.

Q: Does metric #9 relate only to clinical biological specimens?
A: For this cooperative agreement, clinical biological specimens. (Note: we plan to add other sample types (e.g., environmental, food) to the cooperative agreement for next FY.

Q: Metric #11: does this include notifying out of jurisdiction officials (e.g. NYS), or just intra-jurisdiction officials (i.e. within NYC)?
A: Both. Appropriate officials are defined in appendix 1 as, at a minimum, the State public health agency director or designee, the local public health agency director or designee in which the affected individual resides and the person or agency submitting the specimen/sample for testing.

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Cities Readiness Initiative

Q: Page 5 of the appendix document under "Additional Activities for Table II-New CRI Recipients" mentions a satellite broadcast or webcast for an Executive Briefing. When will this be held?
A: Per the Q & A document, the broadcast is scheduled for October 19.

Q: Is this a recurring grant? What is the likelihood of sustainability for initiatives put in place by grant activities?
A: CRI has been a funded initiative since FY 2004, since Mass Prophylaxis is a National Priority we anticipate that CRI will be funded next year- however as with any federal program funds are contingent upon availability.

The answers to these questions were developed on June 22, 2006.