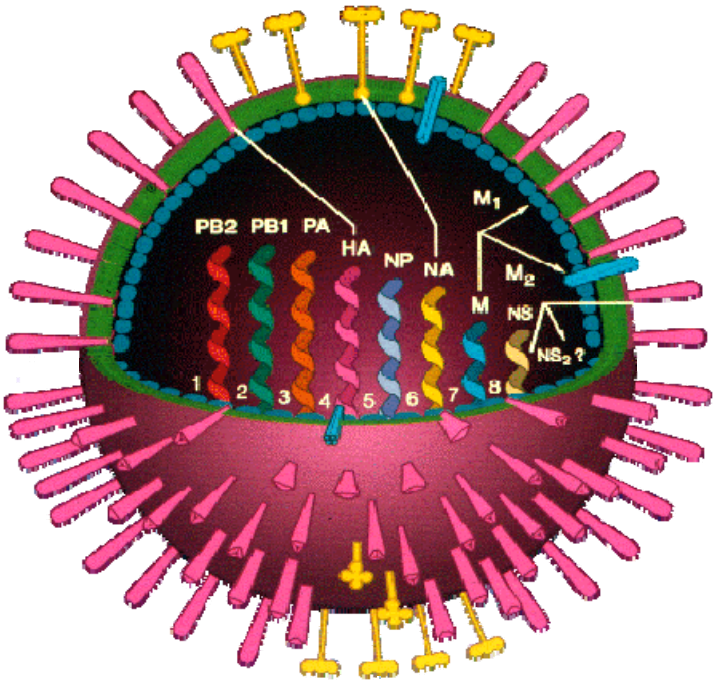

Assessment of States' Operating Plans to Combat Pandemic Influenza

Report to Homeland Security Council

January 2009

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Statement by Secretary Leavitt and Secretary Chertoff

We are pleased to submit this summary report on States' operating plans for combating pandemic influenza. Three pandemics occurred during the Twentieth Century – one, in 1918/19, with catastrophic health and socio-economic consequences. The pandemic threat is real and continuing, irrespective of how much the perception of the threat may wax or wane over time. Therefore, if we are to counter the next pandemic effectively, we must prepare now.

This assessment process has done much to increase understanding by State and Federal Government officials alike as to the demands that an influenza pandemic would place upon them. We are grateful to the Working Group from the participating U.S. Government Departments as well as to their State counterparts for undertaking the arduous efforts that this assessment required. Whatever forms future plans and assessments may take, the health and socio-economic well being of the Nation will be well served by a collective commitment to continuous quality improvement in preparing for, responding to, and recovering from an influenza pandemic.

Purpose

This report summarizes the status of States' operating plans with respect to preparedness for, response to, and recovery from an influenza pandemic. This assessment fulfills a requirement (Action #6.1.1.2) established by the Homeland Security Council, Executive Office of the President of the United States, in its *National Strategy for Pandemic Influenza: Implementation Plan*.[1] Table 1 lists the U. S. Government (USG) Departments, Agencies, and Offices that participated in this assessment through their representatives listed in Appendix A.

Table 1: Participating USG Departments, Agencies, and Offices

- United States Department of Agriculture
- Department of Commerce
- Department of Defense
  - Office of the Assistant Secretary of Defense
  - U.S. Northern Command[2]
- Department of Education
- Department of Health and Human Services
  - Immediate Office of the Secretary
  - Centers for Disease Control and Prevention
  - Office of the Assistant Secretary for Administration and Management
  - Office of the Assistant Secretary for Preparedness and Response
  - National Institutes of Health
- Department of Homeland Security
  - Federal Emergency Management Agency
  - Office of Health Affairs
- Department of Justice
- Department of Labor
  - Office of the Assistant Secretary for Administration and Management
  - Office of the Assistant Secretary for Policy
  - Occupational Health and Safety Administration
- Department of State
- Department of Transportation
- Department of the Treasury
- Department of Veterans Affairs
- Federal Communications Commission
- Homeland Security Council, Executive Office of the President
- U.S. Office of Personnel Management

[1] National Strategy for Pandemic Influenza: Implementation Plan, Homeland Security Council, May 2006. http://www.whitehouse.gov/homeland/pandemic-influenza-implementation.html

[2] This includes the National Guard Bureau

Background

Pandemic influenza could produce a public health emergency that is more daunting than any other type of naturally occurring, accidental, or terrorist-instigated event that our nation has experienced or is likely to experience. First, an influenza pandemic could affect essentially every community in the nation almost simultaneously – i.e., within the space of a few weeks – and, if comparable to or more severe than the influenza pandemic of 1918, could result in 25% or more of the population ultimately experiencing life-threatening illness and/or being forced to dispense with normal activities to care for victims. Second, response activities within each affected community not only will need to be sustained for several months, generally with little or no outside help, but also might be degraded due to substantial influenza-induced absenteeism across the participating entities – public and private. Third, coping with degraded functioning in virtually every aspect of society could be so demanding as to preclude the initiation of significant recovery activities for many months.

Influenza pandemics, whether severe or comparatively mild, are recurring phenomena. The prevailing uncertainty therefore is not whether the world will experience another influenza pandemic but rather when the next one will occur and how severe it will be. And, considering that a catastrophic pandemic could be among the possibilities, thorough preparedness is imperative.

The USG has done, is doing, and must continue to do much to lead the nation as it prepares for the next influenza pandemic. But the USG cannot do the job alone. Pandemic influenza preparedness by its nature must be a shared responsibility among all levels of government (local, State, and Federal), the private sector (for-profit and not-for-profit entities), and individuals and their households. Each entity must 1) understand its unique role (i.e., the ones that only it can fulfill) in preparing for, responding to and recovering from an influenza pandemic; and 2) address its respective challenges to the best of its abilities and resources.

One uniquely important subset of preparedness partners comprises the Governments of the States, the District of Columbia, and the U.S. Territories. This report discusses the status of their respective operating plans for performing critical State-level functions during and after an influenza pandemic.

The Assessment Process

Staging

This report describes the second stage of a two-stage assessment process. Stage One (Stage-1) spanned August 2006 to January 2007. Stage Two (Stage-2) spanned January 2007 to December 2008.

Common to both stages were the following steps: 1) participating USG Departments developed guidance for States'[3] planning and solicited the pertinent information from the States; 2) States submitted planning information in response to the solicitation; 3) USG Departments reviewed those portions of the States' submissions that were pertinent to their respective missions and expertise and provided draft assessments individually to the States for their comments; and 4) the States responded with comments about possible process errors and other matters, which the USG Departments then considered when finalizing their assessments. The Department of Health and Human Services (HHS) coordinated the guidance development, the review process, and the information flow of information between USG Departments and the States.

Stage-2 differed from Stage-1 in three important ways. First, Stage-2 involved more USG components (14 compared to nine). Second, the Stage-2 guidance had a broader scope of Operating Objectives, more detailed Supporting Activities (i.e., tasks), and benefited more from stakeholder critique. Third, whereas State-specific findings were shared only with the respective States after Stage-1, this report makes summary-level State-specific findings public – in accord with the stated intent for Stage-2. The section below entitled "Scope and Content" provides further details regarding the Stage-2 guidance document.

Almost every aspect of Stage-2 benefited from lessons learned during Stage-1. The additional experiences acquired during Stage-2 should serve to enhance future assessments. Pandemic influenza planning, especially the interplay between USG Departments and their State counterparts, would benefit materially from a long-term commitment to such continuous quality improvement.

Scope and Content of the Guidance

The increased scope and detail of the Stage-2 guidance document, compared to that for Stage-1, did more to capture the myriad formidable challenges that an influenza pandemic might exhibit. They are certain to affect not only the health sector (e.g., medical and home health care, public health programs) but also other sectors (e.g., food safety, education, transportation, public safety, and critical infrastructure protection).

As did the guidance document for Stage-1, the Stage-2 guidance document focused on operating plans[4] – that is, plans that manifest 1) clear-cut Operating Objectives, 2) definitive

[3] Hereinafter throughout this report, "States" refers to all 56 entities (the 50 States, the District of Columbia, and the five U. S. Territories) unless otherwise specified.

[4] Federal Emergency Management Agency (FEMA) defines an emergency operations plan as "a document that: describes how people and property will be protected in disaster and disaster threat situations; details who is responsible for carrying out specific actions; identifies the personnel, equipment, facilities, supplies, and other resources available for use in the disaster; and outlines how all actions will be coordinated. See State and Local

implementation strategies, 3) unequivocal specification as to which organizations or individuals are responsible for which elements, and 4) measurable performance objectives. A defining characteristic of an operating plan is that, in whole or in part, it lends itself readily to evidence-based evaluation using the results of discussion-based exercises, operational-based exercises, or performance measurements obtained during the course of responses to actual incidents.

The Stage-2 guidance document, *Federal Guidance to Assist States in Improving State-Level Pandemic Influenza Operating Plans*,[5] accounted for the fact that, faced with an influenza pandemic, a State would be facing three major challenges simultaneously: 1) continue its basic operations, 2) respond to the pandemic, and 3) facilitate the maintenance of critical infrastructure. Thus, the guidance document addressed three Strategic Goals expressed as follows:

- *Strategic Goal A, "Ensure Continuity of Operations of State Agencies and Continuity of State Government," focuses on the role of State government as an employer (i.e., looking inward). State governments are "large employers" and as such need to consider how they will continue to function during the pandemic. Continuing critical services and lifelines that many State residents rely on for survival (e.g., Medicaid, newborn screening, safe food and unemployment insurance) is paramount. If State governments fail to prepare themselves by developing, exercising, and improving comprehensive operating plans, then they will fail in their abilities to meet the other two strategic goals, which focus on external functions (i.e., responding to the event and helping to maintain critical infrastructure).*

- *Strategic Goal B, "Protect Citizens," focuses on the role of State government as a responder to the influenza pandemic. During a pandemic, the State government is conducting business as usual (and perhaps with more intensity) with functions such as disease surveillance and is altering the way the State conducts its business to delay the introduction, slow the spread, or lessen the severity of pandemic influenza (e.g., advising that sick people stay home, banning public gatherings, dismissing students from schools).*

- *Strategic Goal C, "Sustain/Support 17 Critical Infrastructure and Key Resource Sectors (CIKR)," focuses on the role of State government with respect to sustaining publicly- and privately-owned critical infrastructure. Note that infrastructure includes not only physical plants associated with it but also the processes, systems and information that support it. States are responsible for developing and implementing Statewide CIKR protection programs that reflect and align with the full range of homeland security activities presented in the National Infrastructure Protection Plan (NIPP).*[6]

Guide (SLG) 101: Guide for All-Hazard Emergency Operations Planning, page 1-1. http://www.fema.gov/plan/gaheop.shtm

[5] http://www.pandemicflu.gov/news/guidance031108.pdf

[6] The 17 CIKR sectors are: Agriculture and Food; Banking and Finance; Chemical; Commercial Facilities; Commercial Nuclear Reactors, Materials, and Waste; Dams; Defense Industrial Base; Drinking Water and Water

Associated with each Strategic Goal were Operating Objectives (Table 2) and their associated Supporting Activities that were to be addressed in the State's pandemic influenza planning. For each Operating Objective, the guidance document included a corresponding Appendix containing 1) planning or preparedness activities that should be considered while developing a comprehensive, exercisable operating plan, and 2) table shells to help standardize the presentation of the response and recovery Supporting Activities that were included in the State's operating plan.

Table 2: State Government Strategic Goals and Operating Objectives

Strategic Goal	Operating Objective	Appendix
A. Ensure Continuity of Operations of State Agencies & Continuity of State Government	Sustain Operations of State Agencies & Support and Protect Government Workers	A.1
	Ensure Public Health COOP During Each Phase of a Pandemic	A.2
	Ensure Continuity of Food Supply System	A.3
	Ensure Ability to Respond to Agricultural Emergencies & Maintain Food Safety Net Programs	A.4
	Ensure Integration of Uniformed Military Services Needs & Assets	A.5
	Sustain Transportation Systems	A.6
B. Protect Citizens	Ensure Surveillance and Laboratory Capability During Each Phase of a Pandemic	B.1
	Assist with Controls at U.S. Ports of Entry	B.2
	Implement Community Mitigation Interventions	B.3
	Enhance State Plans to Enable Community Mitigation through Student Dismissal and School Closure	B.4
	Acquire & Distribute Medical Countermeasures	B.5
	Ensure Mass Vaccination Capability During Each Phase of a Pandemic	B.6
	Provide Healthcare	B.7
	Manage Mass Fatalities	B.8
	Ensure Communication Capability During Each Phase of a Pandemic	B.9
	Mitigate the Impact of an Influenza Pandemic on Workers in the State	B.10
	Understand Official Communication Mechanisms for Foreign Missions, International Organizations, and Their Members in the United States	B.11
	Integrate EMS and 9-1-1 into Pandemic Preparedness	B.12
	Integrate Public Safety Answering Points into Pandemic Preparedness	B.13
	Overall Operational Readiness	B.14
	Public Safety and Law Enforcement	B.15
C. Sustain/Support 17 Critical Infrastructure Sectors and Key Resources	Define CIKR Protection, Planning &Preparedness Roles & Responsibilities	C.1
	Build Public-Private Partnerships & Support Networks	C.2
	Implement the NIPP Risk Management Framework for a Pandemic	C.3
	Bolster CIKR Information Sharing & Protection Initiatives	C.4
	Leverage Emergency Preparedness Activities for CIKR Protection, Planning & Preparedness	C.5
	Integrate Federal & State CIKR Protection, Planning & Preparedness Activities	C.6
	Allocate Scarce Resources	C.7

Treatment; Emergency Services; Energy; Government Facilities; Information Technology; National Monuments and Icons; Postal and Shipping; Public Health and Healthcare; Telecommunications; and Transportation Systems.

The guidance document also included "keys for successful preparation," accompanied by brief descriptions of each, as follows (verbatim):

- "*Involve State and local Leadership. At the Federal Government level, the White House Homeland Security Council coordinates the work of the Departments, Independent Agencies, and other White House offices. We urge you to identify a coordinator from the Governor's Office to coordinate your State's integrated planning activities and include coordination with local government pandemic planning to ensure that all communities in the State will have a plan. In addition to consistent, strong leadership from the Governor's Office, there should be a senior-level official designated as the pandemic influenza coordinator for the State.*
- *Treat Pandemic as an All-Sectors (Community-Wide) Issue, not just a Health Issue. The USG views the threat of pandemic influenza as not just a health threat but as a threat to all sectors of our society. The USG has committed to using all instruments of national power against the threat. We urge you to address the threat of pandemic with all instruments of State power. This guidance document reinforces this message by identifying State entities that should be involved in specific areas of planning.*
- *Collaborate with neighboring and distant States. Promising practices abound. We urge you to connect with planners in neighboring and distant States to share promising practices and lessons learned.*
- *Collaborate across society at the State level. Local governments, faith- and community-based organizations, philanthropic organizations, and the business community are critical partners for State government. We urge you to engage with them early and often as you develop and refine your plans.*
- *Collaborate with regional Principal Federal Officials. To coordinate the USG's responses to pandemic influenza, the Department of Homeland Security has divided the nation into 5 regions and designated a Principal Federal Official (PFO) for each region. The Department of Health and Human Services has enlarged the expertise available to the PFOs by designating 5 corresponding medical professionals, called Senior Federal Officials for Health (SFOs). You should make contact now and ensure that you understand the channels of communication and the roles of the federal officials."*

Interactions with States

Content of Guidance Document

Stakeholder contributions did much to strengthen the Stage-2 guidance document. After the participating USG entities had drafted their respective portions of the guidance document, HHS, in concert with the Department of Homeland Security (DHS), organized five regional workshops. These occurred in each of the five regions that DHS has designated to facilitate pandemic influenza preparedness and for which DHS and HHS, respectively, have appointed PFOs and SHOs as described above. The SHOs led the workshops in their respective regions. State representatives provided invaluable critiques and insights regarding these draft documents, and the USG participants made liberal use of the commentaries when finalizing the guidance document.

Planning Assistance

A resource annex[7] in the guidance document and other resource documents developed by or accessed through the USG were available for planning and exercising purposes. Discipline- or content-specific checklists, recommendations, templates and other planning tools were available at http://www.pandemicflu.gov/plan/index.html for the States -- and local governments and organizations.

While States were developing their submissions in response to the Stage-2 guidance document, HHS organized a series of three professionally-moderated Webinars, which it broadcast live across the Internet from the HHS television studio on March 13, April 2, and April 30, 2008. Archived versions of these broadcasts are available at http://www.pandemicflu.gov/news/panflu_webinar.html. Each Webinar focused on a different subset of the Operating Objectives that constitute the guidance. Each Webinar involved representatives of the pertinent USG Departments, who not only presented prepared remarks but also responded to questions and comments from viewers. Through these further interactions with stakeholders, the USG Departments' were able to underscore their respective priorities regarding pandemic influenza preparedness, explain why they chose to emphasize particular activities over others, and otherwise clarify their intentions.

Further, through HHS, the participating USG Departments provided a list (see Attachment A) of individuals who could serve as conduits to pertinent expertise for State colleagues.

[7] http://www.pandemicflu.gov/news/guidance_resources031108.pdf

Scoring

Comprehensiveness

The USG Departments rated the Operating Objectives in their respective mission areas for comprehensiveness. That is, reviewers considered the information submitted for each associated Supporting Activity and assessed the degree to which the response described a) a definitive implementation strategy and b) unequivocal specification as to which organizations or individuals are responsible for which elements.

Reviewers had the option not to assign a rating to a particular Supporting Activity if the State had indicated that the item is "not applicable" and offered a convincing justification. The reviewers also had the option to accept and rate a new Supporting Activity proposed by the State if they judged the proposed addition to be relevant to the Operating Objective and of comparable significance to the Supporting Activities already listed.

The scoring schema for each Operating Objective was as follows. For each Supporting Activity, the review team awarded a score of 0, 1, 2, or 3. A percentage for the Operating Objectives was calculated by summing the scores of the Supporting Activities under that Operating Objective and dividing by the total number possible (number of Supporting Activities multiplied by 3 possible points).

Example:

Operating Objective X.1
Supporting Activity - 3/3
Supporting Activity - 2/3
Supporting Activity - 2/3
Supporting Activity - 3/3
Supporting Activity - 2/3
12/15 = 80%

Key:
≥85% = "No Major Gaps"
69-84% = "A Few Major Gaps"
50-68% = "Many Major Gaps"
1-49% = "Inadequate Preparedness"

The percentage derived for the Operating Objective was translated into a standardized verbal designation in accord with the key shown in the text box. Failure to submit information or a non-responsive submission was considered "Inadequate Preparedness." For the example provided, the Score for Operating Objective X.1 is "A Few Major Gaps."

All USG Departments – for standardization purposes – agreed to use the following thresholds when conducting their reviews of each Supporting Activity:

0 = Response missing or Documentation does not address activity.
1 = Minimal response. Documentation indicates only intention or beginning of planning for activity, or only a part of the activity has been addressed.
2 = Substantial, but incomplete, response. Documentation indicates that State has largely addressed activity, but response is not complete or actionable.
3 = Complete response. Documentation indicates actionable plan.

Operational Readiness

The USG Departments jointly assigned a single rating for Operational Readiness for the entire State submission. In particular, based on the information requested in the last sub-Appendix for each of the three Strategic Goals, the Departments determined the number of the Operating Objectives for which the State submitted evidence that it has tested its response capability in some appropriate way.

This number then was divided by the total number of Operating Objectives, expressed as a percentage, and translated into a standardized verbal designation in accord with the key shown in the text box.

Key:
≥50% = "Substantial Evidence of Operational Readiness"
25-49% = "Significant Evidence of Operational Readiness"
1-24% = "Little Evidence of Operational Readiness"

Failure to submit information or a non-responsive submission was considered "Little Evidence of Operational Readiness."

The scoring key for "Operational Readiness" was less stringent than the scoring key for "Comprehensiveness" because the USG Departments recognized that, for many States, many of their agencies still are in an early phase of pandemic influenza planning and thus are not likely to have conducted exercises in all areas that merit such testing of preparedness.

The Operational Readiness scores for Operating Objectives A.3, A.4, B.10, and B.11 were not included in the calculation. The A.3 and A.4 Operating Readiness submissions were not fully reviewed (see Appendix B). The B.10 activities did not lend themselves to testing; it would be difficult to demonstrate readiness for these activities. Since B.10 activities are dependent on the functioning of the State government agencies, where tests were appropriate, they would be captured in A1. B.11 most likely would be accommodated in any exercise of the State's communications plan (B.9).

A high score for Operational Readiness emerging from this assessment should not be interpreted as indicating that a State is truly operationally prepared. Rather, it is an indication that the State is taking steps to ensure that its plan is truly operational and that the Supporting Activities, as addressed in the plan, are actionable and viable as written.

Quality Control

As with Stage-1, the Stage-2 process included a quality control step for the USG Departments' reviews. For all but two of the 27 Operating Objectives, the Departments developed "Draft Concluding Assessments" for States' responses and then, through HHS, furnished these draft documents to the States for comment. Although any and all comments were welcome, the USG reviewers were interested particularly in having State counterparts identify significant missteps in the review process, such as an apparent failure to consider and thus give credit for key information included in the State's submission. The USG reviewers took the States' comments

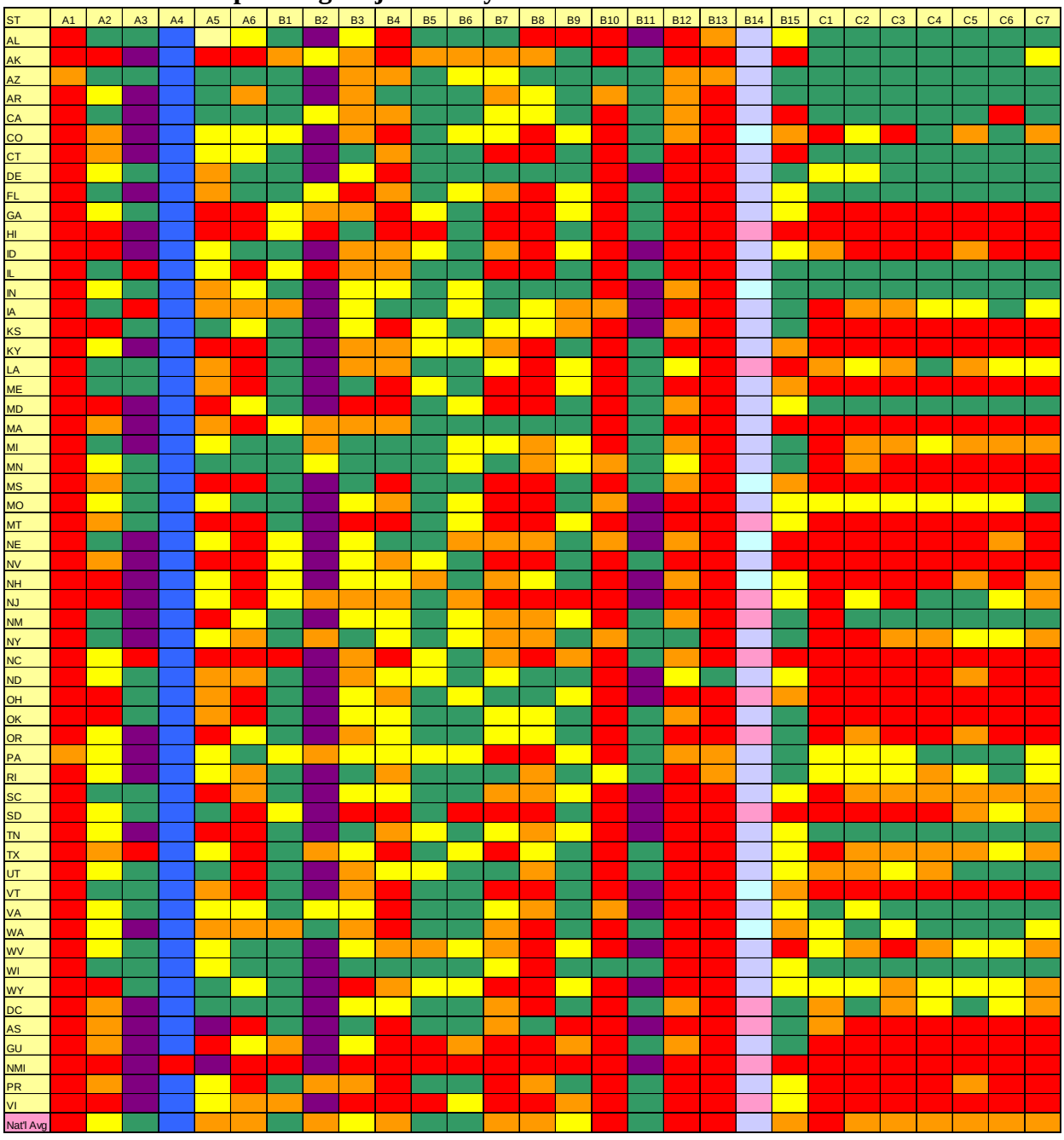
into consideration when preparing the final versions of their "Concluding Assessments." Generally, in the interest of fairness to all States, any new information submitted as part of the quality control process was reviewed but was not used in revising scores.

Findings from the Assessment

This section presents summary findings prepared by each of the USG Departments regarding their reviews of the States' operating plans for combating pandemic influenza. HHS, on behalf of the participating Departments, has provided each State with more detailed State-specific findings.

For Strategic Goals A and B, this section discusses each Operating Objective in turn – first through generic statements about response and recovery plans in the particular thematic area and then through summary data. For Strategic Goal C, this section of the Report addresses all seven Operating Objectives with a generic narrative before presenting summary data for each one. A chart showing the summary ratings for all of the States for all of the Operating Objectives and the overall Operational Readiness measure is included as Table 3.

Table 3: Status of Operating Objectives by State



Scoring for Comprehensiveness

- > or = 85% No Major Gaps
- 69-84% A Few Major Gaps
- 50-68% Many Major Gaps
- 1-49% Inadequate Preparedness
- Not applicable
- Review & Follow-up In Progress (see Attachment C)

Scoring for Operational Readiness (B.14)

- > or = 50% Substantial Evidence of Operational Readiness
- 25-49% Significant Evidence of Operational Readiness
- 1-24% Little Evidence of Operational Readiness

Strategic Goal A – Ensure Continuity of Operations of States Agencies and Continuity of State Government

Operating Objective A.1 - Sustaining Operations of State Agencies and Supporting and Protecting Government Workers

Lead Department – Department of Labor (Office of the Assistant Secretary for Policy, Office of the Assistant Secretary for Administration and Management, Occupational Safety and Health Administration)
Supporting Entities – Department of Commerce, White House Office of Personnel Management, and Department of Health and Human Services (Office of the Assistant Secretary for Administration and Management, National Institutes of Health)

General Comments
For some of the Supporting Activities needed to achieve this Operating Objective, the reviewers believe that the States are better prepared than was indicated by the information submitted. They understand and appreciate the time constraints States were under, but many of the submissions suffered from a lack of coordination or communications among State agencies, and thus what was submitted likely did not capture all the planning that had been done. However, incomplete responses to a data request could indicate a lack of coordination among state agencies when the next pandemic strikes.

The reviewers encountered difficulties while conducting proper assessments because many activities are the responsibility of all State agencies, and it was not clear whether each State agency had an operating plan in place or was prepared to implement it. Lastly, States that submitted numerous documents often times did not have a single overarching State government (i.e., State-wide) plan that referenced additional agency-specific documents. State leaders will need such a document to understand and implement its overall plan for dealing with a pandemic.

States that had a State-wide plan, supplemented by agency plans, or States that had one agency that supplied direction, guidance documents, examples, assistance and/or templates to all agencies seemed to have a better understanding of what planning was needed to sustain operations and protect and support workers during an influenza pandemic. Some States use annexes to their agency Continuity of Operations (COOP) plans; this generally proved to be a good approach to evaluating the unique circumstances of a pandemic and creating plans to address those circumstances. However, a traditional COOP plan does not contain all of the planning requirements needed to sustain State operations during a pandemic and protect and support workers in State agencies. Communication between COOP planners and pandemic planners (if they are not one and the same) is crucial.

The reviews validated the desirability of using Pandemic Coordinators who might ensure that all agencies are prepared and further to ensure consistency (where needed) across agencies. Another successful approach was the coordination of planning through a Working Group, Steering Committee or other State-wide team. In addition, support for and interest by the

Governor's office and requirements that all agencies prepare plans also resulted in stronger, more effective plans.

Summary Data

SUMMARY RATING	NUMBER
No Major Gaps	0
A Few Major Gaps	0
Many Major Gaps	2
Inadequate Preparedness	54
Not Applicable	0
Total	56

STATES WITH NO MAJOR GAPS

None

Operating Objective A.2 – Ensure Public Health COOP During Each Phase of a Pandemic

Lead Department – Department of Health and Human Services (Centers for Disease Control and Prevention)

General Comments

General trends observed among the operating plans included:

- A plan that received a high score provided a plan and procedures that clearly demonstrated the State official's understanding of the activities required for a successful response during an influenza pandemic. Mission essential activities were prioritized and defined clearly – including identification of primary, alternate and secondary alternate points of contact responsible for ensuring those activities continued. The plan reflected internal capabilities, personnel and resources to sustain operations. The plan pre-identified special requirements, tools and skills and indicated how and where to locate them during a pandemic.
- A fully-developed plan provided 1) clear activities to implement social distancing procedures and 2) specific actions to be taken to minimize potential cross contamination. The plan also captured clearly data related to teleworking policies, personnel (both the well and unwell) tracking and monitoring, and captured succinctly data that were relevant to alternate operating locations.
- Finally, the plan provided clear indication of how personnel were being informed and trained on their duties and included records and plans for exercising the plans to ensure that trained personnel had an opportunity to practice plan execution, and in particular, gain "hands-on" knowledge of their expected roles and responsibilities.

State with plans which had low scores:

- Appeared to interpret that COOP planning essentially meant making sure that external health services continued and that prophylaxis could continue to be distributed. They did not demonstrate the understanding that the COOP plan should include internal operations continuity or personnel protection.

- Did not identify accurately or prioritize their essential functions to ensure continuity of those functions with a greatly (40%) reduced workforce.
- Did not demonstrate pre-planning or clear identification of specific policies and procedures related to teleworking, social distancing and personnel monitoring. Instead, the State typically indicated that those functions would be addressed when an event occurred. Attempting to address those issues in the midst of an emergency is not an optimal strategy when there are myriad unknowns and unpredictable events occurring during the pandemic.
- Did not provide evidence of adequate planning for training personnel and conducting exercises… resulting in plans that were either incomplete or incapable of being followed or implemented.

Summary Data

SUMMARY RATING	NUMBER
No Major Gaps	15
A Few Major Gaps	18
Many Major Gaps	11
Inadequate Preparedness	12
Not Applicable	0
Total	56

STATES WITH NO MAJOR GAPS

Alabama	Illinois	Michigan	South Carolina
Arizona	Iowa	Nebraska	Vermont
California	Louisiana	New Mexico	Wisconsin
Florida	Maine	New York	

Operating Objective A.3 – Ensure Continuity of Food Supply System

Lead Department – United States Department of Agriculture

General Comments

This objective only applied to the 27 States with a State meat and/or poultry inspection program. Those States must establish and enforce requirements that are "equal to" the requirements established by the Federal program. Overall, the applicable State plans had no major gaps and appeared to have addressed sufficiently the activities to ensure the continuity of their State program in a pandemic. Where the State's submission was deemed inadequate, it was due to the absence of sufficient documentation to render an assessment, or documentation that was based on a COOP plan. A COOP plan does not ensure in-plant presence of an inspection team, which is required, by statute, for a meat or poultry plant to operate.

It is important to understand that the assessment, even in those cases where the submission was inadequate, is not an assessment of State preparedness to respond to emergencies. The assessment is also not an indication of compliance with the "equal to" statutes, or the safety of the State meat and poultry supply.

Summary Data

SUMMARY RATING	NUMBER
No Major Gaps	23
A Few Major Gaps	0
Many Major Gaps	0
Inadequate Preparedness	4
Not Applicable	29
Total	56

STATES WITH NO MAJOR GAPS

Alabama	Kansas	Missouri	South Carolina	West Virginia
Arizona	Louisiana	Montana	South Dakota	Wisconsin
Delaware	Maine	North Dakota	Utah	Wyoming
Georgia	Minnesota	Ohio	Vermont	
Indiana	Mississippi	Oklahoma	Virginia	

Operating Objective A.4 – Ensure Ability to Respond to Agricultural Emergencies & Maintain Food Safety Net Programs

Lead Department – United States Department of Agriculture

A complete set of ratings for this Operating Objective currently is not available. The United States Department of Agriculture (USDA) deployed virtually all the review team members away from their normal duties to serve for several months as part of the emergency response and recovery efforts associated with the major hurricanes and floods that the United States experienced earlier this year. USDA intends to complete its reviews of the States' submissions for this Operating Objective and communicate its findings directly to the States as soon as possible. It regrets any inconvenience that this delay may cause its State counterparts. Please see Attachment B.

Operating Objective A.5 - Ensure Integration of Uniform Military Services Needs & Assets

Lead Department – Department of Defense (Office of the Assistant Secretary of Defense/ Homeland Defense and Americas' Security Affairs, the Office of the Assistant Secretary of Defense/ Health Affairs, the U.S. Northern Command, and the National Guard Bureau)

General Comments

This Operating Objective examined how well the States/territories integrated the National Guard and active duty military installations into the pandemic influenza planning process.

With respect to the active duty component, a desired goal for the State pandemic influenza plans was to encourage greater communication between the public health community within the installation and their civilian counterparts outside the gate. Another objective was to ensure the States included Department of Defense (DoD) beneficiaries who receive their medical care off

post in their calculations when requesting support (i.e., antiviral drugs, personal protective equipment, and pandemic vaccine) from the Strategic National Stockpile. While DoD is also procuring these items, most of their use will be for supporting operational and deployed active duty military forces.

In many States it was noted the National Guard had an "all-hazards" plan designed to support the State emergency response plan for all contingencies. These plans provide a solid base which can be easily modified to meet the specifics of a pandemic influenza response.

One area some States may wish to re-evaluate in subsequent plans is the allocation of antiviral medications and pandemic flu vaccine. While a few States clearly identified the National Guard as having priority in receiving these items, others have assumed or implied that since National Guard forces are "first responders," they will have the same priority as others in that class. However, without an explicit statement in the plan that National Guard forces should be given a high priority, this assumption may not hold up during times of scarce resources.

Other States used the CDC prioritization matrix[8] for allocating vaccine as their plan for prioritizing the National Guard in a pandemic response. This does meet the requirement; however, the States should understand that for National Guard forces not called to federal active duty, the CDC matrix does not give the National Guard a higher priority than the general public.

Summary Data

SUMMARY RATING	NUMBER
No Major Gaps	9
A Few Major Gaps	19
Many Major Gaps	12
Inadequate Preparedness	14
Not Applicable	2
Total	

STATES WITH NO MAJOR GAPS

Arizona	Kansas	Utah
Arkansas	Minnesota	Wyoming
California	South Dakota	District of Columbia

Operating Objective A.6 – Sustain Transportation Systems

Lead Department - Department of Transportation

General Comments

The national transportation system, vital to every citizen of the U.S., is responsible for moving billions of people and trillions of dollars of goods each year. With business operations often

[8] HHS Pandemic Influenza Plan, Table D-1 (Vaccine Priority Group Recommendations) Available at: http://www.hhs.gov/pandemicflu/plan/appendixd.html

built around the "just-in-time" delivery of goods and services, any disruption to the U.S. transportation system could have repercussions to the U.S. population regardless whether in rural or urban settings. Maintaining a healthy and viable transportation system during a severe pandemic will be highly dependent on the degree of preparedness, ability to respond, and capability of recovery within each of the major transportation modes.

The review of plans submitted by States/Territories indicates that, on the whole, State and Territorial governments have made substantive advances toward complete and actionable pre-pandemic plans with respect to three areas. The first is communication with transportation authorities in neighboring jurisdictions, key stakeholders, emergency response, law enforcement, DoD (National Guard), DHS and any other officials who activate plans or procedures regarding the transportation modes. The second is communication with Federal Operations Centers in accordance with the NRF and Emergency Support Function 1 to provide transportation–specific information during a pandemic. The third is issuing public service announcements and initiating public safety campaigns via posters, brochures, websites, or other media regarding how to reduce or limit the spread of the virus.

However, the reviews also showed that States/Territories, as a whole, are generally not as advanced in pre-pandemic planning efforts to address the specific issues of: (1) implementing additional cleaning/sanitizing methods for transportation systems and cargo; as well as (2) thoroughly cleaning or sanitizing public transportation conveyances and facilities and preparing for future use. Further, some reviews showed an absence of complete and actionable plans related to the principal Operating Objective to keep goods and people moving.

Summary Data

SUMMARY RATING	NUMBER
No Major Gaps	12
A Few Major Gaps	11
Many Major Gaps	8
Inadequate Preparedness	25
Not Applicable	0
Total	56

STATES WITH NO MAJOR GAPS

Arizona	Florida	Minnesota	West Virginia
California	Idaho	Missouri	Wisconsin
Delaware	Michigan	Pennsylvania	District of Columbia

Strategic Goal B – Protect Citizens

Operating Objective B.1 – Ensure Surveillance and Laboratory Capability During Each Phase of a Pandemic

Lead Department – Department of Health and Human Services (Centers for Disease Control and Prevention)

General Comments

Overall, the States are doing well with respect to the following preparedness tasks:

- Establishing adequate lines of communication between State and local public health authorities.
- Commitment to report novel influenza cases to CDC.
- Building upon seasonal influenza laboratory activities.

Many States seem to be struggling with the following preparedness tasks:

- Introducing adequate detail into procedures and protocols. Many plans had statements mirroring the requirements (i.e., repeating what was in the guidance document) but no instruments or steps to execute.
- Planning for electronic death reporting.
- Making significant revisions to plans. Many submissions had gaps in the plans but included more detail in pertinent forms.
- Planning for surge laboratory capacity. Absent intra-State resources to accommodate a significant surge in demand for laboratory services, agreements with neighboring State laboratories are likely to be inadequate.

Summary Data

SUMMARY RATING	NUMBER
No Major Gaps	38
A Few Major Gaps	11
Many Major Gaps	5
Inadequate Preparedness	2
Not Applicable	0
Total	56

STATES WITH NO MAJOR GAPS

Alabama	Indiana	Mississippi	Oregon	West Virginia
Arizona	Kansas	Missouri	Rhode Island	Wisconsin
Arkansas	Kentucky	Montana	South Carolina	Wyoming
California	Louisiana	New Mexico	Tennessee	District of Columbia
Connecticut	Maine	New York	Texas	American Samoa
Delaware	Maryland	North Dakota	Utah	Puerto Rico
Florida	Michigan	Ohio	Vermont	
Idaho	Minnesota	Oklahoma	Virginia	

Operating Objective B.2 – Assist with Controls at US Ports of Entry

Lead Department – Department of Health and Human Services (Centers for Disease Control and Prevention)

General Comments

This Operating Objective applied to the 16 States/territories with a U.S. Quarantine Station. Those areas with an HHS/CDC Quarantine Station work collaboratively with CDC personnel to develop port of entry multi-agency response plans. This year was the first time in which these plans have been reviewed, and many of them were drafts. At this time, States are continuing to identify the required resources and methods of reimbursement for port of entry related interventions. Many States seem to be struggling with preparedness tasks related to arranging for separate quarantine facilities for detaining multiple cohorts of potentially exposed passengers, either on- or off-port or both; and creating plans to address surge capacity needs at ports of entry. Federal and State agencies are clarifying and accepting the shared roles and responsibilities at ports of entry. It is expected that these port of entry plans will continue to improve as these issues are discussed and additional guidance document from the USG is provided.

Summary Data

SUMMARY RATING	NUMBER
No Major Gaps	1
A Few Major Gaps	5
Many Major Gaps	8
Inadequate Preparedness	2
Not Applicable	40
Total	56

STATE WITH NO MAJOR GAPS

Washington

Operating Objective B.3 – Implement Community Mitigation Interventions

Lead Department – Department of Health and Human Services (Centers for Disease Control and Prevention)

General Comments

State readiness for community mitigation planning, as represented by review of 2008 State operational plans, varies widely from State to State. Some States have conducted significant planning to implement "non-pharmaceutical" interventions; however, others are clearly only beginning to do so.

- In general, most States have identified legal authorities, responsible persons and processes for implementation of measures such as school closure or cancellation of large public gatherings. However, for many States, much of the logistical work to specifically identify how this will occur and in what time frame remains to be identified.

- Although a few States have done much work with their local jurisdictions, many States are just beginning to work intensively with local jurisdictions on planning for community mitigation measures. Because almost all of the response will be at a local level, it is critical that States assure that local jurisdictions are educated and have adequate planning and resources at the local level.
- There is a lack of consensus on the best methods for data collection from local jurisdictions (i.e., case counts, measures recommended, measures being implemented, deaths, etc.) to States and then to CDC. This is critically important and is still not agreed upon or evident in their plans. CDC, in collaboration with States, is developing guidance on this topic to standardize information and methodology.
- Not all States have incorporated the recommended interventions in the "Interim Pre-pandemic Planning Guidance"[9] published by CDC in 2007, regarding certain critical aspects of the planning, such as school or childcare closure. This is especially concerning, as several States imply that they do not plan to strategically implement these critical parts of the strategy.
- Most States have not begun to work with businesses, school districts, spiritual leaders or with other non-governmental organizations in planning. These are critical partners that need to be included in pandemic influenza planning.
- Tribal agencies are not well-represented in the plans.
- Although some States have started to use pandemic planning exercises to assess their vulnerabilities and readiness, most States have not started to use that tool. Exercising a plan can be helpful in determining capabilities to implement the plan.
- In general, it appears that States are not as far along in the planning process for non-pharmaceutical community mitigation preparedness, as in other aspects of planning. The federal government should support their efforts in this area, as it may be the single most important aspect of readiness in terms of reducing morbidity and mortality during a pandemic or influenza.

Summary Data

SUMMARY RATING	NUMBER
No Major Gaps	11
A Few Major Gaps	19
Many Major Gaps	19
Inadequate Preparedness	7
Not Applicable	0
Total	56

STATES WITH NO MAJOR GAPS

Connecticut	Michigan	New York	Wisconsin
Hawaii	Minnesota	Rhode Island	American Samoa
Maine	Mississippi	Tennessee	

[9] http://www.pandemicflu.gov/plan/community/community_mitigation.pdf

Operating Objective B.4 – Enhance State Plans to Enable Community Mitigation through Student Dismissal and School Closure

Lead Department - Department of Education
Supporting Department - Department of Health and Human Services (Centers for Disease Control and Prevention)

General Comments
As part of a comprehensive community mitigation strategy, the USG recommends closing schools and day care centers and dismissing students. The authorities for closing schools or dismissing students vary widely among States and localities and a patchwork of laws and regulations govern these authorities. To create comprehensive community mitigation strategies, States were asked to consider the complex implications of closing schools and dismissing students from larger aggregate settings such as day care centers. States were also asked to consider the implications closing schools on both the teaching and learning processes, as well as on the social-emotional effects on all students and families across the age and development spectrum. A comprehensive mitigation strategy would consider the needs of all children and students, from early childhood through higher education, as well as special education and general education students.

Overall, States deferred much of the planning responsibility to their local educational or governing entities. Very few States assumed any sort of coordination responsibility for closing schools or tracking the work that local educational agencies (LEAs), Institutions of Higher Education (IHEs), or child care entities were doing within the States. In the event of a pandemic, it is neither likely that LEAs would have the capacity to operate with equal levels of ability, nor is it likely that the State educational agency (SEA) would be comfortable deferring all responsibility to LEAs with no oversight or coordination. Furthermore, a lack of coordinated State response could potentially compromise the State's ability to successfully mitigate the virus' transmission.

Additionally, States were asked to consider a range of issues directly and indirectly related to closing schools and dismissing students but overall, few States demonstrated an attempt to coordinate efforts across entities. The intent was not to imply that SEAs would have responsibility for all aspects of school closure or student dismissal, but rather that these related efforts be coordinated at the State level. For example, most SEAs do not have responsibility for day care closures but there were limited demonstrated efforts to delineate how day care centers would be closed, whether closures would be voluntary or mandatory, how messages would be communicated to these entities or those messages coordinated. Similarly, there was limited demonstrated coordination between public and private IHEs at the state level to encourage cooperation and communication, particularly related to the use of facilities and incidence tracking.

States did seem to be connected to some State planning efforts, with most States having designated representatives to the State pandemic team (though higher education is often not included in this group) and are participating in emergency operations centers or joint communication efforts or teams.

Summary Data

SUMMARY RATING	NUMBER
No Major Gaps	6
A Few Major Gaps	11
Many Major Gaps	17
Inadequate Preparedness	22
Not Applicable	0
Total	56

STATES WITH NO MAJOR GAPS

Arizona	Michigan	Nebraska
Iowa	Minnesota	Wisconsin

Operating Objective B.5 – Acquire and Distribute Medical Countermeasures

Lead Agency - Centers for Disease Control and Prevention, Department of Health and Human Services

General Comments

There are very few gaps in State readiness for antiviral drug distribution, as represented by review of 2008 State operating plans. State and local jurisdictions have been engaged in mass prophylaxis planning over the past five years and have accomplished a level of capacity to distribute and administer antiviral drugs to their entire population within a timely manner.

- Most State and local jurisdictions have identified legal authorities, responsible persons and processes for receiving, storing and distributing antiviral drugs, personal protective equipment and ancillary medical supplies that would be needed for a pandemic outbreak of influenza and other public health emergencies.
- Most States have established electronic systems for tracking and maintaining inventory. These systems are also designed to support requests for additional inventory by the local jurisdictions during a public health emergency.
- All State and local jurisdictions have conducted exercises and drills to assess gaps in planning and readiness. The exercises are Homeland Security Exercise Evaluation Program compliant and have been used to improve operational plans. Most States have developed a cyclic exercise plan to continue improvement in readiness and documentation of their operational plans.
- Some States have established partnerships and Memoranda of Understanding with their State and local law enforcement agencies. Most law enforcement agencies, in collaboration with the U.S. Marshalls assigned to the Strategic National Stockpile, have conducted assessments to determine security vulnerabilities at warehouse sites as well as the community sites for distribution and administration of antiviral drugs.
- Most States have established working partnerships with businesses, school districts, civic leaders and community organizations. These critical partners are engaged during all phases of planning for mass prophylaxis for pandemic influenza and other public health emergencies. In many States, the partners have played a major role in planning the

- All States have plans and protocols for reporting adverse events to HHS' Food and Drug Administration. The electronic systems that will be used for reporting adverse events vary widely among States.

Assistance and background guidance, including references to storage requirements, logistics requirements, and model workscope documents are available to States from Program Services Consultants in CDC's Division of Strategic National Stockpile.

Summary Data

SUMMARY RATING	NUMBER
No Major Gaps	37
A Few Major Gaps	12
Many Major Gaps	3
Inadequate Preparedness	4
Not Applicable	0
Total	56

STATES WITH NO MAJOR GAPS

Alabama	Illinois	Mississippi	Oklahoma	Washington
Arizona	Indiana	Missouri	Oregon	Wisconsin
Arkansas	Iowa	Montana	Rhode Island	District of Columbia
California	Louisiana	Nebraska	South Carolina	American Samoa
Colorado	Maryland	New Jersey	South Dakota	Puerto Rico
Connecticut	Massachusetts	New Mexico	Texas	
Delaware	Michigan	New York	Vermont	
Florida	Minnesota	Ohio	Virginia	

Operating Objective B.6 – Ensure Mass Vaccination Capability During Each Phase of a Pandemic

Lead Department – Department of Health and Human Services (Centers for Disease Control and Prevention)

General Comments

Overall, the States are doing well with respect to the following tasks:

- Developing State-level Pandemic Influenza vaccination plans.
- Identifying vaccine ship-to sites, planning for secondary allocation and distribution, and developing plans for reporting on vaccine utilization.

Many States are struggling with the following Supporting Activities:

- Transitioning from planning activities to implementation activities.
- Establishing cohesive collaboration among the various State divisions and/or with local and/or regional health departments.

- Recognizing that vaccines will be delivered via a system that is different from, albeit similar to, that used to deliver antiviral drugs – i.e., more frequent deliveries over a longer period of time. While the Strategic National Stockpile procedures (e.g., those for point of dispensing) are a good foundation, States need to have a clear, stand-alone pandemic influenza vaccination plan.
- Writing plans, reviewing, and updating requirements in accord with CDC directions. Major variation in State populations, health department sizes, personnel resources, work loads and other infrastructure issues, and changing federal recommendations might be factors hindering adequate planning.
- Ensuring sufficiently detailed local health department plans. Many States perceive "Home Rule" to be a barrier to asserting authority from the State health department level over local preparedness activities. For example, State officials resent being held accountable for local planning activities when they do not have any direct line authority over local health departments.

Summary Data

SUMMARY RATING	NUMBER
No Major Gaps	31
A Few Major Gaps	19
Many Major Gaps	4
Inadequate Preparedness	2
Not Applicable	0
Total	56

STATES WITH NO MAJOR GAPS

Alabama	Idaho	Nevada	South Carolina	District of Columbia
Arkansas	Illinois	New Hampshire	Tennessee	American Samoa
California	Kansas	North Carolina	Utah	Puerto Rico
Connecticut	Louisiana	North Dakota	Vermont	
Delaware	Maine	Oklahoma	Virginia	
Georgia	Massachusetts	Oregon	Washington	
Hawaii	Mississippi	Rhode Island	Wisconsin	

Operating Objective B.7 – Provide Healthcare

Lead Department – Department of Health and Human Services (Office of the Assistant Secretary for Preparedness and Response)
Supporting Departments - Department of Veterans Affairs; Department of Health and Human Services (Centers for Disease Control and Prevention)

General Comments

Assessing the ability to provide healthcare during a pandemic is difficult because the sector includes a broad range of public and private entities, some of which are for-profit businesses. On a daily basis the healthcare system is under stress with staffing shortages and emergency

department overcrowding. Overall the scores for this Operating Objective are reflective of the current State of the healthcare system.

This Operating Objective includes a broad range of activities, some of which are supported or required by the HHS Hospital Preparedness Program (HPP). The HPP, through its cooperative agreements with States, supports the development and maintenance of capabilities to prevent, protect against, respond to, and recover from all hazards, including pandemic influenza. Current program priorities include interoperable communication systems, bed tracking, volunteer personnel management, fatality management, medical evacuation and partnership/coalition development.

The HPP supports but does not require other activities that were measured under this Operating Objective: alternate care sites, personal protective equipment and infection control supplies. Evaluations of the HPP program by the Government Accountability Office and the Center for Biosecurity at the University of Pittsburgh School of Medicine, respectively, indicate that healthcare preparedness capabilities have improved in those areas that are funded by the program. States and healthcare entities should consider, in the spirit of shared responsibility for pandemic influenza preparedness, whether they are making sufficient investments toward fulfilling this Operating Objective – especially for activities not covered by HPP funding. States that received the highest scores under this Operating Objective had operational plans that clearly identified their State-based systems for volunteer personnel management, bed tracking and interoperable communications, which are HPP requirements.

Successful State submissions generally provided a clear description of the local and State roles and responsibilities for healthcare. Operating plans conveyed what the State would do, what information the State would provide, and how the information would be accessed. These submissions also included information or examples of local initiatives to demonstrate local capability and how local planners were using the information found in the State documents to further their planning. One State actually incorporated tools and initiatives that demonstrated its level of engagement and how it is strategizing to ensure that local planners are able to continue to develop and refine their own community planning efforts.

When the State plans were reviewed, it was expected that the supporting activities would be "actionable." Actionable plans should include identified agency roles, contact numbers, protocols and procedures where applicable. While some of the plans did not reflect this level of detail, it is not possible to know whether the States would have been able to perform the activities during exercises or real events. The review also indicated that States are engaged in developing plans for alternate care sites, scarce resources and recovery, but those plans were not considered "actionable." The reviewers observed that many States are not actively engaging with public health, community health clinics, private physicians, non-hospital healthcare providers and other healthcare partners. The USG should continue to support healthcare system preparedness by encouraging healthcare coalition development through the HPP.

Summary Data

SUMMARY RATING	NUMBER
No Major Gaps	9
A Few Major Gaps	12
Many Major Gaps	15
Inadequate Preparedness	20
Not Applicable	0
Total	56

STATES WITH NO MAJOR GAPS

Alabama	Iowa	Ohio
Delaware	Massachusetts	Rhode Island
Indiana	Minnesota	Utah

Operating Objective B.8 – Manage Mass Fatalities

Lead Department –Department of Health and Human Services (Office of the Assistant Secretary for Preparedness and Response)
Supporting Department - Department of Veterans Affairs

General Comments

Unlike Operating Objective B.7, the supporting activities for Operating Objective B.8 address issues that are not required by the HHS Hospital Preparedness Program (HPP). While the HPP requirements for funding include fatality management planning, funds are targeted for the development of enhanced State/local fatality capabilities, including the need for expanded refrigerated storage capacity and the purchase of mortuary equipment and supplies (i.e. face shields, protective covering, gloves and disaster body bags.) Fatality management activities are in the planning stages for most States.

When the State plans were reviewed, the primary expectation was that the supporting activities under the operating objective must be actionable. The fatality management plans needed to delineate roles and responsibilities of all agencies involved in mass fatality management. The reviewers observed that many States are not actively engaging with their State/local behavioral health and fatality management partners, an activity that is imperative for meeting this Operating Objective. HHS should continue to encourage healthcare coalition development and actionable fatality management plans through the HPP.

Summary Data

SUMMARY RATING	NUMBER
No Major Gaps	7
A Few Major Gaps	8
Many Major Gaps	12
Inadequate Preparedness	29
Not Applicable	0
Total	56

STATES WITH NO MAJOR GAPS

Arizona	Massachusetts	American Samoa
Delaware	North Dakota	
Indiana	Ohio	

Operating Objective B.9 – Ensure Communication Capability during Each Phase of a Pandemic

Lead Department –Department of Health and Human Services (Centers for Disease Control and Prevention)

General Comments

In general, States have made excellent progress in developing communication plans for pandemic influenza response and recovery. States have identified existing Public Information Officers and protocols for answering media inquiries, so the majority of the operating plans addressed the retrofitting those existing procedures. Moreover, most States have pre-identified audiences and communication channels. Some areas for improvement include the following:

- For States that have not yet done so, rigorously and routinely test the communications plans.
- Table-top exercises are useful; however, they are not as helpful as functional exercises which always reveal plan shortcomings.
- States should develop or enhance procedures for corrective action plans following exercises.
- In general, there is a paucity of sufficient plans for the development of culturally appropriate and language-specific essential information in appropriate media and in advance as part of the preparation for an influenza pandemic, particularly in the area of outreach to vulnerable populations.
- Most plans did not include call-down lists with contact numbers and addresses for emergency response information partners as well as key media contacts.
- Many plans did not address all phases of the influenza pandemic.
- Some plans did not identify a process for regular briefings with key stakeholders to develop working relationships not already established in advance of an influenza pandemic.

Summary Data

SUMMARY RATING	NUMBER
No Major Gaps	31
A Few Major Gaps	16
Many Major Gaps	5
Inadequate Preparedness	4
Not Applicable	0
Total	56

STATES WITH NO MAJOR GAPS

Alaska	Illinois	Nebraska	Rhode Island	Wisconsin
Arizona	Indiana	Nevada	South Dakota	District of Columbia
Arkansas	Kentucky	New Hampshire	Texas	Puerto Rico
California	Maryland	New York	Utah	
Connecticut	Massachusetts	North Dakota	Vermont	
Delaware	Mississippi	Oklahoma	Virginia	
Hawaii	Missouri	Oregon	Washington	

Operating Objective B.10 - Mitigate the Impact of an Influenza Pandemic on Workers in the State

Lead Department – Department of Labor (Office of the Assistant Secretary for Policy, Office of the Assistant Secretary for Administration and Management)
Supporting Departments – Department of Commerce, Department of Health and Human Services (Office of the Assistant Secretary for Administration and Management, National Institutes of Health)

General Comments

Many States did not appear to follow the general guidance:

> *"States should: 1) assess which State benefits and other assistance programs can help workers during a pandemic and whether new resources, laws or programs may be needed, and 2) provide information to help workers and their families prepare for a pandemic. Many individuals in the State will be unable to work due to illness, the need to care for ill family members, the need to stay home temporarily when exposed to an ill person, or the need to care for a child dismissed from school. Some workers will lose their jobs because of the pandemic; others may be on unpaid leave (after exhausting their paid leave or because they do not have paid leave). States need to assess the benefits and services available to workers during a pandemic in order to assist them."*

Some States misunderstood this Operating Objective. They did not understand that it was to assist all workers and employers in the State, not just State employees (which was addressed in Operating Objective A.1). Additionally, States did not consider all State programs or services that would be crucial during and after a severe pandemic; they focused on just a few. Both of these difficulties likely would have been avoided with better communication among State pandemic planners and their agencies. (See general comments for Operating Objective A.1.)

Summary Data

SUMMARY RATING	NUMBER
No Major Gaps	2
A Few Major Gaps	1
Many Major Gaps	7
Inadequate Preparedness	46
Not Applicable	0
Total	56

STATES WITH NO MAJOR GAPS
Arizona
Wisconsin

Operating Objective B.11 – Understand Official Communication Mechanisms for Foreign Missions, International Organizations, and Their Members in the United States

Lead Department – Department of State

All States to which this Operative Objective applies were judged as having "No Major Gaps." See Table 2 to identify those States for which this Operating Objective is "Not Applicable."

Operating Objective B.12 – Integrate EMS and 9-1-1 into Pandemic Preparedness

Lead Department – Department of Transportation
Supporting Departments – Department of Health and Human Services, Department of Homeland Security

General Comments
An influenza pandemic could seriously impact the Nation – its health care delivery system, transportation system, economy and social structure. As the nation's health care "safety net," Emergency Medical Services (EMS) will be faced with amplified demands for services while experiencing problems similar to the rest of the Nation – increased employee absenteeism, disruption of supply chains, and increased rates of illness and death. Ensuring EMS is well-integrated into the Nation's pandemic influenza planning and response is essential to the Nation's health and safety in the event of a pandemic. As such, EMS pandemic influenza preparedness should address a variety of issues. These include planning, influenza surveillance and mitigation, maintaining continuity of operations, legal authority, clinical standards and treatment protocols, and workforce protection.

State responses to questions regarding pandemic influenza preparedness were assessed.. The activity that States most frequently completely addressed was having requirements or recommendations in place for EMS agencies for basic infection control procedures.. The most frequent activities States have largely, but not completely, addressed include: (1) establishing an

effective, reliable interoperable communications system among EMS, 9-1-1, emergency management, public safety, public health and health care agencies; and (2) developing system-wide processes for providing vaccines and anti-viral medication to EMS personnel.

The activity that States most frequently did not address was defining the role of EMS providers in "treating and releasing" patients without transporting them to a healthcare facility.

States are encouraged to review the following two documents for additional information and guidance: DOT's *EMS Pandemic Influenza Guidelines for Statewide Adoption* and *Preparing for Pandemic Influenza: Recommendations for Protocol Development for 9-1-1 Personnel and Public Safety Answering Points (PSAPs).* They are available online at http://www.ems.gov.

Summary Data

SUMMARY RATING	NUMBER
No Major Gaps	1
A Few Major Gaps	3
Many Major Gaps	16
Inadequate Preparedness	36
Not Applicable	0
Total	56

STATE WITH NO MAJOR GAPS
New York

Operating Objective B.13 – Integrate Public Safety Answering Points into Pandemic Preparedness

Lead Department - Department of Transportation
Supporting Departments – Department of Commerce, Department of Health and Human Services, Department of Homeland Security, and Federal Communications Commission

General Comments
9-1-1 Public Safety Answering Points (PSAPs) serve as the public's single point of access to EMS, law enforcement and fire services – as well as an avenue for requesting many other services. Ensuring 9-1-1 is well-integrated into the Nation's pandemic influenza planning and response is essential to the Nation's health and safety during a pandemic. 9-1-1 pandemic influenza preparedness should address guiding principles for PSAPs in addition to a variety of issues. These include provision of information to the public, facilitation of call screening, assistance with priority dispatch of limited EMS resources, education and training of PSAP personnel and continuity of operations.

State responses to questions regarding pandemic influenza preparedness were assessed. Activities that States most frequently completely addressed were involving PSAPs in Statewide pandemic influenza planning and delineating the role of PSAPs in the Statewide pandemic influenza plan.

The activity that States most frequently did not address was having protocols and procedures in place to guide PSAP triage and patient classification during an influenza pandemic.

States are encouraged to review the following two documents for additional information and guidance: DOT's *EMS Pandemic Influenza Guidelines for Statewide Adoption* and *Preparing for Pandemic Influenza: Recommendations for Protocol Development for 9-1-1 Personnel and Public Safety Answering Points (PSAPs).* Both are available online at http://www.ems.gov.

Summary Data

SUMMARY RATING	NUMBER
No Major Gaps	1
A Few Major Gaps	0
Many Major Gaps	4
Inadequate Preparedness	51
Not Applicable	0
Total	56

STATE WITH NO MAJOR GAPS
North Dakota

Operating Objective B.14 – Operating Readiness

Table 3 includes each State's Operating Readiness score. Each score is the sum of points awarded for exercising plans relevant to achieving discreet Operating Objectives.

Operating Objective B.15 – Public Safety and Law Enforcement

Lead Department – Department of Justice

General Comments
It is apparent that the approach of the planners for this operating objective, being uniformly State Police or directors of public security, was on a relatively narrowly defined set of law enforcement objectives and approaches. As the inquiry broadened to other elements of the State government or justice sector, the responses were either very general or suggested that the lead agency for the operating objective had no authority or responsibility for those matters.

The single most difficult issue in all the plans related to the question how "State officials [will] coordinate the actions of the interdependent components of the criminal justice system (to include courts, corrections, law enforcement agencies, prosecutors, and probation/parole officials) to avoid or limit interruption of essential services and functions during an influenza pandemic interdependent elements." The majority of responses related narrow jurisdictional approaches: for example, the State Police participate in the operations center and will be following guidance accordingly. Others suggested that the matter was not a responsibility of the

authoring agency. One State, for example, noted that the State Supreme Court established jurisdiction and rules for State courts and therefore it was beyond the authoring agency's responsibility to address such matters in the planning.

This approach raises concerns that the various elements within the overall justice sector specifically, or State government generally, are stove-piping current planning and use as a planning assumption that incident-specific guidance will be available as needed and will satisfy their needs regarding continuity of operations. This may be particularly true in the law enforcement/justice sector, as planning must cross potential separation of powers barriers between the State's executive branch and its judicial branch. However, planning is not, and is not intended to be, a directive activity such that a State executive branch agency might direct action by the judiciary. Rather, truly collaborative planning can ensure the interdependent elements understand each others' assumptions, missions, plans and policies, and can develop standard operating procedures or other guidelines to facilitate operations during a pandemic, thereby minimizing the need to rely on a start-from-scratch, guidance-directed approach during a pandemic. For example, planning now can address how: a law enforcement officer arrests, then screens a suspect for health risks; the system arraigns the individual with due caution for the risks to court personnel, perhaps by video-linked proceedings, and transports the suspect to a detention/correction facility while observing public health protocols; and an attorneys consultation with a client in a detention setting is also conducted under health-risk-sensitive conditions.

Our concern about this approach goes beyond merely the "normal" criminal justice process. Virtually all plans suggest that were movement restrictions or quarantines to be required, judicial orders would be available for enforcement. But a court order requires a proceeding, which, in turn, requires: an appropriate venue; the necessary court personnel (prosecutors, judges, administrative personnel, attorneys); and procedures that govern the proceedings while, at the same time, addressing potential health risks. Failure to develop a shared concept of operations and associated agency- or court-specific processes and procedures through collaborative planning before the event will undercut the ability of the State to enforce some of the fundamental restrictions upon which the plans rely, never mind to address the normal criminal law enforcement issues that arise daily.

Summary Data

SUMMARY RATING	NUMBER
No Major Gaps	18
A Few Major Gaps	18
Many Major Gaps	8
Inadequate Preparedness	12
Not Applicable	0
Total	56

STATES WITH NO MAJOR GAPS

Arizona	Indiana	Mississippi	Oregon	American Samoa
Arkansas	Iowa	New Mexico	Pennsylvania	Guam
Delaware	Kansas	New York	Rhode Island	
Illinois	Minnesota	Oklahoma	District of Columbia	

Strategic Goal C – Sustain/Support 17 Critical Infrastructure Sectors and Key Resources

Lead Department - Department of Homeland Security

Note that the comments below apply to all seven of the Operating Objectives that fall under this Goal.

General Comments

This Goal focuses on the State government's role with respect to sustaining publicly- and privately-owned critical infrastructure. Additional focus emphasizes the State's responsibility for developing and implementing State-wide critical infrastructure sectors and key assets (CIKR) protection programs to help mitigate the effects of pandemic influenza.

DHS reviewers identified that States still face many challenges in integrating and supporting CIKR in their emergency response planning for all-hazards, including pandemic influenza. However, our reviewers were encouraged by the efforts that have been initiated by the States. Most States improved their overall plans and scores from the ones previously submitted.

There were also a few notable efforts and best practices that could be shared with all. For example:

- A dedicated CIKR Pandemic Plan;
- A dedicated Public-Private Partnership Plan for CIKR;
- The establishment an Emergency Support Function (ESF) 24 "Business and Industry" that should be a national model to support CIKR; and
- States incorporating CIKR into their Department Of Health Pandemic Plans.

Finally, DHS and HHS must continue to partner in order to promote CIKR planning with health departments (most of the States name the health department as responsible for managing ALL pandemic response) and in adding CIKR support to the variables tracked for HHS pandemic funding grants.

Summary Data

Operating Objective C.1 – Define CIKR Protection, Planning, and Preparedness Roles and Responsibilities

SUMMARY RATING	NUMBER
No Major Gaps	13
A Few Major Gaps	7
Many Major Gaps	5
Inadequate Preparedness	31
Not Applicable	0
Total	56

STATES WITH NO MAJOR GAPS

Alabama	Arkansas	Florida	Maryland	Wisconsin
Alaska	California	Illinois	Tennessee	
Arizona	Connecticut	Indiana	Virginia	

Operating Objective C.2 – Build Public-Private Partnerships & Support Networks

SUMMARY RATING	NUMBER
No Major Gaps	15
A Few Major Gaps	9
Many Major Gaps	8
Inadequate Preparedness	24
Not Applicable	0
Total	56

STATES WITH NO MAJOR GAPS

Alabama	California	Indiana	Washington
Alaska	Connecticut	Maryland	Wisconsin
Arizona	Florida	New Mexico	District of Columbia
Arkansas	Illinois	Tennessee	

Operating Objective C.3 – Implement the NIPP Risk Management Framework for a Pandemic

SUMMARY RATING	NUMBER
No Major Gaps	15
A Few Major Gaps	5
Many Major Gaps	8
Inadequate Preparedness	28
Not Applicable	0
Total	56

STATES WITH NO MAJOR GAPS

Alabama	California	Illinois	Tennessee
Alaska	Connecticut	Indiana	Virginia
Arizona	Delaware	Maryland	Wisconsin
Arkansas	Florida	New Mexico	

Operating Objective C.4 – Bolster CIKR Information Sharing & Protection Initiatives

SUMMARY RATING	NUMBER
No Major Gaps	20
A Few Major Gaps	5
Many Major Gaps	6
Inadequate Preparedness	25
Not Applicable	0
Total	56

STATES WITH NO MAJOR GAPS

Alabama	Colorado	Indiana	Pennsylvania
Alaska	Connecticut	Louisiana	Tennessee
Arizona	Delaware	Maryland	Virginia
Arkansas	Florida	New Jersey	Washington
California	Illinois	New Mexico	Wisconsin

Operating Objective C.5 – Leverage Emergency Preparedness Activities for CIKR Protection, Planning, and Preparedness

SUMMARY RATING	NUMBER
No Major Gaps	20
A Few Major Gaps	6
Many Major Gaps	11
Inadequate Preparedness	19
Not Applicable	0
Total	56

STATES WITH NO MAJOR GAPS

Alabama	Connecticut	Maryland	Utah
Alaska	Delaware	New Jersey	Virginia
Arizona	Florida	New Mexico	Washington
Arkansas	Illinois	Pennsylvania	Wisconsin
California	Indiana	Tennessee	District of Columbia

Operating Objective C.6 – Integrate Federal and State CIKR Protection, Planning, & Preparedness Activities

SUMMARY RATING	NUMBER
No Major Gaps	20
A Few Major Gaps	9
Many Major Gaps	3
Inadequate Preparedness	24
Not Applicable	0
Total	56

STATES WITH NO MAJOR GAPS

Alabama	Connecticut	Iowa	Tennessee
Alaska	Delaware	Maryland	Utah
Arizona	Florida	New Mexico	Virginia
Arkansas	Illinois	Pennsylvania	Washington
Colorado	Indiana	Rhode Island	Wisconsin

Operating Objective C.7 - Allocate Scarce Resources

SUMMARY RATING	NUMBER
No Major Gaps	16
A Few Major Gaps	6
Many Major Gaps	11
Inadequate Preparedness	23
Not Applicable	0
Total	56

STATES WITH NO MAJOR GAPS

Alabama	Connecticut	Indiana	Tennessee
Arizona	Delaware	Maryland	Utah
Arkansas	Florida	New Mexico	Virginia
California	Illinois	New Mexico	Wisconsin

Concluding Observations

The findings summarized above indicate that, in the aggregate, the States have made important progress toward preparing for their unique roles in combating an influenza pandemic but have much more to do. Most States have major gaps with respect to most of the 27 Operating Objectives.

Preparedness is most advanced, albeit not in every State, with respect to several Operating Objectives that are exclusively or primarily the responsibility of State Public Health agencies: infectious disease surveillance and clinical laboratory operations (B.1), distribution of antiviral drugs and vaccines (B.5), mass vaccination (B.6), and public communications (B.9 and B.11). These achievements no doubt were facilitated to a significant extent by repeated and substantial investments of Federal funds and technical assistance – not only annual awards for public health emergency preparedness in general since 2002 but also emergency supplemental appropriations in 2006 and 2007 that were targeted to pandemic influenza preparedness.

However, with notable exceptions shown in the preceding section and in Table 3, many States, despite the targeted funding and technical assistance, continue to face formidable challenges with respect to other public-health-oriented Operating Objectives. The gaps associated with ensuring continuity of operations for public health functions (A.2) are of particular concern; for even the best plans can fail if managers cannot accommodate the significant absenteeism and disruptions in supporting services and supplies that an influenza pandemic is almost certain to produce. Passenger screening and related public health measures at international ports of entry (B.2) require further planning and attention from State and local public health and emergency management officials in collaboration with the HHS and DHS. Much remains to be done to develop effective and efficient community mitigation processes (B.3) that are applicable across the society – including strategically timed dismissals of students and/or closures of schools (B.4) in accord with plans developed under the aegis of State-level educational officials. Substantial shortfalls persist with respect to accommodating the expected surges in healthcare demand (B.7) and fatalities (B.8). Integration of emergency medical services systems into pandemic influenza preparedness generally is inadequate (B.12).

Similar challenges exist for many States, also with notable exceptions shown in the preceding section and in Table 3, with respect to Operating Objectives that go beyond public health and healthcare preparedness. Continuity of operations for all State agencies (A.1) merits significant attention if substantial socio-economic disruptions are to be avoided during an influenza pandemic. This is true especially for the State agencies that are responsible, respectively, for ensuring food safety (A.3), deploying military assets in pertinent civil-support roles (A.5), maintaining the transportation system (A.6), providing continuity-of-operations guidance to public and private employers across the State (B.10), integrating public safety answering points (e.g., emergency call centers) into pandemic preparedness (B.13), ensuring a strong, sustained law enforcement presence (B.15), and promoting the protection of critical infrastructure and key resources throughout the State (C.1-C.7). The USG has provided guidance and technical assistance for many of these activities but generally has not been in a position to award funds to help States develop them in the context of pandemic influenza preparedness.

The results of this assessment process provide a broad-brush picture of comparative strengths and weaknesses across the various facets of pandemic preparedness. However, readers should be mindful of two caveats. First, the findings are the product of reviews of documents rather than site visits or other direct observations of performance. The actual degree of readiness for any given State and any given Operating Objective therefore may be better or worse than what the submitted documents portray. Second, preparedness is dynamic rather than static. The actual degree of readiness therefore may have improved or deteriorated between the time any given State submitted its planning information and now.

Readers also should be mindful about how the reviewers approached their task. Reviewers rated the plan for each Supporting Activity associated with each Operating Objective, and they almost invariably accorded full credit whenever a State provided a complete response with cited documentation. That is, wherever the State presented a plan for a particular Activity, the reviewers tended to respect the State planners' thinking. When reviewers awarded less that the full rating for a particular Activity, the reason in essentially every case was that relevant information was absent or incomplete.

The assessment process provided numerous opportunities for States to submit additional Supporting Activities that they viewed as important but were not included in the Federal guidance document. Most States did not take advantage of this opportunity. This outcome is unfortunate, for State planners undoubtedly have unique insights that not only could benefit their own citizens but also could offer model practices that can help other States and the Federal Government. Future assessments would benefit if they can do more to tap into grass-roots creativity.

A special feature of Stage-2 was a focus on Operational Readiness - i.e., evidence that States had tested their operating plans through exercises and/or responses to actual emergencies. Such tests are indispensable for determining whether operating plans that seem strong in concept are likely to work well in practice. Many State-level agencies are not yet far enough along in planning for pandemic influenza to have mounted extensive exercise programs. Nevertheless, the States' submissions include numerous examples of selective exercise-based evaluations. Future preparedness efforts could benefit immensely from expansion and refinement of these initiatives.

Attachment A. Members of the USG Working Group

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Department of Defense	A.5	Judi Davenport	(703) 697-5657	Judi.Davenport@osd.mil
		Mark Gentilman	(703) 845-8371	Mark.Gentilman@tma.osd.mil
		Jim Geleta	(703) 601-2639	James.Geleta@us.army.mil
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		Camille Welborn	(202) 549-4647	Camille.Welborn@ed.gov
Department of Health and Human Services	A.2, B.1, B.2, B.3, B.5, B.6, B.7, B.8, B.9	Mark Frank	(404) 639-3743	Mark.Frank@cdc.hhs.gov
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U.S. Office of Personnel Management		Kimberly Moore	(202) 606-1230	Kimberly.moore@opm.gov

Lead: Dr. William F. Raub, Science Advisor to the Secretary, HHS

Attachment B. Letter from USDA

December 16, 2008

Dr. William Raub
Science Advisor to the Secretary
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 638G
200 Independence Avenue, SW
Washington, DC 20201

Dear Dr. Raub:

U.S. Department of Agriculture (USDA) is participating in the project to review State pandemic influenza operating plans, with a focus on USDA objectives contained in the "Federal Guidance to Assist States in Improving State-Level Pandemic Influenza Operating Plans." We are proposing follow-up discussions with individual States and Territories regarding our portion of the assessment, because of circumstances that have precluded our meeting of the target dates. This effort will provide the desired feedback on the pandemic influenza operating plans which were submitted by States and Territories in response to the Federal guidance.

As we view panflu preparedness as a community issue, with national importance, it is vital that USDA should continue to partner in this interagency process. Our two objectives appear as appendices A.3 (assuring the ability of States to continue meat and/or poultry inspection programs to ensure food safety, during a pandemic) and A.4. (ensuring the ability to meet commitments to support responses to agricultural emergencies, and meet nutrition assistance commitments in administering programs and supplying food in an emergency).

The majority of the assessments for appendix A.4 are complete. Our personnel with the required expertise to review these areas have been impacted by a number of natural disasters this year, including the mid-west flooding and hurricanes. We feel it is best to complete the reviews and share the feedback to all States at the same time, as opposed to submitting partial results.

To that end, we request your help in obtaining the names of the appropriate State planners, to include the overall State coordinators and the subject matter contacts for the two USDA objectives A.3 and A.4. Using this approach we will be able to meet the objectives of the tasking in the Implementation Plan, and fulfill the overarching objectives of the National Strategy.

Sincerely,

Ron Niemeyer
Deputy Director of Emergency Programs
USDA DASA-Designated POC

Attachment C. Letter to Governors

[Dated November 14, 2006]

The Honorable George Pataki
Governor of New York
Albany, New York 12224

Dear Governor Pataki:

I appreciate the time you and your staff members spent in planning and convening your state's pandemic influenza summit. It was a pleasure for me and my senior staff to visit every state and discuss this important public health issue. If pandemic influenza occurs, it will greatly affect our society. Its implications will reach far beyond the health sector. I am now writing to ask you to ensure that all your state agencies are actively engaged in the development of the state pandemic influenza plan.

In November 2005, President Bush released the National Strategy for Pandemic Influenza. In May 2006, the Homeland Security Council released the National Strategy for Pandemic Influenza: Implementation Plan, so the strategy could be realized. The Implementation Plan contains objectives and action items for which responsible agencies, timelines and benchmarks are assigned. One such action item requires HHS and DHS to review and approve state pandemic influenza plans.

We brought this task to the attention of your state's public health official last summer. However, I ask you to note this action item goes beyond public health and medical preparedness, because all aspects of state and local government should be prepared for the pandemic. It is critical that you ensure all agencies (e.g., education, emergency management, public safety, transportation, etc.) are actively engaged in the planning and submission process. We have asked states to submit information on their comprehensive state pandemic influenza plans to our Department's Centers for Disease Control and Prevention (CDC) by February 1, 2007. We will provide additional instructions for state submissions within the next month. The Department of Homeland Security will also disseminate this message to their state and local stakeholders.

Thank you for your commitment to improving your state's pandemic influenza preparedness.

Sincerely,

Michael O. Leavitt

cc: The Honorable Michael Chertoff
Secretary of Homeland Security

Attachment D. Letter to Governor's Chief of Staff Accompanying Interim Assessment

January 11, 2008

Dave Stewart
Chief of Staff to the Governor
600 Dexter Avenue
Montgomery, AL 36130-2751

Dear Mr. Stewart:

Last November, we sent to you and your state health official a draft evaluation of your state pandemic flu operations plan. We asked for your assistance in ensuring that appropriate state agency officials reviewed the draft interim assessment and provided comments. We appreciate the state responses we received and wanted to take this opportunity to share with you a summary of your state's Interim Assessment, which concludes the first round of the project.

Strengthening federal and state pandemic influenza preparedness remains a high priority for the Federal Government, and we look forward to working with your state as we develop improved federal guidance to assist states in enhancing their pandemic influenza operational plans. Over the next few weeks, we will engage states in the development of the guidance that will direct a second round of state operations plans. When we issue the resulting solicitation, we would again appreciate your help in ensuring that all relevant state agencies participate.

If you have any questions, please do not hesitate to contact Ms. Laura Caliguiri, Director of Intergovernmental Affairs, at (202) 690-6060 or Dr. William Raub, Science Advisor to HHS Secretary Mike Leavitt, at (202) 205-2882.

Thank you for your assistance.

Sincerely,

Laura Caliguiri
Director
Office of Intergovernmental Affairs

William F. Raub, Ph.D.
Science Advisor to the Secretary

Attachment E. Invitation to Regional Workshops

[Rolling dates, 2008]

The Honorable Deval Patrick
Governor of Massachusetts
Boston, MA 02133

Dear Governor Patrick:

Last month we provided your Chief of Staff and State Health Official the results of a draft interim assessment of your state pandemic influenza planning. With that information, we presented a timeline for next steps, including the U.S. Department of Health and Human Services' (HHS) objective to develop a second and improved guidance document for the preparation of an updated state pandemic influenza operations plan. We intend to develop this guidance in close collaboration with our state, District of Columbia and territorial partners. We believe that such intergovernmental teamwork will help ensure enhanced state and local preparedness for pandemic influenza and will set the stage for subsequent implementation of relevant requirements of P.L. 109-417, the "Pandemic and All Hazards Preparedness Act" (enacted December 19, 2006).

To facilitate this collaboration, the federal government will host a series of regional workshops throughout the month of January in the headquarters cities of the Department of Homeland Security (DHS) Pandemic Influenza Regions. During these workshops, federal staff will seek recommendations from your cabinet officials or their representatives on the expansion, refinement, and/or refocusing of the draft guidance and evaluation criteria. *In order to minimize time demands on senior state officials and to reduce travel costs, we prefer that your state agency representatives take advantage of the video conferencing opportunity described below.*

In anticipation that many of the priority areas from the first round of assessments will remain the same for the second round, we strongly recommend that representatives from several key sectors of state government participate in this workshop, including: Governor's office (e.g., emergency preparedness advisor), Homeland Security, Emergency Management, Law Enforcement, Education, Health, Transportation, Human Resources, National Guard, and Commerce/Business.

The HHS Pandemic Influenza Senior Federal Official for your Region, RADM Mike Milner, will host the workshop on January 22, 2008, from 10:00 a.m. to 1:00 p.m. EST, in the FEMA Headquarters in Boston, 99 High Street, 6th Floor. RADM Milner will present the draft guidance and solicit comments from state officials in your Region.

Again, due to tight state travel budgets and limited seating, we prefer that your designated state agency representatives participate in the workshop by video conference.

We ask that you designate someone in your office to coordinate your state's participation in this workshop. We also request that this individual contact RADM Milner's Executive Assistant,

LCDR Cheryl Fajardo (617-565-1064 or cheryl.fajardo@hhs.gov), by January 16, 2008 with the names and contact information for the participants in the workshop and to make arrangements for the video conferencing. In preparation for the meeting, we would like to conduct a video conferencing link test on Friday, January 18, 2008.

Thank you for your assistance. We look forward to this opportunity to assist you and your state planners.

Sincerely,

William F. Raub, PhD
Science Advisor to the Secretary

Laura Caliguiri
Director
Office of Intergovernmental Affairs