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DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Disease Control and Prevention
Public Health Emergency Preparedness

Announcement Type: Continuation

Funding Opportunity Number: AA154

Catalog of Federal Domestic Assistance Number: 93.283

Application Deadline: July 15, 2006

Notice of Award: August 31, 2006

I. Award Description

Authority: This program is authorized under Authority: 42 U.S.C. 247d-3.

Type of Award: Cooperative Agreement

Anticipated Award Date: August 31, 2006

Budget Period Length: 12 months (August 31, 2006- August 30, 2007)

Project Period: Budget Year Seven

Throughout the project period, the Centers for Disease Control and Prevention's (CDC) commitment to continuation of awards will be conditioned on the availability of funds, evidence of satisfactory progress by the recipient as documented in required reports and the results of performance measurements conducted or prescribed by CDC, and the determination that continued funding is in the best interest of the Federal Government.

Purpose: The purpose of this program is to develop emergency-ready public health departments by upgrading, integrating and evaluating state and local public health jurisdictions' preparedness for and response to terrorism, pandemic influenza, and other public health emergencies with federal, state, local, and tribal governments, the private sector, and non-governmental organizations (NGOs). These emergency preparedness and response efforts are intended to support the National Response Plan (NRP)¹ and the National Incident Management System (NIMS)².

The primary intent of this cooperative agreement is to fund the active participation of recipients in the immediate establishment, use, and continuous improvement of a national system of public health emergency preparedness that uses the CDC Preparedness Goals and associated measures to monitor public health system response performance.

In addition, the activities described in this cooperative agreement guidance are designed to develop emergency-ready public health departments in accord with the National Preparedness Goal (NPG)³, the Public Health and Healthcare Supplement to the NPG⁴,

¹ National Response Plan: http://www.dhs.gov/interweb/assetlibrary/NRP_FullText.pdf

² National Incident Management System <http://www.fema.gov/nims/>

³ Interim National Preparedness Goal: http://www.ojp.usdoj.gov/odp/docs/InterimNationalPreparednessGoal_03-31-05_1.pdf

and CDC's Preparedness Goals. The NPG contains three valuable components to help guide preparedness planning and implementation: the National Planning Scenarios, the Universal Task List (UTL), the Target Capabilities List (TCL)⁵. The Department of Homeland Security (DHS) coordinated the development of the NPG in concert with the Department of Health and Human Services (HHS) and other federal departments as well as with representatives of state, tribal and local public health departments and other stakeholders (e.g., healthcare, emergency management, law enforcement). All of these documents will be refined and extended periodically to capture lessons learned and to introduce new concepts as appropriate.

The NPG has established a common planning framework in which agencies and disciplines in all sectors and at all levels can operate. This common framework helps professionals see the linkages among the unique but related activities they undertake individually to build and enhance national preparedness. It also provides, to the nation, an opportunity to view programs that have traditionally been managed within one particular agency or discipline in a more holistic and connected context. Only when programs are managed and implemented through an interdisciplinary and multi-jurisdictional approach can the nation truly begin to operate in the coordinated fashion that an incident of national significance would demand.

The implementation of preparedness grant programs has been a priority for DHS and HHS. In FY 2005, DHS and HHS made available approximately \$3.878 billion in grant funds to states and local jurisdictions to build and sustain national preparedness through several major grant programs, including:

| Program Title | Sponsoring Agency | FY 2005 Funding |
|--|---|------------------------|
| Homeland Security Grant Program | Office for Domestic Preparedness, DHS | \$2.5 billion |
| Public Health Emergency Preparedness Cooperative Agreement | Centers for Disease Control and Prevention, HHS | \$862 million |
| National Bioterrorism Hospital Preparedness Program | Health Resources and Services Administration, HHS | \$491 million |
| Bioterrorism Training and Curriculum Development Program | Health Resources and Services Administration, HHS | \$25 million |
| Centers for Public Health Preparedness | Centers for Disease Control and Prevention, HHS | \$29 million |

These grant and cooperative agreement programs target distinct but related homeland security stakeholders at the state and local levels. For example, the State Homeland

⁴ Interim Public Health and Healthcare Supplement to the National Preparedness Goal: <http://www.hhs.gov/ophep/npgs.html>

⁵ Draft Target Capabilities List: Version 2.0; December 2005. U.S. Department of Homeland Security Office of Grants and Training (ATTN: Office for Policy, Initiatives, and Analysis) 810 7th Street, NW Washington, DC 20531. Version 2.0 of the Target Capabilities List will be made available on the OGT Secure Portal (<https://odp.esportals.com>) and the Lessons Learned and Information Sharing network (www.llis.gov)

Security Program within the Homeland Security Grants Program (HSGP) addresses all of the capabilities while the Law Enforcement Terrorism Prevention Program focuses specifically on the capabilities related to prevention efforts, and the Metropolitan Medical Response System (MMRS) Program focuses on regionally integrated mass casualty preparedness. Likewise, CDC's Public Health Emergency Preparedness program emphasizes public health capabilities, while the HRSA National Bioterrorism Hospital Preparedness Program focuses on healthcare capabilities.

Using the target capabilities, state and local homeland security, public safety, emergency response, emergency management, and public health professionals can understand the interconnectedness of their tasks both overall (e.g., how they complement one another and support the overall homeland security program), and functionally-specific (e.g., information and intelligence fusion) perspectives and understand how the related missions fit together within the unified vision of national preparedness. It is expected that recipients of this cooperative agreement are planning, implementing and exercising tasks with professionals associated with the Medical Reserve Corps (MRC), MMRS, Citizen Corps Program (CCP) and/or others.

This announcement is only for non-research activities supported by the Centers for Disease Control and Prevention/Agency for Toxic Substances and Disease Registry (CDC/ATSDR). If research is proposed, the application will not be reviewed. For the definition of research, please see the CDC web site at the following Internet address: <http://www.cdc.gov/od/ads/opspoll1.htm>.

Eligibility Information: Eligibility is limited to those recipients currently funded through Cooperative Agreement AA154 and authorized under 42 U.S.C. 247d-3. This includes the 50 states, Puerto Rico, the Virgin Islands, the Pacific Island Jurisdictions (American Samoa, Commonwealth of the Northern Mariana Islands, Guam, Republic of the Marshall Islands, Republic of Palau, and the Federated States of Micronesia), and the localities of Chicago, Los Angeles County, New York City, and Washington, D.C.

Availability of Funds: Approximately \$ 761,000,000 is available in FY2006 to fund 62 states, localities, territories and Freely Associated States of the Pacific for program operations to prepare for and respond to terrorism and other public health emergencies. In addition, \$5,440,000 is available to continue support of existing Early Warning Infectious Disease Surveillance activities. (See Section V. Funding Information)

II. CDC Responsibilities: In a cooperative agreement, CDC staff is substantially involved in the program activities, above and beyond routine grant monitoring.

CDC Activities for this program are as follows:

- Provide Technical Assistance
 - Integration/Coordination of federal funding for preparedness
 - Subject matter expertise on preparedness activities (e.g., laboratory testing, epidemiology and surveillance, SNS preparedness, public health informatics, evaluation, health risk communication)
 - Identification of promising practices
 - Development of performance goals, standards, measures and evaluation instruments

- Guidance on, and in some cases, the conduct of drills and exercises
- Evaluate performance
- Monitor adherence to all relevant USPHS, HHS, CDC rules, regulations and policies regarding cooperative agreements
- Facilitate tribal, military, international, DHS and other federal agency efforts into national public health preparedness efforts and coordinate the public health preparedness responsibilities of the NRP where CDC is the designated lead agency.

III. Recipient Activities: CDC has developed CDC Preparedness Goals and associated measures designed as public health system response performance parameters that are directly linked to the health protection of the public. CDC’s Preparedness Goals are intended to frame urgent public health system response concepts for terrorism and non-terrorism events, including infectious disease, environmental and occupation-related emergencies. For the purposes of this announcement “response” is intended to indicate non-routine public health system reaction to limit possible mortality, morbidity, loss of quality of life, or economic damage. The CDC’s nine Preparedness Goals are:

PREVENT:

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

DETECT AND REPORT:

- (2) Decrease the time needed to classify health events as terrorism or naturally occurring in partnership with other agencies.
- (3) Decrease the time needed to detect and report chemical, biological, radiological agents in tissue, food or environmental samples that cause threats to the public’s health.
- (4) Improve the timeliness and accuracy of communications regarding threats to the public’s health

INVESTIGATE:

- (5) Decrease the time to identify causes, risk factors, and appropriate interventions for those affected by threats to the public’s health.

CONTROL:

- (6) Decrease the time needed to provide countermeasures and health guidance to those affected by threats to the public’s health.

RECOVER:

- (7) Decrease the time needed to restore health services and environmental safety to pre-event levels.
- (8) Improve the long-term follow-up provided to those affected by threats to the public’s health.

IMPROVE:

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

Additional Requirements:

1. Continuation of the Senior Advisory Committee:

In FY 2005, Office of Grants and Training (OGT), CDC, and HRSA all required the establishment of a Senior Advisory Committee (SAC), comprised of senior officials overseeing assistance programs from these and other federal agencies providing homeland security assistance. The SAC is to enhance the integration of disciplines involved in homeland security, including public health and healthcare. This requirement remains in place in FY 2006 and underscores the importance that DHS and HHS put on grantees and subgrantees taking a holistic approach to implementing their strategic homeland security goals and objectives by considering all available support and assistance programs, regardless of the source.

The membership of the SAC must, at a minimum, include state officials directly responsible for the administration of OGT grants and CDC and HRSA cooperative agreements: the State Administrative Agency (SAA), HRSA Program Director/Primary Investigator, HRSA Bioterrorism Hospital Coordinator, and CDC Program Director/Primary Investigator. In addition, program representatives from the following entities should be considered for membership on the committee: State Homeland Security Advisor (if this role is not also the SAA); State Emergency Management Agency Director; State Public Health Officer; State Public Safety Officer (and SAA for Justice Assistance Grants, if different); State EMS Director; State Trauma System Manager; State Citizen Corps POC; United States Coast Guard Area Command or Captain of the Port; Senior Security Officials from Major Transportation Systems; and the Adjutant General.

States are encouraged to broaden membership of the Senior Advisory Committee to include membership from additional disciplines (e.g., medical examiners, legal counsel, agriculture, and finance), local jurisdictions, associations and regional working groups.

2. Ability to Respond:

The ability of state and local public health agencies to respond to emergencies will be evaluated based on responses to real events, if any, and the results of assessments, site visits, drills and exercises conducted or prescribed by CDC. The organizational foci for these performance measurements, at a minimum, will be the state and local public health agencies and the public health agencies that serve the Metropolitan Statistical Areas (MSAs) included in the Cities Readiness Initiative (CRI). (See item 11 below and Appendix 4, Tables I and II)

Further guidance on the development and evaluation of exercises and drills will be forthcoming from CDC. To the extent possible, public health exercises should use standards set by the DHS Homeland Security Exercise Evaluation Program (HSEEP) as well as other recognized exercise programs including those used by the Federal Emergency Management Agency's (FEMA) Emergency Management Institute. These

exercises should test both horizontal and vertical integration with response partners at the local, tribal, state, and federal levels.

3. Reporting Systems:

Recipients must ensure that funds are available to establish and maintain systems to collect and report on the performance measures described in this program announcement and the forthcoming guidance cited above (see Ability to Respond). Reporting is not limited to the state public health agency's performance, but should include, at a minimum, that of the public health agencies that serve the MSAs included in the CRI and selected local and tribal public health entities. Applicants should designate a person who will be responsible for collecting and reporting all performance measure information to CDC.

4. Integration with Other Entities:

Recipients must implement a cohesive planning framework for implementing homeland security initiatives. This cooperative agreement provides resources to support public health efforts within this overall strategy. Recipients should coordinate these activities within their jurisdictions between state and local jurisdictions, tribes, and military installations; among local agencies; with hospitals and major health care entities, including tribal and Public Health Service facilities; among jurisdictional MMRSs and other locally-based programs, and with adjacent states. If applicable, recipients should coordinate with neighboring provinces, tribal/First Nations indigenous jurisdictions and states across international borders.

To emphasize the criticality of a coordinated approach to the management and application of these funding streams, DHS and HHS have established a Preparedness Grant Programs Steering Committee, in June 2005, to strengthen the alignment of each agency's respective grant programs both with each other and within the context of the NPG. Through this committee, DHS and HHS are working to align their programs and develop common language and analytical tools while maintaining the discrete subject areas for each program.

States are likewise encouraged to examine how they are integrating preparedness activities across disciplines. In FY 2006, states must implement a cohesive planning framework that builds and implements homeland security initiatives—to include public health and medical efforts specifically—that leverage all federal (e.g., DHS, HHS) resources and resources from other sources (e.g., local governments, foundations). The Senior Advisory Committee (see Additional Requirements, 1) should serve as a key resource in integration of preparedness activities and funding sources.

5. National Incident Management System (NIMS):

Public health agencies must support public health response functions in the context of NIMS. In accordance with HSPD-5, NIMS provides a consistent approach for federal, state, tribal and local governments to work effectively and efficiently together to prepare for, prevent, respond to, and recover from domestic incidents, regardless of cause, size, or complexity. As a condition of receiving Public Health Emergency Preparedness cooperative agreement funds, recipients agree to adopt and implement

NIMS. In accordance with the eligibility and allowable uses of the cooperative agreement, recipients are encouraged to direct FY 2006 funding towards activities necessary to implement NIMS.

State certification is required to receive FY 2006 preparedness funds.

Recipients are required to certify in their FY06 cooperative agreement applications that they have met the FY05 NIMS requirements. As part of the FY 2006 application, a statement of compliance with the minimum FY 2005 requirements, as certified for the applicant's HRSA Hospital Preparedness Cooperative Agreement, must be submitted as **Attachment 1**.

Applicants are also required to include a statement as **Attachment 2** that NIMS is being adopted at the state/ territorial level for all government departments and agencies, and is being promoted and encouraged among associations, utilities, NGOs, and private sector incident management and response organizations and hospitals.

NIMS compliance activities can be reviewed at
http://www.fema.gov/emergency/nims/nims_compliance.shtm

CDC can restrict funds to recipients that fail to certify that these FY 2005 requirements have been met.

6. Education and Training:

Competency-based education of public health workers, clinicians, and others critical to emergency response should be planned and implemented based on needs identified through assessments and/or evaluations of performance. Recipients are required to continue to support preparedness education and training activities needed to successfully achieve targeted outcomes and preparedness goals.

Recipients are expected to pursue the development, delivery, and evaluation of competency-based preparedness education in conjunction with Centers for Public Health Preparedness (CPHP), and academic experts in other schools of public health, medicine, nursing, and academic health science centers federally funded by CDC and HRSA to enhance preparedness education, training, and exercising. Prior to planning new preparedness education courses or training programs to meet identified needs and training requirements outlined within this guidance, state and local agencies are expected to first consult with CPHPs to identify and utilize existing education programs that have been evaluated for learning effectiveness (i.e., as evidenced by measured knowledge gained through pre- and post-tests, self assessed learner competence, and/or skill demonstrations.) In addition, resources such as learning management systems (e.g. TrainingFinder Real-time Affiliate Integrated Network (TRAIN) and other preparedness educational inventories (e.g. CPHP Resource Center should help facilitate the identification of existing preparedness educational programs that can be accessed, adopted, and adapted for local use, which will result in less duplication and more efficient use of available funds.

7. Public Health Information Network (PHIN):

During the award year, recipients are expected to implement capable, interoperable information systems that support public health preparedness. PHIN Preparedness defines functional requirements in the areas of Early Event Detection, Outbreak Management, Countermeasure and Response Administration, Partner Communications and Alerting, and Connecting Laboratory Systems. All recipients are expected to have or have access to information technology systems whose implementation is PHIN Preparedness Certified⁶, or actively participating in the PHIN Preparedness certification process (<http://www.cdc.gov/phinf/certification/>) during this cooperative agreement cycle. PHIN certification will ensure that systems have the functional requirements necessary to share data and work together in order to implement a national network of public health preparedness systems.

Recipients may choose to meet the functional requirements and specifications by building or enhancing their own systems, purchasing commercial solutions, or using CDC developed software and services. The requirements documents and specification guides include the details of what needs to be implemented in systems to meet these needs. While CDC has software and services available for each of the PHIN Preparedness functional areas, CDC is committed to working with recipients to help support solutions from any viable software solutions providers. The implementation of the PHIN Preparedness functional requirements may require several software systems to cover all of the functional areas, but in some circumstances, recipients may implement a single system that covers more than one functional area. Each PHIN Preparedness functional area can be certified separately. While CDC software and services have been assessed against the PHIN functional and technical requirements, if they are used by recipients to meet the requirements in a PHIN functional area(s), the implementation of the software and services will require certification.

8. Local Health Department Consensus, Approval or Concurrence:

CDC requires documentation with the cooperative agreement application that describes the process used by the applicant to engage local health departments to reach consensus, approval, or concurrence for the proposed use of non-earmarked cooperative agreement funds, including those for pandemic influenza preparedness. Non-earmarked cooperative agreement funds are those funds not designated for urban areas ((e.g. Cities Readiness Initiative (CRI)), Early Warning Infectious Disease Surveillance (EWIDS), or currently established Level 1 Chemical Laboratories.

Applicants are required to submit a list of concurring local health departments and a brief description of the process used to engage local health departments to reach consensus, approval, or concurrence for the proposed use of funds. In addition, applicants are required to provide signed letters of concurrence upon request.

⁶ PHIN compatible means that the information systems meet PHIN standards and specifications are designed to work together with other information systems. The implementation the information systems in the recipients' environment should be compliant with (i.e., satisfy) the requirements of the PHIN functional areas. The PHIN certification process is used to determine if an awardees' implementation satisfies all the critical requirements in the PHIN functional areas.

9. Tribes

CDC requires documentation with the cooperative agreement application that describes the process used by the applicant to engage American Indian tribal governments, Tribal organizations representing those governments, tribal epidemiologic centers, or Alaska Native Villages and Corporations located within their boundaries in reaching consensus, approval, or concurrence for the proposed use of non-earmarked cooperative agreement funds, including those for pandemic influenza preparedness. Non-earmarked cooperative agreement funds are those funds not designated for urban areas ((e.g. Cities Readiness Initiative (CRI)), Early Warning Infectious Disease Surveillance (EWIDS), or currently established Level 1 Chemical Laboratories.

Applicants are required to submit a list of concurring American Indian/Alaska Native entities located within their boundaries and a brief description of the process used to engage them in reaching consensus, approval, or concurrence for the proposed use of funds. In addition, applicants will be required to provide signed letters of concurrence upon request.

10. Special Needs/Vulnerable Populations:

Recipients should be able to document how special needs and vulnerable populations are defined within the jurisdiction as well as their level of involvement and participation in preparedness planning and response. Recipients should be able to document efforts to identify, quantify and communicate with special needs populations within their jurisdiction, as well as how they have provided for assistance to these populations in an emergency (e.g., mass care, shelter-in-place, evacuation). These populations should participate in all preparedness planning activities and exercises.

11. Population Centers /Cities Readiness Initiative

All state recipients will be participating in the Cities Readiness Initiative (CRI). The guidelines for CRI can be found in Appendix 4.

Funded states are expected to ensure the preparedness of major population centers within each state either through the provision of funding to the population centers to ensure their capability to perform the outcomes and activities described and/or (for those states with a centralized public health system that does not fund local health agencies) by directly achieving the performance outcomes and completing the required activities described in this cooperative agreement announcement in those population centers.

Where population centers cross state boundaries, states are expected to work together to determine the most appropriate way of defining the local/regional public health agencies that comprise the population center.

As noted above in Section 3. Reporting Systems, funded states are expected to report on the relevant performance measures (see Appendix 1) for their CRI population

centers/cities, as well as for their state public health agency and selected local and tribal public health entities.

12. Establishment of Pharmaceutical Caches:

Cooperative agreement funds may be used to establish pharmaceutical caches which can include prophylaxis, antibiotics, and antivirals to protect public health professionals and their families. (Please note, however, that due to the more limited focus and one-time nature of the Pandemic Influenza funding, this activity will not be an allowable activity with Pandemic Influenza dollars.)

State and local agencies should coordinate their efforts. Applicants requesting cooperative agreement funds for the purchase of pharmaceutical caches must specify quantity and cost as part of the budget application.

13. Hazards and Vulnerability Assessment:

Recipients are required to develop a risk mitigation plan based on a Hazard and Vulnerability Assessment (HVA). The purpose of the HVA is to assess and identify jurisdiction or community specific hazards and vulnerabilities so that plans may be developed to reduce or eliminate these threats and, where threats can not be eliminated, to ensure that the *public health* consequences of them are minimized.

Assessing hazards, vulnerabilities and risks will enable appropriate protection, prevention, control and mitigation strategies to be planned and tested prior to the actual event. Depending on the geographic location, size, population, industry, topology, etc., each community will have a different set of hazards/disasters to address. The State HVA should be a compilation of assessments from local jurisdictions (at a minimum, the MSAs included in the CRI) and any other risks identified by the state.

To avoid unnecessary duplication of effort, recipients should review and, as appropriate, build on HVAs already conducted or being conducted under funding from HRSA, DHS or other emergency management programs.

14. Collaboration across State, Tribal, Military, and International Borders:

Recipients may use cooperative agreement funds to conduct necessary activities in support of cross jurisdictional planning, coordination, communications, program development, and exercises to enhance health security in the United States. In a jurisdiction that shares state, tribal, military installation or international borders, the public health agency may use cooperative funds to jointly participate in disaster planning meetings (e.g., city-state-tribal collaboration or city-state-province/state collaboration, etc.); exchange health alert messages; exchange epidemiological data; provide mutual aid; and conduct collaborative drills, exercises, and evaluate disaster scenarios. Applicants may propose relevant activities related to meeting the goals, outcomes, tasks or measures as listed above. Proposed activities must be consistent with national laws and regulations of the United States and in harmony with any pre-existing agreements and guidelines.

15 International Cross-Border Early Warning Infectious Disease Surveillance (EWIDS) (Selected awardees):

As in previous years, the Office of Public Health Emergency Preparedness within the HHS' Office of the Secretary is continuing to provide funds for early detection, identification, reporting and investigation of infectious disease outbreaks (both bioterrorist-triggered and naturally occurring) at our borders with Canada and Mexico. See Appendix 3.

IV. Application Content:

The outline below should be used to develop the application for funds. It was derived from a combination of sources: past guidance, HHS priorities, CDC priorities, input from state and local public health partners, CDC and other emergency preparedness subject matter experts, documentation from the NPG, and HSPD-8.

Capabilities - Capabilities are combinations of people, equipment, and supplies. Capabilities “define, generally, the resources required to ... achieve the desired outcome. The capability elements should be viewed as a general guide to the resources that comprise a capability.” These capabilities, in varying degrees of aggregation, are brought to bear during disasters, including terrorism, as well as catastrophic events. “Capabilities provide the means to achieve a measurable outcome resulting from the performance of one or more critical tasks, under specified conditions and standards of performance. A capability may be delivered with any combination of properly planned, organized, equipped, trained and exercised personnel that achieve the desired outcome. Capabilities are based on a foundation of plans, procedures and processes.” (DHS 2005).

A comprehensive budget in which each allocation is linked to a capability should be submitted with the application through the DSLR MIS.

Required Critical Tasks - The critical tasks were obtained from the TCL. In most cases, the public health specific critical tasks associated with a capability are listed. Language was added or modified to make the required critical task more specific to public health. In addition, program requirements specific to CDC and this cooperative agreement were added as sub-bullets under the required critical tasks to assure that each applicant addressed plans to continue implementation of the activities in the next cooperative agreement cycle.

Guidance Organization

The hierarchy of information in this Cooperative Agreement (CA) is as follows:

- CDC Preparedness Goal, as implemented through recipient activities.
- Target Capability: Target Capability names match those used in DHS Target Capabilities List (TCL).
- Critical Tasks: Most Critical Tasks are consistent with those found in the DHS Universal Task List (UTL) for the Capability with which they are associated.
- Measures: Not all Capabilities have both Critical Tasks and Measures.

Recipient Accountability for Critical Tasks and Performance Measures: The performance measures are leading indicators that will allow a national “snapshot” to show how preparedness and response activities, and their associated resources, aid in making a public health system that responds more quickly and comprehensively in a

public health emergency. Full descriptions of the Measures, including definitions of terms, collection methods, and related instructions can be found in the Measures summary contained in Appendix 1 of the guidance.

Applicants are required to address each critical task (using the DSLR-MIS) by proposing activities related to the task. For each activity, applicants will be required to provide plans for this budget year to enhance performance on the critical task

Recipients are strongly encouraged to propose discrete activities that can be completed during the budget cycle by breaking complicated operational plans into separate activities within the DSLR-MIS. Applicants may propose multiple activities for each critical task. For each critical task, applicants are encouraged to consider the following and, as appropriate, propose activities to address these issues:

- NIMS compliance activities
- education and training activities that will be needed to ensure the ability to perform the critical task
- role of tribes, border communities, and populations with special needs in activities related to the critical task
- information technology support related that will be needed to ensure the ability to perform the critical task
- public information/communication needs related to the critical task, particularly those tasks that are related to disseminating public information during emergency operations and how public information is incorporated into incident command systems
- legal or policy considerations or changes that can affect the ability to perform a critical task.

CDC Preparedness Goal 1: PREVENT

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

1A Target Capability: Planning

Required Critical Tasks:

- 1) Maintain a SAC to integrate preparedness efforts across the jurisdiction and leverage funding streams
- 2) Support incident response operations according to all-hazards plan that includes identification and planning for populations with special needs⁷
- 3) Improve regional, jurisdictional, and state all-hazard plans (including those related to pandemic influenza) to support response operations in accordance with NIMS and the NRP⁸

⁷ Public Health Workbook to Define, Locate and Reach Special, Vulnerable, and At-Risk Populations in an Emergency (Draft). <http://www.bt.cdc.gov/workbook/>

⁸ Guide for All-Hazard Emergency Operations Planning: State and Local Guide 101. Federal Emergency Management Agency. April 2001. <http://www.fema.gov/pdf/rrr/slgl101.pdf>

- a) Increase participation in jurisdiction-wide self-assessment using the National Incident Management System Compliance Assessment Support Tool⁹ (NIMCAST)
- b) Assure agency's Emergency Operations Center meets NIMS incident command structure requirements to perform core functions: coordination, communications, resource dispatch and tracking and information collection, analysis and dissemination
- 4) Increase the number of public health responders who are protected through Personal Protective Equipment (PPE), vaccination or prophylaxis
 - a) Have or have access to a system that maintains and tracks vaccination or prophylaxis status of public health responders in compliance with PHIN Preparedness Functional Area *Countermeasure and Response Administration*¹⁰
- 5) Increase and improve mutual aid agreements, as needed, to support NIMS-compliant public health response (e.g., local, regional, and EMAC)
 - a) Increase all-hazard incident management capability by conducting regional, jurisdictional and state training for NIMS and the Incident Command System (ICS)
 - b) Address legal and policy issues regarding ability to execute or fulfill EMAC requests (mutual aid versus mutual support)
- 6) Provide support for continuity of public health operations at regional, state, tribal, local government, and agency level

Measure:

Public health agency has primary and secondary staff identified for core functional roles delineated in the Incident Command System (ICS) for public health

CDC Preparedness Goal 2: DETECT AND REPORT

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

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

Required Critical Tasks:

- 1) Increase the use of disease surveillance and early event detection systems
 - a) Select conditions that require immediate reporting to the public health agency (at a minimum, Category A agents)
 - b) Develop and maintain systems to receive reports 24/7/365
 - c) Have or have access to electronic applications in compliance with PHIN Preparedness Functional Area *Early Event Detection* to support:
 - Receipt of case or suspect case disease reports 24/7/365
 - Reportable diseases surveillance
 - Call triage of urgent reports to knowledgeable public health

⁹ National Incident Management System Compliance Assessment Support Tool (NIMCAST).

<http://www.fema.gov/nimcast/index.jsp>

¹⁰ Public Health Information Network (PHIN) Preparedness Requirements

<http://www.cdc.gov/phinf/>

- professionals
 - Receipt of secondary use health-related data and monitoring of aberrations to normal data patterns
- d) Develop and maintain protocols for the utilization of early event detection devices located in your community (e.g., BioWatch)
- e) Assess timeliness and completeness of disease surveillance systems annually
- 2) Increase sharing of health and intelligence information within and between regions and states with federal, local and tribal agencies
 - a) Improve information sharing on suspected or confirmed cases of immediately notifiable conditions, including foodborne illness, among public health epidemiologists, clinicians, laboratory personnel, environmental health specialists, public health nurses, and staff of food safety programs
 - b) Identify key public health staff that need secret or top secret security clearances and mechanisms within the jurisdiction to obtain needed clearances to ensure access to sensitive information about the nature of health threats and intelligence information¹¹
- 3) Decrease the time needed to disseminate timely and accurate national strategic and health threat intelligence
 - a) Maintain continuous participation in CDC's Epidemic Information Exchange Program (Epi-X)¹²
 - b) Participate in the Electronic Foodborne Outbreak Reporting System (EFORS) by entering reports of foodborne outbreak investigations and monitor the quality and completeness of reports and the time from onset of illnesses to report entry¹³
 - c) Perform real-time subtyping of PulseNet¹⁴ tracked foodborne disease agents. Submit the subtyping data and associated critical information (isolate identification, source of isolate, phenotype characteristics of the isolate, serotype, etc) electronically to the national PulseNet database within 72 to 96 hours of receiving the isolate in the laboratory.
 - d) Have or have access to information systems for 24/7/365 notification/alerting of the public health emergency response system that can reach at least 90% of key stakeholders and is compliant with PHIN Preparedness Functional Area *Partner Communications and Alerting*

Measures:

- 1) Percent of HRSA participating hospitals that transmit clinical and/or hospital utilization data in near real-time to a PHIN-compliant early-event detection information system
- 2) Time to have a knowledgeable public health professional respond 24/7 to a call about an event that may be of urgent public health consequence
- 3) Time to initiate an epidemiologic investigation of an event that may be of urgent public health consequence

¹¹ HHS Guidance: <http://198.102.218.46/doc/Security%20Class%20Guide.doc>

¹² Epidemic Information Exchange Program (Epi-X) <http://www.cdc.gov/epix/>

¹³ Electronic Foodborne Outbreak Reporting System (EFORS) http://www.cdc.gov/foodborneoutbreaks/info_healthprofessional.htm

¹⁴ PulseNet <http://www.cdc.gov/pulsenet/>

- 4) Percent of Pulsed Field Gel Electrophoresis (PFGE) sub-typing data results submitted to the PulseNet national database within 96 hours of receiving isolate at the laboratory

2B. Target Capability: Planning

Required Critical Tasks:

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

CDC Preparedness Goal 3: DETECT AND REPORT

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

3A. Target Capability: Public Health Laboratory Testing

Required Critical Tasks:

- 1) Increase and maintain relevant laboratory support for identification of biological, chemical, radiological and nuclear agents in clinical (human and animal), environmental, and food specimens^{15,16,17}
 - a) Develop and maintain a database of all sentinel (biological)/Level Three (chemical) labs in the jurisdiction using the CDC-endorsed definition that includes:
 - Name
 - contact information
 - BioSafety Level
 - whether they are a health alert network partner
 - certification status
 - capability to rule-out Category A and B bioterrorism agents per state-developed proficiency testing or College of American Pathologists (CAP)¹⁸ bioterrorism module proficiency testing

¹⁵ CDC: Emergency Preparedness and Response - Lab Issues. <http://www.bt.cdc.gov/labissues/>

¹⁶ National Lab Training Network <http://www.phppo.cdc.gov/nltm/default.aspx>

¹⁷ Sentinel (Level A) lab protocols <http://www.asm.org/Policy/index.asp?bid=6342>

¹⁸ College of American Pathologists (CAP)

http://www.cap.org/apps.cap.portal?nfpb=rue&pageLabel=home_page

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

- 2) Increase the exchange of laboratory testing orders and results
 - a) Monitor compliance with public health agency (or public health agency lab) policy on timeliness of reporting results from confirmatory LRN lab back to sending sentinel/Level Three lab (i.e., feedback and linking of results to relevant public health data) with a copy to CDC as appropriate
 - b) Comply with PHIN Preparedness Functional Areas *Connecting Laboratory Systems and Outbreak Management* to enable: a) the linkage of laboratory orders and results from sentinel/Level Three and confirmatory LRN labs to relevant public health (epi) data and b) maintenance of chain of custody

Measures:

1. Percent of tested category A and B agents in specimens/samples for which the LRN reference lab(s) passes proficiency testing
2. Percent of tested chemical agents in specimens/samples for which Level 1 and 2 LRN chemical lab(s) passes proficiency testing
3. Time from shipment of clinical specimens to receipt at a LRN reference laboratory
4. Time from presumptive identification to confirmatory identification of select agents by LRN reference lab
5. Time to have a knowledgeable LRN reference laboratorian answer a call during non-business hours

CDC Preparedness Goal 4: DETECT AND REPORT

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

4A. Target Capability: Health Intelligence Analysis and Production

Required Critical Tasks:

- 1) Increase source and scope of health information
- 2) Increase speed of evaluating, integrating, analyzing, and interpreting health data to detect aberrations in normal data patterns
- 3) Improve integration of existing health information systems, analysis, and distribution of information compliant with PHIN Preparedness Functional Area *Early Event Detection*, including those systems used for identification and tracking of zoonotic diseases
- 4) Improve effectiveness of health intelligence and surveillance activities¹⁹
- 5) Improve reporting of suspicious symptoms, illnesses, or circumstances to the public health agency.
 - a) Maintain a system for 24/7/365 reporting of cases, suspect cases, or unusual events compliant with PHIN Preparedness Functional Area *Early Event Detection*
 - b) Increase number of local sites using BioSense for early event detection

Measure:

Time LRN reference lab generates confirmatory result for an agent of urgent public health consequence to notification of appropriate officials

¹⁹ Updated Guidelines for Evaluating Public Health Surveillance Systems
<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5013A1.htm>

CDC Preparedness Goal 5: INVESTIGATE

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

5A. Target Capability: Epidemiological Surveillance and Investigation

Required Critical Tasks:

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

Measure

Time for state public health agency to notify local public health agency, or local to notify state, following receipt of a call about an event that may be of urgent public health consequence

CDC Preparedness Goal 6: CONTROL

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

6A. Target Capability: Communications

Required Critical Tasks:

- 1) Decrease the time needed to communicate internal incident response information
 - a) Develop and maintain a system to collect, manage, and coordinate information about the event and response activities including assignment of tasks, resource allocation, status of task performance, and barriers to task completion
- 2) Establish and maintain response communications network
- 3) Implement communications interoperability plans and protocols
- 4) Ensure communications capability using a redundant system that does not rely on the same communications infrastructure as the primary system
- 5) Increase the number of public health experts to support Incident Command (IC) or Unified Command (UC)
- 6) Increase the use of tools to provide telecommunication and information technology to support public health response
 - a) Ensure that the public health agency has "essential service" designation from their telephone provider and cellular telephone provider²⁰

²⁰ Government Emergency Telecommunications Service. Accessed March 8, 2005

- b) Ensure that the public health agency has priority restoration designation from their telephone provider
 - c) Ensure that the public health agency's public information line can simultaneously handle calls from at least 1% of the jurisdiction's households (e.g., play a recorded message to callers, transfer callers to a voice mail box or answering service)
- 7) Have or have access to a system for 24/7/365 notification/alerting of the public health emergency response system that can reach at least 90% of key stakeholders and is compliant with PHIN Preparedness Functional Area *Partner Communications and Alerting*

Measures:

- 1) Time to distribute a health alert to key response partners of an event that may be of urgent public health consequence
- 2) Percent of clinicians and public health response plan partners that receive public health emergency communication messages
- 3) Percent of key public health response partners who are notified/alerted via radio or satellite phone when electric grid power, telephones, cellular service and internet services are unavailable
- 4) Time to notify/alert all primary staff (secondary or tertiary staff as needed) with public health agency ICS functional responsibilities that the public health agency's EOC is being activated
- 5) Time for primary staff (secondary or tertiary staff as needed) with public health agency ICS functional responsibilities to report for duty at public health agency's Emergency Operation Center (EOC)

6B. Target Capability: Emergency Public Information and Warning

Required Critical Tasks:

- 1) Decrease time needed to provide specific incident information to the affected public, including populations with special needs such as non-English speaking persons, migrant workers, as well as those with disabilities, medical conditions, or other special health care needs, requiring attention^{21,22}
 - a) Advise public to be alert for clinical symptoms consistent with attack agent
 - b) Disseminate health and safety information to the public
 - c) Ensure that the Agency's public information line can simultaneously handle calls from at least 1% of the jurisdiction's population
- 2) Improve the coordination, management and dissemination of public information
- 3) Decrease the time and increase the coordination between responders in issuing messages to those that are experiencing psychosocial consequences to an event
- 4) Increase the frequency of emergency media briefings in conjunction with response partners via the jurisdiction's Joint Information Center (JIC), if applicable

<http://gets.ncs.gov/>

²¹ CDC Crisis and Emergency Risk Communication Manual

http://www.orau.gov/cdcynergy/erc/content/activeinformation/resources/CERC_course_materials.htm

²² Emergency Preparedness Initiative Guide on the Special Needs of People with Disabilities for Emergency Managers, Planners, and First Responders

<http://www.nod.org/resources/pdfs/epiguide2005.pdf>

- 5) Decrease time needed to issue public warnings, instructions, and information updates in conjunction with response partners
- 6) Decrease time needed to disseminate domestic and international travel advisories
- 7) Decrease the time needed to provide accurate and relevant public health and medical information to clinicians and other responders

Measure:

Time to issue critical health message to the public about an event that may be of urgent public health consequence

6 C. Target Capabilities: Responder Safety and Health

Required Critical Tasks:

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

6D. Target Capability: Isolation and Quarantine

Required Critical Tasks:

- 1) Assure legal authority to isolate and/or quarantine individuals, groups, facilities, animals and food products^{23,24,25,26}
- 2) Coordinate quarantine activation and enforcement with public safety and law enforcement, including federal authorities with jurisdiction.
- 3) Improve monitoring of adverse treatment reactions among those who have received medical countermeasures and have been isolated or quarantined
- 4) Coordinate public health and medical services among those who have been isolated or quarantined
- 5) Improve comprehensive stress management strategies, programs, and crisis response teams among those who have been isolated or quarantined

²³ The Model State Emergency Health Powers Act. The Center for Law and the Public's Health at Georgetown and Johns Hopkins Universities. December 21, 2001. <http://www.publichealthlaw.net/MSEHPA/MSEHPA2.pdf>

²⁴ Public Health Emergency Legal Preparedness Checklist: Interjurisdictional Legal Coordination for Public Health Emergency Preparedness. The Center for Law and the Public's Health at Georgetown and Johns Hopkins Universities. December 2004. <http://www.publichealthlaw.net/Resources/ResourcesPDFs/Checklist%201.pdf>

²⁵ Public Health Emergency Legal Preparedness Checklist: Local Government Public Health Emergency Legal Preparedness and Response. The Center for Law and the Public's Health at Georgetown and Johns Hopkins Universities. December 2004. Accessed January 14, 2005

<http://www.publichealthlaw.net/Resources/ResourcesPDFs/Checklist%202.pdf>

²⁶ Public Health Emergency Legal Preparedness Checklist: Civil Legal Liability and Public Health Emergencies. The Center for Law and the Public's Health at Georgetown and Johns Hopkins Universities. December 2004. Accessed January 14, 2005 <http://www.publichealthlaw.net/Resources/ResourcesPDFs/Checklist%203.pdf>

- 6) Direct and control public information releases about those who have been isolated or quarantined
- 7) Decrease time needed to disseminate health and safety information to the public regarding risk and protective actions
- 8) Have or have access to information systems to collect, manage, and coordinate information about isolation and quarantine, compliant with PHIN Preparedness Functional Area *Countermeasure and Response Administration*

Measure:

Time to issue an isolation or quarantine order

6E. Target Capability: Mass Prophylaxis

Required Critical Tasks:

- 1) Decrease the time needed to dispense mass therapeutics and/or vaccines
 - a) Implement local, (tribal, where appropriate), regional and state prophylaxis protocols and plans
 - b) Achieve and maintain the Strategic National Stockpile (SNS) preparedness functions described in the current version of the Strategic National Stockpile guide for planners
 - c) Ensure that smallpox vaccination can be administered to all known or suspected contacts of cases within 3 days and, if indicated, to the entire jurisdiction within 10 days²⁷
 - d) Have or have access to information systems to collect, manage, and coordinate information about the administration of countermeasures, including isolation and quarantine, compliant with PHIN Preparedness Functional Area *Countermeasure and Response Administration*
- 2) Decrease time to provide prophylactic protection and/or immunizations to all responders, including non-governmental personnel supporting relief efforts
- 3) Decrease the time needed to release information to the public regarding dispensing of medical countermeasures via the jurisdiction's JIC (if JIC activation is needed)

Measure:

Adequacy of state and local plans to receive and dispense medical countermeasures as demonstrated through assessment by the Strategic National Stockpile/Cities Readiness Initiative

6F. Target Capability: Medical Surge

Required Critical Tasks:

- 1) Improve tracking of cases, exposures, adverse events, and patient disposition
 - a) Have or have access to information systems that provides these capabilities compliant with PHIN Preparedness Functional Area *Outbreak Management*
- 2) Decrease the time needed to execute medical and public health mutual aid agreements

²⁷ Smallpox Response Planning
<http://www.bt.cdc.gov/agent/smallpox/response-plan/index.asp>

- 3) Improve coordination of public health and medical services
 - a) Ensure epidemiology response capacity consistent with hospital preparedness guidelines for surge capacity
 - b) Participate in the development of plans, procedures, and protocols to identify and manage local, tribal, and regional public health and hospital surge capacity
- 4) Increase the proficiency of volunteers and staff performing collateral duties in performing epidemiology investigation and mass prophylaxis support tasks
- 5) Increase the number of physicians and other providers with experience and/or skills in the diagnosis and treatment of infectious, chemical, or radiological diseases or conditions possibly resulting from a terrorism-associated event who may serve as consultants during a public health emergency

6G. Target Capability: Mass Care

Required Critical Tasks:

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

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

Required Critical Tasks:

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

CDC Preparedness Goal 7: RECOVER

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

7A. Target Capability: Environmental Health

Required Critical Tasks:

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

Measure:

Time to issue guidance to the public after an event

CDC Preparedness Goal 8: RECOVER

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

8A. Target Capability: Economic and Community Recovery

Required Critical Tasks:

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

CDC Preparedness Goal 9: IMPROVE

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

9A. Target Capability: Planning

Required Critical Tasks:

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

Measures:

- 1) Time to complete an After-Action Report (AAR) with corrective action plan(s).
- 2) Time to re-evaluate area(s) requiring corrective action

V. Funding Information

Availability of Funds: Approximately \$ 761,000,000 is available in FY2006 to fund 62 states, localities, territories and Freely Associated States of the Pacific for program operations to prepare for and respond to public health emergencies. "States, Localities and Territories" is defined as the 50 states, 5 territories (Puerto Rico, the Virgin Islands, American Samoa, Commonwealth of the Northern Mariana Islands, Guam,) three Freely Associates States of the Pacific (Republic of the Marshall Islands, Republic of Palau, and the Federated States of Micronesia), and the localities of Chicago, Los Angeles County, New York City, and Washington, D.C.

Budget Year Seven (August 31, 2006-August 30, 2007) funding is as follows:

| | |
|-----------------------------------|---|
| \$699,013,268 | Base funding |
| \$ 54,786,732 | Urban Area focused funding as described in Appendix 4 |
| \$ 7,200,000 | Chemical Laboratories funds available to California, Michigan, New Mexico, New York and Virginia only |
| \$761,000,000 | Subtotal of funds available for all recipients |
| Additional Funding Sources | |
| \$ 5,440,000 | Early Warning Infectious Disease Surveillance (EWIDS) funds available to select recipients (see Appendix 3) |

The CDC Public Health Emergency Preparedness Cooperative Agreement provides funding to state, local, and territorial public health agencies to develop, improve, and sustain their preparedness and response capabilities using a base plus population formula. Each state recipient and Puerto Rico will receive a base amount of \$3.91 million, plus an amount equal to its proportional share of the national population as reflected in the U.S. Census estimates for July 1, 2005. The District of Columbia, New York City, Los Angeles County, and Chicago will continue to receive a base amount of \$5 million. Due to their demographic characteristics and unique programmatic needs, American Samoa, the U.S. Virgin Islands, Guam, the Northern Mariana Islands, the Marshall Islands, the Federated States of Micronesia and Palau will each receive \$391,000 plus a population-based allocation.

Beginning in FY 2007, CDC envisions that allocation of funds among eligible entities and among preparedness priorities will be influenced increasingly by considerations of awardees’ performance in enhancing public health and healthcare emergency preparedness and the relative merits of applicants’ proposed initiatives toward selected preparedness priorities as determined by national competition”

Additionally, recipients are reminded that any continuation of funding under this cooperative agreement is contingent upon responsiveness to the program guidance, measured progress in meeting the performance measures, and proper stewardship of these congressionally-appropriated funds. These funds may be withheld in their entirety or in part until the conditions of the award are met. In extreme cases of lack of demonstrated performance or mismanagement of these funds, HHS, acting through the CDC Administrator, will terminate the cooperative agreement and de-obligate these funds from the awardee’s account in the payment management system. On the other hand, every effort will be made to recognize superior and innovative accomplishments of recipients.

Unallowable Costs

- Funds may not be used for research
- Reimbursement of pre-award costs is not allowed
- Cooperative agreement funds under this program can not be used to purchase vehicles of any kind
- Cooperative agreement funds may not be used to purchase incentive items

Supplantation: Cooperative agreement funds cannot supplant any current state or local expenditures. Supplantation refers to the replacement of non-federal funds with federal fund intended to support the same activities. The Public Health Service Act, Title I, Section 319 (c) specifically States: "SUPPLEMENT NOT SUPPLANT. -- Funds appropriated under this section shall be used to supplement and not supplant other federal, state, and local public funds provided for activities under this section." Therefore, the law strictly and expressly prohibits supplantation.

Cost Sharing or Matching: Matching funds are not required for this program.

Redirection of Funds: Prior approval is required for all funding redirections for sums greater than 25% of the total budget for Budget Year Seven or \$250,000 (whichever is less). Monies may be redirected between/among budget categories under the following conditions:

- Recipient must request redirection from the CDC Procurement and Grants Office (PGO), and
- Recipient must notify the CDC DSLR Project Officer.

Reporting of Estimated Unobligated Funds: Recipients are required to identify the estimated unobligated balance from the current budget period on Form 424A, Section A and provide an interim Financial Status Report (FSR).

Consistent with Federal appropriations law and HHS grants management policy, some or all of the reported estimated unobligated balance (up to 75%) may be requested as part of your Budget Year Seven (August 31, 2006 – August 30, 2007).

Use of Unobligated Funds

Current unobligated balances as reported on the FSR can be awarded in lieu of new funds to either pay for new activities or to offset expenses that were specifically approved and funded in the current budget period but will not be obligated prior to August 30, 2006.

VI. Submission Information: Electronic applications via the DSLR MIS system are due on July 15, 2006 11:59 PM EST.

Submission via DSLR MIS: Applicants are required to use this system in lieu of paper-based applications. CDC provides an Internet-based system (DSLR MIS) for submitting applications electronically, including narrative and budget. The DSLR MIS will enable applicants to complete most required forms electronically, which can then be signed and uploaded into the system.

Follow the online instructions. The MIS will notify the Project Officer that the application is ready for review and prevent any further changes to the application by the applicant, pending any recommendations from the Project Officer.

Secure Data Network (SDN): Access to the Secure Data Network using a digital certificate is required in order to submit an application in DSLR MIS. Approval of the

digital certificate may take several days. See Appendix 8 for detailed instructions on obtaining a digital certificate to access the CDC web portal <https://sdn.cdc.gov> and use the electronic application system. Any questions or problems concerning use of the DSLR MIS should be directed to your project officer.

Required Forms

- All forms are available from the Secure Data Network (<https://sdn.cdc.gov>). In addition, Form PHS 5161-1 is available from the CDC Procurement and Grants office at the following Internet address: <http://www.cdc.gov/od/pgo/forminfo.htm>
- Application budget preparation guidance is also available at: <http://www.cdc.gov/od/pgo/funding/budgetguide2004.htm>
- Forms SF-424 (Cover page) and SF-424B (Assurances) are available from the DSLR MIS application site and the Office of Management and Budget: http://www.whitehouse.gov/omb/grants/grants_forms.html
- Form SF-424A (Budget Information) will be generated and pre-populated automatically from the DSLR MIS budget application site. A blank form SF-424A can also be obtained at the following Internet address: http://www.whitehouse.gov/omb/grants/grants_forms.html

Dun and Bradstreet Data Universal Numbering System

Applicants are required to have a Dun and Bradstreet Data Universal Numbering System (DUNS) number to apply for a grant or cooperative agreement from the Federal government. The DUNS number is a nine-digit identification number, which uniquely identifies business entities. Obtaining a DUNS number is easy and there is no charge. To obtain a DUNS number, access www.dunandbradstreet.com or call 1-866-705-5711. If an application form does not have a DUNS number field, please write the DUNS number at the top of the first page of the application, and/or include the DUNS number in your application cover letter.

Additional requirements that may require you to submit additional documentation with your application are listed in section “VI.2. Administrative and National Policy Requirements.”

VII. Review Process:

Technical Review: Applications will be reviewed for technical acceptability by DSLR Project Officers and other CDC subject matter experts to determine:

- the applicant’s current capability to perform the outcomes and critical tasks
- that the operational plan clearly and adequately addresses the goals, outcomes, tasks, and measures
- the extent to which the applicant clearly defines an evaluation plan that leads to continuous quality improvement of public health emergency response
- the extent to which the applicant presents a detailed budget with a line item justification and any other information to demonstrate that the request for assistance is consistent with the purpose and objectives of the cooperative agreement.

Intergovernmental Review of Applications: Applications are subject to Intergovernmental Review of Federal Programs, as governed by Executive Order (EO) 12372. This order sets up a system for State and local governmental review of proposed federal assistance applications. Contact your State single point of contact (SPOC) as early as possible to alert the SPOC to prospective applications, and to receive instructions on your State's process. Click on the following link to get the current SPOC list: <http://www.whitehouse.gov/omb/grants/spoc.html>

VIII. Award Notices

Recipients will receive a Notice of Grant Award (NGA) from the CDC Procurement and Grants Office. The NGA shall be the only binding, authorizing document between the recipient and CDC. The NGA will be signed by an authorized Grants Management Officer and mailed to the recipient Project Director identified in the application.

IX. Administrative and National Policy Requirements

45 CFR Part 74 and Part 92

For more information on the Code of Federal Regulations, see the National Archives and Records Administration at the following Internet address: <http://www.access.gpo.gov/nara/cfr/cfr-table-search.html>

The following additional requirements apply to this project:

- AR-7 Executive Order 12372
- AR-9 Paperwork Reduction Act Requirements
- AR-10 Smoke-Free Workplace Requirements
- AR-11 Healthy People 2010
- AR-12 Lobbying Restrictions
- AR-16 Security Clearance Requirement
- AR-21 Small, Minority, and Women-Owned Business
- AR-24 Health Insurance Portability and Accountability Act Requirements
- AR-25 Release and Sharing of Data

Additional information on these requirements can be found on the CDC web site at the following Internet address: <http://www.cdc.gov/od/pgo/funding/ARs.htm>.

X. Technical Reporting Requirements

Quarterly Progress Reports for Budget Year Seven must be submitted through the DSLR MIS. CDC will provide templates for these reports to assess program outcomes related to activities undertaken in Budget Year Six. In addition, recipients may be required to submit information upon request based on changing threat status or national security priorities. Progress reports for activities undertaken in this budget period, as well as special topics related to the goals and objectives, are due on:

- **January 15, 2007** (for activities undertaken August 31, 2006 - November 30, 2006)
- **April 15, 2007** (for activities undertaken December 1, 2006 - February 28, 2007)
- **July 15, 2007** (for activities undertaken March 1-May 30, 2007).

- **November 30, 2007** (for activities undertaken May 31-August 30, 2007).

Financial Status Reports (FSR): A separate Financial Status Report is required for each component of the cooperative agreement for which a recipient is funded, e.g., general cooperative agreement, CRI, EWIDS and Chemical Laboratories. An original and two copies must be submitted in hard copy to CDC's PGO as follows:

- Mid-year estimated FSRs due **May 30, 2007** (for August 31, 2006 - February 28, 2007)
- Final FSRs are due 90 days after the end of the budget period , **November 30, 2007** (for August 31, 2006 - August 30, 2007)

Please submit the hard copies of your FSRs to:

Attn: Sharon Robertson
Acquisition and Assistance, Branch VI
Procurement and Grants Office, CDC
2920 Brandywine Road, MS K-75
Atlanta, GA 30341-4146
Telephone: 770-488-2748
Email Address: sqr2@cdc.gov

XI. Agency Contacts

DSLRL Project Officers – see Appendix 9.

For general questions, contact:


Sharon Robertson
Grants Management Specialist—Regions 1, 2, 3, 4, 10
Acquisition and Assistance Branch VI
Procurement and Grants Office
Centers for Disease Control and Prevention (CDC)
2920 Brandywine Road
Atlanta, Georgia 30341-4146
Telephone: (770) 488-2748
E-mail address: sqr2@cdc.gov

Angela Webb
Grants Management Specialist—Regions 5, 6, 7, 8, 9
Acquisition and Assistance Branch VI
Procurement and Grants Office
Centers for Disease Control and Prevention (CDC)
2920 Brandywine Road
Atlanta, Georgia 30341-4146
Telephone: (770) 488-2784
E-mail address: aqw6@cdc.gov

XII. Attachments

- Appendix 1: Performance Measures
- Appendix 2: Funding Table
- Appendix 3: Early Warning Infectious Disease Surveillance (EWIDS)
- Appendix 4: Cities Readiness Initiative (CRI)
- Appendix 5: Centers for Public Health Preparedness (CPHP) Program
- Appendix 6: Direct Assistance
- Appendix 7: National Public Health Radio Network (NPHRN)
- Appendix 8: SDN Instructions
- Appendix 9: DSLR Project Officers
- Appendix 10: Evaluation Plan Guidance
- Appendix 11: Tribal Government and Local Jurisdiction NIMS Compliance Activities
- Appendix 12: State and Territorial NIMS Compliance Activities
- Appendix 13: Target Capabilities Matrix
- Appendix 14: ChemPack Continuation Guidance

Dated:


for William P. Nichols, MPA
Director
Procurement and Grants Office
Centers for Disease Control and Prevention

Appendix 1: Performance Measures

The following table describes a set of measures, targets, definitions, instructions, and a brief overview of data collection and submission methods. CDC will continue to require self-reported information as part of the technical reporting requirements for funded applicants. In addition, CDC will implement independent validation of self-reported information in this project period to ensure the validity and accuracy of the information. Additional guidance about phasing-in of measures will be forthcoming from CDC.

Grantees are required to report on the measures as described under data collection and submission methods. Although much of the information required for these measures can be obtained during commonly occurring urgent events (e.g., infectious disease outbreaks), grantees are expected to conduct drills and exercises to ensure that information is available for each of the measures described below. In addition, grantees should plan drills and exercises that stress their routine urgent response systems to ensure that they are building capacity for larger scale events. In each of these circumstances, grantees must implement data systems to accurately capture required information and self-report requested information to CDC. For some measures, data collected will include information from both CDC-conducted drills as well as grantee self-reported information, if available.

| CDC Preparedness Goal | Proposed Measure | Jurisdictional Target | Definitions & Other Guidance | Instructions | Jurisdictional Measurement Level | Data Collection and Submission Methods |
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| PRE-EVENT | | | | | | |
| <p>Goal 1: PREVENTION</p> <p>Increase the use and development of interventions known to prevent human illness from chemical, biological, radiological agents, and naturally occurring health threats.</p> | <p>1. Public health agency has primary and secondary (backup) staff identified for core functional roles delineated in the Incident Command System (ICS) for public health</p> | <p>For 100% of core public health ICS functional roles, public health agency has documented contact information for primary and secondary (backup) staff</p> | <p>Note: The functional roles are:</p> <ul style="list-style-type: none"> • Incident Commander • Public Information Officer • Safety Officer • Operations Section Chief • Planning Section Chief • Logistics Section Chief • Finance/Administration Section Chief <p>Detailed descriptions of the functional roles and the Incident Command System can be found in “National Incident Management System,” March 2004, available at: http://www.dhs.gov/interweb/assetlibrary/NIMS-90-web.pdf</p> | <p>Numerator: # of public health ICS core functional roles for which the public health agency has a documented list of contact information for primary and secondary (backup) staff</p> <p>Denominator: 7 roles for both primary and secondary (backup) staff</p> | <p>State and local</p> | <p>Self-report data submitted semi-annually as part of CDC progress report.</p> <p>Data submitted may be validated by an independent party during scheduled site visits.</p> <p>State awardees should collect and report information for staff employed at the state-level and compile information from local public health agencies located within the MSAs described in the cooperative agreement guidance.</p> <p>Local awardees will report on staff employed at the local public health agency only.</p> |

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| <p>Goal 2: DETECTION AND REPORTING</p> <p>Decrease the time needed to identify health events that could result from terrorism or naturally-occurring events, in partnership with other agencies.</p> | <p>2. Percent of HRSA National Bioterrorism Hospital Preparedness Program (NBPHPP) awardee hospitals that transmit clinical and/or hospital utilization data in near real-time to a PHIN-compliant early-event detection information system</p> | <p>90% of HRSA awardee hospitals</p> | <p>Definitions: Clinical data includes at least two of the following: patient chief complaint, physician diagnosis, or micro laboratory test orders and results.</p> <p>Hospital utilization data includes the total number of staffed beds, the number of occupied beds, and the number of unoccupied beds; for the whole facility, and by facility unit.</p> <p>Near real-time is defined to be 24 hours or less from the time clinical data is obtained to the time it is transmitted into the early event detection system.</p> <p>In the 2006/2007 grant year, PHIN-compliant means that an awardee's implementation of information systems in the specified PHIN Functional Area(s) is PHIN Preparedness certified, or has minimally been base-lined for PHIN certification (i.e., validated). (Standards, self-assessment tools and certification process available at: http://www.cdc.gov/phin/certification/index.html).</p> | <p>Numerator: Number of HRSA awardee hospitals that transmitted clinical and/or hospital utilization data within 24 hours from the time it was obtained to a PHIN-compliant early-event detection information system</p> <p>Denominator: Number of HRSA awardee hospitals</p> <p>Note: If a hospital either did not transmit data within the last 6 months, or transmitted data, but not within 24 hours of receiving it, it will not be counted in the numerator.</p> | <p>State and local</p> | <p>Self-report data submitted annually as part of CDC progress report.</p> <p>Data submitted may be validated by an independent party during scheduled site visits.</p> |
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| | <p>3. Time to have a knowledgeable public health professional respond 24/7 to a call about an event that may be of urgent public health consequence.</p> | <p>Mean = 15 minutes</p> | <p>Definition: Knowledgeable public health professional: Employee or contractor of the public health agency with an appropriate combination of education and experience to make basic inquiries of a caller to determine what level of call escalation should occur.</p> <p>Call about an event that may be of urgent public health consequence: Call about an event that requires the immediate commitment of public health assets to further investigate and respond</p> | <p>Start time: Time that the call from the CDC DEOC first rings at the public health agency.</p> <p>Stop time: Time that knowledgeable professional at the public health agency answers or returns the call.</p> <p>Note: The recorded stop time will include any elapsed time due to call transfers, callback time, etc.</p> <p>Note: CDC DEOC will use the public health agency's published phone number.</p> | <p>State and local</p> | <p>Data collected during ongoing CDC-initiated drills. Computed values for state-level awardees will include aggregated results for state public health agency and local public health agencies located the MSAs described in the cooperative agreement guidance.</p> |
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| | <p>4. Time to initiate an epidemiologic investigation of an event that may be of urgent public health consequence.</p> | <p>Mean = 1 hour from notification of an event that may be of urgent public health consequence.</p> | <p>Definition: Event that may be of urgent public health consequence: An event that requires the immediate commitment of public health assets to further investigate and respond.</p> <p>Note: The initiation of an investigation includes taking action on any one of the following: designing or modifying data collection materials and databases, collecting health data, case finding, contact tracing, developing case descriptions, and identifying risk factors and populations at risk.</p> | <p>Start time: Time that public health agency receives a call about an event that may be of urgent public health consequence</p> <p>Stop time: Time that public health agency epidemiologist initiates an investigation of the event.</p> <p>Time includes contacting epidemiologist and assigning the investigation.</p> | <p>State and local</p> | <p>Self-report data submitted semi-annually as part of CDC progress report.</p> <p>Data submitted may be validated by an independent party during scheduled site visits.</p> <p>CDC will collect mean, median, minimum, and maximum times for events during the reporting period.</p> <p>Awardees should keep paper and/or electronic log(s) that contains: 1) date and time from public health agency determination that an event may be of urgent public health consequence; and 2) date and time of beginning of epidemiological investigation and name of epidemiologist or designated official.</p> |
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| | 5. Percent of Pulsed Field Gel Electrophoresis (PFGE) sub-typing data results submitted to the PulseNet national database within 96 hours of receiving isolate at the laboratory. | 90% of PFGE sub-typing data results are submitted to PulseNet within 96 hours | <p>Start time: Date and time PFGE isolate is received (or agent is isolated in pure culture if lab processes clinical specimen) at the laboratory whether during working or off-duty hours</p> <p>Stop time: Date and time pattern submitted to PulseNet server/team</p> | <p>Numerator: # of <i>E. coli</i> 0157:H7 and <i>L. monocytogenes</i> PFGE sub-typing results submitted to CDC's PulseNet database within 96 hours of receipt of isolate at the laboratory</p> <p>Denominator: Total # of <i>E. coli</i> 0157:H7 and <i>L. monocytogenes</i> isolates PFGE pattern-analyzed.</p> | State | <p>Self-report data submitted quarterly as part of CDC progress report.</p> <p>Data submitted may be validated by an independent party during scheduled site visits.</p> <p>Information must include: Name of agent (i.e. <i>E. coli</i> 0157:H7 or <i>L. monocytogenes</i>); date and time is received at the lab; date and time pattern analysis is completed; and date and time pattern submitted to PulseNet.</p> |
| <p>Goal 3: DETECTION AND REPORTING</p> <p>Decrease the time needed to detect and report chemical, biological, radiological agents in tissue, food, or environmental samples that cause threats to the public's health.</p> | 6. % of tested agents for which the Laboratory Response Network (LRN) reference labs passes proficiency testing | Reference labs has a passing rating for 100% of tested based on LRN - sponsored proficiency tests in which lab participated | <p>Applies to funded LRN reference labs only.</p> <p>Tested agents include those agents tested through LRN sponsored proficiency tests in which the lab participated.</p> | Information will be collected as part of routine LRN proficiency testing. No additional reporting is required. | State | <p>Data from CDC Bioterrorism Preparedness and Response LRN proficiency test reports.</p> <p>Proficiency test results data will be collected separately for each agent tested at each funded LRN lab.</p> |
| | 7. % of tested chemical agents for which Level 1 and 2 Laboratory Response Network (LRN) chemical labs passes proficiency testing | Level 1 and/or Level 2 chemical labs has a passing rating for 100% of tested chemical agents based on LRN-sponsored proficiency tests in which lab participated | <p>Applies to funded Level 1 and 2 LRN labs only.</p> <p>Tested chemical agents include those agents tested through LRN sponsored proficiency tests in which the lab participated.</p> | Information will be collected as part of routine LRN proficiency testing. No additional reporting is required. | State | <p>Data from CDC National Center for Environmental Health LRN proficiency test reports.</p> <p>Proficiency test results data will be collected separately for each agent tested at each funded LRN lab.</p> |

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| | <p>8. Time from shipment of clinical biological specimens to receipt at a LRN reference laboratory.</p> | <p>Mean = 6 hours</p> | <p>Note: Report data only on shipments of clinical specimens that potentially contain agents thought to be of urgent public health consequence.</p> <p>LRN reference labs and clinical laboratories must negotiate agreements to ensure that the level and credibility of potential threats can be discussed to determine the urgency.</p> <p>Urgent public health consequence: An event that requires the immediate commitment of public health assets to further investigate and respond.</p> | <p>Start time: Time that clinical biological specimen or culture of agent of urgent public health consequence is ready for shipment from sentinel lab to reference lab.</p> <p>Stop time: Receipt of clinical biological specimen or sample containing an agent of urgent public health consequence at LRN reference lab.</p> | <p>State and local funded LRN reference labs</p> | <p>Self-report data submitted quarterly as part of CDC progress report.</p> <p>Data submitted may be validated by an independent party during scheduled site visits.</p> <p>Grantee should collect and report data for each reference lab located within its jurisdiction.</p> <p>Mean, median, minimum, and maximum times from shipment to receipt for all shipments made during the reporting period will be collected.</p> <p>Receiving labs should record the information from the chain of custody documentation to include: 1) date and time, 2) originating lab name and location, and 3) shipment description/code.</p> |
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| | <p>9. Time from presumptive identification to confirmatory identification of select agents by Laboratory Response Network (LRN) reference lab.</p> | <p>Targets from presumptive to confirmatory identification:</p> <p><i>Bacillus anthracis</i>: <4 days</p> <p><i>Francisella tularensis</i>: <7 days</p> <p><i>Yersinia pestis</i>: <6 days</p> | <p>Note: The following presumptive identification times are provided as general guidance. Although presumptive identification is not currently being measured, grantees should strive to reach these time frames:</p> <p>Presumptive identification times (minimum/maximum):</p> <table border="1" data-bbox="800 391 1249 610"> <thead> <tr> <th>Agent</th> <th>Minimum</th> <th>Maximum</th> </tr> </thead> <tbody> <tr> <td><i>Bacillus anthracis</i></td> <td>6 hours</td> <td>24 hours</td> </tr> <tr> <td><i>Francisella tularensis</i></td> <td>6 hours</td> <td>24 hours</td> </tr> <tr> <td><i>Yersinia pestis</i></td> <td>6 hours</td> <td>24 hours</td> </tr> </tbody> </table> | Agent | Minimum | Maximum | <i>Bacillus anthracis</i> | 6 hours | 24 hours | <i>Francisella tularensis</i> | 6 hours | 24 hours | <i>Yersinia pestis</i> | 6 hours | 24 hours | <p>Start time: Time LRN reference lab determines presumptive identification of agent</p> <p>Stop time: Time confirmatory identification is made</p> | <p>State and local funded LRN reference labs</p> | <p>Self-report data submitted semi-annually as part of CDC progress report.</p> <p>Data submitted may be validated by an independent party during scheduled site visits.</p> <p>Information should include: 1) type of agent; 2) date and time of presumptive identification; and 3) date and time of confirmatory identification.</p> |
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| Agent | Minimum | Maximum | | | | | | | | | | | | | | | | |
| <i>Bacillus anthracis</i> | 6 hours | 24 hours | | | | | | | | | | | | | | | | |
| <i>Francisella tularensis</i> | 6 hours | 24 hours | | | | | | | | | | | | | | | | |
| <i>Yersinia pestis</i> | 6 hours | 24 hours | | | | | | | | | | | | | | | | |
| | <p>10. Time to have a knowledgeable Laboratory Response Network (LRN) reference laboratorian respond to a call during non-business hours.</p> | <p>Mean = 15 minutes</p> | <p>Non-business hours include before 8AM and after 5PM on weekdays and anytime on weekends and holidays.</p> <p>Knowledgeable laboratorian: Employee or contractor of the reference laboratory with an appropriate combination of education and experience to make basic inquiries of caller to determine what level of escalation should occur.</p> | <p>Start time: Time that a call from the CDC DEOC first rings at the LRN reference lab or on-call duty officer.</p> <p>Stop time: Time that knowledgeable LRN reference laboratorian responds to or returns the call.</p> <p>Recorded stop time will include any elapsed time due to call transfers, callback time, etc.</p> | <p>State and local funded LRN reference labs</p> | <p>Data collected during semi-annual CDC-initiated drills.</p> | | | | | | | | | | | | |

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| <p>Goal 4: DETECTION AND REPORTING</p> <p>Improve the timeliness and accuracy of communications regarding threats to the public's health.</p> | <p>11. Time LRN reference lab generates confirmatory result for an agent of urgent public health consequence to notification of appropriate officials.</p> | <p>Mean = 2 hours</p> | <p>Definitions: Agent of public health consequence: agents requiring immediate notification per LRN and state/local policy.</p> <p>Appropriate officials: Include, at a minimum, State public health agency director or designee and local public health agency director or designee in the community in which the affected individual resides and the person or agency that submitted the specimen/sample for testing.</p> <p>Note: Data to be collected from public health LRN reference labs. Confirmatory identification includes both positive and negative results.</p> | <p>Start time: Time that a confirmatory identification of an agent of urgent public health consequence is made.</p> <p>Stop time: Time that public health director or designated official acknowledges receipt of the result</p> | <p>State and local</p> | <p>Self-report data submitted quarterly as part of CDC progress report.</p> <p>Data submitted may be validated by an independent party during scheduled site visits.</p> <p>CDC will collect start and stop times for each event during the reporting period.</p> <p>LRN information should include (at a minimum): 1) name of agent tested; 2) date and time of confirmatory identification; 3) notification date and time; 4) name/city of agency/agencies notified; and 5) name/title of notified official. Lab should maintain and submit requested data for each relevant event during the reporting period.</p> <p>Notified agency/agencies information should include: 1) date and time of notification; 2) name/city of notifying agency; and 3) agent and lab confirmatory result.</p> |
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| <p>Goal 5: INVESTIGATION</p> <p>Decrease the time to identify causes, risk factors, and appropriate interventions for those affected by threats to the public's health.</p> | <p>12. Time for State/territory public health agency to notify local public health agency, or local to notify State, following receipt of a call about an event that may be of urgent public health consequence</p> | <p>Mean = 60 minutes from notification of an event that may be of urgent public health consequence.</p> | <p>Definitions: Call about an event that may be of urgent public health consequence: Call about an event that requires the immediate commitment of public health assets to further investigate and respond.</p> <p>Note: Applies to those calls where the call-taker determines that the event may be of urgent public health consequence and a commitment of assets is required</p> | <p>Start time: Time that public health agency receives a call about an event that may be of urgent public health consequence and warrants involvement of their state or local counterpart.</p> <p>Stop time: Time when public health agency notifies its counterpart at the next level (e.g. State notifies local or local notifies State).</p> | <p>State and local</p> | <p>Data collected during semi-annual CDC-initiated drills and self-reported data submitted semi-annually as part of CDC progress report.</p> <p>Awardees should keep either a paper or electronic log, regardless of the mode of communication used.</p> <p>Notifying agency's log should contain: 1) name(s) of agency/agencies to which notification was made, 2) date and time</p> <p>Receiving agency's log should contain: 1) name of agency notification was received from, 2) date and time</p> <p>State awardees will report on calls made to local public health agencies; locals will report on calls made to the state public health agency.</p> |
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| <p>Goal 6: CONTROL</p> <p>Decrease the time to needed to provide countermeasures and health guidance to those affected by threats to the public's health.</p> | <p>13. Time to distribute a health alert to key response partners of an event that may be of urgent public health consequence.</p> | <p>Mean = 6 hours from the time a decision is made to notify partners</p> | <p>Definition: An event of that may be of urgent public health consequence: An event that requires the immediate commitment of public health assets to further investigate and respond.</p> <p>Key public health response partners: To be defined by the jurisdiction but should include, at a minimum, emergency management, hospitals, fire, police, and the jurisdiction's EOC.</p> | <p>Start time: Date and time that a decision is made to issue a health alert</p> <p>Stop time: Date and time that public health agency sends a health alert to response partners</p> | <p>State</p> | <p>Self-report data submitted semi-annually as part of CDC progress report.</p> <p>Data submitted may be validated by an independent party during scheduled site visits.</p> <p>CDC will collect mean, median, minimum, and maximum times for events during the reporting period.</p> <p>Awardees should keep paper and/or electronic log(s) that contains: 1) date and time that determination is made that an event may be of urgent public health consequence and that a health alert is needed; 2) date and time of a health alert is distributed to key public health response partners; and 3) name of response partner(s) that should receive the health alert.</p> |
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| | <p>14. Percent of clinicians and public health response plan partners who receive public health emergency communication messages</p> | <p>70% of clinicians and public health partners receive messages within the specified time.</p> | <p>Definitions: Public health response partners comprise functional groups or roles defined by the jurisdiction and might be listed in the agencies emergency response plan.</p> <p>Delivery time and whether acknowledgement is required or not are sender-specified attributes (see Partner Communications and Alerting Functional Requirements, PHIN Preparedness, Version 1.0). When acknowledgements are required, “delivery time” includes time for acknowledgement. Available delivery times are: 1) within 15 minutes; 2) within 60 minutes; 3) within 24 hours; and 4) within 72 hours.</p> <p>Note: In this context, a message is classified as “received: if an acknowledgement is made by the recipient within the time specified in the message. The time specified will vary based on the level of urgency of the message.</p> <p>Note: In this context, “clinicians” refer to clinicians listed in the public health agency’s Health Alert Network database.</p> | <p>Numerator: # of clinicians and response plan partners that acknowledge message within the specified delivery time.</p> <p>Denominator: Total # of health alert messages sent that required acknowledgement.</p> | <p>State</p> | <p>Awardees should collect information by drilling or exercising the notification/acknowledgement process at least semi-annually and reporting the information semi-annually as part of CDC progress report.</p> <p>Data submitted may be validated by an independent party during scheduled site visits.</p> <p>Data sources may include computer-generated electronic message transmittal and acknowledgement times and/or paper records of acknowledgments phoned or radioed in.</p> |
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| | <p>15. Percent of key public health response partners who are notified via radio or satellite phone when electric grid power, telephones, cellular service, and Internet services are unavailable.</p> | <p>75% of response partners acknowledge message within 5 minutes of communication being sent</p> | <p>Definitions: Key public health response partners: To be defined by the jurisdiction but should include, at a minimum, emergency management, hospitals, fire, police, and the jurisdiction's EOC.</p> <p>Note: This does not imply simultaneous contact with all response partners. Rather, it is assumed that each partner will be contacted sequentially and respond within 5 minutes of communication being sent.</p> <p>Note: Any system that will enable communications to occur between public health and its key response partners when power, phones, etc. are unavailable, e.g. satellite phone, radio, communication equipment able to be powered by a generator, can be used to address this measure.</p> | <p>Numerator: # of response partners who acknowledge receipt within 5 minutes of communication being sent</p> <p>Denominator: # response partners to whom communication was sent</p> <p>.</p> | <p>State and local</p> | <p>Awardees should collect information by drilling or exercising the notification/acknowledgment process at least quarterly and reporting the information semi-annually as part of CDC progress report.</p> <p>Data submitted may be validated by an independent party during scheduled site visits.</p> |
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| | <p>16. Time to notify all primary staff (secondary or tertiary staff as needed) with public health agency ICS functional responsibilities that the public health agency's Emergency Operations Center (EOC) is being activated.</p> | <p>Mean = 60 minutes</p> | <p>Note: The public health agency should have a pre-identified list of primary, secondary, and tertiary personnel required to staff its EOC upon initial activation.</p> | <p>Start time: Time that public health director or designated official sends notification that the public health agency's EOC will be activated.</p> <p>Stop time: Time that final pre-identified primary (secondary or tertiary as needed) staff member with ICS functional responsibilities acknowledges the notification.</p> | <p>State and local</p> | <p>Awardees should collect information by drilling or exercising the notification process at least semi-annually and reporting the information quarterly as part of CDC progress report.</p> <p>Data submitted may be validated by an independent party during scheduled site visits.</p> <p>Awardees should keep paper and/or electronic log(s) or other documentation that contains: 1) date and time public health director sends notification of intent to activate EOC; and 2) date and time acknowledgement of notification is received from each person in core EOC staffing group.</p> |
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| | <p>17. Time for primary staff (secondary or tertiary staff as needed) with public health agency ICS functional responsibilities to report for duty at public health agency's Emergency Operation Center (EOC).</p> | <p>Mean = 2 ½ hours from time that public health director or designated official receives notification that the public health agency's EOC will be activated.</p> | <p>Note: The intent is that each functional area is staffed. Therefore, only the primary person OR his/her backup (secondary or tertiary, if necessary) should be included in personnel count.</p> <p>Awardees should have a pre-identified list of core staff required to staff the public health agency's EOC upon initial activation.</p> | <p>Start time: Time that public health director or designated official sends notification that the agency's EOC will be activated.</p> <p>Stop time: Time when the last primary public health agency staff member with ICS functional responsibilities is signed in (physically or electronically) at the public health agency's EOC.</p> | <p>State and local</p> | <p>Awardees should collect information by drilling or exercising the notification process at least quarterly and reporting the information semi-annually as part of CDC progress report.</p> <p>Data submitted may be validated by an independent party during scheduled site visits.</p> <p>Awardees should keep paper and/or electronic log(s) or other documentation that contains: 1) date and time public health director sends notification of intent to activate EOC; and 2) date, and time each person in core staffing group signs in at EOC.</p> |
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| | 18. Time to issue critical health message to the public about an event that may be of urgent public health consequence | Mean = 6 hours from the determination that a public message is needed | <p>Definition: An event of that may be of urgent public health consequence: An event that requires the immediate commitment of public health assets to further investigate and respond.</p> <p>Critical health message: Message to the public issued that contains information about the event, status, recommended protective actions, and commitment to communicating updates. Examples of ways of issuing messages include information to clinicians via web sites, listservs, etc.; hotlines; press releases; and/or outreach to special population groups.</p> | <p>Start time: Time that a decision is made to issue a critical health message to the public</p> <p>Stop time: Time that public health director or designated official issues the first critical health message.</p> | State and local | <p>Self-report data submitted semi-annually as part of CDC progress report.</p> <p>Data submitted may be validated by an independent party during scheduled site visits</p> <p>Awardees should keep paper and/or electronic log(s) or other documentation that contains: 1) event type and brief description; 2) date and time from public health agency determination that an event may be of urgent public health consequence AND a public message is needed; 3) Date and time decision is made to issue critical health message to public; 4) date, time, and mechanism through which the public health message is issued to the public; and 5) Date and time that public health director or designated official issues first critical health message.</p> |
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| | 19. Adequacy of State and local plans to receive and dispense medical countermeasures as demonstrated through assessment by the Strategic National Stockpile/Cities Readiness Initiative (CRI) | Agency has a passing rating on 100% of all elements and functions based on its most recent Strategic National Stockpile/Cities Readiness Initiative (CRI) assessment | Definitions: A Strategic National Stockpile/Cities Readiness Initiative Assessment is an onsite evaluation conducted by CDC SNS program staff. | Information will be collected as part of routine SNS/CRI assessment. No additional reporting is required. | State and local | Data collected annually from CDC SNS/CRI assessment reports. The SNS/CRI rating for each element/function assessed will be collected separately for each awardee. |
| | 20. Time to issue an isolation or quarantine order | Mean = 3 hours from the decision that an order is needed | | Start Time: Time that public health agency determines that isolation or quarantine is needed Stop time: Time that governor or legally-authorized authority signs an isolation or quarantine order | State and local | Self-report data submitted annually as part of CDC progress report. Awardees should collect data in drills, exercises, or real events conducted at least annually. Data submitted may be validated by an independent party during scheduled site visits. |

POST-EVENT

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| <p>Goal 7: RECOVER</p> <p>Decrease the time needed to restore health services and environmental safety to pre-event levels.</p> | <p>21. Time to issue guidance to the public after an event</p> | <p>Mean = 6 hours from the time a decision is made to provide recovery-related information to the public</p> | <p>Definition: Guidance: Public health protection information related to air, food, safety, soil, and vector control issued to notify the public of precautionary or protective actions that they can take following an event.</p> | <p>Start time: Time that a decision is made to provide recovery-related information to the public</p> <p>Stop time: Time that public health director or designated official first provides recovery-related information to the public after an event has occurred</p> | <p>State and local</p> | <p>Self-report data submitted semi-annually as part of CDC progress report.</p> <p>Data submitted may be validated by an independent party during scheduled site visits.</p> <p>Awardees should keep paper and/or electronic log(s) or other documentation that contains: 1) event type and brief description; 2) date and time that a decision was made to provide recovery-related information to the public; and 3) date and time that the public health director or designated.</p> |
| <p>Goal 8: RECOVER</p> <p>Improve the long-term follow-up provided to those affected by threats to the public's health.</p> | <p>No Measure</p> | | | | | |

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| <p>Goal 9: IMPROVE</p> <p>Decrease the time to needed to implement recommendations from after-action reports following threats to the public's health.</p> | <p>22. Time to complete an After-Action Report (AAR) with corrective action plan(s).</p> | <p>Mean = 60 days from conclusion of an exercise or real event</p> | <p>The AAR should include a prioritized list identifying the top five items that are exclusively public health-related for corrective action and corresponding time-line for implementation.</p> <p>The top five items should be determined by prioritizing items by the potential for loss of life, injury, or property damage.</p> | <p>Start time: Date of the day following public health agency's EOC deactivation after the drill, exercise, or real event.</p> <p>Stop time: Date AAR is sent to public health agency director or designated official.</p> | <p>State and local</p> | <p>Self-report data submitted semi-annually as part of CDC progress report.</p> <p>Data submitted may be validated by an independent party during scheduled site visits.</p> <p>The public health agency director or designated official should keep paper or electronic copies of AARs for all events that occur during the reporting period (including date of receipt of AAR).</p> |
| | <p>23. Time to re-evaluate area(s) requiring corrective action.</p> | <p>Mean = 180 days after AAR is completed.</p> | <p>Note: The aim is for re-evaluation of area(s) requiring corrective action that may be exclusively related to the public health agency's planning and/or operations.</p> | <p>Start time: Date and time AAR is sent to public health agency director or designated official.</p> <p>Stop time: Date and time drill or exercise is held to re-evaluate at least one of the top five items identified in the corrective action plan reported in performance measure #22.</p> | <p>State and local</p> | <p>Self-report data submitted semi-annually as part of CDC progress report.</p> <p>Data submitted may be validated by an independent party during scheduled site visits.</p> |

Appendix 2: 2006 Funding Distribution Table

| Grantee | Total Base Funding | FY 2006 Cities Readiness Funding | FY 2006 Focus Area D supplement | FY 2006 EWIDS funding | Total Allocation |
|----------------------|--------------------|----------------------------------|---------------------------------|-----------------------|------------------|
| Alabama | \$11,132,549 | \$200,000 | | | \$11,332,549 |
| Alaska | \$4,961,673 | \$200,000 | | \$15,000 | \$5,176,673 |
| American Samoa | \$483,221 | | | | \$483,221 |
| Arizona | \$13,321,724 | \$1,559,294 | | \$587,973 | \$15,468,991 |
| Arkansas | \$8,313,998 | \$200,000 | | | \$8,513,998 |
| California | \$45,422,665 | \$5,944,226 | \$1,566,409 | \$1,463,654 | \$54,396,954 |
| <i>Chicago</i> | \$9,535,667 | \$2,150,000 | | | \$11,685,667 |
| Colorado | \$11,302,692 | \$1,040,857 | | | \$12,343,549 |
| Connecticut | \$9,472,607 | \$400,000 | | | \$9,872,607 |
| Delaware | \$5,246,694 | \$265,242 | | | \$5,511,936 |
| District of Columbia | \$5,872,385 | \$830,000 | | | \$6,702,385 |
| Florida | \$32,100,782 | \$2,845,063 | | | \$34,945,845 |
| Georgia | \$18,286,895 | \$1,270,346 | | | \$19,557,241 |
| Guam | \$658,616 | | | | \$658,616 |
| Hawaii | \$5,930,741 | \$200,000 | | | \$6,130,741 |
| Idaho | \$6,174,623 | \$200,000 | | \$15,000 | \$6,389,623 |
| Illinois | \$19,599,862 | \$998,379 | | \$15,000 | \$20,613,241 |
| Indiana | \$13,848,908 | \$638,175 | | \$15,000 | \$14,502,083 |
| Iowa | \$8,610,613 | \$200,000 | | | \$8,810,613 |
| Kansas | \$8,259,380 | \$465,100 | | | \$8,724,480 |
| Kentucky | \$10,523,404 | \$337,267 | | | \$10,860,671 |
| <i>Los Angeles</i> | \$20,744,292 | \$3,436,517 | | | \$24,180,809 |
| Louisiana | \$11,078,386 | \$400,000 | | | \$11,478,386 |
| Maine | \$6,004,128 | \$200,000 | | \$117,309 | \$6,321,437 |
| Marshall Islands | \$485,107 | | | | \$485,107 |
| Maryland | \$12,784,678 | \$1,186,275 | | | \$13,970,953 |

| | | | | | |
|---------------------------|--------------|-------------|-------------|-------------|--------------|
| Massachusetts | \$14,049,795 | \$1,462,811 | | | \$15,512,606 |
| Michigan | \$19,948,063 | \$1,482,503 | \$1,493,995 | \$296,641 | \$23,221,202 |
| Micronesia | \$562,809 | | | | \$562,809 |
| Minnesota | \$12,043,711 | \$1,039,508 | | \$50,928 | \$13,134,147 |
| Mississippi | \$8,538,914 | \$200,000 | | | \$8,738,914 |
| Missouri | \$13,101,485 | \$1,300,711 | | | \$14,402,196 |
| Montana | \$5,392,713 | \$200,000 | | \$23,838 | \$5,616,551 |
| Nebraska | \$6,697,069 | \$200,000 | | | \$6,897,069 |
| Nevada | \$7,736,634 | \$924,204 | | | \$8,660,838 |
| New Hampshire | \$5,985,802 | \$251,569 | | \$15,000 | \$6,252,371 |
| New Jersey | \$17,724,896 | \$1,169,318 | | | \$18,894,214 |
| New Mexico | \$6,965,822 | \$200,000 | \$1,139,103 | \$46,838 | \$8,351,763 |
| New York | \$21,579,768 | \$924,434 | \$1,477,224 | \$427,665 | \$24,409,091 |
| <i>New York City</i> | \$17,842,162 | \$5,100,000 | | | \$22,942,162 |
| North Carolina | \$17,669,936 | \$207,858 | | | \$17,877,794 |
| North Dakota | \$4,918,913 | \$200,000 | | \$28,198 | \$5,147,111 |
| Northern Marianas Islands | \$518,846 | | | | \$518,846 |
| Ohio | \$22,076,542 | \$2,098,508 | | \$15,000 | \$24,190,050 |
| Oklahoma | \$9,532,169 | \$200,000 | | | \$9,732,169 |
| Oregon | \$9,679,815 | \$571,687 | | | \$10,251,502 |
| Palau | \$423,673 | | | | \$423,673 |
| Pennsylvania | \$23,606,643 | \$2,614,150 | | \$15,000 | \$26,235,793 |
| Puerto Rico | \$10,109,253 | | | | \$10,109,253 |
| Rhode Island | \$5,615,387 | \$365,904 | | | \$5,981,291 |
| South Carolina | \$10,652,835 | \$200,000 | | | \$10,852,835 |
| South Dakota | \$5,139,585 | \$200,000 | | | \$5,339,585 |
| Tennessee | \$13,359,228 | \$400,000 | | | \$13,759,228 |
| Texas | \$40,135,143 | \$4,413,697 | | \$2,046,577 | \$46,595,417 |
| Utah | \$7,823,438 | \$200,000 | | | \$8,023,438 |

| | | | | | |
|---------------------|----------------------|---------------------|--------------------|--------------------|----------------------|
| Vermont | \$4,897,319 | \$200,000 | | \$47,557 | \$5,144,876 |
| Virgin Islands (US) | \$563,765 | | | | \$563,765 |
| Virginia | \$15,901,815 | \$1,041,548 | \$1,523,269 | | \$18,466,632 |
| Washington | \$13,873,923 | \$1,296,773 | | \$182,822 | \$15,353,518 |
| West Virginia | \$6,789,088 | \$205,861 | | | \$6,994,949 |
| Wisconsin | \$12,682,964 | \$548,947 | | \$15,000 | \$13,246,911 |
| Wyoming | \$4,717,055 | \$200,000 | | | \$4,917,055 |
| Total | \$699,013,268 | \$54,786,732 | \$7,200,000 | \$5,440,000 | \$766,440,000 |

Appendix 3: Early Warning Infectious Disease Surveillance (EWIDS)

Regionally, the U.S. Border States EWIDS grantees have been participating in international planning and implementation of cross-border infectious disease surveillance and epidemiology activities along the U.S. northern and southern borders by promoting collaborations with Canadian provinces and Mexican states as well as with US tribes straddling the international border with these neighboring countries.

Continently, the Security and Prosperity Partnership (SPP) of North America supports and facilitates dual bi-national and trilateral initiatives that aim to strengthen international cross-border bio-protection and economic prosperity through health security in the United States, Mexico and Canada.

The preparedness goals, target capabilities and critical tasks of the U.S. Border States EWIDS project can help achieve the following SPP key milestones related to specific epidemiology and surveillance aspects of public health emergencies:

- Plan and launch a workshop on cross-border early warning infectious disease surveillance that would include local, state/provincial and national stakeholders to share solutions to common problems and exchange best practices. (Trilateral),
- Identify and address impediments to information exchanges in the early stages of public health emergencies (Dual Bi-national).
- Explore mechanisms and protocols toward creating early warning infectious disease surveillance systems that are interoperable along and across our shared borders (Dual Bi-national), and
- Plan and test infrastructure for 24/7/365 early warning case reporting (Trilateral),

The SPP-EWIDS trilateral workshop will be useful in bringing together all relevant stakeholders to strengthen coordination and planning regarding common goals and objectives among states/provinces and tri-nationally. This conference could provide information and identify ways in which to take a more unified approach toward collaborative cross-border preparedness and response planning, in the spirit of both the SPP and EWIDS frameworks.

The Department of Health and Human Services, Office of Public Health Emergency Preparedness (DHHS-OPHEP), continues to provide supplemental funds for early detection, identification, reporting and investigation of infectious disease outbreaks.

During this budget year, in recognition of the fact that States sharing a common border with neighboring Canada or Mexico have some natural affinities and common challenges with respect to planning and implementing cross-border surveillance and epidemiological activities, the U.S. Border States Early Warning Infectious Disease Surveillance (EWIDS) project will continue to offer the opportunity for States to submit a regional proposal. This approach, which is strictly voluntary, may be most appealing to States that have already undertaken joint planning activities

either because they share a common border with Canada or Mexico or because they wish to leverage their capabilities and resources as well as U.S. Border States EWIDS funding. Although U.S. Border States EWIDS funds would still be allocated on a State-by-State basis, this approach will capitalize on the synergies created by activities that a number of U.S. Border States have initiated.

States interested in this opportunity must jointly develop a common U.S. Border States EWIDS proposal that would be broader in scope than what each State could submit on its own. Within the proposal, each of the participating States must clearly identify the specific activities for which it would be individually responsible and accountable. In this common proposal, each State would clearly identify a set of activities for which it would assume lead responsibility. There would be minimal duplication of effort among the States and, all four States would be able to benefit from each other's efforts. States that wish to take advantage of this opportunity must each submit a copy of the common proposal that was jointly developed. However, each State should submit its own budget reflecting not only the specific activities for which it would be responsible but also the amount of its U.S. Border States EWIDS funds.

In accordance with their authorizing legislation, U.S. Border States EWIDS funds are intended strictly for the support of surveillance and epidemiology-related activities to address bioterrorism and other outbreaks of infectious diseases. U.S. Border States EWIDS funds are not to be used to support non-infectious disease surveillance or broader border activities in terrorism preparedness. Consequently, these funds may not be used to finance any chemical, radiological, nuclear or other emergency preparedness activities. Moreover, U.S. Border States EWIDS funds cannot be used to supplant surveillance and/or epidemiological activities already supported by other funding sources. However, U.S. Border States EWIDS funds can be used to enhance coordination and integration, with other existing cross-border infectious disease surveillance and epidemiology activities. Furthermore, States and local jurisdictions along the borders may engage in effective collaborations regarding the improvement of early warning infectious disease surveillance capacities and related homeland security strategy and capabilities enhancements. Where appropriate, EWIDS activities should engage, or continue to engage, in detailed coordination/collaboration with homeland security initiatives [i.e. near border Urban Area Security Initiative (UASI) and Metropolitan Medical Response System (MMRS) jurisdictions].

The aim of the U.S. Border States EWIDS project is to enhance coordination among neighboring states along the U.S.- Mexico border, and the U.S.- Canada border to:

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

Proposed activities must be consistent with the laws and regulations of the United States. The DSLR MIS template provides space for responses to the U.S. Border States EWIDS guidance for eligible recipients. These activities will be updated in the MIS as part of regular progress reports. Recipients may propose to address any of the following critical tasks but are not required to address all of them.

CDC Preparedness Goal 2: PREVENT

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

2A Target Capability: Intelligence/Information Sharing and Dissemination

Critical Task(s):

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

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

CDC Preparedness Goal 3: DETECT/REPORT

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

3A Target Capability: Public Health Laboratory Testing

Critical Task(s):

- 1) If not already undertaken, survey and assess the surveillance and laboratory capacity on each side of the international border including those of any tribes located within states that share an international border and the connectivity among these laboratories with a view towards (a) identifying and addressing needs or gaps with respect to their consistency or uniformity of testing standards, notification protocols, and laboratory-based surveillance data exchange practices and (b) developing bi-national, regional laboratory response capabilities.
- 2) Improve cross-border, electronic sharing of laboratory information with public health officials and other partners in neighboring jurisdictions (to facilitate the rapid formulation of an appropriate response to and control of the outbreak). Specific objectives are for jurisdictions on both sides of the international border to: (1) coordinate availability of and access to laboratories with appropriate expertise 24/7/365, and (2) test clinical specimens, food samples, and environmental samples for **biological agents** that could be used for terrorism.
- 3) Develop and maintain a database of all sentinel/clinical labs in grantee's border region that includes name, contact information, Bio-Safety Level, certification status, and whether they are part of an information-sharing network. The database should also include the names and contact information for reference labs used by the sentinel/clinical labs in the border region.
- 4) In coordination with local public health agencies on both sides of the border, apply information technology to develop or enhance electronic disease surveillance, including electronic disease reporting from clinical and public health laboratories and linkage of laboratory results to case report information.
- 5) Partner with Schools of Public Health and/or CDC's Centers for Public Health Preparedness to develop binational training activities to enable border health professionals in the U.S., Canada and Mexico to receive introductory or advanced training jointly with their U.S. counterparts in surveillance, epidemiology, laboratory methods and information technologies that are relevant to the detection, reporting and investigation of infectious disease outbreaks.

CDC Preparedness Goal 5: INVESTIGATE

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

5A Target Capability: Epidemiological Surveillance and Investigation

Critical Task(s):

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

Appendix 4: Cities Readiness Initiative (CRI) Guidance

Introduction:

Since 1999, the Federal government has expended significant effort and resources to enhance the safety of Americans through the development of the Strategic National Stockpile (SNS). As part of this effort, the Centers for Disease Control and Prevention (CDC) has worked directly with state and local officials to develop receipt, distribution and dispensing plans and capabilities for providing stockpile items to citizens down to the local level. The initial focus and efforts have been primarily at the state level. As a natural next step and in an effort to leverage the concepts found in the Homeland Security Presidential Directive (HSPD) 5, the National Incident Management System (NIMS), and the National Response Plan (NRP), CDC is expanding its practice of working with states and other eligible jurisdictions toward ensuring a thoroughly integrated local, State, and where necessary, federal response to a bioterrorism event. The first part of this next step is to increase and enhance readiness of selected cities, in collaboration with State, federal, and private sector partners, to make full and effective use of SNS assets in the event of a public health catastrophe or act of terrorism for which the SNS can provide applicable countermeasures. A worst case scenario would be a bioterrorism attack over a large geographic area with an agent such as *Bacillus anthracis*, the organism that causes anthrax. In this case, antibiotics must reach the identified population within 24 - 48 hours to have the greatest life-saving effect. While great strides have been made in recent years, few localities are fully prepared to distribute and dispense SNS assets in this timeframe.

To this end, CDC will continue the CRI initiative that began in (FY) 2004 to provide special funding targeted to 36 selected metropolitan statistical areas (MSAs). Additional funding is also being provided to conduct the next phase of 36 CRI MSAs. This addition will induct a National Cities Readiness Initiative focus for (FY) 2007. Every state will have at least one CRI jurisdiction. This document is provided to assist grantees in developing applications for budget year seven (August 31, 2006 - August 30, 2007) of a project period that begins August 31, 2006.

The identification of MSAs was employed to assist in the funding allocation. The CRI funding does not require the establishment of a MSA plan. Instead, jurisdictions within the MSA are expected to continue with their existing mass prophylaxis planning structure and coordinate across the MSA.

To ensure that all preparedness activities are coordinated and integrated at the state, regional, and local levels, recipients should address recipient activities that relate to the CDC cooperative agreement within the existing framework of goals, outcomes, tasks and measures required for a response to bioterrorism and other public health emergencies.

The jurisdictions eligible for this targeted continued funding for the CRI are listed in Table I:

TABLE I—Existing CRI Recipients

| Grantee | CRI City | MSA/CRI Jurisdiction (Only the largest cities are listed. This list does not include the entire geographical area) |
|----------------|-----------------|---|
| Arizona | Phoenix | Phoenix-Mesa-Scottsdale, AZ |
| California | Riverside | Riverside-San Bernardino-Ontario, CA |
| California | Sacramento | Sacramento-Arden-Arcade-Roseville, CA |
| California | San Diego | San Diego-Carlsbad-San Marcos, CA |
| California | San Francisco | San Francisco-Oakland-Fremont, CA |
| California | San Jose | San Jose-Sunnyvale-Santa Clara, CA |
| Chicago | Chicago | Chicago-Naperville-Joliet, IL-IN-WI |
| Colorado | Denver | Denver-Aurora, CO |
| Delaware | Philadelphia | Philadelphia-Camden-Wilmington, PA-NJ-DE |
| Florida | Miami | Miami-Miami Beach-Ft Lauderdale, FL |
| Florida | Orlando | Orlando, FL |
| Florida | Tampa | Tampa-St. Petersburg-Clearwater, CA |
| Georgia | Atlanta | Atlanta-Sandy Springs-Marietta, GA |
| Illinois | Chicago | Chicago-Naperville-Joliet, IL-IN-WI |
| Indiana | Indianapolis | Indianapolis, IN |
| Los Angeles | Los Angeles | Los Angeles-Long Beach-Santa Ana, CA |
| Maryland | Baltimore | Baltimore-Towson, MD |
| Maryland | Washington D.C | Washington-Arlington-Alexandria, DC-VA-MD |
| Massachusetts | Boston | Boston-Quincy, MA |
| Michigan | Detroit | Detroit-Warren-Livonia, MI |
| Minnesota | Minneapolis | Minneapolis-St. Paul-Bloomington, MN |
| Missouri | St. Louis | St Louis, MO-IL |
| Missouri | Kansas City | Kansas City, MO-KS |
| Nevada | Las Vegas | Las Vegas-Paradise, NV |
| New York City | New York City | New York-Northern New Jersey-Long Island, NY-NJ-PA |
| Ohio | Cincinnati | Cincinnati-Middletown, OH-KY-IN |
| Ohio | Cleveland | Cleveland-Elyria-Mentor, OH |
| Ohio | Columbus | Columbus, OH |
| Oregon | Portland | Portland-Vancouver-Beaverton, OR-WA |
| Pennsylvania | Philadelphia | Philadelphia-Camden-Wilmington, PA-NJ-DE |
| Pennsylvania | Pittsburgh | Pittsburgh, PA |
| Rhode Island | Providence | Providence-New Bedford-Fall River, RI-MA |
| Texas | Dallas | Dallas-Fort Worth-Arlington, TX |
| Texas | Houston | Houston-Baytown-Sugar Land, TX |
| Texas | San Antonio | San Antonio, TX |
| Virginia | Virginia Beach | Virginia Beach-Norfolk-Newport News, VA-NC |
| Virginia | Washington D.C | Washington-Arlington-Alexandria, DC-VA-MD |
| Washington | Seattle | Seattle-Tacoma-Bellevue, WA |
| Washington D.C | Washington D.C | Washington-Arlington-Alexandria, DC-VA-MD |
| Wisconsin | Milwaukee | Milwaukee-Waukesha-West Allis, WI |

The new jurisdictions eligible for funding to be included in CRI are listed in Table II:

TABLE II—New CRI Recipients

| Grantee | CRI City | MSA/CRI Jurisdiction Title (Only the largest cities are listed. This list does not include the entire geographical area) |
|----------------|-----------------|---|
| Alabama | Birmingham | Birmingham-Hoover, AL |
| Alaska | Anchorage | Anchorage, AK |
| Arkansas | Little Rock | Little Rock-North Little Rock, AR |
| California | Fresno | Fresno, CA |
| Connecticut | Hartford | Hartford-West Hartford-East Hartford, CT |
| Connecticut | New Haven | New Haven-Milford, CT |
| Delaware | Dover | Dover, DE |
| Hawaii | Honolulu | Honolulu, HI |
| Idaho | Boise | Boise City-Nampa, ID |
| Illinois | Peoria | Peoria, IL |
| Iowa | Des Moines | Des Moines, IA |
| Kansas | Wichita | Wichita, KS |
| Kentucky | Louisville | Louisville, KY-IN |
| Louisiana | New Orleans | New Orleans-Metairie-Kenner, LA |
| Louisiana | Baton Rouge | Baton Rouge, LA |
| Maine | Portland | Portland-South Portland-Biddeford, ME |
| Mississippi | Jackson | Jackson, MS |
| Montana | Billings | Billings, MT |
| Nebraska | Omaha | Omaha-Council Bluffs, NE-IA |
| New Hampshire | Manchester | Manchester-Nashua, NH |
| New Jersey | Trenton | Trenton-Ewing, NJ |
| New Mexico | Albuquerque | Albuquerque, NM |
| New York | Buffalo | Buffalo-Niagara Falls, NY |
| New York | Albany | Albany-Schenectady-Troy, NY |
| North Carolina | Charlotte | Charlotte-Gastonia-Concord, NC-SC |
| North Dakota | Fargo | Fargo, ND-MN |
| Oklahoma | Oklahoma City | Oklahoma City, OK |
| South Carolina | Columbia | Columbia, SC |
| South Dakota | Sioux Falls | Sioux Falls, SD |
| Tennessee | Nashville | Nashville-Davidson--Murfreeseboro, TN |
| Tennessee | Memphis | Memphis, TN-MS-AR |
| Utah | Salt Lake City | Salt Lake City, UT |
| Vermont | Burlington | Burlington-South Burlington, VT |
| Virginia | Richmond | Richmond, VA |
| West Virginia | Charleston | Charleston, WV |
| Wyoming | Cheyenne | Cheyenne, WY |

Expected Program Activities:

The primary goal of the Cities Readiness Initiative is to minimize the loss of lives during a catastrophic public health emergency by providing needed drugs to 100% of a city's identified population within a 48 hour time frame.

CRI Objectives:

1. Create and sustain the capacity to provide antibiotics to the MSA's entire population within 48 hours of the decision to do so.
2. Integrate command and control of state and local emergency operations systems to allow for effective communications
3. Institute a public information system to direct, mobilize and continually inform the public about mass antibiotic dispensing
4. Ensure security measures to protect people, locations and critical assets involved in the distribution and dispensing of antibiotics

Additional Activities for TABLE I - Existing CRI Recipients

- Continue to develop and augment your scalable plans with supporting infrastructure so that these selected MSAs are prepared to provide oral medications during an event to their entire population within 48 hours.
 - Identify points of dispensing (PODs) sites to accommodate the provision of antibiotics to the affected population
 - Recruit volunteer staff for POD operations and populate the appropriate volunteer registry (Medical Reserve Corps, Community Emergency Response Teams, etc.)
 - Orient and train volunteer staff (clinical and non-clinical) for POD operations. Training could include pre-event and/or just-in-time tools
 - Conduct POD site surveys to ensure suitability of facilities in supporting POD operations. Operational Manuals should be developed specific to each POD site.
 - Coordinate with state and local law enforcement to develop a comprehensive security plan
 - Coordinate with jurisdictions across the MSA to ensure consistent health communication messaging and dissemination of public information
- Develop plans to provide prophylaxis through alternate methods to increase population throughput to decrease the burden on PODs
 - Examples include: Drive-thru POD, company prophylaxis, mobile mass prophylaxis teams
 - Determine threshold criteria for shifting from a clinical dispensing model to a non-clinical model of dispensing.
- Develop a plan in conjunction with the United States Postal Service (USPS) to deploy elements of the jurisdiction's USPS to complement the POD strategy with the delivery of antibiotics to residences (Exceptions to this requirement may be granted by the Division of Strategic National Stockpile in collaboration with the Centers for Disease Control and the Department of Health and Human Services).
- Assemble state SNS and local CRI planners to convene periodic CRI meetings to enable participants to engage in the exchange of CRI information, update SNS plans, educate and train volunteers, and network to improve CRI program success.

Additional Activities for TABLE II - New CRI Recipients

- Develop plans with supporting infrastructure by following the same guidance as listed above in TABLE I – CRI cities with the exception of USPS planning.
- Participate in an initial executive briefing via satellite broadcast or webcast. (The purpose of this briefing is to provide an understanding of the CRI and its mission to the appropriate staff of all involved agencies and offices within the state, city, and county and will be offered early during the budget year.)

Program Content:

Recipients should continue to coordinate planning and program implementation activities to ensure that state and local health departments, hospitals, other health care entities, and state and local public safety and emergency management agencies are able to mount a collective response featuring seamless interaction of their event-specific capabilities in the following areas:

- Dispensing of Oral Medications at the PODs
- Providing Oral Medications to First Responders & Critical Infrastructure Personnel
- Public Information and Communications
- Distribution of Medical Materiel to Healthcare Facilities
- Tactical Communications between Command and Control Elements

Application Guidelines:

Please respond to the following recipient activities for the eligible cities using the DSLR Management Information System.

TABLE I Cities

1. Summarize progress on SNS activities over the last year. This should include updates on items 2 and 3 below.
2. Summarize the current status of plans for antibiotic distribution within the designated city – indicating the number of Points of Dispensing (PODs) that the city is able to establish, the number of personnel (paid staff and volunteers) that are likely to be available for this purpose, and the estimated number of individuals to whom the PODs can provide antibiotic prophylaxis over a 48-hour period.
3. Describe actions that will be taken over the next budget year to ensure that antibiotics can be dispensed to the entire jurisdiction over a 48-hour period. Included in these actions are non traditional PODs including the postal plan or other local option developed to meet the 48-hour deadline.
 - a. Please note: HHS and USPS have made the joint policy decision to pause all CRI cities working through Postal Plan programmatic development at the Strategic Security Plan (SSP) approval milestone – the step prior to actual program implementation - until a new Memorandum of Understanding (MOU) has been devised between the agencies and a CRI Postal Plan development pilot in Seattle WA has been conducted. While HHS and USPS recognize and appreciate the hard work put forth to date by existing CRI awardees that have already engaged the Postal Service, Postal volunteer solicitation and detailed planning cannot be formally initiated until the Seattle pilot is underway, the timeline for which is still

to be determined based on the completion of the new interagency agreement establishing complementary Federal roles and responsibilities. HHS Office of Public Health Emergency Preparedness (OPHEP) has agreed to take the owner/administrator role for Postal Plan safety support and is in the process of balancing that mission with the aims of its Home MedKit Evaluation in St. Louis.

Those CRI cities exploring the Postal Plan modality who have not yet submitted an SSP for Federal review are encouraged to continue their efforts in analyzing their operational objectives for the Postal Plan and determining baseline security requirements and coverage; questions and/or requests for clarification should be made through respective CDC SNS Program Preparedness Branch and USPS HQ Program Support Team contacts. For those new to the Postal programmatic planning process, SNS PPB SME can provide greater insight and assist them in engaging the Postal Service's national program office once certain preliminary information has been forwarded. Postal modality must be planned in accordance with USPS Planning Instructional and the DHS/HHS/USPS MOA, copies of which are available through the SNS PPB SMEs.

- b. Please note: The USPS, depending on the nature of its operational structure in a particular area, may have to plan on a MSA-wide basis as opposed to targeted plans with individual jurisdictions within that MSA, or may have to plan on a state to state basis for MSAs that cross state boundaries, and thus will depend in these cases on the state(s) to coordinate regional response planning between USPS and regional public health and emergency management entities.
4. Describe actions that will be taken over the next budget year to ensure that jurisdictions within an MSA will have coordinated mass prophylaxis activities and health communication messaging across the MSA.

TABLE II CRI Cities

Identify the staff that will be the points of contact for this initiative and provided information for the second activity above.

All recipients must provide a budget using the DSLR MIS indicating how the applicant proposes to use the targeted funds. CDC will work with the grantee during the course of the budget period to facilitate rebudgeting should the findings from successive applications of the SNS Assessment Tools warrant such changes.

Program Outcome:

The Cities Readiness Initiative is designed to significantly improve the operational capability of 72 large metropolitan areas to receive, distribute and dispense SNS assets. Each designated city should be able, in the wake of a bioterrorism event for which antibiotics are an appropriate countermeasure, to provide such prophylaxis to the entire population within 48 hours of the time of the decision to do so.

For the Table I CRI Cities, the local SNS plan should be designed so that it can accommodate an influx of federal government assets – particularly the United States Postal Service – in an event where the combined assets of the city and State are likely to be inadequate to dispense the antibiotics in sufficient time to protect their citizens.

Critical Capacities and Measurement:

Each of the planning jurisdictions included in the 72 MSA/CRI jurisdictions will be assessed on the below listed critical tasks except when the critical capacity resides at the State.

TABLE I Existing CRI Recipients

To familiarize state staff on the CRI assessment process, the DSNS SME and the state SNS Coordinator will conduct joint assessments of 25% (rounded up) of the existing planning jurisdictions (i.e. City, County, Region) within each MSA/CRI jurisdiction. The most populated jurisdictions will be prioritized. To assist in the assessment process, the state is required to conduct assessments on all MSA/CRI jurisdictions within 90 days of the last joint DSNS/State assessment and report findings to the DSNS SME. In consultation with the State, DSNS will select random jurisdictions to validate the state assessment findings.

TABLE II New CRI Recipients

An initial assessment of the most populated jurisdiction within each MSA will be conducted within 3 months of the executive briefing. It will be conducted jointly by the by the DSNS SME and state staff to provide a baseline.

Following the baseline assessment, the assessment schedule for the TABLE II cities will follow the schedule outlined above in the TABLE I Cities.

The Critical Capacities and essential SNS functions are as follows:

1. Developing an SNS Plan
2. Command and Control.
3. Requesting SNS Assets.
4. Management of SNS Operations.
5. Tactical Communication.
6. Public Information.
7. Security Support.
8. Receipt, Staging and Storing SNS Assets.
9. Repackaging
10. Controlling SNS Inventory.
11. Dispensing Oral Medications.
13. Treatment Center Coordination.
14. Train, Exercise and Evaluate.

For more information on these functional areas, refer to the SNS Assessment Tool and the Receiving, Distributing and Dispensing Strategic National Stockpile Assets: A Guide for Preparedness - Version 10.(Draft) June 2005

Program Budget:

In those cases where the state is the awardee, the majority of funds must be forwarded to the cities and other selected MSA health agencies identified in TABLE I and II.. States will have a coordinating role and must participate in the CRI activities with local jurisdictions. States should budget funds so that they can perform those functions. Targeted funds may be allocated by the recipient cities within their own jurisdiction and, as appropriate, within adjacent jurisdictions that make up the metropolitan area for staff, fringe benefits, travel, training, supplies, call down equipment, contracts [including distribution (if needed), training, public information, and dispensing exercising], and Point of Distribution equipment (computers, printers, signage, communications, etc.). States must provide detailed descriptions of the funding going to local areas for CRI in their budget.

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

It is important that equipment purchased under this priority is interoperable with equipment purchased with funds from DHS State Homeland Security Grant Program (SHSGP) for first responders.

Appendix 5: Centers for Public Health Preparedness (CPHP) Program

The following information has been provided to assist Grantees in utilizing academic resources in Centers for Public Health Preparedness.

Background

The Centers for Public Health Preparedness (CPHP) program was initiated in 2000 to strengthen terrorism and emergency preparedness by linking academic expertise to state and local health agency needs. This unique program brings together fifty-two community colleges, colleges, and universities with a common focus on public health preparedness to establish a national network of education and training resources. CPHPs work in close collaboration with state and local health agencies to develop, deliver, and evaluate preparedness education based on community need for public health workers, healthcare providers, students, and others.

Program Goals

The five-year CPHP Program goals are to:

1. Strengthen public health workforce readiness through implementation of programs for life-long learning;
2. Strengthen capacity at State and local levels for terrorism preparedness and emergency public health response; and,
3. Develop a network of academic-based programs contributing to national terrorism preparedness and emergency response, by sharing expertise and resources across State and local jurisdictions.

Program Priorities

Based on the availability of funds and CDC strategic imperatives, key priorities for 2005-2006 CPHP activities are to:

1. Collaborate with health care and public health agencies across the nation to help them meet preparedness education and learning needs;
2. Maximize outreach of existing preparedness materials; and,
3. Enhance the evidence base for effective preparedness education.

Program Activities

CPHP Program activities are categorized into three distinct areas as follows:

Education and Training Activities

The primary focus of CPHP program activities is the delivery of education, training, and dissemination of new information related to enhancing emergency preparedness and response. Preparedness education activities may be either partner-requested based on a community need, or academic or university student-focused. Examples of these activities include: courses, train-the-trainer programs, conferences, workshops, preparedness curriculum development, internships, and training exercises/drills.

- **Partner-requested Activities (Other than Education / Training)**
State and local agency partners and the CPHP mutually identify needs other than education or training that can be met based on CPHP qualifications, expertise, and resources available to commit to the specific activity. Examples of this type of activity include: exercises or drills to assess participants' knowledge, skills, and abilities to respond; assistance with measuring key performance indicators of public health preparedness; and ongoing assessment of workforce education and training needs.
- **Supportive Activities**
Supportive activities are activities needed for general support of preparedness education, outreach, partnerships, and CPHP program evaluation. Other examples of activities include: ongoing enhancement of resources for education or information dissemination; publications; convening state and local preparedness partners for on-going planning; and maintenance of learning management systems.

Network Activities

- **Collaboration Group Activities**
The purpose of the CPHP collaboration group activities is to enhance collaboration across the CPHP Network and with CDC, to minimize duplication in development of materials, and to maximize outreach of existing resources. The collaborative groups are comprised of CPHP faculty experts and one or two CDC Staff Experts as needed. Groups are convened based on similar work, interest, and expertise related to preparedness topics, education methods, or audiences. A staff member from the Association of Schools of Public Health (ASPH) coordinates each group and provides critical logistical support to ensure successful collaboration (i.e. meeting schedules, conference call set-up, minutes, etc).

Two types of collaboration group activities occurred during the 2004-2005 program year – Exemplar Groups and Short-term Collaboration groups. For the 2005-2006 program year, there are twenty Collaboration Groups and each CPHP is required to participate in at least one.

- **Resource Center**
To maximize outreach of all CPHP-developed preparedness education materials CDC and the Association of Schools of Public Health (ASPH) have developed an online CPHP Resource Center, <http://www.asph.org/acphp/phprc.cfm>. Available via the Internet, the Resource Center provides users with access to CPHP-developed educational programs, course materials, slide notes, etc., for adoption and/or adaptation by CPHP program participants and their partners.
- **Preparedness Education Calendar**
ASPH provides users with an up-to-date Preparedness Education Calendar, <http://www.asph.org/acphp/educationCalendar.cfm>. This calendar lists preparedness

training and education-related conferences, institutes, and other scheduled educational offerings, offered by CPHPs, and open for enrollment.

- National Public Health Preparedness Referral Service
ASPH provides a free emergency preparedness and response to match preparedness needs of state and local health agencies and national organizations with available expertise, trainings and other useful services found within the CPHPs. This service is available at the following website: <http://www.asph.org/acphp/expertises/search.cfm>,

Appendix 6 Direct Assistance

Direct Assistance

Funding awarded through direct assistance is part of the total award, not an addition to the award. Direct assistance funds **MUST** be used in the federal Fiscal Year (FY) in which they are appropriated. Personnel funded through direct assistance may be split between two federal fiscal years. For example, a career epidemiology field officer hired through direct assistance may be funded from August 31-September 30, 2006, with FY06 funding provided with this award and from October 1-August 30, 2007, with FY07 funding.

Direct Assistance (Contracts and Task Orders):

- a. To obligate Direct Assistance funds in an amount of less than \$100,000, each applicant must submit a Performance-based Statement of Work (see below) for each contract or task order supported by Direct Assistance Funding.
- b. To obligate Direct Assistance funds in an amount greater than \$100,000 but less than \$500,000, each applicant must submit the following items for each contract or task order supported by Direct Assistance funding:
 - **Performance-based Statement of Work:** The Division of State and Local Readiness has a variety of Statement of Work templates available to any applicant upon request. Although a performance-based Statement of Work is tailored to the specifics of each project, it should contain these common elements:
 - Background - general, non-technical terms and explains why the acquisition is required; its relationship to past, current, or future projects; summary of statutory and applicable program authorities and regulations.
 - Project Objective – a succinct statement of the purpose of the acquisition, outlining expected results and anticipated benefits.
 - Scope of Work – an overall, non-technical description of the work to be performed that expands upon project objectives, while avoiding going into all of the details required; identifies and summarizes various phases of the project; and defines limits in terms of specific objectives, time, special provisions, or limitations. The Scope of Work must be consistent with the requirements.
 - Detailed Technical Requirements – clearly and precisely describes the work in terms of what is to be the required output rather than either how the work will be accomplished or the number of hours to be provided; provides requirements that do not limit a contractor to providing a specific product or service, rather the contractor is provided with the objectives to be accomplished, the end goal, or the desired achievement, including all pertinent information needed for a contractor or vendor to submit a proposal; identifies any budgetary, environmental, or other constraints; clearly and firmly defines the criteria for acceptance for all end

supplies or deliverables associated with the contract. Statement of Work places maximum responsibility for performance on the contractor as the contractor is being hired based upon his/her expertise and ability to perform the performance-oriented requirements.

- Reporting Schedule – specifies how the contractor shows that he/she has fulfilled all obligations; clearly identifies the performance-based criteria to be used by the Government for acceptance; define the mechanism by which the contractor can demonstrate progress and compliance with the requirements, and presents any problems it may have encountered. The preparation and submission of technical and financial progress reports on a timely basis reflect on a contractor’s efforts to certify satisfactory progress. Specific requirements to submit periodic financial and technical progress reports, to include format and templates will be provided by the Division of State and Local Readiness.
- Special Consideration – Include all and any information that does not fit into one of the other sections of the Statement of Work.
- References – Provide a detailed list and description of any studies, reports, and other data referred to elsewhere in the Statement of Work.
- **Independent Government Cost Estimate:** The independent government cost estimate is the government’s estimate of the costs associated with a particular contract project. The cost estimate determines the amount of money that should be set aside for funding the project and the cost estimate serves as a standard to which the offeror’s costs or price proposals will be compared when the offeror’s proposal is evaluated. The cost estimate includes direct costs (i.e., labor, material, travel, per diem, printing, consultants, etc.) and indirect costs (i.e., fringe benefits, overhead, and general and administrative expense rates). This is the government’s assessment of the probable cost of the supplies or services to be acquired and serves as a basis for determining the reasonableness of an offeror’s proposed costs and understanding of the Statement of Work. The cooperative agreement applicant may request assistance in developing a cost estimate from their project officer in the Division of State and Local Readiness.
- **Quality Assurance Surveillance Plans:** These plans must recognize the responsibility of the contractor to carry out its quality control obligations and must contain measurable inspections and acceptance criteria corresponding to the performance standards contained in the original performance-based Statement of Work. This plan must focus on the level of performance required by the performance-based Statement of Work, rather than the methodology used by the contractor to achieve that level of performance. The plan may also include:
 - technical progress and financial status reports (already a requirement for all direct assistance projects);
 - site visits to evaluate contract performance against scheduled or reported performance;

- review of invoices and vouchers to assess reasonableness of costs claimed and relate the total expenditures to the physical progress of the contract, based on monitoring activities (i.e., site visits, progress reports, etc.)
1. Please submit the following documents, electronically, to Gregory Lanman in the Division of State and Local Readiness at GHL2@cdc.gov:
 - a. **Contract/Task Order less than \$100,000:** Submit a performance-based Statement of work as described and outlined in this document.
 - b. **Contract/Task Order greater than \$100,000, but less than \$500,000:** Submit a performance-based Statement of Work; independent cost estimate; and quality assurance surveillance plan as described and outlined in this document.
 - c. If you are considering a contract or task order in an amount larger than \$500,000, please contact Gregory Lanman in the Division of State and Local Readiness at (404) 639-7127 as soon as possible.
 2. Upon receipt of each contract/task order package, the Division of State and Local Readiness will obtain proposals and quotes for the requested services, supplies, or equipment through federal contracts. The awardee will receive the proposals for review and selection according to their technical evaluation factors. Contract/task order awards will be based upon your evaluation criteria and selection decision.
 3. The Division of State and Local Readiness will obligate all Direct Assistance funding and will assume an active partnership as part of your Quality Assurance Surveillance Plan. This partnership will include oversight of the contract/task order, monitoring contract/task order expenditures and funding balances, and by coordinated site visits by the Project Officers of the Division of State and Local Readiness.
 4. For additional information or if you have any questions, please contact Gregory Lanman in the Division of State and Local Readiness at (404) 639-7127 or by email at GHL2@cdc.gov

Direct Assistance (Equipment):

CDC will provide a list of equipment that may be purchased through direct assistance. Generally, direct assistance equipment purchases are limited to the purchase of laboratory equipment.

Direct Assistance (Personnel): Public Health Readiness Field Assignees

In FY 2006, CDC Public Health Readiness Field Assignees may be available to provide long term (one to two years) on-site assistance to eligible recipients in the form of Direct Assistance awards. Placement of these Direct Assistance personnel will be based on the needs of host agencies and the availability of CDC staff in a variety of public health disciplines, including public health management, laboratory science, epidemiology, health communications, and environmental health.. Direct Assistance personnel assigned through this cooperative agreement

will receive training in critical aspects of public health preparedness and emergency response to prepare them to respond to local, state, regional and national public health emergencies.

Assignment of Direct Assistance personnel funded through this cooperative agreement, including Public Health Advisors and Career Epidemiology Field will be coordinated with the Field Services Activity in the CDC Portfolio Management Project.

Requests for new Public Health Readiness Field assignees during this budget period should be discussed with the DSLR Project officer prior to including them in the budget and budget justification sections of your annual funding application. Direct Assistance Personnel costs will be based on published pay and allowances/reimbursement rates established by the Office of Personnel Management. The value of personnel for the budget period will be deducted from the amount of financial assistance that would otherwise be made available to the recipient under the applicable allocation, formula, or other determination of award amount but will be deemed to be part of the award and to have been paid to the recipient.

Public Health Readiness Field Program assignees detailed to a recipient remain Federal employees; they are subject to increases, adjustments, and any other benefits that would otherwise apply. Provision for changed costs will be negotiated with the recipient in advance as this may change the amount of financial assistance provided. Assignees are supervised by DSLR staff. Assignees will be instructed as to the process and timing for submitting travel authorizations and claims for reimbursement as well as other requests to incur costs or be reimbursed for costs related to personnel details. Assignees shall maintain documentation of payments for in-State and local travel costs and other payments as grant-related records. These records are subject to review and audit by or on behalf of CDC.

Public Health Readiness Field Program personnel may be placed in any position compatible with their training and skills and which meets the needs of the awardee. They are also subject to the daily work supervision of any State/local employees under whose direction they are assigned.

Public Health Readiness Field assignees are subject to the provisions of the existing *Agreement to Detail* that defines the respective responsibilities of CDC and recipients regarding Direct Assistance assignments of CDC personnel. CDC will review this agreement with Awardee officials upon execution of the detail.

If you are interested in the Public Health Readiness Field staffing option, you should contact your DSLR Project Officer to discuss specific staffing needs and how to include the request for Direct Assistance personnel in the application. Be prepared to discuss the specific duties and responsibilities proposed for the Direct Assistance assignee and where the assignee would work in your organizational structure.

Appendix 7: National Public Health Radio Network (NPHRN)

During emergencies, CDC as well as state and local health departments are called upon to provide vital information to the affected and non-affected areas. The nation's infrastructure dependent networks (telephone, cell, internet) provide the backbone for both the transmission and receipt of this vital information. However, during emergencies it is not uncommon for these infrastructure dependent networks to either be damaged, overloaded, or destroyed preventing effective and reliable communication.

Recognizing the vulnerabilities of traditional communication networks, CDC has been collaborating with federal, state, and local partners in the initial development of the National Public Health Radio Network (NPHRN). Members of the network will be federal partners, state and local health departments. The NPHRN will provide a backup High Frequency (HF) communication platform for public health stakeholders to transmit and receive vital information. Specifically, the NPHRN will;

- 1) Provide back-up/redundant communications capacity with state and Federal agencies and a wide range of other responders during an emergency;
- 2) Ensure reliable long haul two-way communications in times of crises
- 3) Provide additional methods to gather event intelligence and situational awareness
- 4) Enable public health stakeholders access to redundant/secure wireless communications with Public Health Partners/Law Enforcement and other first responders;
- 5) Enable public health partners to participate in National, State and Local Disaster C Coordination;
- 6) Provision existing Non-Infrastructure Dependent Communications Assets in use by Federal/State/Local Agencies.
- 7) Enable CDC and partners to provide assistance to and receive assistance from other radio networks - FEMA's NECN, NCS "SHARES" Network, State/local partners, federal agencies, and NGOs (ARES, Red Cross, etc...);
- 8) Allow communications on reserved frequencies for CDC and state/local health authorities.
- 9) Enable CDC and partners to participate in regular practice exercises with Federal/State/Local Agencies/NGOs.

Historically, CDC has funded state/local partners to purchase, install and implement HF radio capabilities at state and city/county health departments. To date, this acquisition has been accomplished at various sites around the country. For these partners and the partners who are still acquiring HF capability, the NPHRN will provide a platform to utilize their HF assets.

For participation in the NPHRN, partners should work with CDC to receive and implement the NPHRN Operations Plan. Key items within the plan will detail:

- A. NPHRN Mission Statement
- B. NPHRN System Requirements
- C. NPHRN System Description
- D. Concept of Operations
 1. Activation

- 2. Termination
- 3. Tests
- 4. Reports
- E. Equipment Requirements
- F. Station Licenses & ALE Addresses
- G. Responsibilities
- H. Coordination with other agencies and NGOs
- I. Training/Exercise
- J. Appendices and Exhibits

Appendix 8: SDN Instructions

CDC Secure Data Network (SDN) Digital Certificate Access to the SLPPMIS Grant Management System

Prior to applying for an SDN Digital Certificate to gain access to the SLPPMIS Grant Management System, please contact your jurisdiction's BT Coordinator. Your application for a Digital Certificate cannot be approved unless individual rights have been assigned to you in the SLPPMIS System by your BT Coordinator. Without individual rights being assigned, your application CANNOT be approved until such time that your BT Coordinator creates them in the SLPPMIS System.

You will also not be granted access to the SLPPMIS System just by having your BT Coordinator assign you rights to the System. You must still individually apply for your own SDN Digital Certificate. Both pieces must be in place prior to you receiving approval for your Digital Certificate.

Please NOTE that if you currently have rights to access the SLPPMIS Grant Management System and are simply applying to renew your SDN Digital Certificate, you do not need to contact your BT Coordinator. Your current (or recently expired) rights to the system will be re-established.

INSTRUCTIONS CONTAINED IN THIS DOCUMENT

How to . . .

- I. Apply for an SDN Digital Certificate
(For both First Time and Existing SDN Users)
- II. Install an SDN Digital Certificate
- III. Importing an SDN Digital Certificate
- IV. Access the Secure Data Network (SDN)
- V. Request Additional Activities
- VI. Check an Expiration Date of an Existing SDN Digital Certificate

I. APPLY FOR AN SDN DIGITAL CERTIFICATE:

Regardless if applying for the first time, or renewing an existing SDN Digital Certificate, please follow the steps below to complete your on-line application to gain access to the SLPPMIS Grant Management System.

1. Access the SDN enrollment website at:

<https://ca.cdc.gov>

- Enter the general registration password.
(For security reasons, the general registration password is only available through your BT Coordinator or the Division of State and Local Readiness Program Staff at the CDC.)
- Review the Digital Certificate and System Requirements, then select the “Enroll” button.

2. Enter Personal Information

- Enter all required fields with complete information, confirming all of your information prior to selecting the “Next” button.
- Select the “Next” button.

3. Select a Program and Activity

- Select ONLY “*State and Local Preparedness Program MIS*” Program.
(Upon initial enrollment, you may only select one program from the available list. *After obtaining your Digital Certificate, you will be able to request additional programs and activities via the SDN. See Request Additional Activities Section Below.*)
- Select ONLY “Grant Application” Activity.
(Staging Activity is an internal-only testing environment.)
- Select the “Next” button.

4. Choose a Personal Challenge Phrase

- Follow the instructions on creating a Personal Challenge Phrase.
Enter and confirm your Personal Challenge Phrase.
- Select the “Next” button to complete the enrollment process.

II. TO INSTALL AN SDN DIGITAL CERTIFICATE:

After completing the application (enrollment process), you will receive an email within three to five business days (usually less) indicating your SDN Digital Certificate is ready, along with instructions on how to retrieve and install it. If you have internal IT support, it is recommended that they assist you with the installation. If the initial attempt to install a Certificate fails, you will have no choice but to return back to step 1 and apply for a Digital Certificate all over again.

Any additional assistance needed during the installation of a Digital Certificate, please contact the CDC SDN Support Desk at:

800 532-9929 or,
770 216-1276 or,
cdcsdn@cdc.gov

III. IMPORTING AN SDN DIGITAL CERTIFICATE:

After completing the installation of your SDN Digital Certificate to your primary computer, you may import your Certificate to another computer (i.e. laptop or home PC) allowing you access to the SDN remotely (outside of your primary workspace). Please remember that your Certificate is assigned to you, and should not be shared with others, or put on 'public' machines.

To import your Certificate to another computer:

1. Export the existing Certificate from your primary computer:
 - A. Open Internet Explorer (web browser) on the computer that has the valid Certificate
 - B. Select the "Tools" menu item from the top of the screen (you do not need to be on the SDN website)
 - C. Select "Internet Options" (the last option on the bottom of the list)
 - D. Select the "Content" tab (which should be the middle selection across the row of tabs at the top of the "Internet Options" box)
 - E. Select the "Certificates" button in the middle of the "Content" tab
 - F. Select the appropriate Certificate by clicking on it one time
 - G. Select "Export" by clicking on it one time. This will open up the export wizard.
 - H. Click "Next"
 - I. Select the option to export the private key and click "Next"

- J. Select the box to export all Certificates in the path **and** disable the strong protection
 - K. Select a password and click “Next”
 - L. Select a file location to Save the Certificate
2. Import the existing Certificate to your laptop (or other computer assigned to you):
- A. Open Internet Explorer on your laptop (or other computer)
 - B. Select the “Tools” menu item from the top of the screen (you do not need to be on the SDN website)
 - C. Select “Internet Options” (the last option on the bottom of the list)
 - D. Select the “Content” tab (which should be the middle selection across the row of tabs at the top of the “Internet Options” box)
 - E. Select the “Certificates” button in the middle of the “Content” tab
 - F. Select “Import” by clicking on it one time. This will open up the import wizard.
 - G. Type in the file name or click browse to locate the Certificate and click “Next”
 - H. Type in the password and click “Next”
 - I. Select the option to automatically store the Certificate based on type and click “Next”

You will now have access to the Secure Data Network (SDN) from both your primary computer, as well as a secondary one. Please note that when you update your primary Certificate (due to expiration or failure), you will need to complete this process again so that the current Certificate assigned to you is on all computers that you use to access the SDN.

Any additional assistance needed during the importing of a Digital Certificate, please contact the CDC SDN Support Desk at:
800 532-9929 or,
770 216-1276 or,
cdcsgn@cdc.gov

IV. ACCESS THE SECURE DATA NETWORK (SDN)

After obtaining and installing an SDN Digital Certificate, the SDN website can be accessed at:

<https://sdn.cdc.gov>

V. REQUEST ADDITIONAL ACTIVITIES

To request additional activities (either to access the SLPPMIS Grant Management System or another CDC program that runs on the SDN) after already having obtained and successfully installed an SDN Digital Certificate:

1. Log into the SDN (at the website listed above – <https://sdn.cdc.gov>)
2. Near the top left of the screen under the “My Application” section, select “Request Additional Activities”
3. Select the Program and Activities you are requesting.
4. If approved, you will have access to the other programs requested. You will not have to re-load or change anything related to your current Digital Certificate.

VI. CHECK AN EXPIRATION DATE OF AN EXISTING SDN DIGITAL CERTIFICATE

1. Open Internet Explorer (web browser)
2. Select the “Tools” menu item from the top of the screen (you do not need to be on the SDN website)
3. Select “Internet Options” (the last option on the bottom of the list)
4. Select the “Content” tab (which should be the middle selection across the row of tabs at the top of the “Internet Options” box)
5. Select the “Certificates” button in the middle of the “Content” tab
6. View the “Expiration Date” next to the Certificate with your name. That is the date your current SDN Digital Certificate will expire.
7. To exit, select the “Close” button at the bottom of the “Certificates” box, then “Cancel” at the bottom of the “Internet Options” box.

APPENDIX 9: DSLR PROJECT OFFICERS

| Region | Projects | Project Officer | Telephone | E-mail |
|-------------|--|---------------------------|----------------|--------------|
| I | Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont | Zach Harris | (404) 639-7265 | zah5@cdc.gov |
| II | New York City, New York, New Jersey, Puerto Rico, Virgin Islands | Dorotha Love Hall | (404) 639-7649 | dit1@cdc.gov |
| III | Delaware, Maryland, Pennsylvania, Virginia, West Virginia, District of Columbia | Keesler King | (404) 639-7423 | knk8@cdc.gov |
| IV-A | Alabama | Keesler King (Acting) | (404) 639-7423 | knk8@cdc.gov |
| | Florida | Zach Harris (Acting) | (404) 639-7265 | zah5@cdc.gov |
| | Georgia | John Scott (Acting) | (404) 639-7435 | jps5@cdc.gov |
| | Mississippi | Zach Harris (Acting) | (404) 639-7265 | zah5@cdc.gov |
| IV-B | Kentucky, North Carolina, South Carolina, Tennessee | Jean Popiak (Acting) | (404) 639-7438 | lzp9@cdc.gov |
| V | Chicago, Illinois, Indiana, Ohio, Michigan, Minnesota, Wisconsin | John Scott | (404) 639-7435 | jps5@cdc.gov |
| VI-A | Arkansas | Vanda Kelley (Acting) | (404) 639-7876 | vmm1@cdc.gov |
| | Louisiana | Trevia Brooks (Acting) | (404) 639-7613 | tnb9@cdc.gov |
| | New Mexico | Monica Farmer (Acting) | (404) 639-7938 | mwf7@cdc.gov |
| | Oklahoma | Stephanie Dopson (Acting) | (404) 639-7441 | sld9@cdc.gov |
| | Texas | Stephanie Dopson (Acting) | (404) 639-7441 | sld9@cdc.gov |
| VII | Iowa, Kansas, Missouri, Nebraska | Trevia Brooks | (404) 639-7613 | tnb9@cdc.gov |
| VIII | Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming | Monica Farmer | (404) 639-7938 | mwf7@cdc.gov |
| IX-A | Arizona, California, Los Angeles, Nevada | Vanda Kelley | (404) 639-7876 | vmm1@cdc.gov |
| IX-B | American Samoa, Commonwealth of Northern Mariana Islands (CNMI), Hawaii, Guam, Marshall Islands, Palau, Federated States of Micronesia | Monica Farmer (Acting) | (404) 639-7938 | mwf7@cdc.gov |
| X | Alaska, Idaho, Oregon, Washington | Stephanie Dopson | (404) 639-7441 | sld9@cdc.gov |

Appendix 10: Evaluation Plan Guidance

This outline serves as guidance for the development of an evaluation plan that addresses both a jurisdiction's public health preparedness and CDC's performance measures. The evaluation plan should include but is not limited to the following:

Summary of Evaluation Plan Document

- Purpose (intended uses)
- Audience (consider information needs)
- Stakeholder involvement (include letters of support or other documentation)
- Supporting/reference documents (e.g., jurisdiction's strategic plan, mutual aid agreements, previous data reports, evaluation reports, etc.)
- Plans for dissemination to evaluation findings both internally and externally

Background/Introduction

- Public health preparedness in the jurisdiction
- Identified jurisdiction-specific hazards, threats, and vulnerabilities (as permitted)
- Roles of federal, state, and local preparedness partners and stakeholders
- Description of special populations or other relevant public health concerns
- Designated lead for coordinating evaluation activities
- Allocation of resources for evaluation

Description of Evaluation Methodology

- Identified evaluation questions that align and support CDC's preparedness goals (prevention, detection/reporting, investigation, control, and recovery)
- Discussion of both process and outcome evaluation
- State program goals and SMART objectives (SMART=specific, measurable, achievable, realistic, and time-bound)
- Justification for evaluation methodology (cross check with evaluation standards of utility, feasibility, propriety, and accuracy) See <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr4811a1.htm>, Boxes 13-17

Data Collection/Data Sources

- All data sources with detailed descriptions
- "Indicator or Measure/Data Source" table
- Strengths and limitations of data sources
- Discussion of limitations (triangulation, other)

Analysis Plan

- Describe plans for analysis of indicators and measures
- Describe how these indicators and measures address the evaluation questions

Reporting, Dissemination & Program Improvement

- Brief description of jurisdiction's planned interim and final reports (include required and/or legislative reports)

- Formats for information dissemination (consider security concerns)
- Discussion on plans to utilize and share lessons learned from evaluation results
- List of stakeholders that will receive reports

Appendix 11: Tribal Government and Local Jurisdiction Compliance Activities

In March 2004, the Secretary of Homeland Security, at the request of the President, released the National Incident Management System (NIMS). The NIMS is a comprehensive system that improves tribal and local response operations through the use of the Incident Command System (ICS) and the application of standardized procedures and preparedness measures. It promotes development of cross-jurisdictional, statewide, and interstate regional mechanisms for coordinating response and obtaining assistance during a large-scale or complex incident.

Tribal and local authorities, not federal, have the primary responsibility for preventing, responding to, and recovering from emergencies and disasters. The overwhelming majority of emergency incidents are handled on a daily basis by a single jurisdiction at the local level. It is critically important that all jurisdictions comply with the NIMS because the challenges we face as a nation are far greater than the capabilities of any one jurisdiction; they are not, however, greater than the sum of all of us working together through mutual support. Homeland Security Presidential Directive 5 (HSPD- 5), *Management of Domestic Incidents*, requires all federal departments and agencies to adopt and implement the NIMS, and requires state¹ and local² jurisdictions to implement the NIMS to receive federal preparedness funding.

NIMS compliance should be considered and undertaken as a community-wide effort. The benefit of NIMS is most evident at the local level, when a community as a whole prepares for and provides an integrated response to an incident. Incident response organizations (to include local public health, public works, emergency management, fire, emergency medical services, law enforcement, hazardous materials, private sector entities, non-governmental organizations, medical organizations, utilities, and others) must work together to comply with NIMS components, policies, and procedures. Implementation of the NIMS in every tribal and local jurisdiction establishes a baseline capability that once established nationwide, can be used as a foundation upon which more advanced homeland security capabilities can be built.

Small and/or rural jurisdictions will benefit from a regional approach. In many instances smaller communities may not have the resources to implement all elements of NIMS on their own. However, by working together with other localities in their regions, these jurisdictions will be able to pool their resources to implement NIMS.

When NIMS is fully implemented, your local community or jurisdiction will be able to:

²⁸ As defined in the Homeland Security Act of 2002, the term “State” means any State of the United States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, and any possession of the United States.” 6 U.S.C. 101 (14)

² As defined in the Homeland Security Act of 2002, Section 2(10): the term “local government” means “(A) county, municipality, city, town, township, local public authority, school district, special district, intrastate district, council of governments... regional or interstate government entity, or agency or instrumentality of a local government: an Indian tribe or authorized tribal organization, or in Alaska a Native village or Alaska Regional Native Corporation; and a rural community, unincorporated town or village, or other public entity.” 6 U.S.C. 101(10)

- Ensure common and proven incident management doctrine, practices, and principles are used to plan for, protect against, respond to, and recover from emergency incidents and preplanned events;
- Maintain a response operation capable of expanding to meet an escalating situation and the ability to integrate resources and equipment from intrastate and interstate mutual aid agreements, state-provided assistance, and federal government response;
- Order and track response assets using common resource typing and definitions, and draw on mutual aid agreements for additional assistance;
- Establish staging and allocation plans for the re-distribution of equipment, supplies, and aid coming into the area from other localities, states, or the federal government through mutual aid agreements;
- Conduct situational assessments and establish the appropriate ICS organizational structure to effectively manage the incident; and
- Establish communication processes, procedures and protocols that will ensure effective interoperable communications among emergency responders, 9-1-1 centers, and multi-agency coordination systems (Emergency Operations Centers).

In federal Fiscal Year 2005, the Secretary of Homeland Security provided guidance to each state, outlining initial actions that should be taken to implement the NIMS. The letter to the nation's governors included a list of recommended actions for tribal and local governments to help them work towards NIMS compliance. A copy of this letter is posted on the NIMS webpage at: http://www.fema.gov/nims/nims_compliance.shtm. Recommended FY 2005 NIMS activities included:

- Institutionalize the use of the Incident Command System;
- Complete the NIMS awareness course IS-700 NIMS: An Introduction;
- Formally recognize NIMS and adopt NIMS principles and policies;
- Establish a NIMS compliance baseline by determining the NIMS requirements that have already been met; and
- Develop a strategy and timeline for full NIMS implementation.

By completing these activities, communities will have made substantial progress toward full NIMS implementation by the start of Fiscal Year 2007 (i.e. October 1, 2006). In federal Fiscal Year 2006, tribes and local communities will be required to complete several activities to comply with the NIMS. The attached implementation matrix describes the actions that jurisdictions must take by September 30, 2006 to be compliant with NIMS.

Completion of these actions will position tribal and local communities to better manage prevention, response and recovery efforts. The matrix identifies activities that are underway by the NIMS Integration Center (NIC) to support the effective implementation of NIMS as well as activities that will be required for NIMS implementation in future years.

The matrix also provides information on where to find technical assistance resources to support these compliance actions. For example, the National Incident Management Capability Assessment Support Tool (NIMCAST) is an example of a product designed to assist communities in determining their current NIMS compliance baseline. The NIMS is much more than just a list of required elements; it is a new approach to the way we prepare for and manage incidents, one that will lead to a more effective utilization of resources and enhanced prevention, preparedness, and response capabilities. Moreover, full NIMS implementation is a dynamic and multi-year phase-in process with important linkages to the National Response Plan (NRP), the Homeland Security Presidential Directive - 8 (i.e. the “National Preparedness Goal”) and the National Infrastructure Protection Plan (NIPP). Future refinement to the NIMS will evolve as policy and technical issues are further developed and clarified at the national level. This may well result in additional requirements being issued by the NIC as to what will constitute continuous full NIMS compliance in FY2007 and beyond.

More information on NIMS, NIMS compliance, and answers to frequently asked questions are available on the NIMS Integration Center Web page (<http://www.fema.gov/nims>).

NIMS Implementation Matrix for Tribal and Local Jurisdictions

| Required Tribal/Local Jurisdiction Action for FY 2006 Compliance | FY 2006 Compliance Activities | |
|---|--|--|
| | Guidance and Technical Assistance Resources | Future Activities |
| Community Adoption | | |
| Adopt NIMS at the community level for all government departments and agencies; as well as promote and encourage NIMS adoption by associations, utilities, non-governmental organizations (NGOs), and private sector incident management and response organizations. | <ul style="list-style-type: none"> • Adopt NIMS through executive order, proclamation, resolution, or legislation as the jurisdiction's official all-hazards, incident response system. • Develop a baseline assessment of the NIMS implementation requirements that your jurisdiction already meets and using that baseline, develop a strategy for full NIMS implementation and maintenance. • The NIMS Capability Assessment Support Tool (NIMCAST) is available at: www.fema.gov/nimcast/index.jsp • Sample templates for executives: www.fema.gov/nims/nims_toolsandtemplates.shtm | <ul style="list-style-type: none"> • Amend or re-authorize, as necessary. |
| Command and Management | | |

| FY 2006 Compliance Activities | | |
|--|---|--|
| Required Tribal/Local Jurisdiction Action for FY 2006 Compliance | Guidance and Technical Assistance Resources | Future Activities |
| <p><u>Incident Command System (ICS):</u> Manage all emergency incidents and preplanned (recurring/special) events in accordance with ICS organizational structures, doctrine, and procedures, as defined in NIMS. ICS implementation must include the consistent application of Incident Action Planning and Common Communications Plans.</p> | <ul style="list-style-type: none"> • Institutionalize ICS: Terms and definitions: www.fema.gov/txt/nims/institutionalizing_ics.txt • Incorporate concepts and principles of NIMS Chapter II, Command and Management including ICS characteristics such as common terminology, modular organization, management by objectives, incident action planning, manageable span of control, pre-designated incident facilities, comprehensive resource management, integrated communications, transfer of command, unity of command, unified command, personnel and resource accountability, and information and intelligence management. | <ul style="list-style-type: none"> • Continue to manage incidents and events using ICS. |
| <p><u>Multi-agency Coordination System:</u> Coordinate and support emergency incident and event management through the development and use of integrated multi-agency coordination systems, i.e develop and maintain connectivity capability between local Incident Command Posts (ICPs, local 911 Centers, local Emergency Operations Centers (EOCs) and state EOC.</p> | <ul style="list-style-type: none"> • NIMS Chapter II, Command and Management. | <ul style="list-style-type: none"> • Revise and update processes and plans. • The Emergency Management Institute (EMI) is currently developing an independent study and classroom course on NIMS Multi-Agency Coordination Systems. Additional information will be posted on the NIMS Integration Center Web page when available. See http://www.fema.gov/nims. • The NIMS Integration Center will feature best practices on the NIMS Web page. See http://www.fema.gov/nims. |

| FY 2006 Compliance Activities | | |
|--|---|---|
| Required Tribal/Local Jurisdiction Action for FY 2006 Compliance | Guidance and Technical Assistance Resources | Future Activities |
| <p><u>Public Information System:</u> Implement processes, procedures, and/or plans to communicate timely, accurate information to the public during an incident through a Joint Information System and Joint Information Center.</p> | <ul style="list-style-type: none"> • NIMS Chapter II, Command and Management. • Public Information Training (E388, Advanced Public Information Officers and G290, Basic Public Information Officers) | <ul style="list-style-type: none"> • Revise and update processes and plans. • The Emergency Management Institute (EMI) is currently developing an independent study and classroom course on NIMS Public Information Systems. Additional information will be posted on the NIMS Integration Center Web page when available. See http://www.fema.gov/nims. • Information on who should complete these courses also will be posted on the NIMS Web page. • The NIMS Integration Center will feature best practices on the NIMS Web page. See http://www.fema.gov/nims. |
| Preparedness: Planning | | |
| <p>Establish the community's NIMS baseline against the FY 2005 and FY 2006 implementation requirements.</p> | <ul style="list-style-type: none"> • Assess which NIMS implementation requirements your community already meets. The NIMS Capability Assessment Support Tool (NIMCAST) is available to facilitate this: www.fema.gov/nimcast/index.jsp | <ul style="list-style-type: none"> • Update strategy as appropriate and close capability gap. |

| FY 2006 Compliance Activities | | |
|---|---|---|
| Required Tribal/Local Jurisdiction Action for FY 2006 Compliance | Guidance and Technical Assistance Resources | Future Activities |
| Develop and implement a system to coordinate all federal preparedness funding to implement the NIMS across the community. | <ul style="list-style-type: none"> • A list of the Federal preparedness grant programs that have been reported to the NIC are available on the NIMS Web page at: www.fema.gov/nims • 2005 Homeland Security Grant Program Guidance: http://www.ojp.usdoj.gov/odp/docs/fy05hsgp.pdf • National Preparedness Goal and National Preparedness Guidance: http://www.ojp.usdoj.gov/odp/assessments/hspd8.htm • Catalog of Federal Domestic Preparedness Assistance (CFDA): http://www.cfda.gov | |
| Revise and update plans and SOPs to incorporate NIMS components, principles and policies, to include planning, training, response, exercises, equipment, evaluation, and corrective actions | <ul style="list-style-type: none"> • 2005 Homeland Security Grant Program Guidance: http://www.ojp.usdoj.gov/odp/docs/fy05hsgp.pdf • National Preparedness Goal and National Preparedness Guidance: http://www.ojp.usdoj.gov/odp/assessments/hspd8.htm | <ul style="list-style-type: none"> • Update plans and SOPs, incorporating lessons learned and best practices from exercises and response operations. • Emergency Operations Plan (EOP) guidance is under development and will be posted on the NIMS Integration Center Web page at: www.fema.gov/nims. |

| FY 2006 Compliance Activities | | |
|--|---|--|
| Required Tribal/Local Jurisdiction Action for FY 2006 Compliance | Guidance and Technical Assistance Resources | Future Activities |
| Participate in and promote intrastate and interagency mutual aid agreements, to include agreements with the private sector and non-governmental organizations. | <ul style="list-style-type: none"> • EMAC model state-county mutual aid deployment contract: http://www.emacweb.org/?123 • EMAC model intrastate mutual aid legislation: http://www.emacweb.org/docs/NEMA%20Proposed%20Intrastate%20Model-Final.pdf | <ul style="list-style-type: none"> • Expand mutual aid agreements beyond support services and equipment to include information sharing. • Support and adopt the ongoing efforts of the NIMS Integration Center (NIC) to develop a national credentialing system. • Credentialing guidance is under development by the NIMS Integration Center. Throughout the development process, drafts will be posted on the NIMS Web page for review and comment by interested stakeholders. • Credential first responders in conformance with national standards. |
| Preparedness: Training | | |
| Complete IS-700 NIMS: An Introduction | <ul style="list-style-type: none"> • On-line course: http://training.fema.gov/EMIWeb/IS/is700.asp • NIMS National Standard Curriculum Training Development Guidance: http://www.fema.gov/pdf/nims/nims_training_development.pdf • All personnel with a direct role in emergency preparedness, incident management, or response must complete this training | <ul style="list-style-type: none"> • Ensure that NIMS training is part of the program for all new employees, recruits and first responders who have a direct role in emergency preparedness, incident management, or response. • The NIMS Integration Center is working to establish a mechanism that will allow State and local jurisdictions direct access to course completion data. Additional information will be posted on the NIMS Integration Center Web page when available. See http://www.fema.gov/nims. |

| FY 2006 Compliance Activities | | |
|---|---|--|
| Required Tribal/Local Jurisdiction Action for FY 2006 Compliance | Guidance and Technical Assistance Resources | Future Activities |
| Complete IS-800 NRP: An Introduction | <ul style="list-style-type: none"> On-line course available at: http://www.training.fema.gov/emiweb/IS/is800.asp NIMS National Standard Curriculum Training Development Guidance: http://www.fema.gov/pdf/nims/nims_training_development.pdf The NIMS Web page provides for who should complete this training. http://www.fema.gov/nims | <ul style="list-style-type: none"> Ensure that NRP training is part of the program for all appropriate new employees, recruits and first responders. The NIMS Integration Center is working to establish a mechanism that will allow State and local jurisdictions direct access to course completion data. Additional information will be posted on the NIMS Integration Center Web page when available. See http://www.fema.gov/nims. |
| Complete ICS 100 and ICS 200 Training | <ul style="list-style-type: none"> ICS 100: http://www.training.fema.gov/emiweb/IS/is100.asp ICS 100: http://www.usfa.fema.gov/training/nfa ICS 200: http://www.training.fema.gov/emiweb/IS/is200.asp ICS 200: http://www.usfa.fema.gov/training/nfa NIMS National Standard Curriculum Training Development Guidance: http://www.fema.gov/pdf/nims/nims_training_development.pdf The NIMS Web page provides guidance for who should complete this training. http://www.fema.gov/nims. | <ul style="list-style-type: none"> Complete ICS 300 and ICS 400. Complete training that may be required to satisfy credentialing standards. Ensure that ICS training is part of the program for all new employees, recruits and first responders. The NIMS Integration Center is working to establish a mechanism that will allow States and local jurisdictions direct access to course completion data. Additional information will be posted on the NIMS Integration Center Web page when available. See http://www.fema.gov/nims. |

Preparedness: Exercises

| FY 2006 Compliance Activities | | |
|--|---|--|
| Required Tribal/Local Jurisdiction Action for FY 2006 Compliance | Guidance and Technical Assistance Resources | Future Activities |
| Incorporate NIMS/ICS into all tribal, local and regional training and exercises. | <ul style="list-style-type: none"> NIMS training information: www.fema.gov/nims/nims_training.shtm NIMS National Standard Curriculum Training Development Guidance: http://www.fema.gov/pdf/nims/nims_training_development.pdf DHS ODP Exercise Information: http://www.ojp.usdoj.gov/odp/exercises.htm | <ul style="list-style-type: none"> Continue to incorporate NIMS into all local training and exercises, to include drills, tabletop exercises, functional exercises, and full-scale exercises. |
| Participate in an all-hazard exercise program based on NIMS that involves responders from multiple disciplines and multiple jurisdictions. | <ul style="list-style-type: none"> 2005 Homeland Security Grant Program Guidance: http://www.ojp.usdoj.gov/odp/docs/fy05hsgp.pdf National Preparedness Goal and National Preparedness Guidance: http://www.ojp.usdoj.gov/odp/assessments/hspd8.htm DHS ODP Exercise Information: http://www.ojp.usdoj.gov/odp/exercises.htm NIMS National Standard Curriculum Training Development Guidance: http://www.fema.gov/pdf/nims/nims_training_development.pdf | <ul style="list-style-type: none"> Continue to participate in NIMS -oriented exercises, to include drills, tabletop exercises, functional exercises, and full-scale exercises. |
| Incorporate corrective actions into preparedness and response plans and procedures. | <ul style="list-style-type: none"> DHS ODP Exercise Information: http://www.ojp.usdoj.gov/odp/exercises.htm | |

| FY 2006 Compliance Activities | | |
|--|--|---|
| Required Tribal/Local Jurisdiction Action for FY 2006 Compliance | Guidance and Technical Assistance Resources | Future Activities |
| Resource Management | | |
| Inventory community response assets to conform to homeland security resource typing standards. | <ul style="list-style-type: none"> Propose modifications or new resource definitions to the NIMS Integration Center for inclusion in the resource typing effort. Resource typing definitions: http://www.fema.gov/nims/mutual_aid.shtm | <ul style="list-style-type: none"> Develop and implement a resource inventory, ordering, and tracking system. The Emergency Management Institute (EMI) is currently developing a course on NIMS Resource Management. Additional information will be posted on the NIMS Integration Center Web page at http://www.fema.gov/nims when the course is available. |
| To the extent permissible by law, ensure that relevant national standards and guidance to achieve equipment, communication, and data interoperability are incorporated into tribal and local acquisition programs. | <ul style="list-style-type: none"> ODP Equipment Program: http://www.ojp.usdoj.gov/odp/grants_goals.htm 2005 Homeland Security Grant Program Guidance: http://www.ojp.usdoj.gov/odp/docs/fy05hsgp.pdf National Preparedness Goal and National Preparedness Guidance: http://www.ojp.usdoj.gov/odp/assessments/hspd8.htm DHS SAFECOM Program: http://www.safecomprogram.gov/SAFECOM | |

| FY 2006 Compliance Activities | | |
|--|--|---|
| Required Tribal/Local Jurisdiction Action for FY 2006 Compliance | Guidance and Technical Assistance Resources | Future Activities |
| Communication & Information Management | | |
| <p>Apply standardized and consistent terminology, including the establishment of plain English communications standards across public safety sector.</p> | <ul style="list-style-type: none"> • Incident response communications (during exercises and actual incidents) should feature plain English commands so they will be able to function in a multi-jurisdiction environment. Field manuals and training should be revised to reflect the plain English standard. • '10' codes may continue to be used during non-emergency, internal department communications. | <ul style="list-style-type: none"> • Continue featuring common terminology and plain English commands for all response activities. • The Emergency Management Institute (EMI) is currently developing a course on NIMS Communication and Information Management. Additional information will be posted on the NIMS Integration Center Web page at http://www.fema.gov/nims when the course is available. |

Appendix 12: State and Territorial Compliance Activities

In March 2004, the Secretary of Homeland Security, at the request of the President, released the National Incident Management System (NIMS). The NIMS is a comprehensive system that will improve response operations through the use of the Incident Command System (ICS) and other standard procedures and preparedness measures. It will also promote development of cross-jurisdictional, statewide and interstate regional mechanisms for coordinating incident management and obtaining assistance during large-scale or complex incidents.

The NIMS Integration Center (NIC) recognizes that the overwhelming majority of emergency incidents are handled on a daily basis by a single jurisdiction at the local level. However, it is critically important that all jurisdictions comply with the NIMS because the challenges we face as a nation are far greater than the capabilities of any one jurisdiction; they are not, however, greater than the sum of all of us working together through mutual support. Homeland Security Presidential Directive 5 (HSPD- 5), *Management of Domestic Incidents*, requires all federal departments and agencies to adopt and implement the NIMS, and requires states, territories, tribes and local governments to implement the NIMS to receive federal preparedness funding.

States¹ play an important role in ensuring the effective implementation of the NIMS. They must ensure that the systems and processes are in place to communicate the NIMS requirements to local² jurisdictions and support them in implementing the NIMS. The NIMS implementation requirements for local jurisdictions are available in a separate matrix to support this communication and coordination between the States and local jurisdictions. States must also implement specific NIMS implementation actions as outlined in this matrix.

States should encourage and support a regional approach to NIMS implementation among its jurisdictions. In some instances smaller communities may not have the resources to implement all elements of NIMS on their own. However, by working together with other localities in their regions, they will be able to pool their resources to implement NIMS.

When NIMS is fully implemented, states and local jurisdictions will be able to:

- Ensure common and proven incident management doctrine, practices and principles are used to plan for, protect against, respond to and recover from emergency incidents and preplanned events;

¹ As defined in the Homeland Security Act of 2002, the term “State” means any State of the United States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, and any possession of the United States.” 6 U.S.C. 101 (14)

² As defined in the Homeland Security Act of 2002, Section 2(10): the term “local government” means “(A) county, municipality, city, town, township, local public authority, school district, special district, intrastate district, council of governments... regional or interstate government entity, or agency or instrumentality of a local government: an Indian tribe or authorized tribal organization, or in Alaska a Native village or Alaska Regional Native Corporation; and a rural community, unincorporated town or village, or other public entity.” 6 U.S.C. 101(10)

- Maintain a response operation capable of expanding to meet an escalating situation and the ability to integrate resources and equipment from intrastate and interstate mutual aid agreements, state-provided assistance and federal government response;
- Order and track response assets using common resource typing and definitions, and draw on mutual aid agreements for additional assistance;
- Establish staging and allocation plans for the re-distribution of equipment, supplies and aid coming into the area from other localities, states or the federal government through mutual aid agreements;
- Conduct situational assessments and establish the appropriate ICS organizational structure to effectively manage the incident; and
- Establish communication processes, procedures and protocols that will ensure effective interoperable communications among emergency responders, 9-1-1 centers and multi-agency coordination systems such as Emergency Operations Centers (EOC).

In federal Fiscal Year 2005, the Secretary of Homeland Security provided guidance to each state, outlining initial actions that should be taken to implement the NIMS. The letter to the nation's governors included a list of actions for States and territories to take towards NIMS compliance. A copy of this letter is posted on the NIMS webpage at: http://www.fema.gov/nims/nims_compliance.shtm. Minimum FY 2005 NIMS activities included:

- Incorporating NIMS into existing training programs and exercises;
- Ensuring that Federal preparedness funding (including DHS Homeland Security Grant Program, Urban Area Security Initiative (UASI) funds) support NIMS implementation at the state and local levels (in accordance with the eligibility and allowable uses of the grants);
- Incorporating NIMS into Emergency Operations Plans (EOP);
- Promotion of intrastate mutual aid agreements;
- Coordinating and providing technical assistance to local entities regarding NIMS; and
- Institutionalizing the use of the Incident Command System (ICS).

To receive FY 2006 preparedness grant funds from any federal department or agency, states will have to self-certify that they have met the minimum FY 2005 requirements. A self-certification letter will be provided to each state and territory. Additional information is also available on the NIMS Web page at: www.fema.gov/nims.

In federal Fiscal Year 2006, states, territories, tribes and local communities will be required to complete several activities to comply with the NIMS. The attached implementation matrix describes the actions that states must take by the end of federal FY 2006 (September 30, 2006) to be compliant with NIMS. These implementation requirements are in addition to the FY 2005 NIMS requirements as established in the Sept. 8, 2004, letter to the governors. A copy of that letter is available on the NIMS Web page at: www.fema.gov/nims.

Beginning in FY 2007, which starts on October 1, 2006, all federal preparedness funding will be conditioned upon full compliance with the NIMS. By completing the FY 2005 activities as well as the FY2006 activities outlined in this matrix, states and territories will have achieved what is considered to be full NIMS implementation by FY 2007.

Completion of the FY 2006 actions will result in a statewide infrastructure that will support NIMS implementation among all state and territorial agencies as well as at the tribal and local levels. The effective and consistent implementation of the NIMS in every state and territory will result in a strengthened national capability to prepare for, respond to and recover from any type of incident. The matrix identifies activities that are underway by the NIMS Integration Center to support the effective implementation of NIMS as well as activities that will be required for NIMS implementation in future years.

The matrix also provides information on where to find technical assistance resources to support these compliance actions. For example, the National Incident Management Capability Assessment Support Tool (NIMCAST) is a product designed to assist communities in determining their current NIMS compliance baseline. The NIMS is much more than just a list of required elements; it is a new approach to the way we prepare for and manage incidents, one that will lead to a more effective utilization of resources and enhanced prevention, preparedness and response capabilities. Moreover, full NIMS implementation is a dynamic and multi-year phase-in process with important linkages to the National Response Plan (NRP), Homeland Security Presidential Directive - 8 (i.e. the “National Preparedness Goal”) and the National Infrastructure Protection Plan (NIPP). Future refinement to the NIMS will evolve as policy and technical issues are further developed and clarified at the national level. This may well result in additional requirements being issued by the NIC as to what will constitute continuous full NIMS compliance in FY2007 and beyond.

More information on NIMS and NIMS compliance, and answers to frequently asked questions are available on the NIMS Integration Center Web page (<http://www.fema.gov/nims>).

NIMS Implementation Matrix for States and Territories

| FY 2006 Compliance Activities | | |
|---|--|--------------------------|
| Required State/Territorial Action for FY 2006 Compliance | Guidance and Technical Assistance Resources | Future Activities |
| State Adoption and Infrastructure | | |

| FY 2006 Compliance Activities | | |
|---|---|--|
| Required State/Territorial Action for FY 2006 Compliance | Guidance and Technical Assistance Resources | Future Activities |
| <p>Adopt NIMS at the state/territorial level for all government departments and agencies; as well as promote and encourage NIMS adoption by associations, utilities, non-governmental organizations (NGOs) and private sector incident management and response organizations.</p> <p>Monitor formal adoption of NIMS by all tribal and local jurisdictions.</p> | <ul style="list-style-type: none"> • Adopt NIMS through executive order, proclamation, resolution or legislation as the state's official all-hazards, incident response system. • Develop a baseline assessment of NIMS requirements that your jurisdiction already meets and using that baseline, develop a strategy for full NIMS implementation and maintenance. • The NIMS Capability Assessment Support Tool (NIMCAST) is available at: www.fema.gov/nimcast/index.jsp • Sample templates for executives: www.fema.gov/nims/nims_toolsandtemplates.shtm | <ul style="list-style-type: none"> • Amend or re-authorize, as necessary. |
| <p>Establish a planning process to ensure the communication and implementation of NIMS requirements across the state, including local governments and tribes. This process must provide a means for measuring progress and facilitate reporting.</p> | <ul style="list-style-type: none"> • FY 2006 NIMS Implementation Matrix for Local Jurisdictions | |
| <p>Designate a single point of contact within the state government to serve as the principal coordinator for NIMS implementation statewide.</p> | <ul style="list-style-type: none"> • Consider establishing new or leverage existing cross-jurisdictional and cross-discipline advisory group to assist and ensure full implementation of NIMS. | |

| FY 2006 Compliance Activities | | |
|---|---|-------------------|
| Required State/Territorial Action for FY 2006 Compliance | Guidance and Technical Assistance Resources | Future Activities |
| <p>To the extent permissible by law, ensure that federal preparedness funding to state and territorial agencies and tribal and local jurisdictions is linked to the satisfactory progress in meeting the requirements related to FY06 NIMS implementation requirements.</p> | <ul style="list-style-type: none"> • The <i>National Incident Management System (NIMS)</i> March 2004, the NIMS implementation requirements, and Homeland Security Presidential Directive 5 are all available on the NIMS Web page at: www.fema.gov/nims • NIMS Capability Assessment Support Tool (NIMCAST): www.fema.gov/nimcast/index.jsp • 2005 Homeland Security Grant Program Guidance: http://www.ojp.usdoj.gov/odp/docs/fy05hsgp.pdf • National Preparedness Goal and National Preparedness Guidance: http://www.ojp.usdoj.gov/odp/assessments/hspd8.htm | |
| <p>To the extent permissible by state and territorial law and regulations, audit agencies and review organizations should routinely include NIMS implementation requirements in all audits associated with federal preparedness grant funds. This process will validate the self-certification process for NIMS compliance.</p> | <ul style="list-style-type: none"> • The <i>National Incident Management System (NIMS)</i> March 2004, the NIMS implementation requirements, and Homeland Security Presidential Directive 5 are all available on the NIMS Web page at: www.fema.gov/nims • NIMS Capability Assessment Support Tool (NIMCAST): www.fema.gov/nimcast/index.jsp • A list of the Federal preparedness grant programs that have been reported to the NIC are available on the NIMS Web page at: www.fema.gov/nims • 2005 Homeland Security Grant Program Guidance: http://www.ojp.usdoj.gov/odp/docs/fy05hsgp.pdf • National Preparedness Goal and National Preparedness Guidance: http://www.ojp.usdoj.gov/odp/assessments/hspd8.htm | |
| Command and Management | | |

| FY 2006 Compliance Activities | | |
|---|--|--|
| Required State/Territorial Action for FY 2006 Compliance | Guidance and Technical Assistance Resources | Future Activities |
| <p><u>Incident Command System (ICS):</u> Manage all emergency incidents and preplanned (recurring/special) events in accordance with ICS organizational structures, doctrine and procedures, as defined in NIMS. ICS implementation must include the consistent application of Incident Action Planning and Common Communications Plans.</p> | <ul style="list-style-type: none"> • Institutionalize ICS: Terms and definitions: www.fema.gov/txt/nims/institutionalizing_ics.txt • Incorporate concepts and principles of NIMS Chapter II, Command and Management including ICS characteristics such as common terminology, modular organization, management by objectives, incident action planning, manageable span of control, pre-designated incident facilities, comprehensive resource management, integrated communications, transfer of command, unity of command, unified command, personnel and resource accountability and information and intelligence management. | <ul style="list-style-type: none"> • Continue to manage incidents and events using ICS. |
| <p><u>Multi-agency Coordination System:</u> Coordinate and support emergency incident and event management through the development and use of integrated multi-agency coordination systems, i.e. - develop and maintain connectivity capability between local Incident Command Posts (ICP), local 911 Centers, local Emergency Operations Centers (EOCs), the state EOC and regional and/federal EOCs and /NRP organizational elements.</p> | <ul style="list-style-type: none"> • NIMS Chapter II, Command and Management. | <ul style="list-style-type: none"> • Revise and update processes and plans. • The Emergency Management Institute (EMI) is currently developing an independent study and classroom course on NIMS Multi-Agency Coordination Systems. Additional information will be posted on the NIMS Integration Center Web page when available. See http://www.fema.gov/nims. • The NIMS Integration Center will feature best practices on the NIMS Web page. See http://www.fema.gov/nims. |

| FY 2006 Compliance Activities | | |
|---|--|---|
| Required State/Territorial Action for FY 2006 Compliance | Guidance and Technical Assistance Resources | Future Activities |
| <p><u>Public Information System:</u></p> <p>Institutionalize, within the framework of ICS, the Public Information System, comprising of the Joint Information System (JIS) and a Joint Information Center (JIC). The Public Information System will ensure an organized, integrated, and coordinated mechanism to perform critical emergency information, crisis communications and public affairs functions which is timely, accurate, and consistent. This includes training for designate participants from the Governor's office and key state agencies</p> | <ul style="list-style-type: none"> • NIMS Chapter II, Command and Management. • Public Information Training (E388, Advanced Public Information Officers and G290, Basic Public Information Officers) | <ul style="list-style-type: none"> • Revise and update processes and plans. • The Emergency Management Institute (EMI) is currently developing an independent study and classroom course on NIMS Public Information Systems. Additional information will be posted on the NIMS Integration Center Web page when available. See http://www.fema.gov/nims. • Information on who should complete these courses also will be posted on the NIMS Web page. • The NIMS Integration Center will feature best practices on the NIMS Web page. See http://www.fema.gov/nims. |
| Preparedness: Planning | | |
| <p>Establish the state's NIMS baseline against the FY 2005 and FY 2006 implementation requirements</p> | <ul style="list-style-type: none"> • Assess which NIMS implementation requirements the state already meets. The NIMS Capability Assessment Support Tool (NIMCAST) is available to facilitate this: www.fema.gov/nimcast/index.jsp | <ul style="list-style-type: none"> • Update state's Homeland Security strategy and any other state preparedness strategies and plans as appropriate and close capability gap. |

| FY 2006 Compliance Activities | | |
|---|--|---|
| Required State/Territorial Action for FY 2006 Compliance | Guidance and Technical Assistance Resources | Future Activities |
| Coordinate and leverage all federal preparedness funding to implement the NIMS. | <ul style="list-style-type: none"> • A list of the Federal preparedness grant programs that have been reported to the NIC are available on the NIMS Web page at: www.fema.gov/nims • 2005 Homeland Security Grant Program Guidance: http://www.ojp.usdoj.gov/odp/docs/fy05hsgp.pdf • National Preparedness Goal and National Preparedness Guidance: http://www.ojp.usdoj.gov/odp/assessments/hspd8.htm • Catalog of Federal Domestic Preparedness Assistance (CFDA): http://www.cfda.gov | |
| Revise and update plans and SOPs to incorporate NIMS and National Response Plan (NRP) components, principles and policies, to include planning, training, response, exercises, equipment, evaluation and corrective actions | <ul style="list-style-type: none"> • National Response Plan (NRP): http://www.dhs.gov/nationalresponseplan • 2005 Homeland Security Grant Program Guidance: http://www.ojp.usdoj.gov/odp/docs/fy05hsgp.pdf • National Preparedness Goal and National Preparedness Guidance: http://www.ojp.usdoj.gov/odp/assessments/hspd8.htm | <ul style="list-style-type: none"> • Update plans and SOPs, incorporating lessons learned and best practices from exercises and response operations. • Emergency Operations Plan (EOP) guidance is under development and will be posted on the NIMS Integration Center Web page at: www.fema.gov/nims. |

| FY 2006 Compliance Activities | | |
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| Required State/Territorial Action for FY 2006 Compliance | Guidance and Technical Assistance Resources | Future Activities |
| Promote intrastate and interagency mutual aid agreements, to include agreements with the private sector and non-governmental organizations. | <ul style="list-style-type: none"> • EMAC model state-county mutual aid deployment contract: http://www.emacweb.org/?123 • EMAC model intrastate mutual aid legislation: http://www.emacweb.org/docs/NEMA%20Proposed%20Intrastate%20Model-Final.pdf | <ul style="list-style-type: none"> • Expand mutual aid agreements beyond support services and equipment to include information sharing. • Support and adopt the ongoing efforts of the NIMS Integration Center (NIC) to develop a national credentialing system. • Credentialing guidance is under development by the NIMS Integration Center. Throughout the development process, drafts will be posted on the NIMS Web page for review and comment by interested stakeholders. • Credential first responders in conformance with national standards. |
| Preparedness: Training | | |
| Leverage training facilities to coordinate and deliver NIMS training requirements in conformance with the NIMS National Standard Curriculum. | <ul style="list-style-type: none"> • NIMS National Standard Curriculum Training Development Guidance: http://www.fema.gov/pdf/nims/nims_training_development.pdf | |

| FY 2006 Compliance Activities | | |
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| Required State/Territorial Action for FY 2006 Compliance | Guidance and Technical Assistance Resources | Future Activities |
| Complete IS-700 NIMS: An Introduction | <ul style="list-style-type: none"> On-line course: http://training.fema.gov/EMIWeb/IS/is700.asp NIMS National Standard Curriculum Training Development Guidance: http://www.fema.gov/pdf/nims/nims_training_development.pdf All personnel with a direct role in emergency preparedness, incident management or response must complete this training. | <ul style="list-style-type: none"> Ensure that NIMS is part of the program for all new employees, recruits and first responders. The NIMS Integration Center is working to establish a mechanism that will allow states and local jurisdictions direct access to course completion data. Additional information will be posted on the NIMS Integration Center Web page when available. See http://www.fema.gov/nims. |
| Complete IS-800 NRP: An Introduction | <ul style="list-style-type: none"> On-line course available at: http://www.training.fema.gov/emiweb/IS/is800.asp NIMS National Standard Curriculum Training Development Guidance: http://www.fema.gov/pdf/nims/nims_training_development.pdf The NIMS Web page provides guidance for who should complete this training. http://www.fema.gov/nims. | <ul style="list-style-type: none"> Ensure that NRP training is part of the program for all appropriate employees, recruits and first responders. The NIMS Integration Center is working to establish a mechanism that will allow states and local jurisdictions direct access to course completion data. Additional information will be posted on the NIMS Integration Center Web page when available. See http://www.fema.gov/nims. |

| FY 2006 Compliance Activities | | |
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| Required State/Territorial Action for FY 2006 Compliance | Guidance and Technical Assistance Resources | Future Activities |
| Complete ICS 100 and ICS 200 Training | <ul style="list-style-type: none"> ICS 100: http://www.training.fema.gov/emiweb/IS/is100.asp ICS 100: http://www.usfa.fema.gov/training/nfa ICS 200: http://www.training.fema.gov/emiweb/IS/is200.asp ICS 200: http://www.usfa.fema.gov/training/nfa NIMS National Standard Curriculum Training Development Guidance: http://www.fema.gov/pdf/nims/nims_training_development.pdf The NIMS Web page provides guidance for who should complete this training. http://www.fema.gov/nims. | <ul style="list-style-type: none"> Complete ICS 300 and ICS 400. Complete training that may be required to satisfy credentialing standards. Ensure that ICS training is part of the program for all new employees, recruits and first responders. |
| Preparedness: Exercises | | |
| Incorporate NIMS/ICS into all state and regional training and exercises. | <ul style="list-style-type: none"> NIMS training information: www.fema.gov/nims/nims_training.shtm NIMS National Standard Curriculum Training Development Guidance: http://www.fema.gov/pdf/nims/nims_training_development.pdf DHS ODP Exercise Information: http://www.ojp.usdoj.gov/odp/exercises.htm | <ul style="list-style-type: none"> Continue to incorporate NIMS into all state training and exercises, to include drills, tabletop exercises, functional exercises and full-scale exercises. |
| Participate in an all-hazard exercise program based on NIMS that involves responders from multiple disciplines and multiple jurisdictions. | <ul style="list-style-type: none"> 2005 Homeland Security Grant Program Guidance: http://www.ojp.usdoj.gov/odp/docs/fy05hsgp.pdf National Preparedness Goal and National Preparedness Guidance: http://www.ojp.usdoj.gov/odp/assessments/hspd8.htm DHS ODP Exercise Information: http://www.ojp.usdoj.gov/odp/exercises.htm NIMS National Standard Curriculum Training Development Guidance: http://www.fema.gov/pdf/nims/nims_training_development.pdf | <ul style="list-style-type: none"> Continue to participate in NIMS -oriented exercises, to include drills, tabletop exercises, functional exercises and full-scale exercises. |

| FY 2006 Compliance Activities | | |
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| Required State/Territorial Action for FY 2006 Compliance | Guidance and Technical Assistance Resources | Future Activities |
| Incorporate corrective actions into preparedness and response plans and procedures. | <ul style="list-style-type: none"> DHS ODP Exercise Information: http://www.ojp.usdoj.gov/odp/exercises.htm | |
| Resource Management | | |
| Inventory state response assets to conform to homeland security resource typing standards. | <ul style="list-style-type: none"> Resource typing definitions: http://www.fema.gov/nims/mutual_aid.shtm Propose modifications or new resource definitions to the NIMS Integration Center for inclusion in the resource typing effort. | <ul style="list-style-type: none"> Develop and implement a resource inventory, ordering and tracking system. The Emergency Management Institute (EMI) is currently developing a course on NIMS Resource Management. Additional information will be posted on the NIMS Integration Center Web page at http://www.fema.gov/nims when the course is available. |
| Develop state plans for the receipt and distribution of resources as outlined in the National Response Plan (NRP) Catastrophic Incident Annex and Catastrophic Incident Supplement | <ul style="list-style-type: none"> http://www.dhs.gov/nationalresponseplan | |
| To the extent permissible by state and local law, ensure that relevant national standards and guidance to achieve equipment, communication and data interoperability are incorporated into state and local acquisition programs. | <ul style="list-style-type: none"> ODP Equipment Program: http://www.ojp.usdoj.gov/odp/grants_goals.htm 2005 Homeland Security Grant Program Guidance: http://www.ojp.usdoj.gov/odp/docs/fy05hsgp.pdf National Preparedness Goal and National Preparedness Guidance: http://www.ojp.usdoj.gov/odp/assessments/hspd8.htm DHS SAFECOM Program: http://www.safecomprogram.gov/SAFECOM | |

| FY 2006 Compliance Activities | | |
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| Required State/Territorial Action for FY 2006 Compliance | Guidance and Technical Assistance Resources | Future Activities |
| Communication & Information Management | | |
| <p>Apply standardized and consistent terminology, including the establishment of plain English communications standards across public safety sector.</p> | <ul style="list-style-type: none"> • Incident response communications (during exercises and actual incidents) should feature plain English commands so they will be able to function in a multi-jurisdiction environment. Field manuals and training should be revised to reflect the plain English standard. • '10' codes may continue to be used during non-emergency, internal department communications. | <ul style="list-style-type: none"> • Continue featuring common terminology and plain English commands for all response activities. • The Emergency Management Institute (EMI) is currently developing an independent study and classroom course on NIMS Communication and Information Management. Additional information will be posted on the NIMS Integration Center Web page when available. See http://www.fema.gov/nims. • Information on who should complete these courses also will be posted on the NIMS Web page. |

Appendix 13: Target Capabilities Matrix

| 37 Target Capabilities and Categories | SHSP | UASI | LETPP | MMRS | CCP | EMPC | Transit | Port | Bus | Rail | Firefighters | NBHPP | BT/CDP | PHEPCA |
|---|------|------|-------|------|-----|------|---------|------|-----|------|--------------|-------|--------|--------|
| Common Target Capabilities | | | | | | | | | | | | | | |
| Planning | Y | Y | Y | Y | * | Y | Y | Y | Y | Y | Y | Y | | Y |
| Community Preparedness and Participation | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | | | |
| Communications | Y | Y | Y | Y | * | Y | Y | Y | Y | Y | Y | Y | | Y |
| Risk Management | Y | Y | | | * | Y | Y | Y | Y | Y | | | | |
| Prevent Mission Area Target Capabilities | | | | | | | | | | | | | | |
| Info Gathering and Recognition of Indicators and Warnings | Y | Y | Y | Y | * | | Y | Y | Y | Y | | | | |
| Law Enforcement Investigation and Operations | Y | Y | Y | | * | | Y | Y | | Y | | | | |
| Intelligence Analysis and Production | Y | Y | Y | | * | | Y | Y | | Y | | | | |
| CBRNE Detection | Y | Y | Y | Y | * | Y | Y | Y | Y | Y | Y | Y | Y | |
| Intelligence / Information Sharing and Dissemination | Y | Y | Y | | * | Y | Y | Y | Y | Y | | | | |
| Protect Mission Area Target Capabilities | | | | | | | | | | | | | | |
| Critical Infrastructure Protection | Y | Y | Y | | * | | Y | Y | Y | Y | | | | |
| Epidemiological Surveillance & Investigation | Y | Y | | Y | | | | | | | | Y | Y | Y |
| Public Health Laboratory Testing | Y | Y | | Y | | | | | | | | Y | Y | Y |
| Food and Agriculture Safety and Defense | Y | Y | | | * | Y | | | | | | | | |
| Respond Mission Area Target Capabilities | | | | | | | | | | | | | | |
| Onsite Incident Management | Y | Y | | | * | Y | Y | Y | Y | Y | Y | Y | | |
| Citizen Protection: Evacuation and/or In-Place Protection | Y | Y | | Y | * | Y | Y | Y | Y | Y | | | | |
| Emergency Operations Center Management | Y | Y | | | * | Y | Y | Y | Y | Y | | | | |
| Isolation and Quarantine | Y | Y | | Y | * | Y | Y | Y | | Y | | Y | | Y |
| Critical Resource Logistics and Distribution | Y | Y | | Y | * | Y | Y | Y | Y | Y | | | | |
| Urban Search & Rescue | Y | Y | | Y | * | Y | Y | | | Y | Y | | | |
| Volunteer Management and Donations | Y | Y | | | * | Y | | | | | | | | |
| Emergency Public Information and Warning | Y | Y | | Y | * | Y | Y | Y | Y | Y | | | | Y |
| Responder Safety and Health | Y | Y | | Y | * | Y | Y | Y | Y | Y | Y | Y | Y | Y |
| Triage and Pre-Hospital Treatment | Y | Y | | Y | * | | Y | Y | Y | Y | Y | Y | Y | |
| Public Safety and Security Response | Y | Y | | Y | * | Y | Y | Y | Y | Y | Y | | | |
| Medical Surge | Y | Y | | Y | * | | | | | | | Y | Y | |
| Animal Health Emergency Support | Y | Y | | | * | | | | | | | | Y | |
| Medical Supplies Management and Distribution | Y | Y | | Y | * | Y | Y | Y | Y | Y | | Y | Y | |
| Environmental Health | Y | Y | | Y | * | | | | | | | | | Y |
| Mass Prophylaxis | Y | Y | | Y | * | Y | Y | Y | Y | Y | | Y | Y | Y |
| Explosive Device Response Operations | Y | Y | | | * | | Y | Y | | Y | Y | | | |
| Mass Care | Y | Y | | Y | * | Y | Y | Y | Y | Y | | | | |
| Firefighting Operations/Support | Y | Y | | Y | * | | Y | Y | Y | Y | Y | | | |
| Fatality Management | Y | Y | | Y | * | Y | Y | Y | Y | Y | | Y | | |
| WMD/Hazardous Materials Response and Decontamination | Y | Y | | Y | * | Y | Y | Y | Y | Y | Y | Y | Y | |
| Recover Mission Area Target Capabilities | | | | | | | | | | | | | | |
| Structural Damage and Mitigation Assessment | Y | Y | | | * | | Y | Y | Y | Y | | | | |
| Economic & Community Recovery | Y | Y | | | * | Y | Y | Y | Y | Y | | | | |
| Restoration of Lifelines | Y | Y | | | * | | Y | Y | Y | Y | | | | |

Appendix 14: ChemPack Continuation Guidance

The CHEMPACK Project continues to assist Project Areas in the placement of CHEMPACK containers. As of May 1, 2006, 25 Project Areas have received CHEMPACK containers. Fielding and product sustainment schedules are being developed for the Project Areas who are currently awaiting fielding of their CHEMPACK assets. This appendix services as a resource for all Project Areas who are currently participating in the CHEMPACK Project and those who have requested and are awaiting fielding of CHEMPACK assets.

Participation in CHEMPACK Project is strictly voluntary for public health agencies. However, other entities (e.g., emergency management) in the state might choose to participate even if the public health department chooses not to participate.

Jurisdictions participating in the CHEMPACK Project must ensure that selected cache site storage locations meet specific U.S. Federal Drug Administration (FDA) regulations. These FDA regulations are based upon established pharmaceutical storage requirements specific to suitable space, lighting, ventilation, temperature, sanitation, humidity, and security.

Based upon the CHEMPACK Pilot Study conducted in New York City, South Dakota, and Washington State, the average cache site modification cost for CHEMPACK container storage is expected to be between \$2,000 and \$2,500 per storage site. It is important that public health agencies collaborate with the appropriate Emergency Response Agencies to implement the placement of CHEMPACK containers in selected locations where first responders will have ready access to the containers during a nerve agent release.

Funding for the initial cost of the CHEMPACK cache site modification and the sustainment over time of the cache sites can be defrayed by a variety of funding sources including local, state, and other federal agencies or programs including HRSA or MMRS, and private funds.

Recipients of the Public Health Emergency Preparedness Cooperative Agreement can also request redirection of current year funds or request carry over un-obligated prior-year funds, to support the cost incurred with receiving and managing CHEMPACK Project materiel. Redirection and carryover requests must contain a statement listing which program activities will not be completed if the request is approved. All requests must be submitted through DSLR MIS.

Questions related to cooperative agreement funds should be directed to the appropriate project officer in the Coordinating Office for Terrorism Preparedness and Emergency Response (COTPER) Division of State and Local Readiness.

Background:

Division Strategic National Stockpile Program (DSNS)
Coordinating Office for Terrorism Preparedness and Emergency Response (COTPER)
Centers for Disease Control and Prevention (CDC)

CHEMPACK Project

Operational Protocol

Terrorist attacks against United States citizens and US interests around the world culminated in the mass destruction of the World Trade Center and damage to the Pentagon on September 11, 2001. Intelligence sources believe that terrorist groups will continue their destructive activities and may use unconventional weapons in order to maximize casualties. To defend against these threats as well as accidental releases or natural disasters, planners and responders must be able to quickly mobilize resources to minimize and mitigate the effect of a nuclear, biological, chemical, or radiological (NBCR) terrorist attack. While preventing such an event is the primary goal, it is probable that not all terrorist efforts can be stopped. In the aftermath of a weapon of mass destruction (WMD) event, an accidental release of chemical or natural disaster, first responders will focus on response activities designed to mitigate morbidity, mortality and destruction of property.

One scenario involves terrorists using chemical weapons. Terrorist organizations may have access to many different types of chemical agents to use in WMD attacks. The likely choice may be a nerve agent. Depending on the duration of exposure or dose, nerve agents can cause immediate nervous system failure and death. Nerve agent antidotes include:

- Atropine sulfate, which blocks the effects of excess acetylcholine;
- Pralidoxime chloride (2PAM), which reactivates acetyl cholinesterase, and therefore reduces the level of acetylcholine; and
- Diazepam, which reduces the severity of acetylcholine-induced convulsions that can contribute to death or long term neurological effects in survivors.

The DSNS Program has numerous caches of medical equipment, pharmaceuticals and vaccines in strategic locations throughout the United States, including the medicines described above. Under its mandate, the DSNS Program has a maximum 12-hours response time. However, this response time is inadequate for a nerve agent event, where treatment must be accomplished quickly, usually within 60 minutes, in order to save as many lives as possible.

As a result, the Centers for Disease Control and Prevention has established a voluntary participation project (CHEMPACK) for the “forward” placement of sustainable repositories of nerve agent antidotes in numerous locations throughout the United States, so that they can be immediately accessible for the treatment of affected persons. Under the CHEMPACK Project, the DSNS Program will:

- maintain federal ownership of the CHEMPACK Project containers and the nerve agent antidote with the Project Areas having custody of the assets once placed.
- assist Project Areas in strategically placing two types of nerve agent antidote containers.
 - one Hospital container having a capacity to treat approximately 1000 casualties based upon duration of exposure.
 - one EMS container having a capacity to treat approximately 454 casualties based upon duration of exposure.

- implement strategies to maximize the shelf-life of the antidotes to minimize procurement costs and maintain materiel quality, through the Federal Drug Administration's (FDA) Shelf Life Extension Program (SLEP).

The CHEMPACK Project protocol allows the DSNS Program to maintain accountability and centralized control of the caches to fulfill the criteria for the SLEP program. This operational protocol makes caches immediately available to state / local communities for use in case of an event involving nerve agents.

Definitions:

CHEMPACK: the sustainable repository of nerve agent antidotes and other necessary and certain supporting equipment to care for individuals exposed to nerve agents, including but not limited to auto-injectors, bulk symptomatic treatment supplies, and self-monitoring storage containers. The CHEMPACK Project provides two types of containers:

- 1) The Emergency Medical Service (EMS) container that is designed for use by emergency responders (materiel packaged primarily in auto-injectors), and
- 2) The Hospital container that is designed for hospital dispensing (materiel packaged primarily in multi-dose vials for precision dosing and long term care).

Shelf Life Extension Program (SLEP): SLEP, managed by the Food and Drug Administration (FDA), is designed to extend the shelf-life of pharmaceuticals and lengthen their periods of effectiveness. The SLEP defers costs by extending the expiration date of stored pharmaceuticals rather than replacing stocks that have reached a set expiration date. Through centrally located automated monitoring devices, the DSNS Program staff is able to ensure that conditions of CHEMPACK materiel comply with SLEP guidelines, thus enabling CHEMPACK to provide the state a long-term capability.

To meet the objectives of the CHEMPACK Project deployment, Project Areas (i.e., CDC 62 Project Areas) and the CDC/DSNS Program incur specific responsibilities.

State and Local Responsibilities (Project Areas):

1. Authorize breaking the CHEMPACK container seal and use the packaged products only when designated state officers, employees and agents determine that an accidental or intentional nerve agent release has threatened the medical security of the community; has put multiple lives at a risk; is beyond local emergency response capabilities; and the materiel is medically necessary to save lives.
2. Designate a single person to be the state-wide point of contact (POC) for CHEMPACK. Provide that individual's contact numbers during normal business hours and after hours (office phone, cell phone, pager, email and fax). Also, designate an alternate (APOC) to backup the State CHEMPACK POC, and provide corresponding contact information.

This information shall be provided to the DSNS Program within 30 days of the State's decision to participate in CHEMPACK.

3. Notify DSNS Program of any changes in contact personnel within one business day of assignment of a new POC / APOC.
4. Determine the quantity and type of CHEMPACK containers (EMS / Hospital), required to meet the needs of state and local first responders to respond to a nerve agent event, (within stipulated budget constraints) and provide this information to the DSNS Program.
5. Develop a CHEMPACK Operational Plan for deployment, surveillance and maintenance operations as an addendum to the State Emergency Response Plan. The plan should address: asset placement; distribution; coverage areas; security; procedures for control, authorization and use of CHEMPACK assets. This plan shall be provided to the DSNS Program at least 30 days prior to the expected state fielding dates.
6. Provide the address of each cache storage location and ensure pre-coordinated access for DSNS Program personnel to cache locations as needed to monitor CHEMPACK materiel and provide this information to the DSNS Program at least 45 days prior to expected state fielding dates.
7. Ensure that cache storage locations are of a suitable size; designed to provide adequate lighting, ventilation, temperature control; provide sanitation, humidity, and space and security conditions for storage of pharmaceuticals. See Project Areas Responsibility for CHEMPACK Cache Storage.
8. Ensure proper disposal in accordance with applicable federal, state, and local regulations of expired CHEMPACK medical materiel and provide copies of the destruction documentation to the DSNS Program. The state is responsible for disposing Atropine sulfate, Dizaepam and sterile water in accordance with applicable federal, state, and local regulation.
9. Conduct joint inventories with the CHEMPACK fielding team upon initial placement and approximately every 18 months thereafter.
10. Provide adequate transportation of CHEMPACK materiel in an emergency, to include coordinating with state and local officials and emergency planning members for use of vehicles, freeway routes, and airfields.
11. Ensure storage facilities have the capability to rapidly move CHEMPACK materiel as required. This may include, but is not limited to, hydraulic lifts, forklifts, loading docks, or ramps.
12. Provide a list of personnel with access to the CHEMPACK containers at each cache location to the DSNS Program POC at the time of fielding, and update as changes occur.

13. Ensure cache storage locations correct non-complying environmental and security conditions identified by DSNS Program POC in a timely manner (usually within one hour). When conditions cannot be corrected within 12 hours, the CHEMPACK Logistics Team will coordinate with the State CHEMPACK POC to move CHEMPACK container(s) to an acceptable location to safeguard the quality or security of the materiel.
14. Notify the CHEMPACK Logistics Team within two hours if a CHEMPACK cache storage location loses climate control. Any reports of materiel stored outside of the accepted storage range will be handled on a case-by-case basis. Outcomes could range from having the materiel remain in the SLEP to removing the materiel from the SLEP program and the state forfeiting the long-term sustainability of the resource.
15. Coordinate with DSNS Program personnel to ensure the maintenance of proper security and environmental conditions for CHEMPACK materiel during any non-emergency movement (to include pre-positioning assets for special events). Movements of CHEMPACK materiel not specifically directed by the DSNS Program shall be funded by the state.
16. Notify the DSNS program within 24 hours of an emergency deployment. The deployment report should identify the amount of CHEMPACK expended and the amount of materiel returned to the container.
17. In the event of a non-emergency use or compromise of CHEMPACK materiel, the state will report the loss to the DSNS Program as soon as possible following discovery. Within 48 hours of the discovery of the loss the state must submit a report documenting the circumstances resulting in the loss and providing an inventory of materiel lost or destroyed.

The Project Areas will ensure the provision of the following facilities or conditions for each CHEMPACK storage locations. The standards for schedule IV controlled substances and pharmaceuticals are based upon the following DEA and FDA criterion:

1. Provide a locked room or cage. The CHEMPACK container is constructed of Lexan® mesh and is approved by the Drug Enforcement Agency (i.e., double locked standard, 24/7 security monitoring, and controlled designated entry) for storage of Class IV controlled substances. For this reason, there is no requirement for floor to ceiling construction. The purpose of the enclosed room or cage is to control access and ensure compliance with applicable federal, state and local pharmaceutical regulations.
2. Install an intrusion detection device, directed toward the CHEMPACK containers, to alert cache location security or pharmacy personnel of possible intrusion into the storage area. The sensor must be physically monitored on a 24-hour basis by security or pharmacy personnel. Cache location security managers will test the interior devices according to manufacturer specifications to ensure proper operation.

3. Ensure each container is locked with a padlock and access to the key is limited; key control shall be the responsibility of the DEA registrant and/or the cache location pharmacy director.
4. Ensure a minimum clearance of 72” aisles and 34” doorways to maneuver containers in and out of the storage location.
5. Provide a minimum of 40 sq. ft. of floor space per container at each cache location.
6. Ensure accessibility to CHEMPACK containers. CHEMPACK container dimensions are 60.5” long X 32.5” wide X 60.5” high and weigh approximately 600 pounds, depending on container type.
7. Ensure CHEMPACK containers are stored in a climate-controlled environment with room temperature maintained between 59 to 86 degrees Fahrenheit (15 degrees and 30 degrees Celsius). Humidity levels must be maintained below 60% in accordance with CFR 21, sec 205 and 211.
8. Provide one dedicated data quality analog phone line per Sensaphone®. The telephone line must be a Plain Old Telephone Service (POTS) type line (this line may not be a shared line). Digital lines on private branch exchanges (PBX) or private telephone switchboards will not work with the Sensaphone®.
9. Ensure one dedicated standard 120VAC, 60HZ, 10W, UL-listed power outlet power source per Sensaphone®. The outlet should be connected to an existing facility emergency generator or the location must provide an uninterruptible power supply (UPS) device.
10. Provide a fire detection and alarm device and adequate fire suppression in accordance with applicable federal, state and local pharmaceutical regulations and fire codes.
11. Provide standard lighting to ensure CHEMPACK personnel can clearly see lot numbers and product expiration dates as required by applicable federal, state and local pharmaceutical regulations.

CDC/DSNS/CHEMPACK Project Responsibilities:

1. Determine the contents and recommended doses of standardized CHEMPACK container packages and a treatment formulary to treat patients exposed to nerve agents.
2. Procure and deliver the CHEMPACK materiel to cache storage locations identified by the Project Area.

3. Provide SATCO® C Drug Enforcement Agency (DEA) containers. The CHEMPACK containers will be equipped with one padlock; a Sensaphone®; a back-up temperature monitoring system and a DSNS Program serial numbered container seal.
4. Determine in its sole discretion the suitability of CHEMPACK cache locations within the Project Area.
5. Provide a DSNS Program fielding team to install the CHEMPACK containers at state designated cache locations, conduct a joint inventory with designated cache location personnel, and validate the operational status of CHEMPACK environmental and security monitoring equipment.
6. Ensure that Schedule IV controlled substances are secured in a locked DEA approved CHEMPACK container and that a state designated pharmacy or medical professional with a DEA registration for that location has inventoried and assumed custody of the materiel.
7. Provide resources and assets required to sample, restock, re-label, and dispose of CHEMPACK materiel subject to the SLEP.
8. Provide resources and assets required to perform surveillance and quality assurance/quality control of CHEMPACK assets.
9. Conduct periodic audits, including quality assurance and quality control inspections, to verify that the state or city is implementing proper inventory, storage, and security procedures for CHEMPACK assets.

Resources:

1. Funding for the initial CHEMPACK installation and cache site sustainment cost can be defrayed by a variety of funding sources including local, state, and other federal agencies such as DHS, DOJ, MMRS, and private funds.
2. State Public Health Departments receiving funding through the Centers for Disease Control and Prevention (CDC) Public Health Emergency Preparedness Cooperative Agreement are encouraged to request redirection of current year funds or carry over unobligated period-year funds, to support the cost associated with receiving and managing CHEMPACK Project materiel. Redirected and carryover request should be sent through normal channels to the CDC Procurement and Grants Office (PGO). Questions related to CDC cooperative agreement funds should be directed to the appropriate project officer in the Coordinating Office for Terrorism Preparedness and Emergency Response (COTPER) Division of State and Local Readiness (DSLRL).
3. The HRSA National Bioterrorism Hospital Preparedness Program (NBHPP) has joined with the DSNS Program CHEMPACK Project to support cache build out. NBHPP funds

earmarked for Medications and Medical supplies may be used to offset reasonable costs associated with the retrofit of CHEMPACK cache storage facilities to meet FDA / SLEP requirements. Questions related to the use of these funds should be directed to the HRSA Coordinator in your state or directly to HRSA NBHPP.

4. The Project Areas will not be responsible for any cost related to the CHEMPACK containers / chemical antidotes, or transportation cost for initial installation. The DSNS Program will allocate CHEMPACK containers to Project Areas, based upon their population (2000 US Census).

Points of Contact:

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