RFA/PA Number: CDC-RFA-TP11-1101

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PART 1. OVERVIEW INFORMATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

Federal Agency Name: Centers for Disease Control and Prevention (CDC)

Funding Opportunity Title: Public Health Emergency Preparedness Cooperative Agreement

Announcement Type: New – Type 1

Agency Funding Opportunity Number: CDC-RFA-TP11-1101

Catalog of Federal Domestic Assistance Number: 93-069 Public Health Emergency Preparedness

Key Dates:

Application Deadline: June 17, 2011; 5:00 p.m. Eastern Time

Executive Summary

Public health threats are always present. Whether caused by natural, unintentional, or intentional means, these threats can rapidly overwhelm routine public health systems. Being prepared to prevent, respond to, and rapidly recover from public health threats is critical for protecting and securing our nation's public health.

The 2009 H1N1 influenza pandemic underscored the importance of communities being prepared for potential threats. Because of its unique abilities to respond to infectious, occupational, or environmental outbreaks and events, the Centers for Disease Control and Prevention (CDC) plays a pivotal role in ensuring that state and local public health systems are prepared for these and other public health incidents. CDC provides funding and technical assistance to public health departments nationwide through the Public

Health Emergency Preparedness (PHEP) cooperative agreement to build and strengthen their abilities to respond effectively to public health threats. PHEP awardees include 50 states, four directly funded localities, and eight territories and freely associated states.

This ongoing support of public health departments has forged a strong partnership that helps to protect the nation's communities from public health threats. This shared investment has been evident during numerous recent responses, ranging from routine food-borne outbreaks to the 2009-2010 H1N1 influenza pandemic response, which demonstrated that prepared public health systems are the cornerstone of an effective public health response during national public health emergencies.

While it is evident that public health departments have made significant progress in preparing for emergencies, CDC's new five-year PHEP cooperative agreement seeks to advance public health preparedness by:

- Establishing a prioritized and consistent set of public health preparedness capabilities,
- Encouraging public health departments to measure their ability to achieve the public health preparedness capabilities and report how PHEP funds are used to achieve these capabilities,
- Addressing lessons learned during the recent H1N1 influenza pandemic response regarding the administrative preparedness necessary at the state and local levels for effective response as well as provide an improved mechanism for awarding response funding,

- Accelerating a public health emergency response funding by including a second funding authority provision for contingent emergency response funding.
- Funding a limited number of higher population metropolitan statistical areas to develop all-hazards public health risk reduction strategies, and
- Quantifying the return on investment of public funds used for preparedness.

Capabilities-based Approach

To assist state and local public health departments in their strategic planning, CDC has developed 15 capabilities to serve as national public health preparedness standards. CDC's *Public Health Preparedness Capabilities: National Standards for State and Local Planning* (hereafter referred to public health preparedness capabilities) provides a guide that PHEP awardees can use to better organize their work, plan their priorities, and decide which capabilities they have the resources to build or sustain.

Public Health Preparedness Capabilities. Public health departments continue to face multiple challenges, including an ever-evolving list of public health threats. Concerns have been raised that declining preparedness funds will negatively impact their ability to achieve or sustain preparedness progress. These concerns underscore the need to establish national standards to ensure that federal preparedness funds are directed to priority areas within individual jurisdictions. The importance of being able to quantify return on investment is particularly important as resources for preparedness investments diminish.

In response to these concerns, CDC implemented a systematic process for defining a set of public health preparedness capabilities to assist public health departments with their strategic planning. CDC identified the following 15 public health preparedness capabilities (shown in their corresponding domains) as the basis for state and local public health preparedness. These domains are intended to convey the significant dependencies between certain capabilities.

Biosurveillance

- Public Health Laboratory Testing
- Public Health Surveillance and Epidemiological Investigation

Community Resilience

- Community Preparedness
- Community Recovery

Countermeasures and Mitigation

- Medical Countermeasure Dispensing
- Medical Materiel Management and Distribution
- Non-pharmaceutical Interventions
- Responder Safety and Health

Incident Management

- Emergency Operations Coordination

Information Management

- Emergency Public Information and Warning
- Information Sharing

Surge Management

- Fatality Management
- Mass Care
- Medical Surge
- Volunteer Management

Prioritization of Public Health Preparedness Capabilities. CDC strongly recommends that awardees prioritize the order of the capabilities in which they intend to invest based upon: 1) their jurisdictional risk assessments (see the Community Preparedness capability for additional or supporting detail on the requirements for this risk assessment), 2) an assessment of current capabilities and gaps using CDC's *Public Health Preparedness Capabilities: National Standards for State and Local Planning*, and 3) CDC's recommended tiered strategy for capabilities:

Tier 1 Capabilities:

- Public Health Laboratory Testing
- Public Health Surveillance and Epidemiological Investigation
- Community Preparedness
- Medical Countermeasure Dispensing
- Medical Materiel Management and Distribution
- Responder Safety and Health
- Emergency Operations Coordination
- Emergency Public Information and Warning

- Information Sharing
-

Tier 2 Capabilities:

- Non-Pharmaceutical Intervention
- Medical Surge
- Volunteer Management
- Community Recovery
- Fatality Management
- Mass Care

CDC's tiered strategy is designed to place emphasis on the Tier 1 capabilities as these capabilities provide the foundation for public health preparedness. Awardees are strongly encouraged to build the priority resource elements in the Tier 1 capabilities prior to making significant or comprehensive investments in Tier 2 capabilities.

A Systematic Approach. The content of each public health preparedness capability is based on evidence-informed documents, applicable preparedness literature, and subject matter expertise gathered from across the federal government and the state and local practice community. In developing the public health preparedness capabilities, CDC reviewed key legislative and executive directives to identify public health preparedness priorities. These include the following:

- Section 319C-1 of the Public Health Service Act, as amended by the Pandemic and All-Hazards Preparedness Act (PAHPA), which authorizes funding through the Public Health Emergency Preparedness cooperative agreement program;
- Homeland Security Presidential Directives 5, 8, and 21; and
- National Health Security Strategy (NHSS).

CDC also reviewed relevant preparedness documents from national partners such as the Association of State and Territorial Health Officials (ASTHO) and the National Association of County and City Health Officials (NACCHO) and third-party organizations including Trust for America's Health and RAND Corporation.

Aligning Across National Programs. PAHPA specifies the need to maintain consistency with specific national programs, including the NHSS preparedness goals. PAHPA also directs that the NHSS be consistent with the DHS National Preparedness Guidelines, a major component of which is the Target Capabilities List. Similar to CDC's *Public Health Preparedness Capabilities: National Standards for State and Local Planning*, the National Preparedness Guidelines establish a capabilities-based approach to preparedness planning.

In addition to aligning with the National Preparedness Guidelines, CDC determined that the public health preparedness capabilities should be aligned with the 10 Essential Public Health Services model developed by the U.S. Department of Health and Human Services

(HHS). CDC concluded that several of the public health preparedness capabilities aligned with multiple Essential Public Health Services. Thus, the public health preparedness capabilities align with both the DHS target capabilities and the HHS 10 Essential Public Health Services, with a focus on the public health capabilities critical to preparedness. The public health preparedness capabilities defined by CDC also directly align with 21 of the NHSS capabilities.

This methodology for selection of the capabilities was peer reviewed by the Board of Scientific Counselors for CDC's Office of Public Health Preparedness and Response. The Board deemed that the methodological approach and the capabilities selected for development were within the scope of state and local preparedness.

CDC's public health preparedness capabilities are consistent with the principles of the new Presidential Policy Directive (PPD) 8: National Preparedness, which focuses on key capabilities and "all-of-Nation" approaches that break down preparedness barriers. PPD 8 replaces HSPD-8 (2003) and HSPD-8 Annex I (2007) and outlines the President's vision for strengthening the security and resilience of the United States through systematic preparation for threats to the nation's security, including acts of terrorism, pandemics, significant accidents, and catastrophic natural disasters.

PPD 8 emphasizes three national preparedness principles:

- An all-of-Nation approach, aimed at enhancing integration of effort across federal, state, local, tribal, and territorial governments; closer collaboration with

the private and non-profit sectors; and more engagement of individuals, families, and communities;

- A focus on capabilities, defined by specific and measurable objectives, as the cornerstone of preparedness. This will enable more integrated, flexible, and agile "all hazards" efforts tailored to the unique circumstances of any given threat, hazard, or actual event; and
- A focus on outcomes and rigorous assessment to measure and track progress in building and sustaining capabilities over time.

Everyday Use. The public health preparedness capabilities represent a national public health standard for state and local preparedness that better prepares public health departments for responding to public health emergencies and incidents and supports the accomplishment of the 10 Essential Public Health Services. Each of the preparedness capabilities identifies priority resource elements that are relevant to both routine public health activities and essential public health services. *While demonstrations of capabilities can be achieved through different means (e.g., exercises, planned events, and real incidents), public health departments are encouraged to use routine public health activities and real incidents to demonstrate and evaluate their public health preparedness capabilities.*

PHEP awardees should use PHEP funding to help build and sustain their public health preparedness capabilities, ensuring that federal preparedness funds are directed to priority areas within their jurisdictions as identified through their strategic planning efforts.

Administrative Preparedness, Risk-Based Funding, and Response Funding

In addition to a capabilities-based approach to preparedness, the 2011-2016 PHEP cooperative agreement will focus on three specific initiatives – two of which are designed to address lessons learned from the recent H1N1 influenza pandemic response:

1. Enhancing administrative preparedness at the state, local, and territorial levels to assure jurisdictions have administrative procedures that enhance response and reduce administrative barriers to effective response;
2. Providing risk-based funding for select jurisdictions to promote the accelerated development of risk reduction strategies that mitigate the public health risks associated with higher population areas; and
3. Providing a mechanism to award contingent supplemental emergency response funding *in the event of* a future pandemic or an all-hazards public health emergency in one or more jurisdictions.

Administrative Preparedness. As awardees apply resources to achieve the 15 public health preparedness capabilities, CDC also recognizes the challenges awardees face during a public health response. In particular, awardees' ability to receive and spend funds effectively can be hampered by local circumstances. In times of constrained resources, it is vital that state, local, and territorial agencies maximize the performance of their programs to meet the challenges associated with public health response.

Incident action plans should include emergency administrative processes that may differ from the awardees' standard processes. Legal spending authorities, financial, personnel (workforce surge) and procurement/contract management policies and procedures play an essential role in a jurisdiction's ability to respond in a timely manner to emergency situations. While CDC recognizes that states, localities, and territories will have different governance structures for dealing with disasters and other public health emergencies, it is critical that awardees are able to receive and use federal emergency funds in a timely manner and consistent with the funding opportunity announcement requirements.

Risk-based Funding. CDC intends to direct funds to 10 major urban areas (includes 14 states and the four directly funded localities) for an all-hazards public health risk reduction funding initiative. (See Appendix 3.) This funding is intended to promote and accelerate the development of strategies that mitigate the public health risks associated with higher population areas. The jurisdictions selected for this initiative include the 10 Tier I urban areas identified in the U.S. Department of Homeland Security's Urban Area Security Initiative (UASI) grant program for fiscal year 2010. However, the purpose of the CDC funding is for *all-hazards public health risk reduction and is not restricted to terrorism preparedness.*

CDC intends to award a total of $10 million for this project, with funding to be directed to the following 10 urban areas:

- Boston; Chicago; Dallas/Fort Worth/Arlington; Houston; Jersey City/Newark; Los Angeles/Long Beach; New York City; Philadelphia; San Francisco Bay; and National Capital Region (Washington D.C.)

For those urban areas where the metropolitan statistical area (MSA) extends beyond the state's geographical borders, funding also will be awarded to those states that are part of the MSA. Risk-based funding is intended to be a one-year pilot project; CDC may elect to extend and/or expand the project in future years.

Response Funding. This guidance also describes a separate mechanism for awarding contingent supplemental emergency response funding that may be issued as supplemental awards in the event of a pandemic or an all-hazards public health emergency in one or more jurisdictions. Specific implementation activities and requirements for awarding of contingent emergency supplemental funds will be issued at the time of the event.

Specific implementation activities and requirements for awarding contingent emergency supplemental funds will be issued at the time of the event. No awardee response is necessary at this time.

PART 2. FULL TEXT

I. FUNDING OPPORTUNITY DESCRIPTION

This section describes:

- FOA authorities
- FOA purpose
- Annual requirements
- Public Health Preparedness Capabilities: National Standards for State and Local Planning

Authorities

This program announcement includes two (2) funding authorities:

Statutory Authority for Public Health Emergency Preparedness Funding

This preparedness program is authorized under Section 319C-1 of the Public Health Service (PHS) Act, as amended by the Pandemic and All-Hazards Preparedness Act of 2006.

Statutory Authority for Contingent Supplemental Emergency Response Funding

Contingent supplemental emergency response awards are authorized under 317(a) and 317(d) of the Public Health Service Act, subject to available funding and appropriation requirements and limitations.

Purpose

This announcement is only for non-research activities supported by CDC. 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/science/integrity/docs/cdc-policy-distinguishing-public-health-research-nonresearch.pdf

Public Health Emergency Preparedness Funding Purpose

The purpose of the 2011-2016 Public Health Emergency Preparedness (PHEP) cooperative agreement program is to assist state, local, and territorial/freely associated state health departments in demonstrating measurable and sustainable progress toward achieving the 15 public health preparedness capabilities and other activities that promote safer and more resilient communities.

Contingent Supplemental Emergency Response Funding Purpose

This guidance also describes a separate mechanism for awarding future **contingent supplemental emergency response funding** that may be issued as supplemental awards in the event of a pandemic or an all-hazards public health emergency in one or more jurisdictions. Such funding is subject to restrictions imposed by CDC at the time of the emergency and would provide funding under circumstances when a delay in award would result in serious injury or other adverse impact to the public.

The purpose of the supplemental funds may include, but not be limited to, the support and enhancement of state and local public health infrastructure that is critical to the response, such as strengthening and sustaining the public health workforce; increasing laboratory capacity and capability; strengthening disease surveillance activities; planning and implementing potentially large scale emergency response activities; developing effective public and risk communication guidance; developing effective community mitigation guidance; purchasing and procuring medical countermeasures; purchasing and procuring personal protective equipment, supplies, and other pandemic or all hazards-related purchases for protecting the public health workforce; training and education of the public health workforce; supporting community and personal preparedness activities; and addressing gaps and other public health preparedness challenges related to public health preparedness and response to a public health emergency.

Since the funding is contingent upon Congressional appropriations, whether CDC can ultimately make awards may depend upon the facts and circumstances that exist at the time of the emergency; the particular appropriation from which CDC would make the awards, including whether it contains limitations on its use, authorities for implementation, or otherwise. Funding will be subject to the funding authority, e.g., sections 317(a) and (d), the relevant notice of award, including restrictions imposed by CDC at the time of the emergency, and applicable grants regulations and policies.

Eligibility

Eligibility for contingency funding will be limited to entities currently funded under PHEP award AA154 assuming such limitation is permitted by the eventual appropriation to fund those awards. Eligibility may be further narrowed, e.g., by geographic location, depending upon the nature of the event giving rise to the award, e.g., hurricane.

Limited Eligibility Justification

The PHEP cooperative agreement is specifically designed to assist state, local, and territorial public health departments with meeting 15 public health preparedness capabilities over the next five years. Subsequent contingent funding is intended to be used by these entities to conduct public health responses using the public health preparedness capabilities related to the PHEP cooperative agreement program. For that reason, the 62 current PHEP awardees who have participated in previous PHEP cooperative agreements are uniquely qualified to maximize response funding to achieve the desired objectives. As stated above, additional limitations upon eligibility may be dictated by the nature of the event giving rise to the award.

No applicant response is necessary at this time. Specific implementation activities and requirements for awarding future contingent emergency supplemental funds will be issued at the time of the event.

The following guidance and requirements pertain to Public Health Emergency Preparedness funding only.

Program Implementation

Recipient Activities for Public Health Emergency Preparedness Funding

CDC, in collaboration with other federal agencies, national partners, and professional organizations, has developed 15 public health preparedness capabilities that serve as national standards for state and local preparedness planning. The 2011-2016 PHEP cooperative agreement program focuses on achieving these public health preparedness capabilities during the five-year project period to advance national public health preparedness. In addition to addressing these capabilities, awardees must meet other annual requirements outlined below.

Annual Requirements

Following is a summary of the PHEP cooperative agreement's annual program requirements for Budget Period 1.

1. Submit all required PHEP funding application components, including project narratives, work plans, and budgets as outlined in Section IV, with an emphasis on short-term and long-term plans to address the *Public Health Preparedness Capabilities: National Standards for State and Local Planning*; and complete and report on activities as described in the application work plans.

Awardees also must include responses to the following as part of their funding applications:

- Local Health Department and Tribal Concurrence. Describe, as relevant, the process used to consult with local public health departments and American Indian/Alaska Native tribes within the jurisdiction to reach consensus, approval, or concurrence on approaches and priorities described in funding applications. (See Section IV, Project Narrative.)

- Administrative preparedness strategies. Describe administrative processes and approaches to receive and use emergency funds to responds to emergency situations in a timely manner and actions to overcome challenges and barriers. (See Section IV, Project Narrative.)

Awardees also must describe in the appropriate sections of their funding applications the activities they plan to conduct to comply with the following requirements.

2. Comply with Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) guidelines. Describe coordination with state Hospital Preparedness Program to implement ESAR-VHP guidelines. (See Section IV, Capabilities Plan: Volunteer Management capability, Function 1: Coordinate volunteers.)

3. Engage the State Office for Aging or equivalent office in addressing the emergency preparedness, response, and recovery needs of the elderly. (See Section IV,

Capabilities Plan: Community Preparedness capability, Function 2: Build community partnerships to support health preparedness; and Community Recovery capability, Function 1: Identify and monitor public health, medical, and mental/behavioral health system recovery needs.)

4. Solicit public comment on emergency preparedness plans and their implementation, including the establishment of an advisory committee or similar mechanism to ensure ongoing public comment. (See Section IV, Capabilities Plan: Community Preparedness capability, Function 2: Build community partnerships to support health preparedness.)

5. Meet National Incident Management System (NIMS) compliance requirements. (See Section IV, Capabilities Plan: Emergency Operations Coordination capability, Function 1: Conduct preliminary assessment to determine need for public activation.)

6. Address the public health and medical needs of at-risk individuals in the event of a public health emergency. (See Section IV, Capabilities Plan: Community Preparedness, Community Recovery, Emergency Public Information and Warning, Mass Care, Medical Surge, and Public Health Surveillance and Epidemiological Investigation capabilities.)

7. In coordination with the Hospital Preparedness Program, inform and educate hospitals in the jurisdiction on their role in public health emergency preparedness and

response. (See Section IV, Capabilities Plan: Medical Surge capability, Function 1: Assess the nature and scope of the incident.)

8. Utilize Emergency Management Assistance Compact (EMAC) or other mutual aid agreements for medical and public health mutual aid. (See Section IV, Capabilities Plan: Emergency Operations Coordination capability.)

9. Assure compliance with the following requirements. Unless otherwise noted, no specific narrative response or attachment is necessary as CDC's Procurement and Grants Office (PGO) considers that acceptance of the Budget Period 1 funding awards constitutes assurance of compliance with these requirements.
   - Submit required progress reports and program and financial data, including progress in achieving evidence-based benchmarks and objective standards and the outcomes of annual preparedness exercises including strengths, weaknesses and associated corrective actions. Reports must describe the preparedness activities that were conducted with PHEP funds, the purposes for which PHEP funds were spent and the recipients of the funds; describe the extent to which the awardee has met stated goals and objectives; and describe the extent to which funds were expended consistent with the awardee's funding application. (See Section VI.)
   - Submit pandemic influenza plans. (See Evidence-based Benchmarks and Objective Standards and Pandemic Influenza Plans.)
   - Submit an independent audit report every two years to the Federal Audit Clearinghouse within 30 days of receipt of the report.

- Have in place fiscal and programmatic systems to document accountability and improvement.
- Conduct at least one preparedness exercise annually, developed in accordance with Homeland Security Exercise and Evaluation Program (HSEEP) standards.
- Provide CDC with situational awareness data generated through interoperable networks of electronic data systems. (See Information Sharing capability.)

Please note the following four annual requirements apply only to those awardees funded for these activities.

10. Comply with Cities Readiness Initiative (CRI) guidelines (See CRI Section; see Section IV, Capabilities Plan: Medical Countermeasure Dispensing and Medical Materiel Management and Distribution capabilities.)
11. Continue Early Warning Infectious Disease Surveillance (EWIDS) efforts. (See Section IV, Capabilities Plan: Public Health Surveillance and Epidemiological Investigation capability, Function 1: Conduct public health surveillance and detection.)
12. Continue Level 1 chemical laboratory surge capacity activities. (See Section IV, Capabilities Plan: Public Health Laboratory Testing capability, Function 3: Conduct testing and analysis for routine and surge capacity.)
13. Develop risk-based funding activities (See Section IV, Project Narrative.)

<u>Cities Readiness Initiative (CRI)</u>

To align with the PHEP cooperative agreement's capabilities-based approach, CRI requirements support the Medical Countermeasure Dispensing and the Medical Materiel Management and Distribution capabilities. As described in those capabilities, CRI supports medical countermeasure distribution and dispensing (MCMDD) for *all-hazards events*, which includes the ability of jurisdictions to develop capabilities for "U.S. cities to respond to a large-scale biologic attack, with anthrax as the primary threat consideration."[1] *This is a change from previous guidance documents in that the CRI scenario planning was specific to an anthrax scenario only. CDC recognizes that jurisdictions need to improve all-hazards planning capabilities and has broadened the CRI criteria to support this activity.*

For state awardees, 75% of their allocated CRI funds must be provided to CRI jurisdictions in support of all-hazards MCMDD planning and preparedness. CRI jurisdictions are defined to include independent planning jurisdictions (as defined by the state and locality) that include those counties and municipalities within the defined metropolitan statistical area (MSA) or the New England County Metropolitan Areas (NECMAs).

CDC has developed a MCMDD composite score to serve as a collective indicator of MCMDD preparedness and operational capability within local/planning jurisdictions, CRI areas, states, directly funded cities, territories, and freely associated states. Local, city, state, and territorial preparedness will be subsequently defined as a composite

[1] Executive Order 13527 Establishing Federal Capability for the Timely Provision of Medical Countermeasures following a Biological Attack, issued December 30, 2009, by President Barack Obama.

measure derived from results of technical assistance reviews (TARs), drill submissions, full-scale exercise, and compliance with programmatic standards.

Early Warning Infectious Disease Surveillance (EWIDS)

The HHS Assistant Secretary for Preparedness and Response (ASPR) provides supplemental funds for the purpose of developing and enhancing cross-border early warning infectious disease surveillance efforts for states sharing a common border with Mexico or Canada. The 20 funded awardees should adhere to the guidance on EWIDS-related critical tasks found in the Public Health Surveillance and Epidemiological Investigation capability. The purpose of the EWIDS project is to enhance coordination among neighboring states along the U.S. borders with Mexico and Canada to:

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

Level 1 Chemical Laboratory Surge Capacity

The 10 funded awardees must address objectives related to chemical emergency response surge capacity as outlined in the Public Health Laboratory Testing capability, including staffing and equipping the lab, maintaining critical instrumentation in a state of readiness,

training and proficiency testing for staff, and participating in local, state, and national exercises. In addition, awardees must describe how to increase laboratory capabilities and capacities consistent with the Laboratory Response Network for chemical terrorism program objectives, including the addition of new high-throughput sample preparation and analysis techniques and analytical capability for new threat agents.

Performance Measures

Measuring performance provides critical information needed to evaluate and report on how well PHEP funding has improved the nation's ability to prepare for and respond to public health emergencies. Detailed measures of performance can foster program improvement by assessing public health departments' capacity and operational capabilities, identifying gaps / areas in need of improvement, and informing technical assistance and other program support needs.

CDC has developed and implemented a standardized set of relevant, feasible, and useful performance measures for CDC's PHEP cooperative agreement that focus on both program accountability and program improvement. These measures are used to publicly report data on state and local programmatic achievements as well as areas in need of improvement.

Beginning in August 2011, PHEP awardees will report on a range of capability-based performance measures. While awardees will not have to report on all performance measures every year, they will be required to collect and report select performance

measure data annually to meet federally required reporting mandates (e.g., HHS Priority Goal), and other programmatic reporting requirements within the following public health preparedness capabilities:

- Community Preparedness (measures under development for implementation in August 2011)
- Emergency Operations Coordination
- Medical Countermeasures Dispensing
- Medical Materiel Management and Distribution
- Public Health Surveillance and Epidemiological Investigation
- Public Health Laboratory Testing

Awardees also may be required to collect and report performance measure data for other public health preparedness capabilities. The list and requirements for reporting annual and other performance measures may change as performances measures are developed and refined. Further detail on performance measures and reporting requirements for Budget Period 1 will be available in CDC's performance measure guidance to be released during the third quarter of 2011.

Evidence-based Benchmarks and Objective Standards and Pandemic Influenza Plans

Section 319C-1 of the Public Health Service (PHS) Act, as amended by the Pandemic and All-Hazards Preparedness Act (PAHPA) of 2006, requires that CDC's PHEP cooperative agreement program meet evidence-based benchmarks and objective standards. Section 319C-1 requires withholding of funding from entities that fail to

achieve benchmarks and objective standards or fail to submit acceptable pandemic influenza operations plans each fiscal year. (See Appendix 6.)

CDC expects all awardees to achieve, maintain, and report benchmarks throughout the five-year project period. CDC reserves the right to modify benchmarks annually as needed and in accordance with CDC goals, objectives, and directives. Awardees shall maintain all documentation that substantiates achievement of benchmarks and make those documents available to CDC staff as requested during site visits or through other requests.

CDC has identified the following benchmarks for Budget Period 1 to be used as a basis for withholding of fiscal year 2012 funding for PHEP awardees. As mandated by PAHPA, awardees that fail to "substantially meet" the benchmarks are subject to withholding of funds penalties to be applied the following fiscal year. Awardees that demonstrate achievement of these requirements are not subject to withholding of funds.

1. Demonstrated capability to rapidly assemble public health staff with lead incident management roles. To meet this benchmark, awardees must demonstrate the capability for pre-identified staff covering activated public health agency incident management lead roles (or equivalent lead roles) to report for duty within 60 minutes or less. Staff assembly must be unannounced. To ensure a timely and effective response to an incident, awardees must demonstrate the capability to immediately assemble public health staff with lead incident management roles. In recognition that an effective response will not

occur if the necessary staff are not available, the ability to assemble lead incident management staff to initiate response actions in a timely manner has been deemed a top priority for CDC and the U.S. Department of Health and Human Services, and has been identified as an HHS Priority Goal for the 50 states. CDC has determined that this measure applies to the 50 state awardees only.

Awardees are strongly encouraged to report data from multiple exercises and / or real incidents. However, awardees are required at a minimum to report data from their health departments on their quickest staff assembly demonstration that occurs during the first six months of Budget Period 1. The demonstration must occur during one of the following:

- Drill
- Functional exercise
- Full-scale exercise
- Real incident (preferable, if possible)

2. Demonstrated adherence to all PHEP application and reporting deadlines. Failure to submit required PHEP program data and reports by the stated deadlines will constitute a benchmark failure. A failure to timely report key program data hinders CDC's ability to analyze data and submit accountability reports as required and jeopardizes CDC's ability to accurately reflect PHEP program achievements and barriers to success. This benchmark applies to all 62 awardees. Required data and reports include:

- PHEP funding application due 60 days following initial publication of the FOA and interim progress reports/noncompeting continuation funding applications due no less than 90 days before the end of the budget period;
- PHEP mid-year progress reports, due 30 days after the first six months of the budget period, including a status update on work plan activities or changes, including local contracts, PAHPA benchmarks, performance measurement and demonstration plan activities, a five-year timeline for addressing the public health preparedness capabilities, and risk-based funding activities (if applicable).
- Annual progress report, due 45 days after the end of the budget period, including an update on work plan activities, local contracts, risk-based funding activities (if applicable), a budget expenditure report, performance measurement and demonstration plan activities.
- Financial report, no later than 90 days after the end of the budget period.

3. Demonstrated capability to receive, stage, store, distribute, and dispense material during a public health emergency. As part of their response to public health emergencies, public health departments must be able to provide countermeasures to 100% of their identified population within 48 hours after the decision to do so. To achieve this standard, public health departments must maintain the capability to plan and execute the receipt, staging, storage, distribution, and dispensing of material during a public health emergency.

Building on the framework and tools already established to assess capabilities to receive, distribute and dispense medical countermeasures, CDC has developed a composite measure to more fully represent preparedness activities and the collective gains of each of the 62 PHEP-funded jurisdictions.

The medical countermeasure distribution and dispensing (MCMDD) composite score will serve as a collective indicator of preparedness and operational capability within local/planning jurisdictions, CRI areas, states, directly funded cities, territories, and freely associated states. CDC will continue to conduct annual technical assistance reviews (TARs) of all 62 PHEP awardees. Local, city, state, and territorial preparedness will be subsequently defined as a composite measure derived from results of TARs, drill submissions, full-scale exercise, and compliance with programmatic standards.

Using the individual composite scores to represent local jurisdiction preparedness, CDC will compute an overall MCMDD composite score for each of the 62 jurisdictions. During the progression of the 2011-2016 PHEP cooperative agreement cycle, jurisdictions will be required to perform and/or submit documentation for a series of composite requirements to meet the advancing MCMDD composite benchmark. With the exception of the annual TAR and drill submission requirements, jurisdictions will have substantial flexibility in determining the order in which they perform or demonstrate capability to meet the composite measure. CDC will provide additional details and guidance on the MCMDD composite measure requirements at a subsequent date.

To demonstrate current capacity and advancements in emergency response capabilities during Budget Period 1, public health departments must comply with the following requirements and submit all required documentation by July 15, 2012:

- The 50 states must meet a minimum overall MCMDD composite benchmark of 43 for Budget Period 1. The overall state composite score will be derived from:

    - DSNS State TAR conducted during Budget Period 1.
    - DSNS Local TAR conducted within each planning/local jurisdiction within each CRI during Budget Period 1. DSNS is responsible for reviewing 25% of the states' CRI jurisdictions, and the state is responsible for reviewing 75% of the CRI jurisdictions using the DSNS local TAR tool.
    - A minimum of three different drills (not the same drill performed three times) conducted within each planning/local jurisdiction within each CRI metropolitan statistical area (MSA) during Budget Period 1. The range in scope of available drills provides jurisdictions with flexibility in meeting the annual drill requirements. The three required drills may be chosen from any of the eight available drills as indicated on the DSNS Extranet website. Drill data and/or Homeland Security Exercise and Evaluation Program **(**HSEEP**)** After Action Reports/Improvement Plans for drill (as indicated) must be submitted through the DSNS Web-based Data Collection System no later than July 15, 2012.

- Compliance with established medical countermeasure distribution and dispensing standards. Target measures and metrics will be detailed in supplemental guidance at a later date.
- At least one full-scale exercise within the five-year PHEP project period that tests and validates medical countermeasures distribution and dispensing plans. Results and documentation of medical countermeasure distribution and dispensing full-scale exercise(s) must be developed in accordance with HSEEP standards and can be performed during any one of the five budget periods of the new PHEP cooperative agreement. Each state will be required to participate in one exercise that demonstrates capabilities for medical countermeasure distribution operations. Each CRI MSA will be required to participate in one exercise that demonstrates capabilities for medical countermeasure dispensing operations. Each CRI MSA (including the four directly funded cities) dispensing exercise must include all pertinent jurisdictional leadership and emergency support function leads, planning and operational staff, and all applicable personnel. States and local jurisdictions are encouraged to work with other emergency response agencies or hospital preparedness programs to develop or leverage existing activities to meet the medical countermeasure distribution and dispensing exercise objectives. Details on the scope and format for reporting these exercise requirements will be provided through subsequent guidance at a later date.

- The four directly funded localities must meet a minimum overall MCMDD composite benchmark of 46 for Budget Period 1. The four cities must each conduct a DSNS Local TAR during Budget Period 1 and meet the minimum overall MCMDD composite benchmark for the performance period. These jurisdictions also must conduct a minimum of three different drills (not the same drill performed three times) during Budget Period 1. The three required drills may be chosen from any of the eight available drills as indicated on the DSNS Extranet website and as outlined above. DSNS is responsible for performing annual reviews of all directly funded cities.

    - Awardees will demonstrate compliance with established medical countermeasure distribution and dispensing standards. Target measures and required data submission will be detailed in supplemental guidance at a later date.
    - Awardees will conduct one full-scale exercise that tests and validates medical supplies distribution and dispensing plans and submit results and documentation developed in accordance with HSEEP standards. The results of full-scale exercise can be performed during any one of the five budget periods of the new PHEP cooperative agreement. Each directly funded city will be required to participate in one CRI MSA exercise that demonstrates capabilities for medical countermeasure distribution and prophylaxis/dispensing operations. Directly funded cities are encouraged to work with other emergency response agencies or hospital preparedness programs to develop or leverage existing activities to meet the medical countermeasure distribution and dispensing exercise objectives. Details

on the scope and format for reporting these exercise requirements will be provided through subsequent guidance at a later date.

- The eight U.S. territories and freely associated states must meet a minimum overall MCMDD composite benchmark of 25 for Budget Period 1. The territories and freely associated states must conduct a DSNS TAR during Budget Period 1 and meet the minimum overall MCMDD composite benchmark for the performance period. These jurisdictions must conduct a minimum of three different drills (not the same drill performed three times) during Budget Period 1. The three required drills may be chosen from any of the eight available drills as indicated on the DSNS Extranet website and as outlined above. DSNS is responsible for performing annual reviews of all territories and freely associated states.

    - Awardees will demonstrate compliance with established medical countermeasure distribution and dispensing standards. Target measures and required data submission will be detailed in supplemental guidance at a later date.
    - Awardees are encouraged to conduct one full-scale exercise performed during any one of the five budget periods of the new PHEP cooperative agreement that tests and validates medical supplies distribution and dispensing plans and submit results and documentation to DSNS. Awardees are encouraged to work with other emergency response agencies or hospital preparedness programs to

develop or leverage existing activities to meet the medical countermeasure distribution and dispensing exercise objectives. Details on the scope and format for reporting these exercise requirements will be provided through subsequent guidance at a later date.

4. Submit H1N1 After-Action Report Improvement Plan Status Reports. Submission of the H1N1 After-action Report (AAR) Improvement Plan Status Report for 2011 is intended to provide summary status updates of the key improvement plan items from awardees' H1N1 AAR and Improvement Plans following the 2009-2010 H1N1 influenza pandemic response. Submission of these reports fulfills the pandemic influenza plan submission requirement. Awardees are required to submit H1N1 AAR Improvement Plan Status Reports by **November 30, 2011.**

Table 1: Criteria to Determine Potential Withholding of Fiscal Year 2012 Funds

	Benchmark Measure	**Yes**	**No**	**Possible % Withholding**
1	Did the awardee (states only) assemble public health staff with lead incident management roles within the 60-minute target?			10%
2	Did the awardee (all awardees) meet all application and reporting deadlines?			
3	Did the awardee (all awardees) demonstrate capability to receive, stage, store, distribute, and dispense material during a public health emergency?			
4	Did the awardee (all awardees) meet the Pandemic Influenza Plan (Public Health Component Meets Standards) requirement by submitting H1N1 after-action report			10.0%

	improvement plan status reports by November 30, 2011?			
Total Potential Withholding Percentage				20.0%

Scoring Criteria

The first three benchmarks are weighted the same, so failure to meet any of the three benchmarks will count as one failure and may result in withholding of 10% of the fiscal year 2012 PHEP base award. Failure to submit H1N1 after-action report improvement plan status reports by November 30, 2011, may result in withholding of 10% of the fiscal year 2012 PHEP base award.

More information on withholding and repayment can be found in Appendix 6.

Data Elements

In addition to benchmarks and performance measures, CDC may request other data elements for PHEP monitoring purposes. Data elements may be used to provide supporting information; establish, track, and monitor public health preparedness capabilities; inform the development of new targets and performance measures; and respond to routine requests for information about the program.

Public Health Preparedness Capabilities: National Standards for State and Local Planning

The purpose of the 2011-2016 Public Health Emergency Preparedness (PHEP) cooperative agreement program is to assist state, local, and territorial/freely associated state health departments in demonstrating measurable and sustainable progress toward achieving the 15 public health preparedness capabilities and other activities that promote safer and more resilient communities.

See Appendix 1 for a summary of the 15 public health preparedness capabilities, priority resource elements, and CDC-defined performance measures. The entire document is available at http://www.cdc.gov/phpr/capabilities/.

How Capabilities Are Organized

The public health preparedness capabilities are numbered and presented alphabetically. Each of the 15 capabilities includes a definition of the capability and list of the associated functions, performance measures, tasks, and resource considerations.

The **Capability Definition** defines the capability as it applies to state, local, tribal, and territorial public health.

The **Function** describes the critical elements that need to occur to achieve the capability.

The **Performance Measure(s)** section lists the CDC-defined performance measures, if any, associated with a function.

The **Tasks** section describes the steps that need to occur to complete the functions.

The **Resource Elements** section lists resources, including priority items and other considerations, needed to build and maintain the ability to perform the function and its associated tasks. These resource elements are organized as follows:

- *Planning:* standard operating procedures or emergency operations guidance, including considerations for legal authorities and at-risk populations, for a jurisdiction or entity's plans for delivering the capability.

- *Skills and Training:* baseline competencies and skills personnel and teams should possess or have access to when delivering a capability.

- *Equipment and Technology:* equipment jurisdictions should have or have access to in jurisdictionally defined quantities sufficient to achieve the capability.

- Note: Certain resource elements have been identified as priority. Jurisdictions may not require all resource elements to fully achieve all of the functions within a capability, but they must *have* or *have access to* the priority resource elements. Remaining resource elements are recommended for consideration by jurisdictions.

The public health preparedness capabilities are shown below in their corresponding domains.

Biosurveillance

- Public Health Laboratory Testing
- Public Health Surveillance and Epidemiological Investigation

Community Resilience

- Community Preparedness
- Community Recovery

Countermeasures and Mitigation

- Medical Countermeasure Dispensing
- Medical Materiel Management and Distribution
- Non-pharmaceutical Interventions
- Responder Safety and Health

Incident Management

- Emergency Operations Coordination

Information Management

- Emergency Public Information and Warning
- Information Sharing

Surge Management

- Fatality Management
- Mass Care
- Medical Surge
- Volunteer Management

Prioritization of Public Health Preparedness Capabilities. CDC strongly recommends that awardees prioritize the order of the capabilities in which they intend to invest based upon: 1) their jurisdictional risk assessments (see the Community Preparedness capability for additional or supporting detail on the requirements for this risk assessment), 2) an assessment of current capabilities and gaps using CDC's *Public Health Preparedness*

Capabilities: National Standards for State and Local Planning, and 3) CDC's recommended tiered strategy for capabilities:

Tier 1 Capabilities:

- Public Health Laboratory Testing
- Public Health Surveillance and Epidemiological Investigation
- Community Preparedness
- Medical Countermeasure Dispensing
- Medical Materiel Management and Distribution
- Responder Safety and Health
- Emergency Operations Coordination
- Emergency Public Information and Warning
- Information Sharing
-

Tier 2 Capabilities:

- Non-Pharmaceutical Intervention
- Medical Surge
- Volunteer Management
- Community Recovery
- Fatality Management
- Mass Care

CDC's tiered strategy is designed to place emphasis on the Tier 1 capabilities as these capabilities provide the foundation for public health preparedness. Awardees are strongly encouraged to build the priority resource elements in the Tier 1 capabilities prior to making significant or comprehensive investments in Tier 2 capabilities.

Suggested Planning Model for Public Health Capabilities

To assist public health departments in using the public health preparedness capabilities for planning, CDC has developed a Public Health Capabilities Planning Model that describes a high-level planning process public health departments may wish to follow to help determine their preparedness priorities, plan appropriate preparedness activities, and demonstrate and evaluate achievement of capabilities. This process also will assist awardees in developing required capabilities plans that must be submitted as part of their funding applications. (See Section IV.)

The Public Health Capabilities Planning Model is not intended to be a prescriptive methodology, but rather it is intended to describe a series of suggested activities for preparedness planning. The model consists of three phases of activities.

Phase 1

- Assess current preparedness state, including organizational roles and responsibilities.

- Determine the extent to which the priority and recommended resource elements for each capability function exist in the jurisdiction. Jurisdictions are encouraged to first self-assess their ability to address the prioritized resource elements of each capability followed by their ability to demonstrate the functions and tasks within each capability.

  Not all public health agencies are expected to 'own' each resource element; jurisdictions are encouraged to partner with both internal and external jurisdictional partners to assure access to resources as needed.

  The resource elements described for each function are not intended to be an exhaustive list of all possible types of resources required; each jurisdiction should also note the presence or absence of any other critical resources needed to meet their needs and any challenges or barriers.

- Determine performance of each capability and function and whether or not it meets the jurisdiction's needs.

Phase 2

- Determine goals by identifying needs and gaps using jurisdictional inputs such as hazards and vulnerability analyses, emergency management plans, after-action reports/improvement plans, and previous performance measurement results.

- Prioritize capabilities and functions and develop plans. The capability definitions are broad; no jurisdiction is expected to be able to address all issues, gaps, and needs across all capabilities in the immediate short term.

- Review jurisdictional inputs, analyze priorities, and determine both short-term (one year) and long-term goals (two years to five years).

Phase 3

- Develop plans by engaging in concrete initiative planning, particularly for the short-term goals.

- For each capability and function, jurisdictions generally will either build, sustain, or, perhaps, scale back the capability and/or function, depending on the needs, gaps, priorities, and goals that have been identified.

- For 'build' and 'sustain' scenarios, jurisdictions are encouraged to pursue partnerships, memoranda of understanding, with other agencies, partners, and jurisdictions.

- For 'scale back' scenarios, jurisdictions should identify the challenges and barriers causing them to scale back their efforts.

- States should consider what types of support are required by their local and tribal health departments and plan assistance or contracts accordingly. Support provided

to local health departments should describe which capabilities and functions are intended to be addressed.

- Develop plans for demonstrating and evaluating the capabilities and functions, especially those that have been newly developed. Demonstrations of capabilities can be through many different means such as exercises, planned events, and real incidents. Jurisdictions are strongly encouraged to use routine public health activities to demonstrate and evaluate their capabilities. Documentation of the exercise, event, or incident, and the use of quality improvement-focused After Action Reports/Improvement Plans is a vital part of this process.

- For those capabilities and functions where CDC-defined performance measures have been developed, jurisdictions are encouraged to collect data for those measures.

CDC ACTIVITIES

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

CDC Activities for Public Health Preparedness Funding:

1. Technical Assistance and Consultation

- Integration/coordination of federal funding for preparedness

- Facilitating access to CDC preparedness subject matter experts (e.g. laboratory testing, epidemiology and surveillance, and environmental health)
- Development of jurisdictional-specific technical assistance plans
- Translating promising/useful practices for dissemination to the field
- Providing technical assistance on achievement of performance measures and benchmarks
- Providing guidance on demonstrating achievement of capabilities and using quality improvement-focused processes to document the process

2. *Monitor performance*
    - Monitoring adherence to all relevant Public Health Service, HHS, and CDC rules, regulations and policies regarding cooperative agreements
3. *Facilitation and coordination*
    - Assuring improved grant alignment across federal preparedness grants and cooperative agreements

Recipient Activities for Response Funding

No activities are specified for this authorization at this time.

CDC Activities for Response Funding

No activities are specified for this authorization at this time.

II. AWARD INFORMATION

Type of Award: Cooperative Agreement.

Award Mechanism: U90

Fiscal Year Funds: FY 2011

Approximate Current Fiscal Year Funding: $674,822,613

Approximate Total Project Period Funding: Subject to availability of funds.

Number of Awards: 62

Anticipated Award Date: August 10, 2011

Budget Period Length: 12 months

Project Period Length: 5 years

Throughout the project period, CDC's 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 determination that continued funding is in the best interest of the federal government.

Funding Amounts by Category for Budget Period 1

A total of $674,822,613 is currently available for Budget Period 1 of the 2011-2016 PHEP cooperative agreement, which begins August 10, 2011. The funding amounts available for the categories below are shown in Appendices 1, 2, and 3. *These numbers are for planning purposes only and will be revised based on the final fiscal year 2011 budget.*

The distribution of funds for Budget Period 1 is calculated using a formula established by the HHS Secretary that includes a base amount for each awardee plus population-based funding. Funding also is awarded for specific preparedness activities.

Base-Plus-Population Funding

CDC allocates PHEP funds using a base-plus-population formula. The base portion is allocated in the following manner:

- 50 states and Puerto Rico - $3 million each
- 4 localities (Chicago, District of Columbia, Los Angeles County, and New York City) - $5 million each
- 7 U.S. territories and freely associated states - $300,000 each

PHEP awardees receive population-based funding equal to their proportional share of the national population as reflected in recent U.S. Census population estimates. The population-based funding is calculated using the available pool of funds remaining after the base funding and other PHEP funding allocations are carved out of the total PHEP allocation. For Budget Period 1, 2009 U.S. Census data were used to calculate the population-based funding.

For states whose base-plus-population funding would be less than the $5 million minimum, their awards were adjusted to ensure they receive the minimum PHEP award.

Cities Readiness Initiative (CRI)

All 50 states and the four directly funded localities receive CRI funding using a population-based calculation. The Budget Period 1 funding formula is calculated using a per capita of $0.34 based on the U.S. Census 2009 population estimates with three exceptions.

1. PHEP jurisdictions that would have received less than $200,000 based on the Budget Period 1 formula were increased to $200,000.
2. PHEP jurisdictions that would have received a greater than 25% reduction in funding based on the Budget Period 1 formula were increased to the amount they received for fiscal year 2010.
3. A new per capita of .32 was applied to the MSAs that did not receive an increase based on the initial formula.

- Early Warning Infectious Disease Surveillance (EWIDS)

  Twenty states situated at the United States borders with Canada or Mexico (Alaska, Arizona, California, Idaho, Illinois, Indiana, Maine, Michigan, Minnesota, Montana, New Hampshire, New Mexico, New York, North Dakota, Ohio, Pennsylvania, Texas, Vermont, Washington, and Wisconsin) are eligible for EWIDS funding provided by HHS through the PHEP cooperative agreement. These funds are in addition to the PHEP funds and are for planning purposes; the funding amounts will be revised based on the final fiscal year 2011 budget

- Level 1 Chemical Laboratory Surge Capacity

  Ten states (California, Florida, Massachusetts, Michigan, Minnesota, New Mexico, New York, South Carolina, Virginia, and Wisconsin) are eligible to receive funding

to support Level 1 chemical laboratory surge capacity personnel, equipment, and/or activities.

- Risk-based Funding

  Eighteen awardees are eligible to receive risk-based funding to support an all-hazards public health risk reduction funding initiative in 10 urban areas. The funding formula is calculated as follows:

  - The four localities that are directly funded by the PHEP cooperative agreement (Chicago, Washington D.C., Los Angeles County, and New York City) and the five states in which the urban areas are primarily located (California, Massachusetts, New Jersey, Pennsylvania, and Texas) each will receive a $400,000 base-plus-population allocation.

The nine states (Delaware, Illinois, Indiana, Maryland, New Hampshire, New York State, Virginia, West Virginia, and Wisconsin) that are part of the metropolitan statistical areas that extend outside the borders of the urban area's primary state or locality each will receive a population allocation or a minimum allocation of $100,000.

III. ELIGIBILITY INFORMATION

Eligibility and Limited Eligibility Justification

Eligibility for the Public Health Emergency Preparedness cooperative agreement program is limited by statute to states or a consortium of states that prepare and submit a sufficient application compliant with the statutory and administrative requirements described in this document. Political subdivisions are also limited to those determined by CDC to meet statutory requirements, which includes those currently funded under PHEP award AA154. See section 319C-1 of the Public Health Service (PHS) Act, as amended by the Pandemic and All-Hazards Preparedness Act of 2006, codified under 42 U.S.C. 247d-3.

Required Registrations

Registering your organization through www.grants.gov, the official agency-wide E-grant website, is the first step in submitting an application online. Registration information is located on the "Get Registered" screen of www.grants.gov. Please visit www.grants.gov at least 30 days prior to submitting your application to familiarize yourself with the registration and submission processes. The "one-time" registration process will take three to five days to complete. However, the Grants.gov registration process also requires that you register your organization with the Central Contractor Registry (CCR). The CCR registration can require an additional one to two days to complete. You are required to maintain a current registration in CCR.

Central Contractor Registration and Universal Identifier Requirements

All applicant organizations **must obtain** a DUN and Bradstreet (D&B) Data Universal Numbering System (DUNS) number as the Universal Identifier when applying for Federal grants or cooperative agreements. The DUNS number is a nine-digit number assigned by Dun and Bradstreet Information Services. An authorized organizational representative (AOR) should be consulted to determine the appropriate number. If the organization does not have a DUNS number, an AOR should complete the **US D&B D-U-N-S Number Request Form** or contact Dun and Bradstreet by telephone directly at 1-866-705-5711 (toll-free) to obtain one. A DUNS number will be provided immediately by telephone at no charge. Note this is an organizational number. Individual Program Directors/Principal Investigators do not need to register for a DUNS number.

Additionally, all applicant organizations must register in the Central Contractor Registry (CCR) and maintain the registration with current information at all times during which it has an application under consideration for funding by CDC and, if an award is made, until a final financial report is submitted or the final payment is received, whichever is later. CCR is the primary registrant database for the federal government and is the repository into which an entity must provide information required for the conduct of business as a recipient. Additional information about registration procedures may be found at the CCR internet site at **www.ccr.gov**.

If an award is granted, the grantee organization must notify potential subrecipients that no organization may receive a subaward under the grant unless the organization has provided its DUNS number to the grantee organization.

Matching Funds

CDC may not award a cooperative agreement to a state or consortium of states under this program unless the awardee agrees that, with respect to the amount of the cooperative agreement awarded by CDC, the state will make available nonfederal contributions in the amount of 10% ($1 for each $10 of federal funds provided in the cooperative agreement) of the award.

Match may be provided directly or through donations from public or private entities and may be in cash or in kind, fairly evaluated, including plant, equipment or services. Amounts provided by the federal government or services assisted or subsidized to any significant extent by the federal government, may not be included in determining the amount of such non-federal contributions.

Exceptions to Matching Funds Requirement

- The match requirement does not apply to the political subdivisions of New York City, Los Angeles County, or Chicago.
- Pursuant to department grants policy implementing 48 U.S.C. 1469a(d), any required matching (including in-kind contributions) of less than $200,000 is waived with respect to cooperative agreements to the governments of American Samoa, Guam, the Virgin Islands, or the Northern Mariana Islands (other than those consolidated under other provisions of 48 U.S.C. 1469). This waiver applies regardless of whether the matching required under the grant equals or exceeds $200,000.

This requirement does not apply to future contingent supplemental emergency response awards that may be authorized under 317(a) and 317(d) of the Public Health Service Act.

Maintaining State Funding (MSF)

Awardees must maintain expenditures for public health security at a level that is not less than the average level of such expenditures maintain by the awardee for the preceding two-year period. This represents an awardee's historical level of contributions related to federal programmatic activities that have been made prior to the receipt of federal funds "expenditures" (money spent). The MSF is used as an indicator of nonfederal support for public health security before the infusion of federal funds. These expenditures are calculated by the awardee without reference to any federal funding that also may have contributed to such programmatic activities in the past. Awardees must stipulate the total dollar amount in their cooperative agreement applications. Awardees must be able to account for MSF separate from accounting for federal funds and separate from accounting for any matching funds requirements; this accounting is subject to ongoing monitoring, oversight, and audit. MSF may not include any matching funds requirement.

This requirement does not apply to future contingent supplemental emergency response awards that may be authorized under 317(a) and 317(d) of the Public Health Service Act.

IV. Application and Submission Information

Address to Request Application Package

Awardees must download the SF424 (R&R) application package associated with this funding opportunity from www.grants.gov. The mandatory application package includes:

- Application for Federal Assistance (SF-424);
- Disclosure of Lobbying Activities (SF-LLL);
- HHS Checklist Form PHS-5161;
- Budget Information for Non-Construction Programs (SF-424A);
- Budget Narrative Attachment Form;
- Project Abstract Summary;
- Project Narrative Attachment Form; and
- Other Attachments Forms (1 each)
    - Attachment A: Indirect Cost Rate Agreement
    - Attachment B: Work Plan

If access to the Internet is not available or if the awardee encounters difficulty in accessing the forms online, contact the HHS/CDC Procurement and Grants Office Technical Information Management Section (PGO TIMS) staff at (770) 488-2700 for further instruction. CDC Telecommunications for the hearing impaired or disabled is available at TTY 1-888-232-6348.

If the awardee encounters technical difficulties with Grants.gov, the applicant should contact Grants.gov Customer Service. The Grants.gov Contact Center is available 24

hours a day, seven days a week, with the exception of all federal holidays. The Contact Center provides customer service to the applicant community. The extended hours provide applicants support around the clock, ensuring the best possible customer service is received any time it's needed. You can reach the Grants.gov Support Center at 1-800-518-4726 or by e-mail at support@grants.gov. Application submissions sent by e-mail, fax, CDs or thumb drives will not be accepted.

Content and Form of Application Submission

Letter of Intent (LOI)

A letter of intent is not applicable to this funding opportunity announcement.

Unless specifically indicated, the preparedness funding opportunity announcement requires submission of the following information:

- Project abstract
- Project narrative
- Work plan
- Budget

Project Abstract

A project abstract must be completed as part of the grants.gov application forms and should be no longer than two pages. The abstract must contain a high-level summary of

the proposed activity suitable for dissemination to the public. It should be a self-contained description of the project and should contain a statement of objectives and methods to be employed. It should be informative to other persons working in the same or related fields and insofar as possible understandable to a technically literate lay reader. This abstract must not include any proprietary/confidential information.

Project Narrative

The project narrative must be uploaded in a PDF file format when submitting via grants.gov. The narrative must be submitted in the following format:

- Maximum number of pages: 20 (does not include risk-based funding information). If your narrative exceeds the page limit, only the first pages which are within the page limit will be reviewed.
- Font size: 12 point unreduced, Times New Roman.
- Spacing: Single spaced.
- Page margin size: 1 inch.

The narrative should address activities to be conducted over the entire project period. The narrative should summarize the overall preparedness strategy for the five-year project period, as well as specific plans for capabilities to be addressed during Budget Period 1. In addition, the project narrative should briefly address challenges, barriers, and plans for addressing these issues. These should directly relate to activities that will be

described in work plans. The project narrative should also include the following elements.

- Administrative preparedness strategies: Suggested page length – 4 pages

  Budget preparedness. The narrative should describe administrative processes and approaches to receive and use emergency funds to respond to emergency situations in a timely manner. Based on evidence from formal incident action plans (IAPs), after-action reports (AARs), and improvement plans (IPs) from the 2009-2010 H1N1 influenza pandemic response or other previous emergency response experience, describe any barriers and challenges to hiring, contracting, and the procurement of necessary resources within a timeframe appropriate to the incident.

  The narrative should also describe actions taken (or planned) to overcome challenges and barriers through changes or improvements in operational and/or administrative processes, authorizing awarded funds to be obligated within an expedited timeframe appropriate to the incident and/or disbursed within the project period of award. Descriptions must include references to the following elements:

  - Emergency procurement and contracting authorities;
  - Current personnel/hiring policies, including impact on workforce surge, e.g., flexibilities in hiring practices associated with emergency preparedness activities; and

- Legal authority to spend federal funds awarded for emergency response.

Legal preparedness. The narrative should describe any legal barriers to effective public health preparedness and response and actions taken or planned to address these challenges, including but not limited to:

- Ensuring a legal framework for information sharing;
- Authority to accept and dispense pharmaceuticals issued under an emergency use authorization (EUA); and
- Legal liability of volunteers

As applicable, awardees also should describe whether memoranda of understanding or other letters of agreement authorizing the exchange of information between the awardee and the Federal Bureau of Investigation (FBI) have been established.

- Risk-based funding strategies (for 18 funded awardees only)

  Risk-based funding strategies should be linked to the Community Preparedness capability. The funds will be distributed as identified in Appendix 3. With the exception of the four directly funded localities, CDC will award the funds to 14 states, with the expectation that states will award the funds to their applicable metropolitan statistical areas (MSA) listed in Appendix 3. CDC expects the states to award the funds to the MSAs within 45 days of receiving CDC's Notice of Award. States are allowed to withhold an administrative fee providing it is reasonable and consistent with other administrative fees. In addition to MSA

partners, CDC encourages awardees to fund other community partners that may be critical to the success of the project. CDC recognizes that awardees will not have had sufficient time to plan and reach consensus on the specific activities at the time of application; therefore, the application submission should include:

- A high-level summary of how the awardees will convene the relevant partners in their MSAs,
- Designation of a lead partner in charge of submitting all deliverables and reports to CDC, and
- A status report on the existence of an MSA-specific risk assessment/hazard and vulnerability assessment that includes all the elements listed in *Function 1, Priority Element 2* of the Community Preparedness capability.

This summary does not count against the narrative page limit.

In addition, awardees must coordinate with their MSA partners and provide CDC with one status report narrative per MSA as part of their PHEP mid-year and annual progress reports. These status reports should describe plans to develop replicable programs and promising/useful practices based on the following required activities:

- Establish a coordinated and synchronized community preparedness planning effort within the entire MSA which includes the following preparedness partners: public health, healthcare systems, emergency medical services, emergency management/homeland security, law enforcement, fire services,

critical infrastructure, and other key sectors. The planning strategies must include an approach for leveraging preparedness funding from all federal and nonfederal sources. The narrative should describe how the MSA will coordinate and develop a plan that addresses the gaps and needs across the MSA and identify the lead agency responsible for submission of the deliverables to CDC (one report per MSA).

- Develop risk mitigation plans to specifically address the public health, medical, and mental/behavioral health needs/risks of the community, including vulnerable populations. Public health risk is defined as "hazard x public health vulnerability". To address and mitigate risk, jurisdictions must first identify their specific public health risks and vulnerabilities. CDC's *Public Health Preparedness Capabilities: National Standards for State and Local Planning*, released in March 2011, provides specific guidance for completing this activity. By the end of Budget Period 1, awardees are required to have addressed all six of the Priority Resource Elements included in *Capability 1: Community Preparedness*. CDC will not require awardees to submit the actual jurisdictional risk assessment, but it will require a summary of the document as a deliverable.
- With input from planning partners, develop a matrix that describes and ranks/prioritizes the public health threats and risks within the jurisdiction.
- Identify the specific public health threats and risks that will be addressed with this funding and propose strategies and activities designed to reduce/mitigate the threats and risks. Activities must be expressed using the SMART approach:

specific, measurable, attainable, realistic, and timely. This funding supports all-hazards public health risk reduction and is not restricted to terrorism preparedness.

- Description of how these risk reduction activities will be sustained in Budget Period 2 and beyond if no additional CDC funding is provided.

- Local Health Department Concurrence Annual Requirement

  Awardees must show evidence that at least a majority, if not all, of local health departments within their jurisdictions approves or concurs with the approaches and priorities described in their applications. State applicants will be required to provide signed letters of concurrence upon request.

  Awardees who are unable to gain 100% concurrence, despite good-faith efforts to do so, should submit a PDF document with their applications describing the reasons for lack of concurrence and the steps taken to address them.

- Tribal Concurrence Annual Requirement.

  Awardees must show evidence that a majority, if not all, of American Indian/Alaska Native tribes within their jurisdictions approves or concurs with the approaches and priorities described in their applications.

  Awardees who are unable to gain 100% concurrence, despite good-faith efforts to do so, should submit a PDF document with their applications describing the

reasons for lack of concurrence and the steps taken to address them.

Work Plan

In addition to the project narrative, a work plan must be submitted with the application forms. The work plan consists of the four sections listed below:

- Capabilities plan
- Local and tribal contracts plan
- Demonstration plan
- Project management plan

Capabilities plan. Awardees must describe current and planned activities to achieve each function within a capability. All functions within each of the 15 capabilities must be addressed in the capabilities plan. The application cannot be submitted if one or more functions are missing activity descriptions. A complete capabilities plan will include:

- A description of each function using one of the four options below that best describes a function's current status:
    - Infrastructure Fully in Place - Function Fully Evaluated and Demonstrated
    - Infrastructure Fully in Place - Function Partially / Not Evaluated and Demonstrated
    - Infrastructure Partially in Place
    - No Infrastructure in Place

- An explanation that supports the chosen description. For example, if "fully in place, fully evaluated" is chosen, provide the date and means by which the function was demonstrated (exercise, planned event, real incident, or routine public health activity). Awardees also should indicate whether the associated function has been implemented at the state level, local level, or combination and provide a brief description.
- A chosen goal for each function, using one of the options below to describe the goal for each function:
    - Build
    - Sustain
    - Scale Back
    - No Goal
- A function goal narrative that supports the chosen goal. The narrative should include the planned activities for meeting the chosen goal. Awardees also should indicate whether the associated function is implemented at the state level, local level, or combination and provide a brief description.
- A description of the planned funding types to be used to achieve a function, using one of the following funding types:
    - PHEP
    - Partial PHEP
    - Other Funding Sources
    - No Funding

If “partial PHEP” or “other funding sources” is chosen, provide information about the funds to be used.

- A description of priority resource elements. Jurisdictions must have or have access to priority resource elements associated with each function to perform a function and its associated tasks. These are identified in the *Public Health Preparedness Capabilities: National Standards for State and Local Planning* document as “Priority.”
- All priority resource elements must be addressed in the awardee’s capabilities plan. For states and localities, the PHEP application will be considered incomplete if a priority resource element is not addressed. Territories and freely associated states are required to address all priority resource elements except where indicated. A complete description of the priority resource element will include:
- A description of the current status of each priority resource element using one of the three options below:
    - Fully in Place
    - Partially in Place
    - Not in Place
- A current status narrative that explains the chosen current status.
- A chosen goal for each priority resource element using one of the three options below:
    - Fully in Place
    - Partially in Place

- Not in Place

- A priority resource element goal narrative that indicates the activities planned for Budget Period 1 that support the chosen goal.
- Any recommended resource elements or awardee-defined resource elements that have associated PHEP-funded activities should also be addressed in the capabilities plan.

Local and tribal contracts plan. Awardees who have local and tribal contracts in their budgets must submit a local governmental contracts plan describing contractual arrangements with local governments or tribes. These plans should describe any contracts with local or tribal health departments within their jurisdictions and the capabilities to be addressed in the contracts. Awardees who have no local governmental contracts should not submit a local governmental contracts plan. For each contract entered into the local governmental contracts plan, the following information must be submitted:

- Contract name;
- Whether contract is with local jurisdiction or tribal entity;
- Association to capabilities / program management categories; and
- Association narrative.

Demonstration plan. Applicants must provide a detailed description of the functions and capabilities to be demonstrated during Budget Period 1. Capability functions can be demonstrated by any of the four following demonstration types:

- Routine public health activity;

- Planned event;
- Real incident; and
- Exercise.

Each demonstration described in the plan should include a narrative of the demonstration, an indication of the functions the demonstration is intended to address, a list of performance measures, and the date of the demonstration. Demonstration plans must include, at a minimum, planned demonstrations that address all annual performance measures. In addition, demonstration plans should indicate whether demonstrations are at the state level, local level, or both, supported by a brief description. Awardees are encouraged, when applicable, to use routine public health activities to demonstrate select functions.

Awardees are required to submit by the end of Budget Period 1 a minimum of two quality improvement-focused After Action Reports/Improvement Plans (AARs/IPs), following the HSEEP AAR/IP template and program standards, as part of their demonstration plans. The AARs/IPs must be submitted to the DSLR secure channel on LLIS.gov.

When submitting demonstration data, awardees are encouraged to provide real incident data.

Program management plan. Awardees who have cross-cutting and general program management activities planned for Budget Period 1 that is not specific to a capability,

such as program administration and evaluation, must submit a program management plan. There are three program management categories:

- Cross-cutting Personnel: Personnel whose activities are primarily cross-cutting across all capabilities or are directed toward the preparedness program overall;
- Other Cross-cutting Resources: Resources other than personnel that are used across capabilities, such as information technology equipment and cell phones; and
- Cross-cutting Projects: Projects or activities that are not related to specific capabilities.

Awardees should provide a narrative describing activities and funding related to each category. For example, describe the activities associated with the preparedness director position and the type of funding (PHEP, for example) to be used to support the position.

Budget

Funding applications must meet the following budget requirements:

- Link budget allocations with one or more work plan components to enable costs to be allocated to capabilities or program management activities.
- Provide a detailed line item budget (include form 424A) and justification of the funding amount requested to support program activities for Budget Period 1.
- Submit budgets reflective of a 12-month budget period.

- The following six elements must be submitted for all newly requested contracts as well as for revisions in scope or budget for any existing contracts:
    - Name(s) of contractor(s);
    - Method of selection (competitive or sole source; less than full and open competition must be justified); period of performance;
    - Description of activities;
    - Method of accountability; and
    - Itemized budget with narrative justification.

Additional budget preparation guidance is available at http://www.cdc.gov/od/pgo/funding/grants/foamain.shtm.

Other Budget Requirements

- Maintaining State Funding (MSF): Awardees are required to document MSF as part of their CDC-RFA-TP11-1101 funding applications. MSF is defined as ensuring that awardee expenditures for public health security are maintained at a level not less than the average of such expenditures for the previous two years. (See Appendix 5 for additional guidance)

- Matching of Federal Funds: PHEP cooperative agreement funding must be matched by nonfederal contributions (by applicable awardees). Non-federal contributions (match) may be provided directly or through donations from public or private entities and may be in cash or in-kind donations, fairly evaluated, including plant, equipment,

or services. Amounts provided by the federal government, or services assisted or subsidized to any significant extent by the federal government, may not be included in determining the amount of such non-federal contributions. Awardees will be required to provide matching funds as described:

- The match requirement for the Budget Period 1 is 10% ($1 for each $10 of federal funds provided in the cooperative agreement).
- Please refer to 45 CFR § 92.24 for match requirements, including descriptions of acceptable match resources. Documentation of match must follow procedures for generally accepted accounting practices and meet audit requirements. The HHS Secretary may not make an award to an entity eligible for PHEP funds unless the eligible entity agrees to make available nonfederal contributions in full as described above. CDC will require each eligible entity to include in its funding application a plan describing the methods and sources of match that the eligible entity agrees to pursue during Budget Period 1. (See Appendix 5 for additional guidance.)

- Carry-over Limits: CDC will set annual carry-over limits. For Budget Period 1, the carry-over limit will be set at 100%, but CDC reserves the right to restrict carry-over for awardees that maintain high carry-over balances.
- Direct Assistance: Awardees planning to request direct assistance (DA) in lieu of financial assistance should complete and submit the DA request form no later than November 15, 2011. Note that DA may be requested in the form of public health advisors, Career Epidemiology Field Officers, or other technical consultants, as well

as for any Statistical Analysis Software (SAS) licenses desired for future budget periods.

- Attendance at Meetings
    - Participation in CDC-sponsored training, workshops, and meetings is essential to the effective implementation of the PHEP cooperative agreement. Awardees are reminded that their annual budgets should include required travel for appropriate staff to attend PHEP-related meetings. These meetings, as outlined in the terms and conditions of the Notices of Awards, should be considered mandatory for the state, local, or territorial PHEP director and/or other applicant staff.

Submission Dates and Times

This announcement is the definitive guidance for application content, submission, and deadline. It supersedes information provided in the application instructions. If the application submission does not meet the deadline published herein, it will not be eligible for review and the applicant will be notified the application did not meet the submission requirements.

Application Deadline: June 17, 2011; 5:00 p.m. Eastern Time.

Intergovernmental Review

The application is 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 the state single point of contact (SPOC) as early as possible to alert the SPOC to prospective applications and to receive instructions on the State's process. Visit the following Web address to get the current SPOC list: http://www.whitehouse.gov/omb/grants_spoc/.

Funding Restrictions

Restrictions, which apply to both awardees and their subrecipients, must be taken into account while writing the budget. Restrictions are as follows:

- Recipients may not use funds for research.
- Recipients may not use funds for clinical care.
- Recipients may supplement but not supplant existing state and/or federal funds for activities described in the budget.
- Recipients may not use funds to purchase vehicles.
- Recipients may only expend funds for reasonable program purposes, including personnel, travel, supplies, and services, such as contractual.
- The direct and primary recipient in a cooperative agreement program must perform a substantial role in carrying out project objectives and not merely serve as a conduit for an award to another party or provider who is ineligible.

Other Submission Requirements

Application Submission

Submit the application electronically by using the forms and instructions posted for this funding opportunity on www.Grants.gov. If access to the Internet is not available or if the awardee encounters difficulty in accessing the forms online, contact the HHS/CDC Procurement and Grant Office Technical Information Management Section (PGO TIMS) staff at (770) 488-2700 for further instruction.

Note: Application submission is not concluded until successful completion of the validation process. After submission of application packages, awardees will receive a "submission receipt" e-mail generated by Grants.gov. Grants.gov will then generate a second e-mail message to awardees that will either validate or reject their submitted application package. This validation process may take as long as two (2) business days. Awardees are strongly encouraged check the status of their application to ensure submission of their application package is complete and no submission errors exists. To guarantee that you comply with the application deadline published in the Funding Opportunity Announcement, awardees are also strongly encouraged to allocate additional days prior to the published deadline to file their application. Non-validated applications will not be accepted after the published application deadline date.

In the event that you do not receive a "validation" e-mail within two (2) business days of application submission, please contact Grants.gov. Refer to the email message generated at the time of application submission or the Application User Guide, Version 3.0 page 57, for instructions on how to track your application.

Electronic Submission of Application

Applications must be submitted electronically at www.grants.gov. Electronic applications will be considered as having met the deadline if the application has been successfully made available to CDC for processing from Grants.gov on the deadline date. The application package can be downloaded from www.grants.gov. Applicants can complete the application package off-line and then upload and submit the application via the grants.gov Web site. Awardees must submit all application attachments using a PDF file format when submitting via grants.gov. Directions for creating PDF files can be found on the grants.gov Web site. Use of file formats other than PDF may result in the file being unreadable by staff.

Applications submitted through grants.gov (http://www.grants.gov), are electronically time/date stamped and assigned a tracking number. The authorized organizational representative (AOR) will receive an e-mail notice of receipt when grants.gov receives the application. The tracking number serves to document submission and initiate the electronic validation process before the application is made available to CDC for processing.

If awardees encounter technical difficulties with grants.gov, they should contact Grants.gov Customer Service. The Grants.gov Contact Center is available 24 hours a day, seven days a week, with the exception of all federal holidays. The Contact Center provides customer service to the applicant community. The extended hours will provide support around the clock, ensuring the best possible customer service is received any time

it's needed. You can reach the Grants.gov Support Center at 1-800-518-4726 or by email at support@grants.gov. Application submissions sent by e-mail, fax, CD's or thumb drives of applications will not be accepted.

Organizations that encounter technical difficulties in using www.grants.gov to submit their application must attempt to overcome those difficulties by contacting the Grants.gov Support Center (1-800-518-4726, support@grants.gov). After consulting with the Grants.gov Support Center, if the technical difficulties remain unresolved and electronic submission is not possible to meet the established deadline, organizations may submit a request prior to the application deadline by email to GMO/GMS for permission to submit a paper application. An organization's request for permission must: (a) include the Grants.gov case number assigned to the inquiry, (b) describe the difficulties that prevent electronic submission and the efforts taken with the Grants.gov Support Center (c) be submitted to the GMO/GMS at least 3 calendar days prior to the application deadline. Paper applications submitted without prior approval will not be considered.

If a paper application is authorized, you will receive instructions from PGO TIMS to submit the original and two hard copies of the application by mail or express delivery service.

V. Application Review Information

Eligible awardees are required to provide measures of effectiveness that will demonstrate the accomplishment of the various identified objectives of the CDC-RFA-TP11-1101. Measures of effectiveness must relate to the performance goals stated in the "Purpose" section of this announcement. Measures of effectiveness must be objective, quantitative, and measure the intended outcome of the proposed program. The measures of effectiveness must be included in the application and will be an element of the evaluation of the submitted application.

Criteria

Eligible applications will be evaluated for:

- The completeness of application

Review and Selection Process

Review

All eligible applications will be initially reviewed for completeness by the CDC Procurement and Grants Office staff. In addition, eligible applications will be jointly reviewed for responsiveness by CDC's Division of State and Local Readiness and PGO. Incomplete applications and applications that are not responsive to the eligibility criteria will not advance through the review process. Applicants will be notified if the application did not meet eligibility and/or published submission requirements.

Selection

All eligible applicants will be selected for funding.

VI. Award Administration Information

Award Notices

Successful applicants will receive a Notice of Award (NoA) from the CDC Procurement and Grants Office. The NoA shall be the only binding, authorizing document between the recipient and CDC. The NoA will be signed by an authorized Grants Management Officer and e-mailed to the program director. A hard copy of the NoA will be mailed to the recipient fiscal officer identified in the application.

Any application awarded in response to this FOA will be subject to the DUNS, CCR Registration and Transparency Act requirements.

Unsuccessful applicants will receive notification of the results of the application review by mail.

Administrative and National Policy Requirements

Successful applicants must comply with the administrative requirements outlined in 45 Code of Federal Regulations (CFR) Part 74 or Part 92, as appropriate. The following additional requirements apply to this project:

- AR-1 Human Subjects Requirements
- AR-7 Executive Order 12372
- AR-8 Public Health System Reporting Requirements
- AR-9 Paperwork Reduction Act Requirements
- AR-10 Smoke-Free Workplace Requirements
- AR-11 Healthy People 2020
- AR-12 Lobbying Restrictions
- AR-21 Small, Minority, and Women-Owned Business
- AR-24 Health Insurance Portability and Accountability Act Requirements
- AR-25 Release and Sharing of Data
- AR-27 Conference Disclaimer and Use of Logos
- AR-29 Compliance with E.O. 13513 Federal Leadership on Reducing Text Messaging While Driving, October 1, 2009

Additional information on the requirements can be found on the CDC Web site at the following Internet address: http://www.cdc.gov/od/pgo/funding/Addtl_Reqmnts.htm.

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

Reporting

- Federal Funding Accountability And Transparency Act Of 2006 (FFATA): Public Law 109-282, the Federal Funding Accountability and Transparency Act of 2006 as amended (FFATA), requires full disclosure of all entities and organizations receiving federal funds including grants, contracts, loans and other assistance and payments through a single publicly accessible Web site, www.USASpending.gov. The Web site includes information on each federal financial assistance award and contract over $25,000, including such information as:

    1. The name of the entity receiving the award;
    2. The amount of the award;
    3. Information on the award including transaction type, funding agency, etc.;
    4. The location of the entity receiving the award;
    5. A unique identifier of the entity receiving the award; and
    6. Names and compensation of highly compensated officers (as applicable).

    Compliance with this law is primarily the responsibility of the federal agency. However, two elements of the law require information to be collected and reported by recipients: 1) information on executive compensation when not already reported through the Central Contractor Registry; and 2) similar information on all sub-wards/subcontracts/consortiums over $25,000.

For the full text of the requirements under the Federal Funding Accountability and Transparency Act of 2006, please review the following Web site: http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=109_cong_bills&docid=f:s2590enr.txt.pdf

- Each funded applicant must provide CDC with an annual Interim Progress Report submitted via www.grants.gov: The interim progress report is due no less than 90 days before the end of the budget period. The Interim Progress Report will serve as the noncompeting continuation application and must contain the following elements:
    - Standard Form ("SF") 424S Form
    - SF-424A Budget Information-Non-Construction Programs
    - Budget Narrative
    - Indirect Cost Rate Agreement
    - Project Narrative

- Additionally, funded applicants must provide CDC with an original, plus two hard copies of the following reports:
    - A mid-year progress report, due 30 days after the first six months of the budget period. This report should include a status update on work plan activities or changes, including local contracts, PAHPA benchmarks, performance measurement and demonstration plan activities, a five-year timeline for addressing the public health preparedness capabilities, and

risk-based funding activities (if applicable).

- An annual progress report, due 45 days after the end of the budget period. This report should include an update on work plan activities, including local contracts, risk-based funding activities (if applicable), a budget expenditure report, and performance measurement and demonstration plan activities.
- A financial status report* (SF 269), no later than 90 days after the end of the budget period.
- Final performance and financial status reports*, no later than 90 days after the end of the project period.
- CDC may require quarterly financial updates due 10 days after the end of each calendar quarter to monitor obligation of PHEP funds.

*Disclaimer: As of February 1, 2011, current financial status report (FSR) requirements are obsolete. Existing practices are being updated to reflect changes for implementation of the new federal financial reporting (FFR) requirements.

These reports must be submitted to the attention of the Grants Management Specialist listed in the Section VII below entitled "Agency Contacts."

VII. Agency Contacts

CDC encourages inquiries concerning this announcement.

For **programmatic technical assistance**, contact:

Sharon Sharpe, Associate Director

Grants Management and Compliance, Division of State and Local Readiness

Department of Health and Human Services

Centers for Disease Control and Prevention

1600 Clifton Road, Mailstop D29

Atlanta, GA 30333

Telephone: (404) 639-0817

E-mail: SSharpe@cdc.gov

For **financial, grants management, or budget assistance**, contact:

Dwight McCants, Grants Management Specialist

Department of Health and Human Services

CDC Procurement and Grants Office

2920 Brandywine Road, Mailstop K69

Atlanta, GA 30341

Telephone: (770) 488-2650

E-mail: JIU2@cdc.gov

For assistance with **submission difficulties,** contact:

Grants.gov Contact Center Phone: 1-800-518-4726.

Hours of Operation: 24 hours a day, 7 days a week. Closed on Federal holidays.

For **submission** questions, contact:

Technical Information Management Section

Department of Health and Human Services

CDC Procurement and Grants Office

2920 Brandywine Road, MS E-14

Atlanta, GA 30341

Telephone: 770-488-2700

Email: pgotim@cdc.gov

CDC Telecommunications for the hearing impaired or disabled is available at:

TTY 1-888-232-6348

VIII. Other Information

For additional information on reporting requirements, visit the CDC Web site at:

http://www.cdc.gov/od/pgo/funding/grants/additional_req.shtm.

Other CDC funding opportunity announcements can be found at www.grants.gov.

Appendix 1
PHEP Budget Period 1 (FY 2011) Funding*

Awardee	FY 2011 Total Base Plus Population Funding	FY 2011 Cities Readiness Initiative Funding	FY 2011 Level 1 Chemical Laboratory Funding	FY 2011 EWIDS Funding	FY 2011 Risk Funding	FY 2011 Total Funding Available
Alabama	$9,181,948	$361,943	$0	$0	$0	$9,543,891
Alaska	$5,000,000	$200,000	$0	$8,000	$0	$5,208,000
American Samoa	$386,162	$0	$0	$0	$0	$386,162
Arizona	$11,659,436	$1,396,511	$0	$205,770	$0	$13,261,717
Arkansas	$6,793,489	$236,324	$0	$0	$0	$7,029,813
California	$38,596,851	$6,215,638	$1,051,433	$507,067	$958,634	$47,329,623
Chicago	$8,743,360	$1,660,875	$0	$0	$616,868	$11,021,103
Colorado	$9,596,869	$816,703	$0	$0	$0	$10,413,572
Connecticut	$7,619,074	$654,082	$0	$0	$0	$8,273,156
Delaware	$5,000,000	$371,083	$0	$0	$100,000	$5,471,083
District of Columbia	$5,787,275	$641,175	$0	$0	$445,610	$6,874,060
Florida	$27,338,046	$3,320,559	$808,167	$0	$0	$31,466,772
Georgia	$15,904,530	$1,752,069	$0	$0	$0	$17,656,599
Guam	$534,256	$0	$0	$0	$0	$534,256
Hawaii	$5,000,000	$290,424	$0	$0	$0	$5,290,424
Idaho	$5,029,444	$194,041	$0	$8,000	$0	$5,231,485
Illinois	$16,206,400	$2,297,498	$0	$8,000	$445,678	$18,957,576
Indiana	$11,432,748	$888,298	$0	$8,000	$100,000	$12,429,046
Iowa	$6,948,940	$238,578	$0	$0	$0	$7,187,518
Kansas	$6,700,664	$464,793	$0	$0	$0	$7,165,457
Kentucky	$8,663,893	$458,637	$0	$0	$0	$9,122,530

Awardee	FY 2011 Total Base Plus Population Funding	FY 2011 Cities Readiness Initiative Funding	FY 2011 Level 1 Chemical Laboratory Funding	FY 2011 EWIDS Funding	FY 2011 Risk Funding	FY 2011 Total Published Amounts
Los Angeles	$17,929,213	$3,151,364	$0	$0	$1,149,040	$22,229,617
Louisiana	$8,897,537	$632,617	$0	$0	$0	$9,530,154
Maine	$5,000,000	$200,000	$0	$36,560	$0	$5,236,560
Marshall Islands	$384,709	$0	$0	$0	$0	$384,709
Maryland	$10,482,705	$1,618,324	$0	$0	$179,986	$12,281,015
Massachusetts	$11,656,559	$1,508,240	$955,994	$0	$716,852	$14,837,645
Michigan	$16,089,010	$1,409,100	$939,437	$99,193	$0	$18,536,740
Micronesia	$441,047	$0	$0	$0	$0	$441,047
Minnesota	$9,913,883	$1,025,007	$968,730	$17,081	$0	$11,924,701
Mississippi	$6,875,603	$274,686	$0	$0	$0	$7,150,289
Missouri	$10,860,947	$1,077,895	$0	$0	$0	$11,938,842
Montana	$5,000,000	$200,000	$0	$9,311	$0	$5,209,311
Nebraska	$5,358,737	$233,269	$0	$0	$0	$5,592,006
Nevada	$6,470,042	$608,907	$0	$0	$0	$7,078,949
New Hampshire	$5,000,000	$335,317	$0	$8,000	$100,000	$5,443,317
New Jersey	$14,432,177	$2,666,026	$0	$0	$986,144	$18,084,347
New Mexico	$5,638,448	$274,529	$972,226	$41,720	$0	$6,926,923
New York	$17,638,000	$1,988,064	$1,452,584	$156,073	$321,833	$21,556,554
New York City	$16,017,495	$3,939,750	$0	$0	$1,038,287	$20,995,532
North Carolina	$15,315,933	$493,676	$0	$0	$0	$15,809,609
North Dakota	$5,000,000	$200,000	$0	$10,805	$0	$5,210,805
Northern Mariana Islands	$367,592	$0	$0	$0	$0	$367,592
Ohio	$18,154,056	$1,779,987	$0	$8,000	$0	$19,942,043
Oklahoma	$7,840,638	$392,729	$0	$0	$0	$8,233,367
Oregon	$8,022,611	$575,663	$0	$0	$0	$8,598,274

Palau	$327,303	$0	$0	$0	$0	$327,303
Pennsylvania	$19,548,490	$2,056,979	$0	$8,000	$709,800	$22,323,269
Awardee	**FY 2011 Total Base Plus Population Funding**	**FY 2011 Cities Readiness Initiative Funding**	**FY 2011 Level 1 Chemical Laboratory Funding**	**FY 2011 EWIDS Funding**	**FY 2011 Risk Funding**	**FY 2011 Total Published Amounts**
Puerto Rico	$8,208,555	$0	$0	$0	$0	$8,208,555
Rhode Island	$5,000,000	$337,027	$0	$0	$0	$5,337,027
South Carolina	$8,988,343	$310,955	$886,849	$0	$0	$10,186,147
South Dakota	$5,000,000	$200,000	$0	$0	$0	$5,200,000
Tennessee	$11,266,198	$832,249	$0	$0	$0	$12,098,447
Texas	$35,536,078	$4,603,915	$0	$737,933	$1,736,687	$42,614,613
Utah	$6,655,796	$361,694	$0	$0	$0	$7,017,490
Vermont	$5,000,000	$200,000	$0	$22,431	$0	$5,222,431
Virgin Islands (U.S.)	$444,166	$0	$0	$0	$0	$444,166
Virginia	$13,348,859	$1,742,952	$838,795	$0	$194,581	$16,125,187
Washington	$11,749,258	$1,232,239	$0	$92,056	$0	$13,073,553
West Virginia	$5,389,141	$216,880	$0	$0	$100,000	$5,706,021
Wisconsin	$10,424,014	$591,514	$1,221,085	$8,000	$100,000	$12,344,613
Wyoming	$5,000,000	$200,000	$0	$0	$0	$5,200,000
TOTAL FY 2011 PHEP FUNDING	**$592,796,528**	**$59,930,785**	**$10,095,300**	**$2,000,000**	**$10,000,000**	**$674,822,613**

* Funding amounts are planning numbers that will change based on the final FY 2011 budget.

Appendix 2
Cities Readiness Initiative (CRI) Funding Table*

Awardee	CRI City	2009 Census Population	BP1 Awardee Total
Alabama	Birmingham	1,131,070	$361,943
Alaska	Anchorage	374,553	$200,000
Arizona	Phoenix	4,364,094	$1,396,511
Arkansas	Little Rock	685,488	
Arkansas	Memphis	53,022	$236,324
California	Los Angeles	3,026,786	
California	Riverside	4,143,113	
California	Sacramento	2,127,355	
California	San Diego	3,053,793	
California	San Francisco	4,317,853	
California	San Jose	1,839,700	
California	Fresno	915,267	$6,215,638
Chicago	Chicago	2,851,268	$1,660,875
Colorado	Denver	2,552,195	$816,703
Connecticut	Hartford	1,195,998	
Connecticut	New Haven	848,006	$654,082
Delaware	Philadelphia	534,634	
Delaware	Dover	157,741	$371,083
Florida	Miami	5,547,051	
Florida	Orlando	2,082,421	
Florida	Tampa	2,747,272	$3,320,559
Georgia	Atlanta	5,475,213	$1,752,069
Hawaii	Honolulu	907,574	$290,424
Idaho	Boise	606,376	$194,041
Illinois	Chicago	5,859,556	
Illinois	St Louis	695,123	
Illinois	Peoria	375,865	$2,297,498
Indiana	Chicago	704,361	
Indiana	Indianapolis	1,743,658	
Indiana	Cincinnati	79,559	
Indiana	Louisville	248,351	$888,298
Iowa	Des Moines	562,906	
Iowa	Omaha	120,554	$238,578

Kansas	Wichita	612,683	
Kansas	Kansas City	839,794	$464,793
Awardee	**CRI City**	**2009 Census Population**	**BP1 Awardee Total**
Kentucky	Louisville	1,010,226	
Kentucky	Cincinnati	423,012	$458,637
Los Angeles	Los Angeles	9,848,011	$3,151,364
Louisiana	Baton Rouge	786,947	
Louisiana	New Orleans	1,189,981	$632,617
Maine	Portland	516,826	$200,000
Maryland	Baltimore	2,690,886	
Maryland	Washington D.C	2,265,578	
Maryland	Philadelphia	100,796	$1,618,324
Massachusetts	Boston	4,165,815	
Massachusetts	Providence	547,433	$1,508,240
Michigan	Detroit	4,403,437	$1,409,100
Minnesota	Fargo	56,763	
Minnesota	Minneapolis	3,146,382	$1,025,007
Mississippi	Jackson	540,866	
Mississippi	Memphis	233,392	$274,686
Missouri	St. Louis	2,140,630	
Missouri	Kansas City	1,227,791	$1,077,895
Montana	Billings	154,553	$200,000
Nebraska	Omaha	728,963	$233,269
Nevada	Las Vegas	1,902,834	$608,907
New Hampshire	Boston	422,865	
New Hampshire	Manchester	405,906	$335,317
New Jersey	New York City	6,386,082	
New Jersey	Philadelphia	1,320,249	
New Jersey	Trenton	366,222	$2,666,026
New Mexico	Albuquerque	857,903	$274,529
New York	Albany	857,592	
New York	Buffalo	1,123,804	
New York	New York City	4,231,304	$1,988,064
New York City	New York City	8,391,881	$3,939,750
North Carolina	Charlotte	1,518,521	
North Carolina	Virginia Beach	24,216	$493,676
North Dakota	Fargo	143,339	$200,000
Ohio	Cincinnati	1,669,325	
Ohio	Cleveland	2,091,286	$1,779,987

Ohio	Columbus	1,801,848	
Awardee	**CRI City**	**2009 Census Population**	**BP1 Awardee Total**
Oklahoma	Oklahoma City	1,227,278	$392,729
Oklahoma	Oklahoma City	1,227,278	$392,729
Oregon	Portland	1,798,945	$575,663
Pennsylvania	Philadelphia	4,012,573	
Pennsylvania	Pittsburgh	2,354,957	
Pennsylvania	New York City	60,529	$2,056,979
Rhode Island	Providence	1,053,209	$337,027
South Carolina	Columbia	744,730	
South Carolina	Charlotte	227,003	$310,955
South Dakota	Sioux Falls	238,122	$200,000
Tennessee	Nashville	1,582,264	
Tennessee	Memphis	1,018,512	$832,249
Texas	Dallas	6,447,615	
Texas	Houston	5,867,489	
Texas	San Antonio	2,072,128	$4,603,915
Utah	Salt Lake City	1,130,293	$361,694
Vermont	Burlington	208,055	$200,000
Virginia	Richmond	1,238,187	
Virginia	Virginia Beach	1,650,282	
Virginia	Washington D.C	2,558,256	$1,742,952
Washington	Seattle	3,407,848	
Washington	Portland	442,896	$1,232,239
Washington D.C	Washington D.C	599,657	$641,175
West Virginia	Charleston	304,214	
West Virginia	Washington D.C	52,750	$216,880
Wisconsin	Chicago	165,382	
Wisconsin	Milwaukee	1,559,667	
Wisconsin	Minneapolis	123,432	$591,514
Wyoming	Cheyenne	88,854	$200,000
Total FY 2011 Cities Readiness Initiative Funding		**175,308,845**	**$59,930,785**

* Funding amounts subject to change based on final FY 2011 budget.

Appendix 3
Risk-Based Funding Table*

Awardee	UASI Tier I Urban Area	Metropolitan Statistical Area	2009 Census Population	BP1 Awardee Total
California	San Francisco Bay Area	San Francisco-Oakland-Fremont, CA	4,317,853	
California	Los Angeles/Long Beach Area	Los Angeles-Long Beach-Santa Ana, CA	3,026,786	$958,634
Chicago	Chicago Area	City of Chicago	2,851,268	$616,868
Delaware	Philadelphia Area	Philadelphia-Camden-Wilmington, PA-NJ-DE	505,564	$100,000
Illinois	Chicago Area	Chicago-Naperville-Joliet, IL-IN-WI	5,859,556	$445,678
Indiana	Chicago Area	Chicago-Naperville-Joliet, IL-IN-WI	704,361	$100,000
Los Angeles	Los Angeles/Long Beach Area	Los Angeles County	9,848,011	$1,149,040
Maryland	Philadelphia Area	Philadelphia-Camden-Wilmington, PA-NJ-DE	100,796	
Maryland	National Capital Region	Washington-Arlington-Alexandria, DC-VA-MD	2,265,578	$179,986
Massachusetts	Boston Area	Boston-Cambridge-Quincy, MA-NH	4,165,815	$716,852
New Hampshire	Boston Area	Boston-Cambridge-Quincy, MA-NH	422,865	$100,000
New Jersey	Jersey City/Newark Area	New York-Northern New Jersey-Long Island, NY-NJ-PA	6,386,082	
New Jersey	Philadelphia Area	Philadelphia-Camden-Wilmington, PA-NJ-DE	1,320,249	$986,144
New York	New York City Area	New York-Northern New Jersey-Long Island, NY-NJ-PA	4,231,304	$321,833
New York City	New York City Area	New York City	8,391,881	$1,038,287
Pennsylvania	New York City Area	New York-Northern New Jersey-Long Island, NY-NJ-PA	60,529	
Pennsylvania	Philadelphia Area	Philadelphia-Camden-Wilmington, PA-NJ-DE	4,012,573	$709,800
Texas	Dallas/Fort Worth/Arlington Area	Dallas-Fort Worth-Arlington, TX	6,447,615	
Texas	Houston Area	Houston-Baytown-Sugar Land, TX	5,867,489	$1,736,687
Virginia	National Capital Region	Washington-Arlington-Alexandria, DC-VA-MD	2,558,256	$194,581
Washington, D.C.	National Capital Region	Washington, D.C.	599,657	$445,610
West Virginia	National Capital Region	Washington-Arlington-Alexandria, DC-VA-MD	52,750	$100,000
Wisconsin	Chicago Area	Chicago-Naperville-Joliet, IL-IN-WI	165,382	$100,000
Total FY 2011 Risk Funding			**74,162,220**	**$10,000,000**

* Funding amounts subject to change based on final FY 2011 budget.

Appendix 4
Public Health Preparedness Capabilities:
National Standards for State and Local Planning

The purpose of the 2011-2016 Public Health Emergency Preparedness (PHEP) cooperative agreement program is to assist state, local, and territorial/freely associated state health departments in demonstrating measurable and sustainable progress toward achieving the 15 public health preparedness capabilities as outlined in the *Public Health Preparedness Capabilities: National Standards for State and Local Planning* document and other activities that promote safer and more resilient communities.

Public Health Preparedness Capabilities: National Standards for State and Local Planning is available at http://www.cdc.gov/phpr/capabilities/.

Below is an at-a-glance summary of the capability definitions, functions, priority resource elements, and associated performance measures.

Capability 1: Community Preparedness
Definition: Community preparedness is the ability of communities to prepare for, withstand, and recover — in both the short and long terms — from public health incidents. By engaging and coordinating with emergency management, healthcare organizations (private and community-based), mental/behavioral health providers, community and faith-based partners, state, local, and territorial, public health's role in community preparedness is to do the following:

- Support the development of public health, medical and mental/behavioral health systems that support recovery
- Participate in awareness training with community and faith-based partners on how to prevent, respond to, and recover from public health incidents
- Promote awareness of and access to medical and mental/behavioral health resources that help protect the community's health and address the functional needs (i.e., communication, medical care, independence, supervision, transportation) of at-risk individuals
- Engage public and private organizations in preparedness activities that represent the functional needs of at-risk individuals as well as the cultural and socio-economic, demographic components of the community
- Identify those populations that may be at higher risk for adverse health outcomes
- Receive and/or integrate the health needs of populations who have been displaced due to incidents that have occurred in their own or distant communities (e.g., improvised nuclear device or hurricane)

Functions and Associated Performance Measures: This capability consists of the ability to perform the functions listed below. At present there are no CDC-defined performance measures for these functions.

Function 1: Determine risks to the health of the jurisdiction

Priority Resource Elements:

P1: *(Priority)* Written plans should include policies and procedures to identify populations with the following:

- Health vulnerabilities such as poor health status
- Limited access to neighborhood health resources (e.g., disabled, elderly, pregnant women and infants, individuals with other acute medical conditions, individuals with chronic diseases, underinsured persons, persons without health insurance)
- Reduced ability to hear, speak, understand, or remember
- Reduced ability to move or walk independently or respond quickly to directions during an emergency
- Populations with health vulnerabilities that may be caused or exacerbated by chemical, biological, or radiological exposure

These procedures and plans should include the identification of these groups through the following elements:

- Review/access to existing health department data sets
- Existing chronic disease programs/maternal child health programs, community profiles
- Utilizing the efforts of the jurisdiction strategic advisory council
- Community coalitions to assist in determining the community's risks

P2: *(Priority)* Written plans should include a jurisdictional risk assessment, utilizing an all-hazards approach with the input and assistance of the following elements:

- Public health and non–public health subject matter experts (e.g., emergency management, state radiation control programs/radiological subject matter experts (http://www.crcpd.org/Map/RCPmap.htm))
- Existing inputs from emergency management risk assessment data, health department programs, community engagements, and other applicable sources, that identify and prioritize jurisdictional hazards and health vulnerabilities

This jurisdictional risk assessment should identify the following elements:

- Potential hazards, vulnerabilities, and risks in the community related to the public health, medical, and mental/behavioral health systems
- The relationship of these risks to human impact, interruption of public health, medical, and mental/behavioral health services
- The impact of those risks on public health, medical, and mental/behavioral health infrastructure

Jurisdictional risk assessment must include at a minimum the following elements:

- A definition of risk

- Use of Geospatial Informational System or other mechanism to map locations of at-risk populations
- Evidence of community involvement in determining areas for risk assessment or hazard mitigation
- Assessment of potential loss or disruption of essential services such as clean water, sanitation, or the interruption of healthcare services, public health agency infrastructure

Function 2: Build community partnerships to support health preparedness

Priority Resource Elements:

P1: *(Priority)* Written plans should include a policy and process to participate in existing (e.g., led by emergency management) or new partnerships representing at least the following 11 community sectors: business; community leadership; cultural and faith-based groups and organizations; emergency management; healthcare; social services; housing and sheltering; media; mental/behavioral health; state office of aging or its equivalent; education and childcare settings.

P2: *(Priority)* Written plans should include a protocol to encourage or promote medical personnel (e.g., physicians, nurses, allied health professionals) from community and faith-based organizations and professional organizations to register and participate with community Medical Reserve Corps or state Emergency Systems for Advance Registration of Volunteer Health Professionals programs to support health services during and after an incident. *(For additional or supporting detail, see Capability 15: Volunteer Management)*

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

Function 4: Coordinate training or guidance to ensure community engagement in preparedness efforts

Priority Resource Elements:

P1: *(Priority)* Written plans should include documentation that public health has participated in jurisdictional approaches to address how children's medical and mental/behavioral healthcare will be addressed in all-hazard situations, including but not limited to the following elements:

- Approaches to support family reunification
- Care for children whose caregivers may be killed, ill, injured, missing, quarantined, or otherwise incapacitated for lengthy periods of time
- Increasing parents' and caregivers' coping skills
- Supporting positive mental/behavioral health outcomes in children affected by the incident
- Providing the opportunity to understand the incident

P2: *(Priority)* Written plans should include a process and procedures to build and sustain volunteer opportunities for residents to participate with local emergency responders and community safety efforts year round (e.g., Medical Reserve Corps). *(For additional or supporting detail, see Capability 15: Volunteer Management)*

Capability 2: Community Recovery

Definition: Community recovery is the ability to collaborate with community partners, (e.g., healthcare organizations, business, education, and emergency management) to plan and advocate for the rebuilding of public health, medical, and mental/behavioral health systems to at least a level of functioning comparable to pre-incident levels, and improved levels where possible.

This capability supports National Health Security Strategy Objective 8: Incorporate Post-Incident Health Recovery into Planning and Response. Post-incident recovery of the public health, medical and mental/behavioral health services and systems within a jurisdiction is critical for health security and requires collaboration and advocacy by the public health agency for the restoration of services, providers, facilities, and infrastructure within the public health, medical, and human services sectors. Monitoring the public health, medical and mental/behavioral health infrastructure is an essential public health service.

Functions and Associated Performance Measures: This capability consists of the ability to perform the functions listed below. At present there are no CDC-defined performance measures for these functions.

Function 1: Identify and monitor public health, medical and mental/behavioral health system recovery needs

Priority Resource Elements:

P1: *(Priority)* Written plans should include processes for collaborating with community organizations, emergency management, and healthcare organizations to identify the public health, medical, and mental/behavioral health system recovery needs for the jurisdiction's identified hazards.

P2: *(Priority)* Written plans should include how the health agency and other partners will conduct a community assessment and follow-up monitoring of public health, medical, and mental/behavioral health system needs after an incident.

(For additional or supporting detail, see Capability 1: Community Preparedness)

P3: *(Priority)* Written plans should include the following elements (either as a stand-alone Public Health Continuity of Operations Plan or as a component of another plan):

- Definitions and identification of essential services needed to sustain agency mission and operations
- Plans to sustain essential services regardless of the nature of the incident (e.g., all-hazards planning)
- Scalable work force reduction
- Limited access to facilities (social distancing, staffing or security concerns)
- Broad-based implementation of social distancing policies if indicated
- Positions, skills and personnel needed to continue essential services and functions (Human Capital Management)
- Identification of agency vital records (legal documents, payroll, staff assignments) that support essential functions and/or that must be preserved in an incident
- Alternate worksites
- Devolution of uninterruptible services for scaled down operations
- Reconstitution of uninterruptible services

Function 2: Coordinate community public health, medical and mental/behavioral health system recovery operations

Function 3: Implement corrective actions to mitigate damages from future incidents

Capability 3: Emergency Operations Coordination

Definition: Emergency operations coordination is the ability to direct and support an event or incident with public health or medical implications by establishing a standardized, scalable system of oversight, organization, and supervision consistent with jurisdictional standards and practices and with the National Incident Management System.

Functions and Associated Performance Measures: This capability consists of the ability to perform the functions listed below. Associated CDC-defined performance measures are also listed below.

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

Function 2: Activate public health emergency operations

Measure 1: Time for pre-identified staff covering activated public health agency incident management lead roles (or equivalent lead roles) to report for immediate duty. Performance Target: 60 minutes or less

Priority Resource Elements:

P1: *(Priority)* Written plans should include standard operating procedures that provide guidance for the management, operation, and staffing of the public health emergency operations center or public health functions within another emergency operations center. The following should be considered for inclusion in the

standard operating procedures:

- Activation procedures and levels, including who is authorized to activate the plan and under what circumstances
- Notification procedures; procedures recalling and/or assembling required incident command/management personnel and for ensuring facilities are available and operationally ready for assembled staff

S1: *(Priority)* Staff involved in incident response should have competency in the incident command and emergency management responsibilities they may be called upon to fulfill in an emergency. A precursor to having competency is for staff to attain the applicable National Incident Management System (NIMS) Certification based on discipline, level and/or jurisdictional requirements. Additional information on NIMS is located at http://www.fema.gov/emergency/nims/.

A suggested approach to establish your NIMS training needs based on CDC guidelines is outlined below.

Tier One: Personnel who, in the event of a public health emergency, will not be working within the emergency operations center/multiagency coordination system or will not be sent out to the field as responders. Applicable training courses are

- National Incident Management System, An Introduction (IS-700a)
- National Response Framework, An Introduction (IS-800.b)

Tier Two: Personnel who, in a public health emergency, will be assigned to fill one of the functional seats in the emergency operations center during the response operation. Applicable training courses are listed below:

- Introduction to Incident Command System (IS-100.b)
- Incident Command System for Single Resources and Initial Action Incidents (IS-200.b)
- National Incident Management System: An Introduction (IS-700a)
- National Response Framework: An Introduction (IS-800.b)

Tier Three: Personnel who, in a public health emergency, have the potential to be deployed to the field to participate in the response, including personnel who are already assigned to a field location. Applicable training courses are listed below:

- Introduction to Incident Command System (IS-100.b)
- Incident Command System for Single Resources and Initial Action Incidents (IS-200.b)
- Intermediate Incident Command System (ICS-300)
- National Incident Management System, An Introduction (IS-700a)
- National Response Framework, An Introduction (IS-800.b)

Tier Four: Personnel who, in a public health emergency, are activated to Incident Management System leadership and liaison roles and are deployed to the field in leadership positions. Applicable training courses are listed below

- Introduction to Incident Command System (IS-100.b)
- Incident Command System for Single Resources and Initial Action Incidents (IS-200.b)
- Intermediate Incident Command System (ICS-300)
- Advanced Incident Command System (ICS-400)
- National Incident Management System, An Introduction (IS-700a)
- National Response Framework, An Introduction (IS-800.b)

Function 3: Develop incident response strategy

Measure 1: Production of the approved Incident Action Plan before the start of the second operational period

Priority Resource Element:

P1: *(Priority)* Written plans should include a template for producing Incident Action Plans. The following should be considered for inclusion in Incident Action Plans as indicated by the scale of the incident:

- Incident goals
- Operational period objectives (major areas that must be addressed in the specified operational period to achieve the goals or control objectives)
- Response strategies (priorities and the general approach to accomplish the objectives)
- Response tactics (methods developed by Operations to achieve the objectives)
- Organization list with Incident Command System chart showing primary roles and relationships
- Assignment list with specific tasks
- Critical situation updates and assessments
- Composite resource status updates
- Health and safety plan (to prevent responder injury or illness)
- Logistics plan (e.g., procedures to support Operations with equipment and supplies)
- Responder medical plan (providing direction for care to responders)
- Map of the incident or of ill/injured persons (e.g., map of incident scene)
- Additional component plans, as indicated by the incident

The use of the following Incident Command System forms or equivalent documentation is recommended: Form 202 – "Incident Objectives," Form 203 – "Organization Assignment List," and Form 204 – "Division/Group Assignment List."

Function 4: Manage and sustain the public health response

Measure 1: Time to complete a draft of an After Action Report and Improvement Plan

Priority Resource Element:

P1: *(Priority)* Written plans should include processes and protocols to ensure the continued performance of pre-identified essential functions during a public health incident and during an incident that renders the primary location where the functions are performed inoperable. This can be a stand-alone plan or annex but at a minimum the plan must include these elements:

- Definitions and identification of essential services needed to sustain agency mission and operations
- Plans to sustain essential services regardless of the nature of the incident (e.g., all-hazards planning)
- Scalable workforce reduction
- Limited access to facilities (e.g., social distancing and staffing or security concerns)
- Broad-based implementation of social distancing policies if indicated
- Positions, skills, and personnel needed to continue essential services and functions (Human Capital Management)
- Identification of agency vital records (e.g., legal documents, payroll, and staff assignments) that support essential functions and/or that must be preserved in an incident
- Alternate worksites
- Devolution of uninterruptible services for scaled-down operations
- Reconstitution of uninterruptible services

For guidance on developing a Continuity of Operations Plan, refer to the resources provided by the Federal Emergency Management Agency: http://www.fema.gov/government/coop/index.shtm

Function 5: Demobilize and evaluate public health emergency operations

Priority Resource Element:

P1: *(Priority)* Written plans should include demobilization procedures for public health operations. The following should be considered for inclusion:

- General information about the demobilization process
- Responsibilities/agreements for reconditioning of equipment/resources
- Responsibilities for implementation of the Demobilization Plan
- General release priorities (i.e., resource type such as staff or equipment to be released) and detailed steps and processes for releasing those resources
- Directories (e.g., maps and telephone listings)

The use of Incident Command System Form 221 - "Demobilization Checkout" or equivalent documentation is recommended.

Capability 4: Emergency Public Information and Warning

Definition: Emergency public information and warning is the ability to develop, coordinate, and disseminate information, alerts, warnings, and notifications to the public and incident management responders.

Functions and Associated Performance Measures: This capability consists of the ability to perform the functions listed below. Associated CDC-defined performance measures are also listed below.

Function 1: Activate the emergency public information system

Priority Resource Elements:

P1: *(Priority)* Written plans should include description of the roles and responsibilities for the Public Information Officer, support staff (depending on incident and subject matter expertise), and potential spokesperson(s) to convey information to the public.

P2: *(Priority)* Written plans should include message templates that address jurisdictional vulnerabilities, should be maintained on a jurisdictionally defined regular basis, and include the following elements:

- Stakeholder identification
- Potential stakeholder questions and concerns
- Common sets of underlying concerns
- Key messages in response to the generated list of underlying stakeholder questions and concerns

S1: *(Priority)* Public Information staff should complete the following National Incident Management System training:

- Introduction to Incident Command System (IS-100.b)
- Incident Command System for Single Resources and Initial Action Incidents (IS-200.b)
- Emergency Support Function 15 External Affairs: A New Approach to Emergency Communication and Information Distribution (IS-250)
- National Incident Management System, An Introduction (IS-700.a)
- National Incident Management System Public Information Systems (IS-702.a)
- National Response Framework, An Introduction (IS-800.b)

S2: *(Priority)* Deliver key messages using principles of crisis and emergency risk communication. To ensure this, the following training must be taken within six months of hire date and at least once every five years thereafter by public information staff within the jurisdiction:

- CDC Crisis and Emergency Risk Communication Basic
- CDC Crisis and Emergency Risk Communication for Pandemic Influenza

These courses may be taken in any of the following ways:

- Self-paced online training, which is available at all times
- Any CDC webinar course, which is offered four times per year
- In-person training at CDC, which is offered four times per year
- Access to Crisis and Emergency Risk Communication courses at the Preparedness and Emergency Response Learning Centers

If for any reason staff is not able to attend these courses, completing training given by staff that has been CDC trained is acceptable (train the trainer model).

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

Priority Resource Element:

E1: *(Priority)* Minimum components of a Virtual Joint Information Center:

- Equipment to exchange information electronically within the jurisdiction and CDC, in real-time, if possible
- Shared site or mechanism or system to store electronic files of joint information center products, e-mail group lists, incident information, and scheduling

Minimum components of a Virtual Joint Information Center for territory jurisdictions entail the following:

- Electronic access to both the CDC public website and the World Health Organization shared information site

Function 3: Establish and participate in information system operations
Function 4: Establish avenues for public interaction and information exchange
Function 5: Issue public information, alerts, warnings, and notifications
Measure 1: Time to issue a risk communication message for dissemination to the public

Capability 5: Fatality Management

Definition: Fatality management is the ability to coordinate with other organizations (e.g., law enforcement, healthcare, emergency management, and medical examiner/coroner) to ensure the proper recovery, handling, identification, transportation, tracking, storage, and disposal of human remains and personal effects; certify cause of death; and facilitate access to mental/behavioral health services to the family members, responders, and survivors of an incident.

Functions and Associated Performance Measures: This capability consists of the ability to perform the functions listed below. At present there are no CDC-defined performance measures for these functions.

Function 1: Determine role for public health in fatality management

Priority Resource Element:

P1: *(Priority)* Written plans should include memoranda of agreement, memoranda of understanding, mutual aid agreements, contracts, and/or letters of agreement with other agencies to support coordinated activities and with other jurisdictions to share resources, facilities, services, and other potential support required during the management of fatalities. Requests should be determined by the local authority and follow the jurisdictional escalation process (i.e., local to state to federal).

- State and federal resources (to include Disaster Mortuary Operational Response Teams) are requested when anticipated resource needs exceed the local capacity. County/jurisdictional plans should address mass fatality planning and thresholds for requesting additional resources.
- Federal resources should be engaged/notified through the U.S. Department of Health and Human Services (HHS) Regional Emergency Coordinators
- Resources available through mutual aid (e.g., Emergency Management Assistance Compact (EMAC), memoranda of understanding, and/or memoranda of agreement) should be engaged/notified through appropriate channels (EMAC Coordinator, emergency management)

Function 2: Activate public health fatality management operations
Function 3: Assist in the collection and dissemination of antemortem data

Priority Resource Element:

P1: *(Priority)* Written plans should include a procedure for the collection of antemortem data. Consideration should be given to the inclusion of these elements:

- Data collection/dissemination methods
  - □ Call Center or 1-800 number
  - □ Family Reception Center
  - □ Family Assistance Center
- Staff who can perform the following functions:
  - □ Administrative activities
  - □ Interviews of families in order to acquire antemortem data
  - □ System data entry of antemortem data

Function 4: Participate in survivor mental/behavioral health services

Priority Resource Elements:

P1: *(Priority)* Written plans should include processes and protocols developed in conjunction with jurisdictional mental/behavioral health partners to identify services to provide to survivors after an incident involving fatalities. Written plans should include a contact list of pre-identified resources that could provide mental/behavioral health support to responders and families according to the

incident. Consideration should be given to the inclusion of the following elements:

- Mental/behavioral health professionals
- Spiritual care providers
- Hospices
- Translators
- Embassy and Consulate representatives when international victims are involved

P2: *(Priority)* Written plans should include list of staff selected in advance of an incident that could potentially fill the fatality management roles adequate to a given response.

Function 5: Participate in fatality processing and storage operations

Priority Resource Element:

P1: *(Priority)* Written plans should include protocols that ensure that the health department, through healthcare coalitions or other mechanisms, supports the coordination of healthcare organization fatality management plans with the jurisdictional fatality management plan.

Capability 6: Information Sharing

Definition: Information sharing is the ability to conduct multijurisdictional, multidisciplinary exchange of health-related information and situational awareness data among federal, state, local, territorial, and tribal levels of government, and the private sector. This capability includes the routine sharing of information as well as issuing of public health alerts to federal, state, local, territorial, and tribal levels of government and the private sector in preparation for, and in response to, events or incidents of public health significance.

Functions and Associated Performance Measures: This capability consists of the ability to perform the functions listed below. At present there are no CDC-defined performance measures for these functions.

Function 1: Identify stakeholders to be incorporated into information flow

Priority Resource Elements:

P1: *(Priority)* Written plans should include processes to engage stakeholders that may include the following:

- Law enforcement
- Fire
- Emergency Medical Services

- Private healthcare organizations (e.g., hospitals, clinics, large corporate medical provider organizations and urgent care centers)
- Fusion centers
- For states: local health departments, tribes and territories
- Individuals who have or may need a security clearance, based on functional role

P2: *(Priority)* Written plans should include a role-based public health directory that will be used for public health alert messaging. The directory profile of each user includes the following elements:

- Assigned roles
- Multiple device contact information
- Organizational affiliation

Function 2: Identify and develop rules and data elements for sharing

Priority Resource Elements:

P1: *(Priority)* Written plans should include a listing of data-exchange requirements for each stakeholder (including the use of common terminology, definitions, and lexicon by all stakeholders) that adhere to available national standards for data elements to be sent and data elements to be received.

P2: *(Priority)* Written plans should include health information exchange protocols for each stakeholder that identify determinants for exchange and which may include the following elements:

- Unusual cluster(s) or illness that threaten closure of institutional settings (e.g., illness among healthcare workers or prisoners)
- High burden of illness or a cluster of illness confined to a specific population (e.g., racial or ethnic group, or vulnerable populations)
- Illness burden that is expected to overwhelm local medical or public health resources
- A public health laboratory finding of interest (e.g., a novel virus identified by lab) that is not picked up clinically or through other surveillance
- Large numbers of patients with similar and unusual symptoms
- Large number of unexplained deaths
- Higher than expected morbidity and mortality associated with common symptoms and/or failure of patients to respond to traditional therapy
- Simultaneous clusters of similar illness in noncontiguous areas
- Received threats or intelligence
- Incidents in other jurisdictions that raise possible risk in home jurisdiction (e.g., elevation of pandemic influenza alert level)

Function 3: Exchange information to determine a common operating picture

Priority Resource Elements:

P1: *(Priority)* Written plans should include a protocol for the development of public health alert messages that include the following elements:

- Time sensitivity of the information
- Relevance to public health
- Target audience
- Security level or sensitivity
- The need for action may include
    - □ Awareness
    - □ Request a response back
    - □ Request that specific actions be taken

Capability 7: Mass Care

Definition: Mass care is the ability to coordinate with partner agencies to address the public health, medical, and mental/behavioral health needs of those impacted by an incident at a congregate location. This capability includes the coordination of ongoing surveillance and assessment to ensure that health needs continue to be met as the incident evolves.

Functions and Associated Performance Measures: This capability consists of the ability to perform the functions listed below. At present there are no CDC-defined performance measures for these functions.

Function 1: Determine public health role in mass care operations
Function 2: Determine mass care needs of the impacted population

Priority Resource Elements:

P1: *(Priority)* Written plans should include an assessment form to be used in shelter environmental health inspections, including at a minimum the following elements:

- Identification of barriers for disabled individuals
- Structural integrity
- Facility contamination (e.g., radiological, nuclear, or chemical)
- Adequate sanitation (e.g., toilets, showers, and hand washing stations) and waste removal
- Potable water supply
- Adequate ventilation
- Clean and appropriate location for food preparation and storage

P2: *(Priority)* Written plans should include a list of pre-identified site(s) that have undergone an initial assessment to determine their adequacy to serve as congregate locations (based on the size, scope, and nature of potential incidents and jurisdictional risk assessment).

E1: *(Priority)* Have or have access to a tool for health screening of individuals during shelter registration. The following are suggested elements for inclusion:

- Immediate medical needs
- Assistive device needs
- Mental health needs
- Sensory impairment or other disability
- Medication use
- Need for assistance with activities of daily living
- Substance abuse

Function 3: Coordinate public health, medical, and mental/behavioral health services

Priority Resource Elements:

P1: *(Priority)* Written plans should include memoranda of understanding, memoranda of agreement, or letters of agreement with medication providers, including but not limited to the following elements:

- Requesting medication from providers
- Bringing medication to congregate locations
- Storing and distributing medication at congregate locations
- Referring and transporting individuals to pharmacies and other providers for medication

(For additional or supporting detail, see Capability 8: Medical Countermeasure Dispensing, Capability 9: Medical Materiel Management and Distribution, and Capability 10: Medical Surge)

P2: *(Priority)* Written plans should include a scalable congregate location staffing model based on number of individuals, resources available, competing priorities, and time frame in which intervention should occur that is incident-driven and, at a minimum, includes the ability to provide the following elements:

- Medical care services
- Management of mental/behavioral disorders
- Environmental health assessments (e.g., food, water, and sanitation)
- Data collection, monitoring, and analysis
- Infection control practices and procedures

P3: *(Priority)* Written plans should include procedures to coordinate with partner agencies to transfer individuals from general shelters to specialized shelters or medical facilities if needed, including the following procedural elements:

- Patient information transfer (e.g., current condition and medical equipment needs)
- Physical transfer of patient

(For additional or supporting detail, see Capability 10: Medical Surge)

P4: *(Priority) Written* plans should include a process to coordinate with partner

agencies to monitor populations at congregate locations, including but not limited to the following processes:

- Establishing registries for exposed or potentially exposed individuals for long-term health monitoring
- Separate shelter facilities for monitoring individuals at congregate locations
- Identifying, stabilizing and referring individuals who need immediate medical care or decontamination
- Prioritization of at-risk populations at congregate locations that have specific needs after a radiation incident (e.g., children, elderly, and pregnant women)

P5: *(Priority)* Written plans should include a scalable congregate location staffing matrix identifying at least one back-up for each population monitoring and decontamination response role. Skill sets at a minimum should include the following elements:

- The ability to manage population monitoring operation
- The ability to monitor arrivals for external contamination and assess exposure
- The ability to assist with decontamination services
- The ability to assess exposure and internal contamination

Function 4: Monitor mass care population health

Priority Resource Elements:

P1: *(Priority)* Written plans should include a process to conduct ongoing shelter population health surveillance, including the following elements:

- Identification or development of mass care surveillance forms and processes
- Determination of thresholds for when to start surveillance
- Coordination of health surveillance plan with partner agencies' (e.g., Red Cross) activities

(For additional or supporting detail, see Capability 14: Public Health Surveillance and Epidemiological Investigation)

P2: *(Priority)* Written plans should include templates for disaster-surveillance forms, including Active Surveillance and Facility 24-hour Report forms.

Capability 8: Medical Countermeasure Dispensing

Definition: Medical countermeasure dispensing is the ability to provide medical countermeasures (including vaccines, antiviral drugs, antibiotics, antitoxin, etc.) in support of treatment or prophylaxis (oral or vaccination) to the identified population in accordance with public health guidelines and/or recommendations.

Functions and Associated Performance Measures: This capability consists of the ability to perform the functions listed below. Associated CDC-defined performance measures are also listed below.

Function 1: Identify and initiate medical countermeasure dispensing strategies

Priority Resource Elements:

P1: *(Priority)* Written plans should include standard operating procedures that provide guidance to identify the medical countermeasures required for the incident or potential incident. Consideration should be given to the following elements:

- Number and location of people affected by the incident, including a process to collect and analyze medical and social demographic information of the jurisdiction's population to plan for the types of medications, durable medical equipment, or consumable medical supplies that may need to be provided during an incident, including supplies needed for the functional needs of at-risk individuals.
- Agent or cause of the incident
  (For additional or supporting detail, see Capability 12: Public Health Laboratory Testing)
- Severity of the incident
- Potential medical countermeasures
  (For additional or supporting detail, see Capability 13: Public Health Surveillance and Epidemiological Investigation)
- Time line for establishing medical countermeasure dispensing operations
- Personnel and staffing mix

Function 2: Receive medical countermeasures

Priority Resource Elements:

P1: *(Priority)* Written plans should include protocols to request additional medical countermeasures, including memoranda of understanding or other letters of agreement with state/local partners. Consideration should be given to the following elements:

- Assessment of local inventory/medical countermeasure caches
- Identification of local pharmaceutical and medical-supply wholesalers
- Identification of a decision matrix guiding the process of requesting additional medical countermeasures if local supplies are exhausted. Matrix should take into account the Stafford Act and U.S. Department of Health and Human Services Regional Emergency Coordinators.
- If jurisdictions decide to purchase their own medical countermeasures, they are required to meet regulatory standards (abide by U.S. Food and Drug Administration standards including current good manufacturing practices, have appropriate Drug Enforcement Administration registrations, and be responsible to fund and track medical

countermeasures rotation)

Function 3: Activate dispensing modalities

Measure 1: Composite performance indicator from the Division of Strategic National Stockpile in CDC's Office of Public Health Preparedness and Response

Priority Resource Elements:

P1: *(Priority)* Written plans should include written agreements (e.g., memoranda of agreement, memoranda of understanding, mutual aid agreements or other letters of agreement) to share resources, facilities, services, and other potential support required during the medical countermeasure dispensing activities.

P2: *(Priority)* Written plans should include processes and protocols to govern the activation of dispensing modalities.

- Identify multiple dispensing modalities that would be activated depending on the incident characteristics (e.g., identified population and type of agent/exposure). Consideration should be given to the following elements:
  - □ Traditional public health operated (e.g., open points of dispensing)
  - □ Private organizations (e.g., closed points of dispensing)
  - □ Pharmacies
  - □ Provider offices and clinics
  - □ Military/tribal
  - □ Incarcerated population
  - □ Other jurisdictionally approved dispensing modalities
- Initiate notification protocols with the dispensing locations. The following information should be determined for the sites:
  - □ Dispensing site name/identifier
  - □ Demand estimate (number of people planning to visit the site)
  - □ Required throughput
  - □ Staff required to operate one shift
  - □ Number of shifts of distinct staff
  - □ Staff availability
  - □ Total number of staff required to operate the dispensing location through the whole incident
- Plan for functional needs of at-risk individuals (e.g., wheelchair access for handicapped)
- Identify, assess, prioritize, and communicate legal and liability dispensing barriers to those with the authority to address issues. Consideration should be given to the following elements:
  - □ Clinical standards of care
  - □ Licensing
  - □ Civil liability for volunteers
  - □ Liability for private sector participants

□ Property needed for dispensing medication

Function 4: Dispense medical countermeasures to identified population

Measure 1: Composite performance indicator from the Division of Strategic National Stockpile in CDC's Office of Public Health Preparedness and Response

Priority Resource Elements:

P1: *(Priority)* Written plans should include processes and protocols to govern the dispensing of medical countermeasures to the target population.

- Protocol for screening and triaging patients, taking into consideration an assessment of patient characteristics (e.g., age, weight, clinical manifestations, available medical history, and drug or food allergies, assessment of radiation exposure duration and time since exposure, presence of radioactive contamination on the body or clothing, intake of radioactive materials into the body, identification of the radioactive isotope, removal of external or internal contamination) to determine the medical countermeasure to dispense
- Ensure that the permanent medical record (or log/file) of the recipient indicates the following information as deemed necessary:
  - □ The date the medical countermeasure was dispensed
  - □ Information on the medical countermeasure including, but not limited to, product name, national drug control number, and lot number
  - □ The name and address of the person dispensing the medical countermeasure. Federal dispensing law requires: name/address of dispenser, prescription number, date of prescription, name of prescriber, name of patient (if stated on prescription), directions for use, and cautionary statements.
  - □ The edition date of the information statement (e.g., pre-printed drug information sheets) distributed
- Ensure medical countermeasure recipient receives the information sheet matching the medical countermeasure dispensed
- Data recording protocols to report the data at an aggregate level to state/federal entities. Considerations should be given to population demographics (e.g., sex, age group, and if an at-risk individual) and dispensing information (e.g., medical countermeasure name, location, and date)

Function 5: Report adverse events

Priority Resource Elements:

P1: *(Priority)* Written plans should include processes and protocols to govern

reporting of adverse events. The following items should be considered in the plans:

- Guidance and communications messages/campaign that articulates the importance of adverse reporting regardless of suspected cause
- Process to ensure individuals receive the information sheet about potential adverse events of the medical countermeasure dispensed and how to report adverse events
- Triage protocols when receiving notifications of adverse events
- Protocols when receiving notifications of adverse events. Information required to document adverse events includes the following:
    - □ Patient, provider, and reporter demographics
    - □ Adverse event
    - □ Relevant diagnostic tests/laboratory data
    - □ Recovery status
    - □ Vaccine(s)/pharmaceutical(s) received, including receipt location, date, vaccine/pharmaceutical type, lot number, and dose number
- Utilize existing federal and jurisdictional adverse event reporting system, processes and protocols

S1: *(Priority)* Public Health staff should be trained on federal as well as their jurisdiction's adverse event reporting system, processes and protocols.

Capability 9: Medical Materiel Management and Distribution

Definition: Medical materiel management and distribution is the ability to acquire, maintain (e.g., cold chain storage or other storage protocol), transport, distribute, and track medical materiel (e.g., pharmaceuticals, gloves, masks, and ventilators) during an incident and to recover and account for unused medical materiel, as necessary, after an incident.

Functions and Associated Performance Measures: This capability consists of the ability to perform the functions listed below. Associated CDC-defined performance measures are also listed below.

Function 1: Direct and activate medical materiel management and distribution

Measure 1: Composite performance indicator from the Division of Strategic National Stockpile in CDC's Office of Public Health Preparedness and Response

Priority Resource Elements:

P1: *(Priority)* Written plans should include documentation of primary and backup receiving sites that take into consideration federal Strategic National Stockpile recommendations. Written plans should include the following elements:

- Type of site (commercial vs. government)

- Physical location of site
- 24-hour contact number
- Hours of operation
- Inventory of material-handling equipment on-site and list of minimum materials that need to be procured and/or delivered at the time of the incident
- Inventory of office equipment on-site and list of minimum materials that need to be procured and/or delivered at the time of the incident
- Inventory of storage equipment (e.g., refrigerators and freezers) on-site and list of minimum materials/supplies that need to be procured and/or delivered at the time of the incident

P2: *(Priority)* Written plans should include transportation strategy. If public health will be transporting material using their own vehicles, plan should include processes for cold chain management, if necessary to the incident. If public health will be using outside vendors for transportation, there should be a written process for initiating transportation agreements (e.g., contracts, memoranda of understanding, formal written agreements, and/or other letters of agreement). Transportation agreements should include, at a minimum, the following elements:

- Type of vendor (commercial vs. government)
- Number and type of vehicles, including vehicle load capacity and configuration
- Number and type of drivers, including certification of drivers
- Number and type of support personnel
- Vendor's response time
- Vendor's ability to maintain cold chain, if necessary to the incident

In addition to this process, public health should have written evidence of a relationship with outside transportation vendors. This relationship may be demonstrated by a signed transportation agreement or documentation of transportation planning meeting with the designated vendor.

P3: *(Priority)* Written plans should include protocols for medical and health-related agencies and organizations to report medical materiel levels to public health at least weekly, but potentially more frequently. (*For additional or supporting detail, see Capability 6: Information Sharing)*

Function 2: Acquire medical materiel

Measure 1: Composite performance indicator from the Division of Strategic National Stockpile in CDC's Office of Public Health Preparedness and Response

Priority Resource Elements:

P1: *(Priority)* Written plans should include a process to request medical materiel (initial request and re-supply requests), including memoranda of understanding

and mutual aid agreements with state/local partners if applicable. These plans should consider the following elements:

- Assessment of local inventory/medical countermeasure caches
- Identification of local pharmaceutical and medical-supply wholesalers
- Assessment of asset request trigger indicators, thresholds, and validation strategies to guide decision-making
- A process for requesting medical countermeasures through the Emergency Management Assistance Compact
- A process for requesting medical countermeasures from the federal level, which takes into account
  - Stafford Act vs. non-Stafford Act declarations
  - National Emergencies Act
  - Coordination between federal and state resources, including memoranda of understanding between CDC and the state
  - Role of U.S. Department of Health and Human Services Regional Emergency Coordinators, if necessary to the incident: http://www.phe.gov/Preparedness/responders/rec/Pages/contacts.aspx
- A process for justifying medical countermeasure requests
- If sites decide to purchase their own medical countermeasures, they are required to meet regulatory standards (i.e., abide by U.S. Food and Drug Administration standards including current good manufacturing practices (cGMP), have appropriate Drug Enforcement Administration registrations, and be responsible to fund and track medical countermeasures rotation)

Function 3: Maintain updated inventory management and reporting system

Measure 1: Composite performance indicator from the Division of Strategic National Stockpile in CDC's Office of Public Health Preparedness and Response

Priority Resource Elements:

P1: *(Priority)* Written plans should include protocols for reporting to jurisdictional, state, regional, and federal authorities. At a minimum, report should include the following elements:

- Amount of materiel received (including receipt date/time and name of individual who accepted custody of materiel)
- Amount of materiel distributed
- Amount of materiel expired
- Current available balance of materiel

(For additional or supporting detail, see Capability 6: Information Sharing)

Function 4: Establish and maintain security

Measure 1: Composite performance indicator from the Division of Strategic National Stockpile in CDC's Office of Public Health Preparedness and Response

Priority Resource Elements:

P1: *(Priority)* Written plans should include processes and protocols that address the maintenance of physical security of medical countermeasures throughout acquisition, storage, and distribution, and include, at a minimum, the following elements:

- Contact information for security coordinator
- Coordination with law enforcement and security agencies to secure personnel and facility
- Acquisition of physical security measures (e.g., cages, locks, and alarms) for materiel within the receiving site
- Maintenance of security of medical materiel in transit

Function 5: Distribute medical materiel

Measure 1: Composite performance indicator from the Division of Strategic National Stockpile in CDC's Office of Public Health Preparedness and Response

Priority Resource Elements:

P1: *(Priority)* Written plans should include an allocation and distribution strategy including delivery locations, routes, and delivery schedule/frequency, and should take into consideration the transport of materials through restricted areas. The strategy should also consider whether recipients will be responsible for acquiring materiel from an intermediary distribution site or if the health department is responsible for delivering materiel.

Function 6: Recover medical materiel and demobilize distribution operations

Measure 1: Composite performance indicator from the Division of Strategic National Stockpile in CDC's Office of Public Health Preparedness and Response

Priority Resource Elements:

P1: *(Priority)* Written plans should include protocols for the storage, distribution, disposal, or return of unused (unopened) medical materiel, unused pharmaceuticals, and durable items, including plans for maintaining integrity of medical materiel during storage and/or distribution within the jurisdictional health system.

Capability 10: Medical Surge

Definition: Medical surge is the ability to provide adequate medical evaluation and care during events that exceed the limits of the normal medical infrastructure of an affected community. It encompasses the ability of the healthcare system to survive a hazard impact and maintain or rapidly recover operations that were compromised.

Functions and Associated Performance Measures: This capability consists of the ability to perform the functions listed below. At present there are no CDC-defined performance measures for these functions.

Function 1: Assess the nature and scope of the incident

Priority Resource Elements:

P1: *(Priority)* Written plans should include documentation of staff assigned and trained in advance to fill public health incident management roles as applicable to a given response. Health departments must be prepared to staff emergency operations centers at agency, local, and state levels as necessary. *(For additional or supporting detail, see Capability 3: Emergency Operations Coordination)*

P2: *(Priority)* Written plans should include documentation that all joint (e.g., healthcare organizations, public health, and emergency management) emergency incidents, exercises, and preplanned (i.e., recurring or special) events operate in accordance with Incident Command Structure organizational structures, doctrine, and procedures, as defined in the National Incident Management System. *(For additional or supporting detail, see Capability 3: Emergency Operations Coordination)*

P3: *(Priority)* Written plans should include process to ensure access into the jurisdiction's bed-tracking system to maintain visibility of bed availability across the jurisdiction.

P4: *(Priority)* Written plans should include processes to engage in healthcare coalitions and understand the role that each coalition partner will play to obtain and provide situational awareness. Coalitions are not expected to replace or relieve healthcare systems of their institutional responsibilities during an emergency, or to subvert the authority and responsibility of the state or local jurisdiction. The purpose of jurisdictional healthcare coalitions is as follows:

- Integrate plan and activities of all participating healthcare systems into the jurisdictional response plan and the state response plan
- Increase medical response capabilities in the community, region and state
    - Prepare for the needs of at-risk individuals and the general population in their communities in the event of a public health emergency
    - Coordinate activities to minimize duplication of effort and ensure coordination among federal, state, local and tribal planning,

preparedness, response, and de-escalation activities
- □ Maintain continuity of operations in the community vertically with the local jurisdictional emergency management organizations
- □ Unify the management capability of the healthcare system to a level that will be necessary if the normal day-to-day operations and standard operating procedures of the health system are overwhelmed, and disaster operations become necessary
- □ Support sufficient jurisdiction-wide situational awareness to ensure that the maximum number of people requiring care receive safe and appropriate care, which may involve, but is not limited to, facilitating the triage and/or distribution of people requiring care to appropriate facilities throughout the jurisdiction and providing appropriate support to these facilities to support the provision of optimal and safe care to those individuals

P5: *(Priority)* Written plans should include processes (e.g., MOUs or other written agreements) to work in conjunction with emergency management, healthcare organizations, coalitions, and other partners to develop written strategies that clearly define the processes and indicators as to when the jurisdiction's healthcare organizations and health care coalitions transition into and out of conventional, contingency, and crisis standards of care. Jurisdiction should utilize the risk assessment to build jurisdiction-specific strategies and triggers. *(For additional or supporting detail, see Capability 1: Community Preparedness)*

Function 2: Support activation of medical surge

Priority Resource Elements:

P1: *(Priority)* Written plans should include the following elements:

- Documentation of process or protocol for how the health agency will access volunteer resources through the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) and the Medical Reserve Corps program of credentialed personnel available for assistance during an incident.
- Documentation of processes for coordinating with health professional volunteer entities (e.g., MRC) and other personnel resources from various levels. (ESAR-VHP Compliance Requirements)

(For additional or supporting detail, see Capability 15: Volunteer Management)

P2: *(Priority)* Written plans should include documentation of the process for how the public health agency will engage in healthcare coalitions and other response partners regarding the activation of alternate care systems. Documentation should also include the following elements:

- Written list of healthcare organizations with alternate care system plans

- Written list of home health networks and types of resources available that are able to assist in incident response
- List of pre-identified site(s) that have undergone an initial assessment to determine their adequacy to serve as an alternate care facility

(For additional or supporting detail, see Capability 7: Mass Care)

P3: *(Priority)* Written plans should include processes and protocols to identify essential situational awareness information for federal, state, local, and non-governmental agencies; private sector agencies; and other Emergency Support Function # 8 partners. Jurisdictional processes to identify essential situational awareness requirements should consider the following elements:

- Identifying essential information
- Defining required information
- Establishing requirements
- Determining common operational picture elements
- Identifying data owners
- Validating data with stakeholders

(For additional or supporting detail, see Capability 6: Information Sharing)

P4: *(Priority)* Written plans should include documentation of participation from jurisdictional and regional pediatric providers and leaders from a variety of settings (e.g., maternal and child health programs, clinic-based, hospital-based, home healthcare, and rehabilitation) in jurisdictional response planning. Plans should include but are not limited to the following elements:

- Process to identify gaps in the provision of pediatric care
- Process to access pediatric providers or pediatric medical liaisons for consultation related to clinical care. In order to access the appropriate level of care or consultation, plans should include lists of healthcare organizations that can stabilize and/or manage pediatric traumatic and medical emergencies and that have written inter-facility transfer agreements that cover pediatric patients.

Function 3: Support jurisdictional medical surge operations

Priority Resource Elements:

P1: *(Priority)* Written plans should include processes and protocols to communicate situational awareness information to federal, state, local, and non-governmental agencies; private sector agencies; and other Emergency Support Function #8 partners at least weekly, but potentially more frequently (e.g., as often as once per operational period). *(For additional or supporting detail, see Capability 6: Information Sharing)*

P2: *(Priority)* Written plans should include documentation that public health participates in the development and execution of healthcare coalition plans to address the functional needs of at-risk individuals. Plans should include a written list of healthcare organizations and community providers that are able to address the functional needs for at-risk individuals and a process to communicate with healthcare organizations and community providers to maintain a current list of available services that support the functional needs of at-risk individuals. *(For additional or supporting detail, see Capability 1: Community Preparedness)*

P3: *(Priority)* Written plans should include processes to support or implement family reunification. Considerations should include the following elements:

- Capturing and transferring the following known identification information throughout the transport continuum:
  - □ Pickup location (e.g., cross streets, latitude & longitude, and/or facility/school)
  - □ Gender and name (if possible)
  - □ For nonverbal or critically ill children, collect descriptive identifying information about the physical characteristics or other identifiers of the child.
  - □ Keep the primary caregiver (e.g., parents, guardians, and foster parents) with the patient to the extent possible

Function 4: Support demobilization of medical surge operations

Priority Resource Elements:

P1: *(Priority)* Written plans should include a process for the jurisdiction to coordinate with state emergency medical services to demobilize transportation assets used in the incident.

P2: *(Priority)* Written plans should include a process to demobilize surge staff to include other state (e.g., MRC) and federal medical resources (e.g., NDMS). Process should include identification of triggers that would identify the need for demobilization. *(For additional or supporting detail, see Capability 15: Volunteer Management)*

Capability 11: Non-Pharmaceutical Interventions

Definition: Non-pharmaceutical interventions are the ability to recommend to the applicable lead agency (if not public health) and implement, if applicable, strategies for disease, injury, and exposure control. Strategies include the following:

- Isolation and quarantine
- Restrictions on movement and travel advisory/warnings
- Social distancing
- External decontamination

- Hygiene
- Precautionary protective behaviors

Functions and Associated Performance Measures: This capability consists of the ability to perform the functions listed below. At present there are no CDC-defined performance measures for these functions.

Function 1: Engage partners and identify factors that impact non-pharmaceutical interventions

Priority Resource Elements:

P1: *(Priority)* Written plans should include documentation of the applicable jurisdictional, legal, and regulatory authorities and policies for recommending and implementing non-pharmaceutical interventions in both routine and incident-specific situations. This includes but is not limited to authorities for restricting the following elements:

- Individuals
- Groups
- Facilities
- Animals (e.g., animals with infectious diseases and animals with exposure to environmental, chemical, radiological hazards)
- Consumer food products
- Public works/utilities (e.g., water supply)
- Travel through ports of entry

Public health departments are strongly encouraged to consult with jurisdictional legal counsel or academic centers for assistance. If applicable by jurisdictional authority, develop written memoranda of understanding or other letters of agreement with law enforcement for enforcing mandatory restrictions on movement.

P2: *(Priority)* Written plans should include documentation of the following elements:

- Contact information of at least two representatives from each partner agency/organization
  - Suggested community partners: schools, community organizations (e.g., churches and homeless shelters), businesses, hospitals, and travel/transportation industry planners
- Memoranda of understanding or other written acknowledgements/agreements with community partners outlining roles, responsibilities, and resources in non-pharmaceutical interventions
- Agreements with healthcare providers which must include at a minimum:
  - Procedures to communicate case definitions determined by epidemiological surveillance
  - Procedures for reporting identified cases of inclusion to the health department

(For additional or supporting detail, see Capability 13: Public Health Surveillance and Epidemiological Investigation)

- Suggested partners: Conference of Radiation Control Program Directors: http://www.crcpd.org/Map/RCPmap.html, other radiation subject matter experts, health physicists, state environmental protection agency, U.S. Department of Energy, and U.S. Department of Agriculture

Function 2: Determine non-pharmaceutical interventions

Priority Resource Elements:

P1: *(Priority)* Written plans should include a jurisdictional non-pharmaceutical intervention "playbook" detailing plans for intervention recommendation and/or implementation, based on potential interventions identified from the jurisdictional risk assessment. Suggested categories of interventions include isolation, quarantine, school and child care closures, workplace and community organization/event closure, and restrictions on movement (e.g., port of entry screenings and public transportation). Each plan should address the following items, at a minimum:

- Staff and subject matter expert roles and responsibilities
- Legal and public health authorities for the intervention actions
- Intervention actions
- List of identified locations that have the specific equipment required for, or locations that are easily adaptable for the intervention
- Contact information/notification plan of community partners involved in intervention (e.g., those providing services or equipment)
- Identification of any issues that may be associated with the implementation of individual community-mitigation measures or the net effect of the implementation of measures (secondary effects)
- Intervention-specific methods for information dissemination to the public (e.g. information cards to be distributed at ports of entry during movement restrictions)
- Processes for de-escalation of intervention once it is no longer needed
- Documentation of the intervention during an incident

(For additional or supporting detail, see Capability 1: Community Preparedness and Capability 4: Emergency Public Information and Warning)

Function 3: Implement non-pharmaceutical interventions

Priority Resource Elements:

P1: (*Priority)* Written plans should include agreements with healthcare coalitions and other community partners to coordinate support services to individuals during isolation or quarantine scenarios. *(For additional or supporting detail, see Capability 10: Medical Surge)*

P2: *(Priority)* Written plans should include procedures to support the separation of cohorts of potentially exposed travelers from the general population at ports of entry. Plans should include but are not limited to the following elements:

- Identification of resources (e.g., staff, facilities, and equipment) at or near ports of entry to be used for separation of cohorts
- Scalable plans to accommodate cohorts of various sizes in identified facilities
- Local and state Communicable Disease Response Plan compatible with CDC's Division of Global Migration and Quarantine guidance
- Applicable state/local legal authorities for detention, quarantine, and conditional release of potentially exposed persons and isolation of ill persons
- Processes for transportation of cohorts to, and security at, pre-identified sites

Function 4: Monitor non-pharmaceutical interventions

Capability 12: Public Health Laboratory Testing

Definition: Public health laboratory testing is the ability to conduct rapid and conventional detection, characterization, confirmatory testing, data reporting, investigative support, and laboratory networking to address actual or potential exposure to all-hazards. Hazards include chemical, radiological, and biological agents in multiple matrices that may include clinical samples, food, and environmental samples (e.g., water, air, and soil). This capability supports routine surveillance, including pre-event or pre-incident and post-exposure activities.

Functions and Associated Performance Measures: This capability consists of the ability to perform the functions listed below. Associated CDC-defined performance measures are also listed below.

Function 1: Manage laboratory activities

Measure 1: Time for sentinel clinical laboratories to acknowledge receipt of an urgent message from the CDC Public Health Emergency Preparedness (PHEP)-funded Laboratory Response Network biological (LRN-B) laboratory

Measure 2: Time for initial laboratorian to report for duty at the CDC PHEP-funded laboratory

Priority Resource Elements:

P1: *(Priority)* Written plans must include at a minimum the identification of laboratories and laboratory networks within the jurisdiction as well as procedures for interaction with the following laboratories and groups:

- LRN-B reference laboratories within the jurisdiction

- □ Support and ensure LRN-B reference laboratory communication with all LRN-B sentinel and all other LRN-B reference laboratories within the jurisdiction
- CDC's LRN chemical (LRN-C) laboratories within the jurisdiction
- CDC's LRN radiological (LRN-R) laboratories within the jurisdiction (if program funds become available)
- Other state laboratories within the jurisdiction
  - □ e.g., non-LRN public health, environmental, agricultural, veterinary, and university laboratories
- Federal laboratory networks and member laboratories within the jurisdiction
  - □ e.g., the Food Emergency Response Network, National Animal Health Laboratory Network, and the Environmental Response Laboratory Network
- Poison control centers for chemical or radiological exposure incidents, such as food poisoning

P2: *(Priority)* Written plans must include the following elements:

- Documented procedures for contacting sentinel laboratories in the event of a public health incident
- Coordination of jurisdiction-wide stakeholders involved in chemical, biological, radiological, nuclear, and explosive response and their standard response guidelines
  - □ e.g., American Society for Testing and Material, Operational Guidelines for Initial Response to a Suspected BioThreat Agent

Function 2: Perform sample management

Measure 1: Percentage of Laboratory Response Network (LRN) clinical specimens without any adverse quality assurance events received at the CDC PHEP-funded LRN-B laboratory for confirmation or rule-out testing from sentinel clinical laboratories

Measure 2: Percentage of LRN non-clinical samples without any adverse quality assurance events received at the CDC PHEP-funded LRN-B laboratory for confirmation or rule-out testing from first responders

Measure 3: Ability of the CDC PHEP-funded Laboratory Response Network chemical (LRN-C) laboratories to collect relevant samples for clinical chemical analysis, package, and ship those samples

Priority Resource Elements:

S1: *(Priority)* Laboratory staff responsible for sample management must maintain certification of laboratory personnel in a shipping and packaging program that meets national and state requirements (e.g., Sample Collection, Packing and Shipping; ShipPack).

Function 3: Conduct testing and analysis for routine and surge capacity

Measure 1: Proportion of LRN-C proficiency tests (core methods) successfully passed by CDC PHEP-funded laboratories

Measure 2: Proportion of LRN-C proficiency tests (additional methods) successfully passed by CDC PHEP-funded laboratories

Measure 3: Proportion of LRN-B proficiency tests successfully passed by CDC PHEP-funded laboratories

Priority Resource Elements:

P1: *(Priority)* Written plans should include the following considerations for surge capacity:

- Options to optimize procedures based on regular and surge personnel, equipment, and facility resources for short-term (e.g., days) and long-term (e.g., weeks to months) response efforts. Options should also be based on best practices and models available on the LRN website or other sources.
- Triage policies that address how the laboratory will manage surge testing, that may include:
  - □ Referral of samples to other jurisdictional laboratories
  - □ Prioritization of testing based upon sample type
  - □ Prioritization of testing based upon risk or threat assessment
  - □ Contingencies to assure newborn screening in a surge situation. Newborn screening can be assured by memoranda of agreement or contracts with commercial vendors
- Ensuring that laboratory testing and reporting can be performed for extended shifts based on need for Level 1 and Level 2 LRN-C laboratories. *(Not applicable for territories)*
- Ensuring that laboratory testing, quality assurance and control review, and reporting can be performed for extended shifts based on need for LRN-R laboratories, if program funds become available

P2: *(Priority)* Written plans should include preventative maintenance contracts and service agreements in place for equipment and instruments utilized in LRN protocols, procedures, and methods – at a minimum. Plans should also include protocols to ensure that equipment and instruments utilized in LRN protocols, procedures, and methods have been inspected and/or certified according to manufacturer's specifications.

S1: *(Priority)* Laboratories participating in radiological or nuclear testing must attain LRN-R (if program funds become available) Proficiency Testing Program Qualified status for all analysis methods transferred by LRN-R through the following:

- Attending LRN–R training, if program funds become available
- Completing the associated laboratory validation exercise, demonstrating performance and precision according to the minimum standards for each

analytical method

S2: *(Priority)* LRN-B reference laboratories must attain competency for LRN-B testing methods by having the ability to test for all agents/sample types/tests listed in the high risk environmental sample testing algorithm posted on the secure LRN website.

S3: *(Priority)* All LRN Laboratories (excluding LRN-B sentinel laboratories) must maintain the competency to pass LRN proficiency tests.

S4: *(Priority)* Laboratories participating in chemical testing must attain LRN-C Proficiency Testing Program Qualified status, through the ability to perform the following:

- Core LRN-C methods testing, for all Level 1 (surge capacity laboratories only) and Level 2 analysis methods transferred by CDC. Core LRN-C methods are identified on the LRN website and updated at least annually.
- Validation and qualification of at least one new analysis method per year is required.

Function 4: Support public health investigations

Measure 1: Time to complete notification between CDC, on-call laboratorian, and on-call epidemiologist

Measure 2: Time to complete notification between CDC, on-call epidemiologist, and on-call laboratorian

Function 5: Report results

Measure 1: Percentage of pulsed field gel electrophoresis (PFGE) subtyping data results for *E. coli* O157:H7 submitted to the PulseNet national database within four working days of receiving isolate at the PFGE laboratory

Measure 2: Percentage of PFGE subtyping data results for *Listeria monocytogenes* submitted to the PulseNet national database within four working days of receiving isolate at the PFGE laboratory

Measure 3: Time to submit PFGE subtyping data results for *Salmonella* to the PulseNet national database upon receipt of isolate at the PFGE laboratory

Measure 4: Time for CDC PHEP-funded laboratory to notify public health partners of significant laboratory results

Priority Resource Elements:

E1: *(Priority)* Each LRN laboratory will build or acquire and configure a jurisdictional Laboratory Information Management System (LIMS) with the ability to send testing data to CDC according to CDC-defined standards. (This will reduce the duplicate entry into multiple data exchange systems, i.e., having to put data into results messenger or other data exchange systems to be able to send to CDC, public health partners, and other submitters). Configuring the LIMS includes the following

elements:

- Developing project plans with deliverables and a timeline to achieve ability to send and receive data from local Laboratory Information Management Solution (LIMS) to CDC and other partners
- Mapping local codes to federal standards (e.g., LRN-B Test Configuration and Vocabulary Requirements, LRN-B Laboratory Results Message Guide)
- Working with IT support staff or developing contractual agreements with LIMS vendors that are familiar with federal (e.g., LIMS integration, Public Health Laboratory Interoperability Project) and industry (e.g., logical observation identities, names, and codes; systematized nomenclature of medicine; HL 7) standards to configure the LIMS
- Validating function of LIMS and structure of message by being able to send a test message to CDC
- Ensuring health information infrastructure and surveillance systems are able to accept, process, and analyze standards-based electronic messages from sending electronic health records (EHRs) as defined by Centers for Medicare & Medicaid Services (42 Code of Federal Regulations Parts 412, 413, 422 et al.) Medicare and Medicaid Programs; Electronic Health Record Incentive Program; Final Rule (published on July 28, 2010 in the Federal Register at http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf) and the Office of the National Coordinator for Health Information Technology (45 Code of Federal Regulations Part 170) Health Information Technology: Initial Set of Standards, Implementation Specifications, and Certification Criteria for Electronic Health Record Technology; Final Rule (published on July 28, 2010 in the Federal Register at http://edocket.access.gpo.gov/2010/pdf/2010-17210.pdf and http://healthit.hhs.gov/portal/server.pt/community/onc_regulations_faqs/3163/faq_3/20765)

Capability 13: Public Health Surveillance and Epidemiological Investigation

Definition: Public health surveillance and epidemiological investigation is the ability to create, maintain, support, and strengthen routine surveillance and detection systems and epidemiological investigation processes, as well as to expand these systems and processes in response to incidents of public health significance.

Functions and Associated Performance Measures: This capability consists of the ability to perform the functions listed below. Associated CDC-defined performance measures are also listed below.

Function 1: Conduct public health surveillance and detection

Measure 1: Proportion of reports of selected reportable diseases received by a public health agency within the jurisdiction-required time frame

Priority Resource Elements:

P1: *(Priority)* Written plans should document the legal and procedural framework that supports mandated and voluntary information exchange with a wide variety of community partners, including those serving communities of color and tribes.

P2: *(Priority)* Written plans should include processes and protocols for accessing health information that follow jurisdictional and federal laws and that protect personal health information via instituting security and confidentiality policies. *(For additional or supporting detail, see Capability 6: Information Sharing)*

P3: *(Priority)* Written plans should include processes and protocols to gather and analyze data from the following:

- Reportable condition surveillance (i.e., conditions for which jurisdictional law mandates name-based case reporting to public health agencies). Jurisdictions should plan to receive Electronic Laboratory Reporting for reportable conditions from healthcare providers using national Meaningful Use standards. *(For additional or supporting detail, see Capability 6: Information Sharing)*
- Syndromic surveillance systems. Jurisdictions are encouraged to establish or participate in such systems to monitor trends of illness or injury, and to provide situational awareness of healthcare utilization
    - Participation in the CDC BioSense data-sharing program is encouraged *(For additional or supporting detail, see Capability 6: Information Sharing)*
- Surveillance of major causes of mortality, including the use of vital statistics as a data source *(For additional or supporting detail, see Capability 5: Fatality Management)*
- Surveillance of major causes of morbidity
- Written plans should be able to adapt to include novel and/or emerging public health threats.

Gathering and analyzing data from the following sources should also be taken into consideration:

- Environmental conditions
- Hospital discharge abstracts
- Information from mental/behavioral health agencies
- Population-based surveys
- Disease registries
- Immunization registries/Immunization information systems
- Active case finding (e.g., by healthcare logs and record reviews)

(For additional or supporting detail, see Capability 1: Community Preparedness, Capability 6: Information Sharing, and Capability 10: Medical Surge)

P4: *(Priority)* Written plans should include procedures to ensure 24/7 health department access (e.g., designated phone line or contact person in place to receive reports) to collect, review, and respond to reports of potential health

threats. *(For additional or supporting detail, see Capability 3: Emergency Operations Coordination)*

P5: *(Priority)* Written plans should include processes and protocols to notify CDC of cases on the Nationally Notifiable Infectious Disease List within the time frame identified on the list, including immediate notification when indicated. Electronic exchange of personal health information should meet applicable patient privacy-related laws and standards, including state or territorial laws. These include the Health Insurance Portability and Accountability Act, the Health Information Technology for Economic and Clinical Health Act, and standards from the National Institute of Standards and Technology and the Office of the National Coordinator for Health Information Technology of the U.S. Department of Health and Human Services. Plans should include procedures to move to electronic case notification using CDC's Public Health Information Network Case Notification Message Mapping Guides.

S1: *(Priority)* Public health staff conducting data collection, analysis, and reporting in support of surveillance and epidemiologic investigations should achieve, at a minimum, the Tier 1 Competencies and Skills for Applied Epidemiologists in Governmental Public Health Agencies.

- When creating new surveillance systems, consideration should be given to securing assistance (e.g., from academic institutions or state-level staff) from individuals with Tier 2 Competencies and Skills for Applied Epidemiologists in Governmental Public Health Agencies.
- Note: Formal educational degree requirement and masters' degree supervision requirement is suggested but not required.

E1: *(Priority)* Have or have access to health information infrastructure and surveillance systems that are able to accept, process, analyze, and share data for surveillance and epidemiological investigation activities. *(For additional or supporting detail, see Capability 6: Information Sharing)*

- Electronic exchange of personal health information should meet applicable patient privacy-related laws and standards, including state or territorial laws. These include the Health Insurance Portability and Accountability Act, the Health Information Technology for Economic and Clinical Health Act, and standards from the National Institute of Standards and Technology and the Office of the National Coordinator for Health Information Technology of the U.S. Department of Health and Human Services. *(For additional or supporting detail, see Capability 6: Information Sharing)*

Function 2: Conduct public health and epidemiological investigations

Measure 1: Percentage of infectious disease outbreak investigations that generate reports

Measure 2: Percentage of infectious disease outbreak investigation reports that contain all minimal elements
Measure 3: Percentage of acute environmental exposure investigations that generate reports
Measure 4: Percentage of acute environmental exposure reports that contain all minimal elements

Priority Resource Elements:

P1: *(Priority)* Written plans should include investigation report templates that contain the following minimal elements:

- Context / Background – Information that helps to characterize the incident, including the following:
  - □ Population affected (e.g., estimated number of persons exposed and number of persons ill)
  - □ Location (e.g., setting or venue)
  - □ Geographical area(s) involved
  - □ Suspected or known etiology
- Initiation of Investigation – Information regarding receipt of notification and initiation of the investigation, including the following:
  - □ Date and time initial notification was received by the agency
  - □ Date and time investigation was initiated by the agency
- Investigation Methods - Epidemiological or other investigative methods employed, including the following:
  - □ Any initial investigative activity (e.g., verified laboratory results)
  - □ Data collection and analysis methods (e.g., case-finding, cohort/case-control studies, environmental)
  - □ Tools that were relevant to the investigation (e.g., epidemic curves, attack rate tables, and questionnaires)
  - □ Case definitions (as applicable)
  - □ Exposure assessments and classification
  - □ Review of reports developed by first responders, lab testing of environmental media, reviews of environmental testing records, industrial hygiene assessments, questionnaires
- Investigation Findings/Results - all pertinent investigation results, including the following:
  - □ Epidemiological results
  - □ Laboratory results (as applicable)
  - □ Clinical results (as applicable)
  - □ Other analytic findings (as applicable)
- Discussion and/or Conclusions – analysis and interpretation of the investigation results, and/or any conclusions drawn as a result of performing the investigation. In certain instances, a Conclusions section without a Discussion section may be sufficient
- Recommendations for Controlling Disease and/or Preventing/Mitigating Exposure – specific control measures or other interventions recommended

for controlling the spread of disease or preventing future outbreaks and/or for preventing/mitigating the effects of an acute environmental exposure
- Key investigators and/or report authors – names and titles are critical to ensure that lines of communication with partners, clinicians, and other stakeholders can be established.

S1: *(Priority)* Maintain staffing capacity to manage the routine epidemiological investigation systems at the jurisdictional level as well as to support surge epidemiological investigations in response to natural or intentional threats or incidents. This is accomplished through the following:
- Surge staff should be competent in Tier 1 Competencies and Skills for Applied Epidemiologists in Governmental Public Health Agencies
- Consideration should be given to securing assistance (e.g., academic institutions or state-level staff) from an individual with Tier 2 Competencies and Skills for Applied Epidemiologists in Governmental Public Health Agencies
- Note: Formal educational degree requirement and masters' degree supervision requirement is suggested but not required.

(For additional or supporting detail, see Capability 15: Volunteer Management)

Function 3: Recommend, monitor, and analyze mitigation actions

Measure 1: Proportion of reports of selected reportable diseases for which initial public health control measure(s) were initiated within the appropriate time frame

Priority Resource Elements:

P1: *(Priority)* Written plans should include protocols for recommending and initiating, if indicated, containment and mitigation actions in response to public health incidents. Protocols include case and contact definitions, clinical management of potential or actual cases, the provision of medical countermeasures, and the process for exercising legal authority for disease, injury, or exposure control. Protocols should include consultation with the state or territorial epidemiologist when warranted. *(For additional or supporting detail, see Capability 8: Medical Countermeasure Dispensing and Capability 11: Non-Pharmaceutical Interventions*

S1: *(Priority)* Public health staff participating in epidemiological investigations should receive awareness-level training with the Homeland Security Exercise and Evaluation After Action Report process.

Function 4: Improve public health surveillance and epidemiological investigation systems

Priority Resource Elements:

P1: *(Priority)* Written plans should include procedures to communicate the improvement plan to key stakeholders (including groups representing at-risk populations) and to implement corrective actions identified in the improvement plan.

Capability 14: Responder Safety and Health

Definition: The responder safety and health capability describes the ability to protect public health agency staff responding to an incident and the ability to support the health and safety needs of hospital and medical facility personnel, if requested.

Functions and Associated Performance Measures: This capability consists of the ability to perform the functions listed below. At present there are no CDC-defined performance measures for these functions.

Function 1: Identify responder safety and health risks

Priority Resource Elements:

P1: *(Priority)* Written plans should include documentation of the safety and health risk scenarios likely to be faced by public health responders, based on pre-identified jurisdictional incident risks, which are developed in consultation with partner agencies (e.g., environmental health, occupational health and safety, jurisdictional Local Emergency Planning Committee, risk-specific subject matter experts). This documentation should include the following elements:

- Limits of exposure or injury necessitating response
- Job-specific worker safety guides (e.g., radiation, heat, fire, and infrastructure damage resulting in other chemical release)
- Potential for post-event medical and mental/behavioral health follow-up assessments

P2: *(Priority)* Written plans should include documentation that identifies public health roles and responsibilities related to the jurisdiction's identified risks, that was developed in conjunction with partner agencies (e.g., state environmental health, state occupational health and safety, and hazard-specific subject matter experts) and emergency managers. This documentation should identify the protective equipment, protective actions, or other mechanisms that public health responders will need to have to execute potential roles. Roles for consideration may include the following elements:

- Conducting environmental health assessments
- Potable water inspections
- Field surveillance interviews

Recommend inclusion of the following groups, at a minimum:

- State versions of Environmental Protection Agency

- State Radiation Control Programs: http://www.crcpd.org/Map/RCPmap.htm
- State Occupational Safety and Health Agency

Function 2: Identify safety and personal protective needs

Priority Resource Elements:

P1: *(Priority)* Written plans should include recommendations for risk-related personal protective equipment for public health responders that have been developed in conjunction with partner agencies (e.g., state environmental health, state occupational health and safety, and risk-specific subject matter experts).

E1: *(Priority)* Have or have access to personal protective equipment that is consistent with the identified risks in the jurisdiction and associated job functions of public health response personnel. This equipment should meet nationally recognized standards as defined by the InterAgency Board for Equipment Standardization and Interoperability (https://iab.gov).

Note: If public health departments elect to purchase personal protective equipment for their responders, they must follow state, Occupational Safety and Health Administration, CDC's National Institute for Occupational Safety and Health, and other applicable regulations regarding the storage, dissemination, fit testing, and maintenance of such personal protective equipment.

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

Priority Resource Elements:

S1: *(Priority)* Public health staff required to use N-95 or other respirators as part of their response role should undergo respiratory function testing.

S2: *(Priority)* Public health staff that perform responder functions, as well as staff identified as surge-capacity personnel, should have documentation of training, with documentation updated a minimum of once per year. Documentation should include training date and manner of delivery (e.g., formal training or "train the trainer"). Formal training examples include CDC courses and CD or DVD-based courses, with completion verified by a formal demonstration.

Function 4: Monitor responder safety and health actions

Priority Resource Elements:

P1: *(Priority)* Written plans should include process and protocols for how the public

health agency, in conjunction with lead partners (e.g., occupational health and safety) will participate in surveillance activities to monitor levels of environmental exposure, environmental effects on the responders, and/or incident-related injuries. *(For additional or supporting detail, see Capability 13: Public Health Surveillance and Epidemiological Investigation)*

E1: *(Priority)* Have or have access to a registry database of responders who were exposed and/or injured during an incident. This database should be updated at a frequency appropriate to the incident.

Capability 15: Volunteer Management

Definition: Volunteer management is the ability to coordinate the identification, recruitment, registration, credential verification, training, and engagement of volunteers to support the jurisdictional public health agency's response to incidents of public health significance.

Functions and Associated Performance Measures: This capability consists of the ability to perform the functions listed below. At present there are no CDC-defined performance measures for these functions.

Function 1: Coordinate volunteers

Priority Resource Elements:

P1: *(Priority)* Written plans should address anticipated volunteer needs in response to incidents or situations identified in the jurisdictional risk assessment including the following elements:

- Identification of functional roles
- Skills, knowledge, or abilities needed for each volunteer task or role
- Description of when the volunteer actions will happen
- Identification of jurisdictional authorities that govern volunteer liability issues and scope of practice

P2: *(Priority)* Written plans should include memoranda of understanding or other letters of agreement with jurisdictional volunteer sources. Suggested partners include but are not limited to the following groups:

- Professional medical organizations (e.g., nursing and allied health)
- Professional guilds (e.g., behavioral health)
- Academic institutions
- Faith-based organizations
- Voluntary Organizations Active in Disasters
- Medical Reserve Corps
- Non-profit, private, and community-based volunteer groups

Partnership agreements should include plans for the following:

- Partner organizations' promotion of public health volunteer opportunities

- Referral of all volunteers to register with jurisdictional Medical Reserve Corps and/or ESAR-VHP
- Policies for protection of volunteer information, including destruction of information when it is no longer needed (e.g., Red Cross, Community Emergency Response Teams, and member organizations of the National and State Voluntary Organizations Active in Disasters)
- Liability protection for volunteers
- Efforts to continually engage volunteers through routine community health activities
- Documentation of the volunteers' affiliations (e.g., employers and volunteer organizations) at local, state, and federal levels (to assist in minimizing "double counting" of prospective volunteers), and provision for registered volunteer Identification cards denoting volunteers' area of expertise

Function 2: Notify volunteers
Function 3: Organize, assemble, and dispatch volunteers

Priority Resource Elements:

P1: *(Priority)* Written plans should include a template for briefing volunteers of current incident conditions, including the following elements:

- Instructions on the current status of the emergency
- Volunteers' role (including how the volunteer is to operate within incident management)
- Just-in-time training
- Safety instructions
- Any applicable liability issues related to the incident and the volunteers' roles, psychological first aid, and/or volunteer stress management

P2: *(Priority)* Written plans should include a process to manage spontaneous volunteers. The process should include, at a minimum, the following elements:

- Process to communicate to the public whether spontaneous volunteers should report, and, if so, where and to whom
- Method to inform spontaneous volunteers how to register for use in future emergency responses
- Method to refer spontaneous volunteers to other organization (e.g., non-profit or Medical Reserve Corps)

(For additional or supporting detail, see Capability 4: Emergency Public Information and Warning)

If spontaneous volunteers will be integrated into a response, the process should include the identification of duties spontaneous volunteers can perform.

Function 4: Demobilize volunteers

Priority Resource Elements:

P1: *(Priority)* Written plans should include a process for releasing volunteers, to be used when the public health department has the lead role in volunteer coordination. The process should include steps to accomplish the following:

- Demobilize volunteers in accordance with the incident action plan
- Assure all assigned activities are completed, and/or replacement volunteers are informed of the activities' status
- Determine whether additional volunteer assistance is needed from the volunteer
- Assure all equipment is returned by volunteer
- Confirm the volunteer's follow-up contact information

(For additional or supporting detail, see Capability 4: Emergency Operations Coordination)

P2: *(Priority)* Written plans should include a protocol for conducting exit screening during out-processing, to include documentation of the following:

- Any injuries and illnesses acquired during the response
- Mental/behavioral health needs due to participation in the response
- When requested or indicated, referral of volunteer to medical and mental/behavioral health services

(For additional or supporting detail, see Capability 14: Responder Safety and Health)

Appendix 5
Matching Funds and Maintaining State Funding Guidance

Matching Funds

Background: Section 319C-1(i)(1)(C) of the Public Health Service Act, as amended by the
Pandemic and All-Hazards Preparedness Act (P.L. 109-417)

Beginning in fiscal year 2009, CDC may not award a cooperative agreement under this program
unless the awardee state (or consortium) agrees that with respect to the amount of the cooperative agreement awarded by CDC that the awardee state (or consortium) will make available (directly or through donations from public or private entities) nonfederal contributions
in an amount equal to:

(i) for the first fiscal year of the cooperative agreement, not less than 5% of such sts ($1 for each $20 of federal funds provided in the cooperative agreement and

(ii) for any second fiscal year of the cooperative agreement, and for any sequent fiscal year of such cooperative agreement, not less than 10% of such costs ($1 for each $10 of federal funds provided in the cooperative agreement).

Administrative Requirement

Matching is calculated on the basis of the federal award amount and is comprised of awardee contributions proposed to support anticipated costs of the project during a specific budget period (confirmation of the existence of funds is supplied by the awardee via their financial status report). Awardees must be able to separately account for stewardship of the federal funds and for any required matching; it is subject to monitoring, oversight, and audit. ***Awardee matching expenditures may not be used to count toward any maintaining state funding requirement***.

Source of Funds

- Nonfederal contributions required in subparagraph (C) above may be provided directly or through donations from public or private entities and may be in cash or in kind, fairly evaluated, including plant, equipment or services.
- Amounts provided by the federal government or services assisted or subsidized to any significant extent by the federal government, may not be included in determining the amount of such nonfederal contributions.
- Fully document, in the cooperative agreement application, the specific costs or contributions proposed to meet the matching requirement, the source of funding or contribution, and how the valuation was determined.

For further guidance, see 45 Code of Federal Regulation (CFR), Part 92.24, Matching or cost sharing.

Exceptions to Matching Funds Requirement

- Matching does not apply to the political subdivisions of New York City, Los Angeles County, and Chicago.
- Pursuant to department grants policy implementing 48 U.S.C. 1469a(d), any required matching (including in-kind contributions) of less than $200,000 is waived with respect to cooperative agreements to the governments of American Samoa, Guam, the Virgin Islands, or the Northern Mariana Islands (other than those consolidated under other provisions of 48 U.S.C. 1469). This waiver applies regardless of whether the matching required under the grant equals or exceeds $200,000.

Matching Funds and Unobligated Funds

When awardees request to carry over unobligated funds from prior year(s), matching funds equal to the new requirement must be on record in the CDC cooperative agreement file, or the awardee must provide evidence with the carry-over request.

Maintaining State Funding (MSF)

Background: Section 319C-1(i)(2) Maintaining State Funding

(A) In General. – An entity that receives an award under this section shall maintain expenditures for public health security at a level that is not less than the average level of such expenditures maintained by the entity for the preceding two-year period.

Administrative Requirement

MSF represents an applicant's historical level of contributions related to federal programmatic activities which have been made prior to the receipt of federal funds "expenditures (money spent)." The MSF is used as an indicator of nonfederal support for public health security before the infusion of federal funds. These expenditures are calculated by the awardee without reference to any federal funding that also may have contributed to such programmatic activities in the past. Awardees must stipulate the total dollar amount in their cooperative agreement applications. ***Awardees must be able to account for MSF separate from accounting for federal funds and separate from accounting for any matching funds requirements; this accounting is subject to ongoing monitoring, oversight, and audit. MSF may not include any matching funds requirement.***

Source: PL 109-417 and 45 Code of Federal Regulation, Part 92

Appendix 6
Withholding and Repayment Guidance

Procedural Consideration
This standard operating procedure (SOP) describes procedures CDC will use to implement withholding or repayment actions in connection with the Public Health Emergency Preparedness (PHEP) cooperative agreement program.

Pandemic and All-Hazards Preparedness Act (PAHPA) Requirements for the PHEP Cooperative Agreement
PAHPA requires the withholding of amounts from entities that fail to achieve benchmarks and objective standards or to submit an acceptable pandemic influenza operations plan, beginning with fiscal year 2009 and in each succeeding fiscal year:

A. **Benchmarks and Statewide Pandemic Influenza Operations Plan**

(1) Enforcement Condition: Awardees fail to meet evidence-based benchmarks and objective standards and/or fail to prepare and submit an acceptable pandemic influenza operations plan.

(2) Enforcement Action:

- Withhold funds – Budget Period 1 (FY 2011) is for the purpose of evaluation to determine the amount to be withheld from the year immediately following year of failure. Additionally, each failure is to be treated as a separate failure for the purposes of the penalties described below:

  - Initial failure - withholding in an amount equal to 10% of funding per failure
  - Two consecutive years of failure - withholding in an amount equal to 15% of funding per failure
  - Three consecutive years of failure - withholding in an amount equal to 20% of funding per failure
  - Four consecutive years of failure - withholding in an amount equal to 25% of funding per failure

- Reallocation of amount withheld – according to Section 319C-1(g)(7), any funds withheld from the PHEP or the Hospital Preparedness Program will be reallocated to the Healthcare Facilities Partnership program.

- Preference in reallocation – according to Section 319C-1(g)(7), any funds withheld from the PHEP or the Hospital

Preparedness Program will be reallocated to the Healthcare Facilities Partnership program in the same state.

Please note 319C-1(g)(6)(B) Separate Accounting: Each failure described under A(1) shall be treated as a separate failure for purposes of calculating amounts withheld under A(2). For example, a failure to achieve applicable benchmarks as a whole will count as one failure and a failure to submit a pandemic influenza operations plan will count as a second failure.

B. **Audit Implementation**

(1) Enforcement Condition: Awardees who fail to submit the required audit or spend amounts in noncompliance.

(2) Enforcement Action: Grants management officer disallows costs and requests payment via standard audit disallowance process or temporarily withholds funds pending corrective action.

C. **Carry-over**

(1) Enforcement Condition: For each budget period, the amount of total unobligated funds that exceed the maximum amount permitted to be carried over by the HHS Secretary.

(2) Enforcement Action: Awardees shall return to the HHS Secretary the portion of the amount of their total unobligated amount that exceeds the maximum amount permitted to be carried over unless waived or reduced. According to Section 319C-1(g)(7), any funds withheld from the PHEP or the Hospital Preparedness Program will be reallocated to the Healthcare Facilities Partnership program, preferably in the same state.

WAIVE OR REDUCE: The awardee may request a waiver of the maximum amount of carry-over of unobligated funds or the HHS Secretary may waive or reduce the amount that must be returned for a single entity or for all entities in a fiscal year if the Secretary determines that mitigating conditions exist that justify the waiver or reduction. The Secretary will make a decision after reviewing the awardee's request for waiver.

The Department of Health and Human Services (HHS) permits awardees to appeal to the Departmental Appeal Board (DAB) certain post-award adverse administrative decisions made by HHS officials (see 45 CFR Part 16). CDC has established a first-level grant appeal procedure that must be exhausted before an appeal may be filed with the DAB

(see 42 CFR § 50.402). CDC will assume jurisdiction for any of the above adverse determinations.