DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30341-3724

May 29, 2008

Dear Colleagues:

The Department of Health and Human Services' (HHS) Centers for Disease Control and Prevention (CDC) announces the availability of Budget Period 9 (BP9) funding for continuation of the Public Health Emergency Preparedness (PHEP) Cooperative Agreement. Funds are intended to upgrade state and local public health jurisdictions' preparedness and response to bioterrorism, outbreaks of infectious diseases, and other public health threats and emergencies. This letter solicits your Interim Progress Report, which serves as your noncompeting continuation application for the budget period August 10, 2008, through August 9, 2009. Instructions for Preparing the Interim Progress Report are included as Appendix 1.

**Background**

The Pandemic and All-Hazards Preparedness Act (PAHPA, P.L.109-417) requires that applications for funding include a description of activities each awardee will conduct to meet the following goals:

- Integrating public health and public and private medical capabilities with other first responder systems;
- Developing and sustaining essential state, local, and tribal public health security capabilities, including disease situational awareness, disease containment, risk communication and public preparedness, and the rapid distribution and administration of medical countermeasures;
- Addressing the public health and medical needs of at-risk individuals[1] in the event of a public health emergency;
- Minimizing duplication and assuring coordination among state, local, and tribal planning, preparedness, and response activities (including Emergency Management Assistance Compact). Such planning shall be consistent with the National Response Framework or

[1]Before, during, and after a public health emergency, members of at-risk populations may have additional needs in one or more of the following functional areas: maintaining independence, communication, transportation, supervision, and medical care. In addition to those individuals specifically recognized as at-risk in the statute, i.e., children, senior citizens, and pregnant women, individuals who may need additional response assistance should include those who have disabilities; live in institutionalized settings; are from diverse cultures; have limited English proficiency or are non-English speaking; are transportation disadvantaged; have chronic medical disorders; and have pharmacological dependency.

any successor plan, the National Incident Management System, and the National Preparedness Goal;

- Maintaining vital public health and medical services to allow for optimal federal, state, local, and tribal operations in the event of a public health emergency; and
- Developing and testing an effective plan for responding to pandemic influenza.

Through the combination of responses to the progress report for the current year, Budget Period 8 (BP8), and the descriptions of your ongoing and any new priority projects, you should demonstrate your compliance with these requirements in BP9. Project officer and subject matter expert review of your Interim Progress Report will focus on your capabilities to meet these goals; insufficient responses shall adversely affect future funding. (Appendix 2)

BP9 continuation guidance provides opportunities to update progress in meeting requirements and pursuing priority projects and also to describe new or to refine existing priorities. This approach is designed to capture what awardees are doing to improve public health preparedness so CDC can answer inquiries about preparedness activities and progress and direct technical assistance where it is most needed.

CDC expects no major changes in priority projects for BP9. While awardees are free to make adjustments to or add new priority projects they believe are needed, CDC expects BP9 to represent a period of continued progress on priorities and maintenance of essential public health emergency response and recovery infrastructure.

**Funding**

The funding amounts available for the programs below are shown in Appendix 3.

Base Funding. As described in the original PHEP Program Announcement AA154, the distribution of funds among the awardees is calculated using a formula established by the Secretary of HHS that includes a base amount for each awardee, as well as a population-based calculation.

Cities Readiness Initiative (CRI). All state awardees and the four funded localities receive CRI funding. Appendix 4 shows Fiscal Year (FY) 2008 funding for CRI and projects FY 2009 funding based on new per capita calculations. The funding formula for FY 2009 is based on $0.330912 per capita using the 2006 estimated U.S. Census population data and is intended to provide level funding across the project areas. This is a variation from previous funding distributions in that there is not a baseline funding amount included with the per capita amount.

Early Warning Infectious Disease Surveillance (EWIDS). States situated at the Unites States' borders with Canada or Mexico are eligible for EWIDS funding. Additional guidance for this program is included in Appendix 5.

Level 1 Chemical Laboratory Surge Capacity. Ten awardees receive funding to support Level 1 Chemical Laboratory Surge Capacity personnel, equipment, and/or activities.

BP9 does not include supplemental funding for pandemic influenza activities or funds designated to improve real-time disease detection (RTDD) by fostering or expanding partnerships with poison control centers or related professional associations. Awardees are encouraged, however, to continue established activities in these areas through partnerships, base funding, and other funding sources as available.

Requests to carry forward unobligated pandemic influenza funds originating in Budget Period 7 (BP7) or BP8 into BP9 will be considered, provided funds are used to support pandemic influenza preparedness-related activities.

Requests to carry forward unspent RTDD funds also will be considered; these funds should be used to continue activities approved for RTDD funding in BP8 or to evaluate the results of those activities planned as one-year demonstrations.

Awardees planning to request direct assistance (DA) in lieu of financial assistance must have completed the DA request form and submitted it no later than February 29, 2008. Note that DA funds may be used only to support CDC assignees to your jurisdiction as public health advisors or career epidemiology field officers. No equipment or maintenance agreements will be supported through DA for BP9.

Beginning with Budget Period 10 (BP10), eligibility for PHEP funds requires participation in the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP). Awardees are required to work with their state Hospital Preparedness Program to continue adopting and implementing the *2008 Interim ESAR-VHP Technical and Policy Guidelines, Standards, and Definitions* (*ESAR-VHP Guidelines*). It is anticipated that sections of the *ESAR-VHP Guidelines* will be continuously refined and updated as new information is available.

The *ESAR-VHP Compliance Requirements* define the capabilities of such a program and can be found in Appendix 6.

**Maintenance of Funding (MOF)**

Awardees are required to document the required MOF as part of the IPR for BP9.

MOF is defined as ensuring that the amount contributed by the entity that receives the award to support public health security does not fall below the average of the amount provided annually during the previous two years. This definition includes:

1. Appropriations specifically designed to support public health emergency preparedness as expended by the entity receiving the award; and
2. Funds not specifically allocated for public health emergency preparedness activities but which support public health emergency preparedness activities, such as personnel assigned to public health emergency preparedness responsibilities or supplies or equipment purchased for public health emergency preparedness from general funds or other lines within the operating budget of the entity receiving the award.
   The definition of expenditures does not include one-time expenses to support public health preparedness and response, such as purchases of antiviral drugs.

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**Matching Requirements**

PHEP cooperative agreement funding must be matched by nonfederal contributions beginning with the distribution of federal Fiscal Year (FY) 2009 funds (BP10). Nonfederal contributions (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 nonfederal contributions. Awardees will be required to provide matching funds as described:

i. For FY 2009, not less than 5% of such costs ($1 for each $20 of federal funds provided in the cooperative agreement); and
ii. For any subsequent 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).

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. Beginning with federal FY 2009, the Secretary of Health and Human Services 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 FY 2008 (BP9) mid-year progress report a plan describing the methods and sources of match that the eligible entity agrees to pursue in FY 2009.

**Evidence-Based Benchmarks and Objective Standards**

In accordance with section 319C-1(g)(1), CDC has established the following evidence-based benchmarks and objective standards. Substantial failure to meet these benchmarks and standards will result in withholding of FY 2009 funds (BP10). According to PL 109-417, any funds withheld from the PHEP cooperative agreement program or the Hospital Preparedness Program will be reallocated to the Healthcare Facilities Partnership program in the same state.

1. <u>Demonstrated capability to notify primary, secondary, and tertiary staff to cover all incident management functional roles during a complex incident.</u>

   To provide an effective and coordinated response to a complex incident, a public health department must maintain a current roster of pre-identified staff available to fill core Incident Command System (ICS) functional roles. During an incident that lasts more than 12 hours, secondary and tertiary staff may be called upon to fill ICS roles, and thus the health department must maintain a roster of all staff qualified for those roles. Testing the staff notification system is critical for an efficient response, especially when the notification is unannounced and occurs outside of regular business hours.

a. Confirm the accuracy of the primary, secondary, and tertiary contact information for all eight ICS functional roles at least once every six months.
b. Test the notification system twice a year, with at least one test being unannounced and occurring outside of regular hours. The test can be a drill or an exercise, or it may be demonstrated by a response to a real incident.

Guidance on the numerator, denominator, and scoring methodology to determine how results will factor in to a withholding penalty for this measure will be available by May 15, 2008.

2. Demonstrated capability to receive, stage, store, distribute, and dispense material during a public health emergency.

   Health departments must be able to provide countermeasures to 100% of their identified population within 48 hours after the decision to do so. To be able to achieve this standard, health departments must maintain the capability to plan and execute the receipt, staging, storage, distribution, and dispensing of material during a public health emergency.
   a. Obtain a score of 69 or higher on the Division of Strategic National Stockpile (DSNS) State Technical Assistance Review by December 31, 2008.
   b. Each planning/local jurisdiction within each Cities Readiness Initiative (CRI) metropolitan statistical area (MSA) conducts a minimum of three DSNS drills by August 10, 2009.
   c. To comply with the PAHPA legislation and for purposes of guiding funding decisions for 2009, the planning/local jurisdiction(s) that comprises the 25% most populous within a CRI MSA conducts at least one of the three DSNS drills prior to December 31, 2008 (with the remaining two drills conducted by August 10, 2009).

   These drills may include any three of the following: staff call down, site activation, facility set-up, pick-list generation, dispensing, and/or modeling of throughput.

Guidance on the numerator, denominator, and scoring methodology to determine how results will factor in to a withholding penalty for this measure will be available by May 15, 2008.

**Maximum Amount of Carryover**

CDC shall determine the maximum percentage amount of an award that a recipient may carry over to the succeeding fiscal year. Unjustifiable unobligated balances will be determined by using the awardee's spend plan and financial status and progress/performance reports. (See Withholding and Repayment Guidance, Appendix 2, for additional information.)

To provide effective program management, an awardee must be able to develop and execute spend plans, make procurements and let contracts on schedule, and otherwise assure the infrastructure capacity to support the attainment of programmatic objectives. One outcome of an effective management infrastructure is the full expenditure of funds awarded in the budget period.

CDC recognizes that there may be justifiable causes (e.g., state hiring freezes, inefficiencies on the part of the awarding agency) or unjustifiable causes (e.g., ineffective management infrastructure at the state level, irregularities in contracting or payment of debt) for dollars to remain unobligated at the end of the budget period even after a robust execution of plans. Therefore, the awardee must immediately communicate with CDC any events occurring between the scheduled spend plan and progress/performance report date which have significant impact upon the cooperative agreement.

CDC will make available by May 15, 2008, additional guidance regarding spend plans and progress/performance reports to determine how results will factor in to a repayment penalty for this measure.

**Pandemic Influenza Plans**

Pandemic influenza operations plans must meet national standards. On July 9, 2008, awardees will submit a second version of their pandemic influenza operations plans based on guidance provided by HHS on March 13, 2008. (See Appendix 7 for a copy of the federal scoring guidelines.) Two scores (Comprehensiveness and Operational Readiness) for each of the seven elements in the "Health and Medical" category will be used by CDC to determine the extent to which criteria have been met, as follows:

Comprehensiveness Score:
- No Major Gaps
- A Few Major Gaps
- Many Major Gaps
- Inadequate Preparedness

Operational Readiness Score:
- Substantial Evidence of Operational Readiness
- Significant Evidence of Operational Readiness
- Little Evidence of Operational Readiness

Failure to meet accepted criteria for pandemic influenza operations planning shall result in the withholding of funds for the FY 2009 budget period. According to PL 109-417, any funds withheld from the PHEP cooperative agreement program or the Hospital Preparedness Program will be reallocated to the Healthcare Facilities Partnership program in the same state. Guidance on the numerator, denominator, and scoring methodology for this measure will be available by May 15, 2008.

**Audit Requirements**

Each entity receiving funds shall, not less than once every two years, audit its expenditures from amounts received from the PHEP cooperative agreement. Such audits shall be conducted by an entity independent of the agency administering the PHEP cooperative agreement in accordance with Office of Management and Budget Circular A-133, Audits of States, Local Governments, and Non-Profit Organizations. Audit reports must be submitted to CDC. Failure to conduct an audit, or expenditures made not in accordance with PHEP cooperative agreement guidance and

grants management policy may result in a requirement to repay funds to the federal treasury or the withholding of future funds.

**Submission Instructions and Requirements**

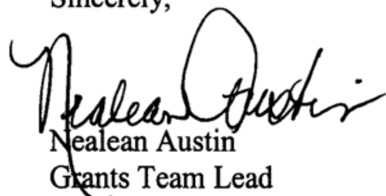
Continuation submissions (the Interim Progress Report) are due to CDC on July 3, 2008. Both the principal investigator and the business office official must sign the completed Interim Progress Report. All submissions are due no later than close of business on July 3, 2008, in the Preparedness Emergency Response System For Oversight, Reporting, and Management Services (PERFORMS) database maintained by CDC's Division of State and Local Readiness (DSLR). The direct link to PERFORMS is https://sdn.cdc.gov. Interim Progress Reports must be submitted on time and in English. Late or incomplete submissions may result in a delay in the award and/or reduction in funds. CDC will only accept requests for deadline extensions on rare occasions, after adequate justification has been provided.

Any programmatic questions regarding your submission should be directed to the appropriate DSLR project officer (Appendix 8). Should you have any grants management questions, including questions related to your budget, please contact the grants management specialist for your region (Appendix 9). You may direct questions about this guidance to dslrpsb@cdc.gov.

**Application Review**

The Procurement and Grants Office (PGO) and DSLR will review the Interim Progress Report for completeness. PGO will analyze the financial/business documentation, and DSLR and subject matter experts from across CDC will analyze the technical/programmatic documentation. Based on the analysis of all documentation, the availability of funds, and the best interest of the government, PGO and DSLR will decide jointly whether to award continuation funding. Following the initial budget review, CDC staff will coordinate calls with program directors to provide an opportunity to collect additional information and correct errors that may affect the final award conditions. Following these conversations, budgets will be finalized and CDC will prepare Notices of Award. CDC may withhold awards due to delinquent reports, inadequate stewardship of federal funds, or failure to meet the terms and conditions of the awards.

Sincerely,



Nealean Austin
Grants Team Lead
Acquisition and Assistance Branch Six
Procurement and Grants Office

Attachments

Appendix 1: Instructions for Preparing the Interim Progress Report
Appendix 2: Withholding and Repayment Guidance
Appendix 3: Funding for Budget Period 9
Appendix 4: FY 2008 and FY 2009 Cities Readiness Initiative Funding
Appendix 5: U.S. Border States Early Warning Infectious Disease Surveillance

Appendix 6: Emergency System for Advance Registration of Volunteer Health Professionals Draft Compliance Requirements
Appendix 7: Federal Guidance to Assist States in Improving State-level Pandemic Influenza Operating Plans (Scoring Process)
Appendix 8: Division of State and Local Readiness Project Officers
Appendix 9: Procurement and Grants Office Grants Management Specialists

## Appendix 1
## Instructions for Preparing the Interim Progress Report

### Background

Awardees are responsible for maintaining progress in each of the preparedness areas described in PHEP Program Announcement AA154. To access that document, as well as the subsequent continuation guidance documents for the PHEP program including information on expected laboratory capabilities and outcomes, click on the following link and scroll to the document you wish to review: http://www.emergency.cdc.gov/planning/coopagreement. Although it is not necessary to describe a priority project for each of these areas, awardees must ensure that they are working toward the capacities and capabilities described. This commitment should be reflected in line item budget justifications and their linkage to outcomes, as well as in responses to requirements and descriptions of priority projects.

Additional related resources developed or compiled by our national public health emergency preparedness partners can be found at www.astho.org, www.naccho.org, and preparedness.asph.org. For information about the Medical Reserve Corps, with which awardees will want to coordinate when planning for and conducting exercises, please go to www.medicalreservecorps.gov.

CDC is designing a program framework that links activities and priority projects to a set of standardized outcomes and performance measures. CDC will collaborate with awardees to develop a comprehensive work plan to be used in describing the program plan for BP10.

Awardees should continue to follow the Homeland Security Exercise and Evaluation Program's (HSEEP) approach to selecting preparedness, response, or recovery objectives. Awardees should use those objectives as a foundation for planning and training and demonstrate capability to reach those objectives by conducting a mix and range of exercises that, in turn, provide information for program improvements. Following the HSEEP strategy also facilitates awardees' demonstration of progress in the core preparedness activities that are overarching and ongoing.

### Submission Instructions

Narrative answers must be provided in English and may not exceed 8,750 characters, which is approximately two and a half pages of 12-point, Times New Roman text, using left/right margins of 1 inch and top/bottom margins of 1.25 inches. Detailed instructions for submitting your Interim Progress Report will be available through a download in PERFORMS (https://sdn.cdc.gov).

Your Interim Progress Report must include the following components:

### I. Budget Period 8 (BP8) Progress Report

Your BP8 progress report will provide the background against which to determine and justify priorities for the upcoming year. In addition, project officers and subject matter experts will use your narratives to identify strengths and weaknesses and to update consultation plans to establish priorities for site visits and technical assistance. Answers that do not clearly demonstrate

compliance with requirements may result in the restriction of funds until additional documentation is provided.

### A. Cross-Cutting Areas and CDC Preparedness Goal-related Updates

Each awardee has been notified, as the result of submitting the end-of-year report for BP7, about the cross-cutting or preparedness goal-related areas in which CDC considers there are still many major gaps to be addressed. Awardees are required to update those areas in the BP8 progress report. Should one or more of these areas coincide with a priority project being undertaken in BP8, you may indicate that in PERFORMS and provide the required information in the context of the priority project update.

Awardees also may update other cross-cutting areas in which progress has been made that will not be reflected in the priority project updates.

### B. Progress on Requirements

Review your BP8 narrative responses describing plans to address PHEP requirements (pre-populated in PERFORMS). Update these responses with your progress to date, making sure to highlight successes, describe barriers you have overcome and/or those yet to be addressed, and request assistance where needed.

Your MOF amount for BP8 will be collected in this section of your progress report. Please follow the instructions in PERFORMS.

### C. Updates on Priority Projects

Review your BP8 priority projects (pre-populated in PERFORMS). In the response boxes provided, describe your progress to date, making sure to highlight successes, describe barriers you have overcome and/or those yet to be addressed, and request assistance where needed. Pay particular attention to updating outputs, which may be rewritten at this time.

### D. Performance Measures

Performance measures are an important tool for awardees to stress their routine urgent response systems, thereby demonstrating they are building the capabilities necessary to respond to larger-scale incidents. Specific guidance on data collection and reporting requirements for the performance measures has been made available to awardees via PERFORMS (https://sdn.cdc.gov). Awardees are expected to report on each measure according to the detailed guidance in this document. As always, awardees are encouraged to request clarification from CDC as needed. The deadline for submitting performance measures data was April 30, 2008.

### E. Current Budget Period Financial Progress

Provide an estimated financial status report (FSR) for BP8. Estimated unobligated funds should be reported separately by component (PHEP, pandemic influenza, chemical

laboratory, EWIDS, RTDD, and CRI). Provide detailed actions to be taken to spend estimated unobligated funds. If you anticipate insufficient funds, provide detailed justification of the shortfall and list the actions taken to bring the obligations in line with the authorized funding level.

## II. Budget Period 9 (BP9) Requirements, Priority Projects, and Budget

Building on the lessons learned from the attacks of September 11, 2001, and Hurricanes Katrina and Rita in 2005, the PAHPA was enacted in December 2006 to improve the nation's public health and medical preparedness and response capabilities for emergencies, whether deliberate, accidental, or natural. The PAHPA amended and added new sections to the PHS Act. Examples of these changes include identifying the Secretary of HHS as the lead official for all federal public health and medical responses to public health emergencies and other incidents covered by the National Response Framework; establishing the position of the Assistant Secretary for Preparedness and Response (ASPR), who will lead and coordinate HHS public health and medical preparedness and response activities, advise the Secretary of HHS during an emergency, and lead the coordination of public health and medical emergency preparedness and response efforts between HHS and other federal agencies; consolidating federal public health and medical response programs under the renamed ASPR; requiring the development and implementation of the National Health Security Strategy; and reauthorizing the Public Health and Emergency Preparedness (PHEP) grants administered by the CDC and the Hospital Preparedness Program (HPP) grants administered by ASPR. In addition to reauthorizing these two grant programs, the PAHPA amended these grant programs to add certain new requirements that awardees must meet.

The Secretary of HHS is required under section 319C-1(g) of the PHS Act to develop and require application of measurable benchmarks and objective standards that measure levels of preparedness with respect to PHEP activities. The Secretary shall withhold funds beginning in FY 2009 from PHEP awardees who fail substantially to meet the applicable benchmarks for the immediately preceding fiscal year and/or who fail to meet accepted criteria for a pandemic influenza operations plan. Thus, PHEP awardees will have funds withheld from their FY 2009 awards if, when expending their FY 2008 PHEP awards, they fail substantially to meet the benchmarks described in the BP9 IPR or to submit a pandemic influenza operations plan that meets accepted criteria. The Secretary of HHS is required to develop and implement a process to notify entities who have failed substantially to meet the evidence-based benchmarks and who have failed to submit a pandemic influenza operations plan that meets accepted criteria.

In addition, there are other requirements that are subject to enforcement actions including repayment of funds or withholding of future funds based on failure to meet certain provisions (e.g., independent audits, carryover limits) that will go into effect with the distribution of FY 2009 funding. Please note these and respond accordingly as insufficient responses shall adversely affect funding. (Appendix 2)

### A. Reporting Requirements

Reporting requirements for BP9 include:

- On April 30, 2009, a progress report representing the period August 10, 2008, through February 28, 2009, program data (capacity, capability, and performance measures and/or benchmarks as outlined in the preceding letter from PGO, as well as budget and potential match documentation), and an estimated FSR; and
- On November 9, 2009, an end-of-year report, program data, and a final FSR.

This information may be used to describe the state of preparedness in public documents.

**B. Program Requirements**

Requirements 1 and 2 are new for BP9 and appear for the first time in PERFORMS. Because you have provided updates in your BP8 progress report for requirements 3 through 10, you should only describe your plans to address those requirements during the upcoming year. Do not repeat information provided in your progress report. Refer to the hyperlinks provided to ensure you are addressing all requirements, through a combination of responses in your BP8 progress report and BP9 submission.

1. Maintenance of Funding (MOF). Please complete the MOF requirement that will calculate the amount of MOF you should be prepared to document during BP9. According to PL 109-417, any funds withheld from the PHEP cooperative agreement program or the Hospital Preparedness Program will be reallocated to the Healthcare Facilities Partnership program in the same state.

2. Match. Documentation of a plan to identify and accumulate the 5% match required to obtain a BP10 award will be a component of your IPR submission in spring 2009.

3. Compliance with Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) guidelines. PHEP awardees are required to describe how they work with their state Hospital Preparedness Program to continue adopting and implementing the *2008 Interim ESAR-VHP Technical and Policy Guidelines, Standards, and Definitions* (*ESAR-VHP Guidelines*).

4. Implement interoperable systems consistent with the Public Health Information Network (PHIN). Describe plans for implementing interoperable systems that demonstrate capabilities consistent with current PHIN requirements and that support the following functions:

    - Identification of events/conditions of public health incidents (CDC Preparedness Goal 2), through biosurveillance, including clinical data exchange with hospitals, urgent care centers, health information exchanges, laboratories, etc.
    - Analysis of data about public health incidents (CDC Preparedness Goals 3, 4, 5), including outbreak management and integration of public health and clinical data.

- Communication of data about public health incidents including dissemination of alerts and secure sharing of preliminary information about suspected events (CDC Preparedness Goal 4).
- Intervention in public health incidents (CDC Preparedness Goal 6), including countermeasure and response administration.

5. Engage the State Office for Aging or equivalent office in addressing the emergency preparedness, response, and recovery needs of the elderly. Describe the activities you will undertake in BP9 to further your work with this resource on behalf of the elderly in your communities.

6. 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. Describe the activities you will undertake in BP9 to address this requirement.

7. Mass Prophylaxis and Countermeasure Distribution and Dispensing. Countermeasure distribution and dispensing is defined in the Homeland Security Presidential Directive 21 (HSPD-21), issued October 18, 2007, as a critical component of public health and medical preparedness. While much has been done to address this critical component of preparedness, existing plans and procedures must be tested to demonstrate state and local operational capability. In accordance with the requirements of HSPD-21, HHS must work with current cooperative agreement programs to demonstrate specific capabilities in tactical exercises and establish procedures to gather performance data from state and local participants on a regular basis to assess readiness. It is for this reason the mass prophylaxis section in this BP9 continuation guidance includes the specified exercise requirements.

   a) Statewide

   - Based on the state's public health preparedness planning infrastructure, describe the actions that will be taken during BP9 to ensure that within each planning/local jurisdiction medical countermeasures can be rapidly dispensed to the affected population.
   - Describe actions that will be taken in BP9 to ensure that critical medical supplies and equipment are appropriately secured, managed, distributed, and restocked in a timeframe appropriate to the incident. Include a brief discussion of your plans to exercise statewide medical supplies management, distribution plans, and personnel, and submit the resulting exercise after action report(s) and improvement plan(s) to your DSNS program consultant by the close of BP9. Note that all scheduled exercises and documents also should be posted to the National Exercise Schedule (NEXS).

   b) Cities Readiness Initiative (CRI)

   - Describe the actions that will be taken by the CRI jurisdiction(s) during BP9 to achieve the point of dispensing (POD) standards provided by DSNS.

- Describe plans to ensure that each planning/local jurisdiction within a CRI metropolitan statistical area (MSA) conducts at least three DSNS POD drills. Note: DSNS will provide a POD drill manual with required metrics and reporting requirements to each project area.
- Describe plans to conduct at least one full-scale or functional mass prophylaxis dispensing exercise in each CRI MSA that includes all pertinent jurisdictional leadership and Emergency Support Function leads, planning and operational staff, and all applicable personnel. Submit the resulting exercise data, after action report(s), and improvement plan(s) to your DSNS program consultant by the close of BP9. All scheduled exercises and documents should be posted to the NEXS.
- In consultation with the states, DSNS will develop a joint strategy to review 100% of the CRI MSA jurisdictions by the end of BP9 using the DSNS Local Technical Assistance Review Tool.

c) Non-CRI Venues

- Describe plans to ensure that a number of non-CRI local jurisdictions equal to the number of CRI MSAs located in the state (e.g. two CRI MSAs located in the state would necessitate two non-CRI planning/local jurisdictions be engaged in this activity) conduct at least one POD drill each. These non-CRI venues (which may be urban, suburban, exurban, or rural) are to be selected in consultation with your DSNS program consultant. Note: DSNS will provide a POD drill manual with requested metrics and reporting requirements to each project area.

8. Early Warning Infectious Disease Surveillance (EWIDS). The HHS Assistant Secretary for Preparedness and Response (ASPR) continues to provide supplemental funds for the purpose of developing and enhancing cross-border early warning infectious disease surveillance efforts for states sharing a common land border with Mexico or a land or Great Lakes maritime border with Canada.

   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 level;
   - Strengthen capacity for cross-border detection, reporting, and prompt investigation of infectious disease outbreaks;
   - Explore mechanisms to create interoperable systems to share surveillance (including laboratory) data; and
   - Develop the public health workforce to undertake these activities.

   Describe your plans to meet the EWIDS objectives during BP9.

9. Level 1 Chemical Laboratory Surge Capacity. Describe your plans for BP9 to address objectives related to chemical emergency response surge capacity, including staffing

and equipping the lab, training and proficiency testing the staff, and participating in local, state, and national exercises. Also describe how you will 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.

10. Centers for Public Health Preparedness (CPHP). Describe your plans during BP9 to develop, deliver, and evaluate competency-based training and education programs based on identified needs of state and local public health agencies for building workforce preparedness and response capabilities in conjunction with the CPHP program. If you work with Project Public Health Ready or an Advanced Practice Center, please briefly describe that work as well.

11. Assurances. Awardees must ensure that they will:

- Submit as required: at mid-year, a progress report, performance data, and an estimated FSR; and at the end of the year, a final progress report, performance data, and a final FSR.
- Submit an independent audit report every two years, within 30 days of the report being submitted to the agency.
- Conduct at least two preparedness exercises annually, developed in accordance with HSEEP standards. After action reports/improvement plans for these exercises must be submitted to your project officer no later than the following year's Interim Progress Report. Required exercises may be pandemic influenza-related exercises.
- Inform and educate hospitals in the jurisdiction on their role in public health emergency preparedness.
- Address the public health and medical needs of at-risk individuals in the event of a public health emergency.
- Implement an accountability system to ensure satisfactory annual improvement. (NOTE: During BP9, accountability will be demonstrated through data reporting on capacities, capabilities, and performance and routine monitoring and reporting of progress toward the achievement of outputs described in the work plan for that period.)
- Meet National Incident Management System (NIMS) compliance requirements.

PGO considers that the awardee's acceptance of the Notice of Award for BP9 constitutes assurance of compliance with these requirements. There is no item in PERFORMS that requires a response to these assurances; no narrative response or attachment is necessary.

Requirement #12 should be addressed by submitting the designated attachments.

12. Local Health Department and Tribal Concurrence. Provide evidence that at least a majority, if not all, of local health departments and American Indian/Alaska Native tribes within your borders approves or concurs with the approaches and priorities described in this application. Evidence must be demonstrated separately for local health officials and tribal entities.

    Documentation for local health department concurrence may be accomplished by:

    - Completing a list in PERFORMS (https://sdn.cdc.gov) noting the consensus of a majority of local health officials whose collective jurisdictions encompass a majority of the state's population; or
    - Attaching in PERFORMS (https://sdn.cdc.gov) the statement of the president of the State Association of County and City Health Officials (SACCHO) that a majority of local health officials whose collective jurisdictions encompass a majority of the state's population agree with the SACCHO's decision.

    In addition, state applicants will be required to provide signed letters of concurrence upon request.

    Documentation for tribal concurrence may be accomplished by:

    - Attaching in PERFORMS (https://sdn.cdc.gov) a letter of concurrence from the Indian Health Board representing the tribes within your jurisdiction;
    - Attaching individual letters of concurrence from the American Indian/Alaska Native tribes within the jurisdiction; or
    - Attaching a Word document describing the reasons for lack of concurrence and the steps the state has taken to address them.

13. Biosurveillance Exercises. Using information collected through a sample of seasonal influenza vaccination clinics, each grantee will report to CDC data on vaccination doses administered.

    The group of participating seasonal influenza vaccination clinics must include at least one in each CRI metropolitan statistical area and at least one in each of an equal number of non-CRI venues. The latter may be urban, suburban, exurban, or rural and are to be selected in consultation with your DSNS program consultant.

    These data can be reported by one of the following three options put forth by the National Center for Immunization and Respiratory Diseases and the National Center for Public Health Informatics: 1) data exchange using an existing immunization information system, 2) direct entry of aggregate counts into the Countermeasure and Response Administration's (CRA) web-based system, or 3) direct entry of individual patient-level data into the CRA's web-based system, which then automatically aggregates the counts. Additional information on this exercise requirement can be found at http://www.cdc.gov/phin/activities/applications-services/cra/pan-flu.html.

## C. Awardee-Determined Priority Projects

In recognition of the maturation of the PHEP program and the understandable differences in needs, resources, and threats among awardees, CDC designed a new approach for BP8 emphasizing awardee-determined priority projects.[2] Those projects that are expected to remain incomplete by the end of BP8 may be carried into BP9. In addition, awardees may propose new priority projects for BP9.

Priority projects for BP9 are expected to build upon and complement BP8 activities described in your progress report. In addition, priority projects must support the intent of the original PHEP Program Announcement AA154.

Awardees will describe each priority project using the standard work plan provided in PERFORMS. Complete each section thoroughly and concisely. As you describe each project, follow the template to ensure that you include all information.

## D. Detailed Line Item Budget and Justification

1. Budget

   Provide a detailed line item budget (include form 424A) and justification of the funding amount requested to support program activities for the upcoming budget period. Awardees should submit a budget reflective of a 12-month budget period. Refer to PHEP Program Announcement AA154 as well as all amendments for component-specific information.

   The prospective documentation of your MOF amount for BP9 will be collected as described in Section IIB: Program Requirements. According to PL 109-417, any funds withheld from the PHEP cooperative agreement program or the Hospital Preparedness Program will be reallocated to the Healthcare Facilities Partnership program in the same state.

   The following information must be submitted for all newly requested contracts as well as for revisions in scope or budget for any existing contract:

   - 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

[2] A "priority project" is defined for this purpose as a collection of actions that are linked to a common goal and expected long-term outcomes. Priority projects may be designed to address gaps, to remediate problems, or to focus effort and resources on areas in need of significant immediate improvement. Identifying priority projects does not mean awardees will discontinue their other activities.

- Itemized budget with narrative justification.

Additional budget preparation guidance can be downloaded from: http://www.cdc.gov/od/pgo/funding/grants/foamain.shtm.

2. Requests to Carry Forward Unobligated Funds

Awardees may request to carry over unobligated funds from either of the two prior budget periods into the current budget period. All requests to carry over unobligated funds should be based on a one-time, nonrecurring need. There is no guarantee that new funds will be available to continue activities in the succeeding budget period(s). Requests should include at a minimum:

- The proposed use of funds, by program component/area;
- A justification for the need to use funds as proposed;
- An explanation for how the funds will enhance current activities;
- A detailed line item budget;
- A timeline/period of performance for the proposed activities; and
- An accurate, complete FSR, broken down by component.

**Requests to carry forward unobligated funds from previous budget periods should be submitted by June 2, 2008,** to allow time for PGO to process the requests and the awardees time to obligate the funds by August 9, 2008. No requests to carry unobligated balances forward into BP8 will be considered after June 2. Unobligated funds may be used to offset the FY 2008 (BP9) award.

This approach to liquidating unobligated balances is being taken to minimize the amount of funds that appear on the FSR as unobligated at the end of the year. The PAHPA includes provisions to redirect unobligated dollars above a particular threshold to other preparedness initiatives beginning with FY 2009 (BP10). CDC encourages awardees to spend dollars in the year in which they are awarded and to identify legitimate nonrecurring activities which previously unobligated dollars could support as early in the year as possible.

Keep in mind PAHPA requirements include a cap on the maximum amount of carryover (unobligated funds) a grantee can request at the end of a budget period. Please refer to the following description, which appeared in a Federal Register notice published immediately preceding release of this guidance.

**Maximum Amount of Carryover**

CDC shall determine the maximum percentage amount of an award that a recipient may carry over to the succeeding fiscal year. Unjustifiable unobligated balances will be determined by using the awardee's spend plan and financial status and

progress/performance reports. (See Withholding and Repayment Guidance, Appendix 2, for additional information, including the process to seek a waiver for this requirement).

To provide effective program management, an awardee must be able to develop and execute spend plans, make procurements and let contracts on schedule, and otherwise assure the infrastructure capacity to support the attainment of programmatic objectives. One outcome of an effective management infrastructure is the full expenditure of funds awarded in the budget period.

CDC recognizes that there may be justifiable causes (e.g., state hiring freezes, inefficiencies on the part of the awarding agency) or unjustifiable causes (e.g., ineffective management infrastructure at the state level, irregularities in contracting or payment of debt) for dollars to remain unobligated at the end of the budget period even after a robust execution of plans. Therefore, the awardee must immediately communicate with CDC any events occurring between the scheduled spend plan and progress/performance report date which have significant impact upon the cooperative agreement.

CDC will make available by May 15, 2008, additional guidance regarding spend plans and progress/performance reports to determine how results will factor in to a repayment penalty for this measure.

3. Additional Information

Participation in CDC-sponsored training, workshops, and meetings is essential to the effective implementation of the PHEP cooperative agreement. Awardees are reminded that the annual budget should include travel for appropriate staff to attend a minimum of one CDC-sponsored meeting for three days in Washington, D.C., and one two-day regional meeting. In addition, the travel budget for chemical laboratory staff should include funding for two staff members to attend one five-day trip to CDC for hands-on training, as well as one field education course or other technical training and one professional/technical meeting per person.

**Appendix 2**
**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.

A. **Pandemic and All-Hazards Preparedness Act (PAHPA) requirements for the PHEP Cooperative Agreement** The 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:

**Benchmarks and Statewide Pandemic Influenza Operations Plan**

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

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.

(2) Enforcement Action:

- Withhold funds – Fiscal Year 2008 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 PL 109-417, any funds withheld from the PHEP or the Hospital Preparedness Program will be reallocated to the Healthcare Facilities Partnership program in the same state.
- Preference in reallocation –According to PL 109-417, any funds withheld from the PHEP or the Hospital Preparedness Program will be reallocated to the Healthcare Facilities Partnership program in the same state.

**WAIVE OR REDUCE:** The Secretary of Health and Human Services may waive or reduce the withholding as described above 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.

**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.

Adjudication: Enforcement will be in accordance with 45 CFR Part 16.

**Carryover**

(1) Enforcement Condition: For each fiscal year, the percentage amount of an award unexpended by an awardee exceeds the maximum percentage permitted by the Secretary.

(2) Enforcement Action: Awardees shall return to the Secretary the portion of the unexpended amount that exceeds the maximum permitted to be carried over. According to PL 109-417, any funds withheld from the PHEP or the Hospital Preparedness Program will be reallocated to the Healthcare Facilities Partnership program in the same state.

**WAIVE OR REDUCE:** The awardee may request a waiver of the maximum percentage amount or the Secretary may waive or reduce the withholding as described above 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 grantees 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 § 50.404). CDC will assume jurisdiction for any of the above adverse determinations.

## Appendix 3
## Funding for Budget Period 9

| Awardee | Total Base Plus Population Funding | FY 2008 Cities Readiness Initiative Funding* | FY 2008 Level 1 Chemical Laboratory Funding | FY 2008 EWIDS Funding | FY 2008 Total Allocation* |
|---|---|---|---|---|---|
| **Alabama** | $9,870,450 | $370,643 | $0 | $0 | $10,241,093 |
| **Alaska** | $4,800,000 | $200,000 | $0 | $15,000 | $5,015,000 |
| **American Samoa** | $386,338 | $0 | $0 | $0 | $386,338 |
| **Arizona** | $12,211,808 | $1,559,294 | $0 | $456,569 | $14,227,671 |
| **Arkansas** | $7,199,137 | $236,352 | $0 | $0 | $7,435,489 |
| **California** | $41,641,349 | $6,252,803 | $1,096,486 | $1,170,732 | $50,161,370 |
| ***Chicago*** | $9,232,673 | $2,150,000 | $0 | $0 | $11,382,673 |
| **Colorado** | $10,101,028 | $1,040,857 | $0 | $0 | $11,141,885 |
| **Connecticut** | $8,235,803 | $691,902 | $0 | $0 | $8,927,705 |
| **Delaware** | $4,626,077 | $373,923 | $0 | $0 | $5,000,000 |
| **District of Columbia** | $5,868,743 | $830,000 | $0 | $0 | $6,698,743 |
| **Florida** | $29,378,223 | $3,357,581 | $204,697 | $0 | $32,940,501 |
| **Georgia** | $16,988,709 | $1,700,300 | $0 | $0 | $18,689,009 |
| **Guam** | $555,484 | $0 | $0 | $0 | $555,484 |
| **Hawaii** | $4,920,394 | $307,790 | $0 | $0 | $5,228,184 |
| **Idaho** | $5,190,739 | $200,000 | $0 | $15,000 | $5,405,739 |
| **Illinois** | $17,546,626 | $2,350,585 | $0 | $15,000 | $19,912,211 |
| **Indiana** | $12,431,712 | $889,155 | $0 | $15,000 | $13,335,867 |
| **Iowa** | $7,454,910 | $247,153 | $0 | $0 | $7,702,063 |
| **Kansas** | $7,129,227 | $469,112 | $0 | $0 | $7,598,339 |
| **Kentucky** | $9,283,417 | $467,118 | $0 | $0 | $9,750,535 |
| ***Los Angeles*** | $19,415,953 | $3,436,517 | $0 | $0 | $22,852,470 |

| Awardee | Total Base Plus Population Funding | FY 2008 Cities Readiness Initiative Funding* | FY 2008 Level 1 Chemical Laboratory Funding | FY 2008 EWIDS Funding | FY 2008 Total Allocation* |
|---|---|---|---|---|---|
| **Louisiana** | $9,405,459 | $592,727 | $0 | $0 | $9,998,186 |
| **Maine** | $4,974,288 | $200,000 | $0 | $96,856 | $5,271,144 |
| **Marshall Islands** | $390,307 | $0 | $0 | $0 | $390,307 |
| **Maryland** | $11,389,285 | $1,649,106 | $0 | $0 | $13,038,391 |
| **Massachusetts** | $12,616,466 | $1,517,013 | $672,291 | $0 | $14,805,770 |
| **Michigan** | $17,685,389 | $1,482,503 | $1,045,797 | $239,552 | $20,453,241 |
| **Micronesia** | $461,346 | $0 | $0 | $0 | $461,346 |
| **Minnesota** | $10,719,087 | $1,060,505 | $798,619 | $38,195 | $12,616,406 |
| **Mississippi** | $7,348,030 | $281,717 | $0 | $0 | $7,629,747 |
| **Missouri** | $11,728,377 | $1,300,711 | $0 | $0 | $13,029,088 |
| **Montana** | $4,800,000 | $200,000 | $0 | $22,876 | $5,022,876 |
| **Nebraska** | $5,641,694 | $235,370 | $0 | $0 | $5,877,064 |
| **Nevada+** | $6,728,049 | $924,204 | $0 | $0 | $7,652,253 |
| **New Hampshire** | $4,964,310 | $337,744 | $0 | $15,000 | $5,317,054 |
| **New Jersey** | $16,033,543 | $2,755,260 | $0 | $0 | $18,788,803 |
| **New Mexico** | $5,919,958 | $271,300 | $797,372 | $66,150 | $7,054,780 |
| **New York** | $19,134,509 | $2,028,087 | $1,034,057 | $322,137 | $22,518,790 |
| ***New York City*** | $17,271,459 | $5,100,000 | $0 | $0 | $22,371,459 |
| **North Carolina** | $16,230,655 | $465,842 | $0 | $0 | $16,696,497 |
| **North Dakota** | $4,800,000 | $200,000 | $0 | $23,132 | $5,023,132 |
| **Northern Marianas Islands** | $423,185 | $0 | $0 | $0 | $423,185 |
| **Ohio** | $19,724,596 | $2,098,508 | $0 | $15,000 | $21,838,104 |
| **Oklahoma** | $8,346,953 | $393,316 | $0 | $0 | $8,740,269 |
| **Oregon** | $8,528,530 | $571,687 | $0 | $0 | $9,100,217 |

| Awardee | Total Base Plus Population Funding | FY 2008 Cities Readiness Initiative Funding* | FY 2008 Level 1 Chemical Laboratory Funding | FY 2008 EWIDS Funding | FY 2008 Total Allocation* |
|---|---|---|---|---|---|
| **Palau** | $330,743 | $0 | $0 | $0 | $330,743 |
| **Pennsylvania** | $21,129,493 | $2,614,150 | $0 | $15,000 | $23,758,643 |
| **Puerto Rico** | $8,867,670 | $0 | $0 | $0 | $8,867,670 |
| **Rhode Island** | $4,646,715 | $365,904 | $0 | $0 | $5,012,619 |
| **South Carolina** | $9,455,476 | $308,696 | $204,697 | $0 | $9,968,869 |
| **South Dakota** | $4,800,000 | $200,000 | $0 | $0 | $5,000,000 |
| **Tennessee** | $12,021,315 | $823,492 | $0 | $0 | $12,844,807 |
| **Texas** | $37,298,949 | $4,462,725 | $0 | $1,593,702 | $43,355,376 |
| **Utah** | $6,809,517 | $353,322 | $0 | $0 | $7,162,839 |
| **Vermont** | $4,800,000 | $200,000 | $0 | $41,316 | $5,041,316 |
| **Virgin Islands (US)** | $462,244 | $0 | $0 | $0 | $462,244 |
| **Virginia** | $14,417,637 | $1,738,122 | $1,066,288 | $0 | $17,222,047 |
| **Washington** | $12,554,626 | $1,296,773 | $0 | $160,783 | $14,012,182 |
| **West Virginia** | $5,716,596 | $216,692 | $0 | $0 | $5,933,288 |
| **Wisconsin** | $11,300,815 | $592,786 | $279,696 | $15,000 | $12,188,297 |
| **Wyoming** | $4,800,000 | $200,000 | $0 | $0 | $5,000,000 |
| **TOTAL FY 2008 PHEP FUNDING** | **$629,146,071** | **$64,169,347** | **$7,200,000** | **$4,352,000** | **$704,867,418** |

**NOTES:**
*** FY 2008 Cities Readiness Initiative Funding and FY 2008 Total Allocation include $6.4 million that will be funded with carryover funds in lieu of new funding.**

## Appendix 4
## Fiscal Year 2008 and Fiscal Year 2009 Cities Readiness Initiative Funding

| Awardee | FY 2008 Cities Readiness Initiative Funding | FY 2009 Cities Readiness Initiative Funding |
|---|---|---|
| **Alabama** | $370,643 | $364,010 |
| **Alaska** | $200,000 | $200,000 |
| **American Samoa** | $0 | $0 |
| **Arizona** | $1,559,294 | $1,336,614 |
| **Arkansas** | $236,352 | $233,266 |
| **California** | $6,252,803 | $6,252,803 |
| ***Chicago*** | $2,150,000 | $937,580 |
| **Colorado** | $1,040,857 | $797,085 |
| **Connecticut** | $691,902 | $673,103 |
| **Delaware** | $373,923 | $373,923 |
| ***District of Columbia*** | $830,000 | $200,000 |
| **Florida** | $3,357,581 | $3,357,581 |
| **Georgia** | $1,700,300 | $1,700,300 |
| **Guam** | $0 | $0 |
| **Hawaii** | $307,790 | $301,085 |
| **Idaho** | $200,000 | $200,000 |
| **Illinois** | $2,350,585 | $2,350,585 |
| **Indiana** | $889,155 | $889,155 |
| **Iowa** | $247,153 | $240,225 |
| **Kansas** | $469,112 | $469,112 |
| **Kentucky** | $467,118 | $459,899 |
| ***Los Angeles*** | $3,436,517 | $3,291,941 |
| **Louisiana** | $592,727 | $592,727 |
| **Maine** | $200,000 | $200,000 |
| **Marshall Islands** | $0 | $0 |
| **Maryland** | $1,649,106 | $1,649,106 |
| **Massachusetts** | $1,517,013 | $1,517,013 |
| **Michigan** | $1,482,503 | $1,478,835 |
| **Micronesia** | $0 | $0 |
| **Minnesota** | $1,060,505 | $1,029,179 |
| **Mississippi** | $281,717 | $272,040 |
| **Missouri** | $1,300,711 | $1,087,082 |
| **Montana** | $200,000 | $200,000 |
| **Nebraska** | $235,370 | $231,966 |
| **Nevada** | $924,204 | $588,209 |
| **New Hampshire** | $337,744 | $337,744 |
| **New Jersey** | $2,755,260 | $2,755,260 |
| **New Mexico** | $271,300 | $270,293 |

| Awardee | FY 2008<br>Cities Readiness Initiative<br>Funding | FY 2009<br>Cities Readiness Initiative<br>Funding |
|---|---|---|
| **New York** | $2,028,087 | $2,028,087 |
| ***New York City*** | $5,100,000 | $2,718,253 |
| **North Carolina** | $465,842 | $465,842 |
| **North Dakota** | $200,000 | $200,000 |
| **Northern Marianas Islands** | $0 | $0 |
| **Ohio** | $2,098,508 | $1,805,560 |
| **Oklahoma** | $393,316 | $387,941 |
| **Oregon** | $571,687 | $567,115 |
| **Palau** | $0 | $0 |
| **Pennsylvania** | $2,614,150 | $2,090,493 |
| **Puerto Rico** | $0 | $0 |
| **Rhode Island** | $365,904 | $353,285 |
| **South Carolina** | $308,696 | $298,749 |
| **South Dakota** | $200,000 | $200,000 |
| **Tennessee** | $823,492 | $814,049 |
| **Texas** | $4,462,725 | $4,462,725 |
| **Utah** | $353,322 | $353,322 |
| **Vermont** | $200,000 | $200,000 |
| **Virgin Islands (US)** | $0 | $0 |
| **Virginia** | $1,738,122 | $1,738,122 |
| **Washington** | $1,296,773 | $1,220,162 |
| **West Virginia** | $216,692 | $216,692 |
| **Wisconsin** | $592,786 | $592,786 |
| **Wyoming** | $200,000 | $200,000 |
| **TOTAL Cities Readiness Initiative Funding** | **$64,169,347** | **$57,750,904** |

## Appendix 5
## U.S. Border States Early Warning Infectious Disease Surveillance (EWIDS)

EWIDS awardees are encouraged to continue working toward achieving cross-border early warning and detection of infectious disease health threats and events and overall situational awareness of infectious and emerging disease activity within the broader context of the Pandemic and All-Hazards Preparedness Act (PAHPA), the Security and Prosperity Partnership of North America (SPP), and the World Health Organization's revised 2005 International Health Regulations (IHRs).

Regional border state public health leadership should strive to collaborate with regional HHS resources, (e.g. regional health directors, administrators, and emergency coordinators) and, where appropriate, with other border health and public health epidemiology, laboratory and health alert, and education and training preparedness programs, such as CDC's funded Centers for Public Health Preparedness, FoodNet, PulseNet, Laboratory Response Network, Epi-X, Public Health Information Network, Health Alert Network, Border Infectious Disease Surveillance Project, and CDC Quarantine Stations located at land-based border crossings. Where appropriate, EWIDS activities should also begin collaborating or continue to collaborate with homeland security initiatives [e.g., near border Urban Area Security Initiative (UASI) and Metropolitan Medical Response System (MMRS) jurisdictions] and state-based U.S. Customs and Border Protection personnel at port-of-entry facilities. In a jurisdiction that shares tribal, military installation, or international borders, the public health agency may use cooperative agreement funds to jointly participate in all-hazard planning meetings; exchange health alert messages and epidemic epidemiological data; provide mutual aid; and conduct collaborative drills and exercises.

In accordance with their authorizing legislation, U.S. Border States EWIDS funds are intended strictly for the support of surveillance and epidemiology-related activities to address bioterrorism and other outbreaks of infectious diseases with the potential for catastrophic consequences (including pandemic influenza). U.S. Border States EWIDS funds are not to be used to support noninfectious disease surveillance or broader border activities in terrorism preparedness. Consequently, these funds may not be used to finance any chemical, radiological, nuclear, or other emergency preparedness activities. EWIDS funds cannot be used to supplant surveillance and/or epidemiological activities already supported by other funding sources. However, U.S. Border States EWIDS funds can be used to enhance coordination and integration with other existing cross-border infectious disease surveillance and epidemiology activities including, but not limited to, pandemic influenza preparedness and response.

In your narrative, you must describe how you will address any of the following critical tasks; you are not required to address all of them.

**CDC Preparedness Goal 2: DETECT AND REPORT**
Decrease the time needed to classify health events as terrorism or naturally occurring in partnership with other agencies.

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

**Critical Task(s):**

1) If not already undertaken, collaborate with Canada or Mexico (as appropriate) to design, develop, and adopt a binational surveillance needs assessment tool to be used by public health officials on both sides of the border to identify gaps in the capacity of border jurisdictions to respond to a bioterrorism event or infectious disease outbreak. Specific needs assessment studies should focus on availability of expertise, personnel, and other resources to carry out epidemiology and surveillance activities essential to cross-border epidemiological investigations and response needs.
2) Work with states and provinces across the international border to develop and agree on a list of notifiable conditions and distinguish between select conditions that require immediate reporting to the public health agency (at a minimum, CDC Category A agents) and conditions for which a delay in reporting is acceptable. For those where a delay is acceptable, describe time frames for notification.
3) Develop or improve infectious disease surveillance in a uniform manner along and across the international border by establishing a network of hospitals, clinics, epidemiologists, and laboratories to conduct active sentinel surveillance for emerging infectious diseases and syndromes such as SARS, West Nile Virus, and fever and rash syndromes
4) Continue to develop and evaluate sentinel/syndromic surveillance programs in border hospitals and clinics to rapidly detect (a) influenza-like illness (ILI) and distinguish possible bioterrorism-caused illness from other causes of ILI and (b) severe acute vesicular rash syndromes resembling smallpox and other febrile exanthemas to distinguish possible bioterrorism-caused illness from other causes and assist in case definition through specific clinical entry criteria and differential diagnosis.
5) Continue to engage federally recognized tribes along the international border in your state in cross-border infectious disease surveillance activities through mutual aid compacts, memoranda of understanding, and/or agreements. Where appropriate, include local binational health councils and/or Indian Tribes/Native American organizations in bioterrorism surveillance activities.
6) Assess the timeliness and completeness of your reportable disease surveillance system at least once a year for detecting and reporting outbreaks of infectious diseases in the border region.
7) Formulate, develop, and, when feasible, test a binational 24/7 infectious disease reporting plan that extends its coverage area to jurisdictions on both sides of the border. State, provincial, and/or priority local/tribal public health agencies develop/implement a cross-border early event detection system that:
    - receives immediately notifiable condition and emergent public health threat reports 24/7/365;
    - immediately notifies the agency-designated public health professional 24/7/365;

- has the agency-designated public health professional promptly respond to immediately notifiable condition or emergency public health threat reports 24/7/365; and
- receives reportable disease reports 24/7/365.

8) Conduct joint, cross-border assessments of information technology capabilities essential to infectious disease surveillance.
9) Collaborate with public health officials in border jurisdictions to identify how infectious disease outbreak information can be most rapidly and effectively shared across the border. Together, border jurisdictions should explore the interoperability of information technology systems, i.e., the ability of different types of computers, networks, operating systems, and applications to work together effectively. Jurisdictions on both sides of the border should work toward ensuring the connectivity and interoperability, both vertically and horizontally, of their surveillance and epidemiology relevant information technology (IT) systems.
10) Working with jurisdictions across the border, establish a secure, Web-based communications system that provides for rapid and accurate reporting and discussion of disease outbreaks and other acute health events that might suggest bioterrorism. Include provision for routine communications (e.g., Web, email) and contingency plans for communication systems' failure and alert capacity for emergency notification (e.g., phone, pager) of key staff of counterpart agency across the border.
11) Work with states, tribes, and provinces along the international border to help train personnel regarding notifiable diseases, conditions, syndromes, and their clinical presentations, and reporting requirements and procedures, including those conditions and syndromes that could indicate a bioterrorist event.
12) Conduct joint infectious disease surveillance exercises involving a broad range of appropriate participants from both sides of the international border. This exercise should involve not only border health departments but, where feasible, local hospitals, tribal, and Public Health Service health facilities, hospital laboratories, major community health care institutions, emergency response agencies, and public safety agencies to respond in a coordinated manner.

**CDC Preparedness Goal 3: DETECT AND REPORT**

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

### 3A Target Capability: Public Health Laboratory Testing

**Critical Task(s):**

1) If not already undertaken, survey and assess the surveillance and laboratory capacity on each side of the international border including those of any tribes located within states that share an international border and the connectivity among these laboratories with a view toward (a) identifying and addressing needs or gaps with respect to their consistency or uniformity of testing standards, notification protocols, and laboratory-based surveillance data exchange practices, and (b) developing binational, regional laboratory response capabilities.

2) Improve cross-border, electronic sharing of laboratory information with public health officials and other partners in neighboring jurisdictions (to facilitate the rapid formulation of an appropriate response to and control of the outbreak). Specific objectives are for jurisdictions on both sides of the international border to (1) coordinate availability of and access to laboratories with appropriate expertise 24/7/365, and (2) test clinical specimens, food samples, and environmental samples for **biological agents** that could be used for terrorism.
3) Develop and maintain a database of all sentinel/clinical labs in awardee's border region that includes name, contact information, Bio-Safety Level, certification status, and whether they are part of an information-sharing network. The database should also include the names and contact information for reference labs used by the sentinel/clinical labs in the border region.
4) In coordination with local public health agencies on both sides of the border, apply information technology to develop or enhance electronic disease surveillance, including electronic disease reporting from clinical and public health laboratories and linkage of laboratory results to case report information.
5) Partner with Schools of Public Health and/or CDC's Centers for Public Health Preparedness to develop binational training activities to enable border health professionals in the United States, Canada, and Mexico to receive introductory or advanced training jointly with their U.S. counterparts in surveillance, epidemiology, laboratory methods, and information technologies that are relevant to the detection, reporting, and investigation of infectious disease outbreaks.
6) In coordination with relevant programs (i.e. FoodNet and PulseNet) and other agencies, conduct joint cross-border assessments of active public health surveillance and diagnostic capacities to improve outbreak-associated foodborne and agro-terrorism response capabilities and collaborate on how relevant active food microbiology surveillance information can be effectively shared across the border.

**CDC Preparedness Goal 5: INVESTIGATE**

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

**5A Target Capability: Epidemiological Surveillance and Investigation**

**Critical Task(s):**

1) Develop the capability to undertake joint epidemiological investigations of infectious disease outbreaks along the international border. Such capability should include the ability to jointly:
   - assess the seriousness of the threat and rapidly mobilize in response to an emergency;
   - investigate to identify causes, risk factors, and appropriate interventions;
   - coordinate the tracking of victims, cases, contacts, exposures, prophylaxes, treatments, and patient disposition; and
   - contribute information directly to the public, including special populations, that explains and informs about risk and appropriate courses of action.

2) Continue to convene binational surveillance and epidemiology planning workshops to discuss and plan cross-border surveillance and/or epidemiology-related activities. Such activities should, where feasible, involve a collaborative and regional approach with neighboring U.S. border states and appropriate tribal nations, as well as Mexico or Canada (as appropriate).
3) Conduct capable field epidemiologic investigations, rapid needs assessments, exposure assessments, and response.

**Appendix 6**
**Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) Draft Compliance Requirements**

*In FY 2007, states were required to meet the Electronic System requirements 1-5 by August 8, 2008. **Note:** The Compliance Requirements document was revised, and requirements 1 and 2 have been combined.

**In FY 2008, states are required to meet the remaining compliance requirements by August 8, 2009.

The draft ESAR-VHP compliance requirements identify capabilities and procedures that state[3] ESAR-VHP programs must have in place to ensure effective management and inter-jurisdictional movement of volunteer health personnel in emergencies. Each state must meet all of the compliance requirements. All states must report progress toward meeting these compliance requirements on mid-year and end-of-year progress reports for the Hospital Preparedness Program.

## ESAR-VHP Electronic System Requirements

1. Each state is required to develop an electronic registration system for recording and managing volunteer information based on the data definitions presented in the *2008 Interim ESAR-VHP Technical and Policy Guidelines, Standards and Definitions* (ESAR-VHP *Guidelines).*

   These systems must:

   a) Offer Internet-based registration. Information must be controlled and managed by authorized personnel who are responsible for the data.
   b) Ensure that volunteer information is collected, assembled, maintained and utilized in a manner consistent with all federal, state and local laws governing security and confidentiality.
   c) Identify volunteers via queries of variables as defined by requestor.
   d) Ensure that each state ESAR-VHP system is both backed up on a regular basis and that the back-up version is not co-located.

2. Each electronic system must be able to register and collect the credentials and qualifications of health professionals that are then verified with the issuing entity or appropriate authority identified in the *2008 Interim ESAR-VHP Guidelines*

   a) Each state must collect and verify the credentials and qualifications of the following health professionals. Beyond this list of occupations, a state may

[3] For purpose of this appendix, state refers to any Hospital Preparedness Program grantee, including states, territories, cities, counties, the District of Columbia, commonwealths, or the sovereign nations of Palau, Marshall Islands, and Federated States of Micronesia.

register volunteers from any other occupation it chooses. The standards and requirements for including additional occupations are left to the states.

1) Physicians (allopathic and osteopathic)
2) Registered nurses, including advanced practice registered nurses (APRNs); APRNs include nurse practitioners, certified nurse anesthetists, certified nurse-midwives, and clinical nurse specialists.
3) Pharmacists
4) Psychologists
5) Clinical social workers
6) Mental health counselors
7) Radiologic technologists and technicians
8) Respiratory therapists
9) Medical and clinical laboratory technologists and technicians
10) Licensed practical nurses and licensed vocational nurses

b) Six (6) months after end of the FY 2007 budget period, each state must expand its electronic registration system to include the remaining professions identified in the 2008 *ESAR-VHP Guidelines*.

c) States must add additional professions to their systems as they are added to future versions of the *ESAR-VHP Guidelines.*

3. Each electronic system must be able to assign volunteers to all four ESAR-VHP credential levels. Assignment will be based on the credentials and qualifications that the state has collected and verified with the issuing entity or appropriate authority.

4. Each electronic system must be able to record ALL volunteer health professional/emergency preparedness affiliations of an individual, including local, state, and federal entities.

   The purpose of this requirement is to avoid the potential confusion that may arise from having a volunteer appear in multiple registration systems (e.g., Medical Reserve Corps (MRC), National Disaster Medical System (NDMS), etc.).

5. Each electronic system must be able to identify volunteers willing to participate in a federally coordinated emergency response.

   a) Each electronic system must query volunteers upon initial registration and/or re-verification of credentials about their willingness to participate in emergency responses coordinated by the federal government**.** Responses to this question, posed in advance of an emergency, will provide the federal government with an estimate of the potential volunteer pool that may be available from the states upon request.

   b) If a volunteer responds "Yes" to the federal question, states may be required to collect additional information (e.g., training, physical and medical status, etc.).

6. Each state must be able to update volunteer information and reverify credentials every six months.

Note: The HHS Assistant Secretary of Preparedness and Response (ASPR) will review this requirement regularly for possible adjustments based on the experience of the states.

**ESAR-VHP Operational Requirements**

7. Upon receipt of a request for volunteers from any governmental agency or recognized emergency response entity, all states must: 1) within 2 hours query the electronic system to generate a list of potential volunteer health professionals to contact; 2) contact potential volunteers; 3) within 12 hours provide the requester an initial list of willing volunteer health professionals that includes the names, qualifications, credentials, and credential levels of volunteers; and 4) within 24 hours provide the requester with a verified list of available volunteer health professionals.

8. All states are required to develop and implement a plan to recruit and retain volunteers. ASPR will assist states in meeting this requirement by providing professional assistance to develop a national public education campaign, tools for accessing state enrollment sites, and customized state recruitment and retention plans. This will be carried out in conjunction with existing recruitment and retention practices utilized by states.

9. Each state must develop a plan for coordinating with all volunteer health professional/emergency preparedness entities to ensure an efficient response to an emergency, including but not limited to MRC units and the NDMS teams.

10. Each state must develop protocols for deploying and tracking volunteers during an emergency (mobilization protocols):
    a) Each state is required to develop written protocols that govern the internal activation, operation, and timeframes of the ESAR-VHP system in response to an emergency. Included in these protocols must be plans to track volunteers during an emergency and for maintaining a history of volunteer deployments. ASPR may ask for copies of these protocols as a means of documenting compliance. ASPR will include protocol models in future versions of the *ESAR-VHP Guidelines*.
    b) Each state ESAR-VHP program is required to establish a working relationship with external partners, such as the local and/or state emergency management agency and develop protocols outlining the required actions for deploying volunteers during an emergency. These protocols must ensure 24/7 accessibility to the ESAR-VHP system. Major areas of focus include:
        1) Intrastate deployment: States must develop protocols that coordinate the use of ESAR-VHP volunteers with those from other volunteer organizations, such as the MRC.
        2) Interstate deployment: States must develop protocols outlining the steps needed to respond to requests for volunteers received from another state. States that have provisions for making volunteers employees or agents of the state must also develop protocols for deployment of volunteers to other states through the state emergency management agency via the Emergency Management Assistance Compact (EMAC). Each state must have a

process for receiving and maintaining the security of volunteers' personal information sent to them from another state and procedures for destroying the information when it is no longer needed.

3) Federal deployment: Each state must develop protocols necessary to respond to requests for volunteers that are received from the federal government. Further, each state must adhere to the protocol developed by the federal government that governs the process for receiving requests for volunteers, identifying willing and available volunteers, and providing each volunteer's credentials to the federal government.

**ESAR-VHP Evaluation and Reporting Requirements**

11. Each state must develop a plan for regular testing of its ESAR-VHP system through drills and exercises. These exercises must be consistent with the requirement for drills and exercises as outlined in the Hospital Preparedness Program guidance.

12. Each state must develop a plan for reporting program performance and capabilities.

    Each state will be required to report program performance and capabilities data as specified in the Hospital Preparedness Program guidance and/or *ESAR-VHP Guidelines*. States will report the number of enrolled volunteers by profession and credential level, the addition of program capabilities as they are implemented, and program activity during responses to actual events.

**Appendix 7**
**Federal Guidance to Assist States in Improving**
**State-level Pandemic Influenza Operating Plans**

## Scoring Process

The information provided for the operating objectives will be rated for comprehensiveness, and the evaluators jointly will assign a single rating for operational readiness for the entire state submission.

Comprehensive Score

Reviewers will consider the information submitted for each associated supporting activity and assess the degree to which the response describes a) a definitive implementation strategy and b) unequivocal specification as to which organizations or individuals are responsible for which elements.

Before beginning the rating process, reviewers may modify the list of supporting activities in one or both of two ways. First, they will not assign a rating to a particular supporting activity if the state has indicated that the item is "not applicable" and offered a convincing justification. Second, they will add and rate a new supporting activity as proposed by the state if they judge the proposed addition to be relevant to the operating objective and of comparable significance to the supporting activities already listed.

The scoring schema to be used for each operating objective is as follows. For each supporting activity, the review team will award a score of 0, 1, 2, or 3. A percentage for each operating objective will be calculated by totaling the scores of the supporting activities under that operating objective and dividing that number by the total number possible.

Example:

| Operating Objective X. | Key: |
|---|---|
| Supporting activity - 3/3 | ≥85% = "No Major Gaps" |
| Supporting activity - 2/3 | 69-84% = "A Few Major Gaps" |
| Supporting activity - 2/3 | 50-68% = "Many Major Gaps" |
| Supporting activity - 3/3 | 1-49% = "Inadequate Preparedness" |
| Supporting activity - 2/3 | |
| 12/15 = 80% | |

The percentage derived for the operating objective will be translated into a standardized verbal designation according to the key shown above. No submission or a nonresponsive submission will be classified as "insufficient information to allow assessment."

Operational Readiness Score

The USG departments jointly will assign a single rating for operational readiness for the entire state submission based on the information requested in the last subappendix for each of the three strategic goals. The departments will determine the number of operating objectives for which the state submitted evidence that it has tested its response capability in some appropriate way.

This number then will be divided by the total number of operating objectives, expressed as a percentage, and translated into a standardized verbal designation according to the key below:

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

No submission or a nonresponsive submission will be classified as "insufficient information to enable assessment."

## Appendix 8
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