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CHAPTER 8: STATE, LOCAL, AND TRIBAL PREPAREDNESS

Introduction

Preparedness at the State, local, and tribal levels is critical to the country's ability to respond to and recover from an influenza pandemic because it is at these levels that the most direct response will be implemented. For pandemic influenza preparedness to be effective, it must be a multifaceted effort engaging both traditional public health and health care partners, including mental and behavioral health, and other sector partners and stakeholders such as the business community, public safety and law enforcement, emergency management, education, transportation, social services, mental health and substance abuse services, utilities, and Community-Based Organizations (CBOs) and Faith-Based Organizations (FBOs). The duration, scope, and scale of a pandemic will tax infrastructure and mutual-aid agreements with and across most, if not all, jurisdictions and sectors. One of HHS' roles with respect to State, local, and tribal preparedness is providing advice and recommendations on a number of specific topics such as surveillance, public health interventions, vaccine, antiviral drugs, and communications. These topics are covered for the most part in chapters 1–7 in this document. This chapter addresses the cross-cutting preparedness issue of HHS provision of assistance in strengthening State, local, and tribal preparedness for pandemic influenza.

In the event of an influenza pandemic, States, localities, and tribes must be prepared to respond principally with their existing resources because the ability to shift resources from one part of the country or from a neighboring State to another (as is commonly done for other types of emergencies), will be substantially limited given the widespread scope of a pandemic event. Additionally, deployable Federal personnel assets, namely the National Disaster Medical System (NDMS) and the USPHS Commissioned Corps, will be in short supply due to illness, widespread demand for assistance, and the increased need for these personnel in their primary assignments.

To date, much of the planning for population-based, health-related emergencies has occurred within the public health and health care sectors by HHS and through Federal grants and cooperative agreements to States, Territories, and selected cities. Priority public health issues include detection of a novel virus and the necessary surveillance to track its course, implementation of community containment measures, distribution of antiviral drugs and vaccine to priority groups, coordination and delivery of messages through credible spokespersons, psychosocial support for diverse populations, and development of provisions for vulnerable and difficult to access populations. While guidelines, recommendations, and some resources will emanate from Federal Agencies, requisite action must be implemented at the State, local, and tribal levels for effective preparedness and response.

State, local, and tribal efforts to implement the detection, surveillance, response, communications, and evaluation measures discussed in the preceding paragraph will require use of information systems to support the activities. A critical part of State, local, and tribal preparedness is the use of information systems that adhere to standards that are interoperable across jurisdictions and across sectors. Information-systems standards also will facilitate aggregation of relevant data and information at the Federal level. Relevant requirements and standards for preparedness systems have been developed in consultation with State, local, and tribal partners for the PHIN and are required for use in information systems developed with funds distributed through the Public Health Emergency Preparedness Cooperative Agreement.

Health care preparedness has been a major concern because most hospitals currently have limited capacity to absorb increases in patient load. Increases in patient load concomitant with reduced staffing pose an even greater challenge. The outpatient health care sector will be a critical part of the pandemic response as the majority of ill persons will not require hospital care. If the outpatient sector is overwhelmed, hospitals will be under greater pressure, and may thus compromise the ability to effectively triage those requiring acute and advanced medical care services. In addition, certain outpatient care settings serve especially vulnerable persons who, if unable to receive care, will additionally burden hospitals (and in the case of dialysis patients, for example, hospitals may be unable to provide adequate care). Therefore, planning must address maintaining continuity of services for medically fragile persons and emerging acute-care needs amongst the general population.

A key State-level initiative for identifying health personnel to meet increased patient care needs is the development of a State-based system for the advance-registration and credential verification of volunteers who may be used to augment the staff of a hospital or other health care facility. Development of these State-level systems is being supported through the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) program. The Medical Reserve Corps (MRC), which establishes teams of local volunteer medical and public health professionals who can contribute their skills during times of community need, may be another source of staffing.

Also, a severe influenza pandemic would very likely affect critical infrastructure beyond the obvious impact on the health care system. As a result of absenteeism due to illness, and potentially compounded by public health measures such as school closures or shelter in place (“snow days”), substantial disruption of critical services may occur. This is especially true given the current system of “just-in-time” delivery of medical supplies and equipment. Inventories are already limited and a disruption of only a few days in delivery of goods could result in shortages of essential supplies such as food, fuel, hospital supplies, and pharmacy supplies. In addition, the ability to consistently supply utilities such as water, gas, and electricity may be compromised, resulting in spot shortages.

Therefore, identifying strategies to mitigate the consequences of absenteeism, of social distancing measures, and potentially even of border closures are an important aspect of preparedness. While contingency and continuity-of-business plans have been developed for many large businesses and utility companies, they have not been developed for a scenario of this magnitude and thus must be reworked to reflect a different set of assumptions.

Civil disturbances or a breakdown in public order may occur in situations where the health care system is overwhelmed, countermeasures such as vaccine and antiviral drugs are in limited supply, and shortages of basic necessities due to supply chain disruptions are occurring. State, local, and tribal law enforcement and public safety personnel will play an important role in providing public safety and security during an influenza pandemic. Their role will be proportional to the severity of the pandemic.

Role of HHS in State, Local, and Tribal Preparedness

The HHS role in State, local, and tribal pandemic influenza preparedness is to provide technical assistance and guidance to State, local, and tribal public health and other leadership in their efforts to prevent, prepare for, protect against, and respond to an influenza pandemic.

HHS responsibilities include, but are not limited to

- Providing guidance documents to jurisdictions outlining goals, objectives, and performance measures for pandemic influenza preparedness activities
- Providing recommendations on the essential components of an adequate jurisdictional pandemic influenza preparedness plan
- Providing subject-matter technical assistance in troubleshooting problematic areas of the jurisdiction's plan, systems, or infrastructure to prepare for or respond to an influenza pandemic
- Ranking (or proposed ranking, because HHS priorities are not the last word) priority groups for vaccine distribution
- Holding forums at the Federal level involving stakeholders across disciplines and organizations in which issues related to State, local, and tribal pandemic influenza preparedness can be discussed
- Developing and testing tools (e.g., functional exercises, drills) for use at the State, local, and tribal levels
- Dispersing Congressionally appropriated pandemic influenza preparedness funds to State, local, and tribal jurisdictions
- Providing disease surveillance data to the States before and during an influenza pandemic

Specific Assumptions and Planning Considerations for State, Local, and Tribal Preparedness

- Leadership from Governors, mayors, and tribal leaders is critical to pandemic influenza preparedness. It ensures coordination, completion, and exercising of jurisdiction-wide plans.
- The well-being, health, and safety of the U.S. population requires community-based action as well as regional coordination for effective preparedness and intervention efforts and should include all government entities, including public health, health care, mental health and substance abuse, animal health, law enforcement, social services, business, and essential services.
- There will be limited Federal personnel assets available for deployment to any one jurisdiction.
- Hospitals and other health care settings are currently unprepared to respond to increases in patient load of the magnitude anticipated in a moderate or severe pandemic.
- If the outpatient health care capacity is overwhelmed, the burden placed on hospitals will surge.
- The number of health care workers will be reduced due to illness or absenteeism while they care for ill family members.
- If health care capacity is seriously exceeded, or misconstrued to be so, public anxiety will increase. The incidence of stress-induced symptoms and disruptive or risky behaviors may increase.
- Of individuals in severely disaster-affected communities, 25–30 percent require intensive psychosocial support, as will 5–10 percent of individuals in moderately affected communities. The affect of pandemic influenza is unknown.
- The HHS Secretary will consider granting waivers and implementing other flexibilities and accommodations in order to support State, local, and tribal preparedness with respect to publicly funded health insurance programs (e.g., Medicaid, State Children's Health Insurance Program (SCHIP)).
- The implementation of community containment measures will result in disruption of a variety of services.

HHS Actions and Expectations

Pillar One: Preparedness and Communication

Many activities must be undertaken at all levels of State, local, and tribal government and society to ensure preparedness for pandemic influenza. The role of HHS with respect to State, local, and tribal planning is primarily to provide funding to facilitate planning; to

provide guidance to assist planners; and to facilitate coordination at the State, local, and tribal levels by coordinating at the national level.

The following Pillar One activities where State and local jurisdictions play a role, but the HSC actions are covered in detail in other chapters include Chapter 3, Public Health Interventions, (HSC 5.1.4.3, 9.1.2.1 and 9.1.3.1); Chapter 4, Federal Medical Response (HSC 6.1.2.4); Chapter 5, Vaccines (HSC 6.1.13.9, 6.1.14.1, and 6.1.14.2); Chapter 6, Antivirals (HSC 6.1.6.1, 6.1.9.2, 6.1.13.9, 6.1.14.1, and 6.1.14.2); and Chapter 7, Communications (HSC 6.1.3.2, 6.1.3.3, and 6.1.12.1).

Planning for a Pandemic

A. Action (HSC 4.1.4.3): HHS will work with DOS to ensure that adequate guidance is provided to Federal, State, tribal and local authorities regarding the inviolability of diplomatic personnel and facilities and will with such authorities and DOS to develop methods of obtaining voluntary cooperation from the foreign diplomatic community within the U.S. consistent with U.S. Government treaty obligations. (Also see chapter 3, Pillar One [HSC 4.1.4.3].)

   Timeframe: Within 6 months.

   Measure of Performance: Briefing materials and an action plan in place for engaging with relevant federal, state, tribal and local authorities.

   Step 1: Disseminate to States briefing materials that explain the privileges and immunities of diplomatic personnel.

   Step 2: Disseminate to States briefing materials that explain the process for obtaining voluntary cooperation from the diplomatic community in the case of quarantine, isolation, or related issue.

   Step 3: If requested, serve as an intermediary or support for the State in working with DOS to obtain voluntary cooperation.

B. Action (HSC 5.1.2.1): HHS will work with DHS and in coordination with DOT and USDA, to review existing grants or Federal funding that could be used to support transportation and border-related pandemic planning. (Also see Chapter 3, Public Health Interventions.)

   Timeframe: Within 4 months.

   Measure of Performance: All State, local, and tribal governments are in receipt of, or have access to, guidance for grant applications.

   Step 1: Provide technical assistance to DHS as needed.

Step 2: Determine annually whether any grant programs can be used to support transportation and/or border-related pandemic planning.

Step 3: Develop and publish "allowable cost" matrices. These charts will be provided in HHS and DHS guidance.

Step 4: Post the guidance's and developed "allowable cost" matrices on agency Web sites, as well as disseminate through other established channels.

C. Action (HSC 5.1.2.2): Under the leadership of DOT and in coordination with DHS and transportation stakeholders, HHS will support a series of forums with governors and mayors to discuss transportation and border challenges that may occur in a pandemic, share approaches, and develop a planning strategy to ensure a coordinated national response. (Also see chapter 3, Pillar One [HSC 5.1.2.2].)

Timeframe: Within 12 months.

Measure of Performance: Strategy for coordinated transportation and border planning is developed and forums are initiated.

Step 1: Work with DOT and DHS and relevant associations to schedule forums.

Step 2: Provide technical assistance to DOT and DHS.

D. Action (HSC 5.1.2.3): In coordination with USDA and transportation stakeholders, HHS will assist DOT and DHS, develop planning guidance and materials for State, local, and tribal governments, including scenarios that highlight transportation and border challenges and responses to overcome those challenges, and an overview of transportation roles and responsibilities under the NRP. (Also see chapter 3, Pillar One [HSC 5.1.2.3] and Pillar Two [HSC 5.2.2.1, 5.2.4.6, and 5.2.4.8].)

Timeframe: Within 12 months.

Measure of Performance: State, local, and tribal governments have received or have access to tailored guidance and planning materials.

Step 1: Provide technical assistance to DOT and DHS as needed.

Step 2: Post guidance to HRSA and CDC Web sites that deal with pandemic influenza.

Step 3: As applicable, incorporate this information into funding guidance or send as attachments.

E. Action (HSC 5.1.3.1): In coordination with DOT and USDA, HHS will support DHS in conducting tabletop discussions and other outreach with private sector transportation and border entities to provide background on the scope of a pandemic, to assess current preparedness, and jointly develop a planning guide. (Also see chapter 3, Pillar One [HSC 5.1.3.1].)

Timeframe: Within 8 months.

Measure of Performance: Private sector transportation and border entities have coordinated Federal guidance to support pandemic planning, including a planning guide that addresses unique border and transportation challenges by mode.

Step 1: Provide technical assistance to DHS as needed.

F. Action (HSC 5.1.3.2): HHS will work with DHS and in coordination with DOT, DOC, Treasury and USDA, and with the private sector to identify strategies to minimize the economic consequences and potential shortages of essential goods (e.g., food, fuel, medical supplies) and services during a pandemic.

Timeframe: Within 12 months.

Measure of Performance: The private sector has strategies that can be incorporated into contingency plans to mitigate consequences of potential shortages of essential goods and services.

Step 1: Determine which HHS Operational Division (OPDIV) representation is essential to the workgroup and invite members to attend and participate.

Step 2: All HHS OPDIVs will, to the extent possible, share this information to all relevant grant and cooperative agreement programs and key stakeholders through various avenues that include listservs, Web sites, program letters, grantee/awardee meetings, and conference calls.

G. Action (HSC 6.1.1.1): HHS will work with other partners in the Federal Government and State, local and tribal governments to define and test actions and priorities required to prepare for and respond to a pandemic.

Timeframe: Within 6 months.

Measure of Performance: Completion and communication of national, Departmental, State, local and tribal pandemic influenza response plans; actions and priorities defined and tested.

Step 1: Set expectation that State, local, and tribal governments will coordinate their pandemic plans with businesses, education sector (including private and

public K–12, colleges and universities, and daycare/preschool), and community and faith-based organizations.

Step 2: Provide technical assistance as requested by State, local, and tribal governments to complete jurisdictional pandemic influenza response plans. Monitor public health and health care emergency preparedness cooperative agreement recipients' completion of pandemic influenza response plans. Communicate the national and HHS pandemic influenza plans to the cooperative agreement recipients to increase understanding by the awardees and help ensure that all plans are complementary to one another.

Step 3: Assist in defining pandemic influenza priorities, capabilities, and performance measures.

Step 4: Report the percentage of States with plans that address the pandemic influenza priorities. Take corrective action with those States that do not do so.

Step 5: Develop a planning guide to assist Indian Health Service (IHS) and tribal health care facilities with planning.

Step 6: Set the expectation in emergency preparedness cooperative agreements and grants that at least one exercise per year will be an exercise conducted jointly between HHS- and DHS-funded responders.

Step 7: Provide technical assistance toward assessing gaps, and planning to address gaps, between preparedness information systems and information system capabilities required to be PHIN compatible and to support pandemic flu.

Step 8: Set the expectation in relevant grant and cooperative agreement guidance documents that PHIN-compatible information systems will be available and used routinely to support public health activities that detect, respond to, and evaluate pandemic influenza and other urgent public health events.

Step 9: Disseminate draft technical guidance entitled "Public Health Workbook to Define, Locate, and Reach Special, Vulnerable, and At-Risk Populations in an Emergency" (http://www.bt.cdc.gov/workbook).

H. Action (HSC 6.1.1.2): HHS, in coordination with DHS, will review and approve State pandemic influenza plans to supplement and support DHS State Homeland Security Strategies to ensure that Federal homeland security grants, training, exercises, technical and other forms of assistance are applied to a common set of priorities, capabilities, and performance benchmarks, in conformance with the National Preparedness Goal.

Timeframe: Within 12 months.

Measure of Performance: Definition of priorities, capabilities, and performance benchmarks; percentage of States with plans that address priorities, identify capabilities and meet benchmarks.

Step 1: Participate in the review of DHS State Homeland Security Strategies to ensure consistency among Federal Departments.

Step 2: Project officers will routinely communicate on issues related to pandemic influenza through the established Interagency Advisory Committee. This group will serve as a forum to update agencies on issues and policies related to pandemic influenza and other Federal activities.

Step 3: The Interagency Advisory Committee will solicit project officers, senior leaders, and policymakers from DHS and HHS to define priorities, capabilities, and performance benchmarks related to pandemic influenza in conformance with the National Preparedness Goal.

Step 4: HHS and DHS will set the expectation in their respective emergency preparedness cooperative agreements and grants that at least one exercise per year will be an exercise conducted jointly between HHS and DHS funded responders.

I. Action (HSC 6.1.1.3): HHS will assist DHS and work in coordination with DOJ, DOT, and DOD in DHS preparations to provide emergency response element training (e.g., incident management, triage, security, and communications) and exercise assistance upon request of State, local, and tribal communities and public health entities.

Timeframe: Within 6 months.

Measure of Performance: Percentage of requests for training and assistance fulfilled.

Step 1: Review current training efforts to ensure consistency and coordination, and to reduce the creation of multiple training products. Focus training efforts on the behaviors to be performed differently.

Step 2: Provide technical assistance to DHS as needed.

Step 3: Inform DHS of HHS trainings.

J. Action (No HSC action): HHS will provide guidance to integrate population-based behavioral countermeasures into Federal, tribal and local communication campaigns and message mapping strategies and cross-sector exercise planning and testing to anticipate behavioral responses and impacts on continuity of critical sector-specific operations under varying conditions of medical countermeasure supply and pandemic severity. (Also see Chapter 7, Communications.)

Timeframe: 12 months.

Measure of Performance: Guidance on assisting vulnerable populations during an influenza pandemic completed and disseminated.

Step 1: Work with partners to create and disseminate guidance and technical assistance about specific vulnerable populations (e.g., people with chronic mental and/or substance use disorders); this guidance will also be used to assist States and other partners to include elements about psychosocial factors in exercise planning.

Step 2: Work with partners to create and disseminate clearly articulated statement of objectives for use of behavioral countermeasures tailored for specific populations under varying conditions of medical countermeasure supply and pandemic severity.

K. Action (HSC 6.1.2.3): HHS, in coordination with DHS, DOT, DOD, and VA, will work with State, local and tribal governments and leverage Emergency Management Assistance Compact agreements to develop protocols for distribution of critical medical materiel (e.g., ventilators) in times of medical emergency.

Timeframe: Within 6 months.

Measure of Performance: Critical medical material distribution protocols completed and tested.

Step 1: HHS OPDIVs will provide technical assistance to States and to IHS and tribal health care facilities as needed.

L. Action (HSC 6.1.2.5): HHS will package and offer to the States and Territories the core operating components of an ESAR-VHP system; and encourage all States, and tribal entities to implement the ESAR-VHP program by providing

technical assistance and orientations at State and territory request to implement and operate Federal guideline (ESAR-VHP) compliant systems.

Timeframe: Offer ESAR-VHP system within 6 months; Provide technical assistance and orientations upon request within twelve months.

Measure of Performance: Guidance and technical assistance, as requested, provided to States to implement ESAR-VHP capability, compliant with federal guidelines, in all States and U.S. territories.

Step 1: Support the development of the core operating components of an ESAR-VHP system.

Step 2: Deploy the ESAR-VHP core operating components to as many States (including the District of Columbia) and U.S. Territories as possible.

Step 3: Provide technical assistance to States, the District of Columbia, and U.S. Territories on the implementation and operation of these systems.

M. Action (HSC 6.1.2.6): HHS, in coordination with the USA Freedom Corps and Citizen Corps programs, will continue to work with States and local communities to expand the Medical Reserve Corps program.

Timeframe: Expansion of program by 20 percent within 12 months.

Measure of Performance: Increase number of Medical Reserve Corps units by 20 percent, from 350 to 420 units.

Step 1: Develop outreach and technical assistance strategies and work plans.

Step 2: Develop communications materials.

Step 3: Conduct activities in keeping with these plans at the regional and national levels.

Step 4: The MRC Program will develop guidance to allow a subset of MRC members to volunteer for Federal deployment. This subset will be identified as the Public Health Service Auxiliary. The MRC program will develop and implement procedures for the U. S. Public Health Service (USPHS)Auxiliary volunteers to be preidentified, precredentialed, trained in appropriate disaster response issues, and preprocessed thru the HHS process for unpaid intermittent Federal employees. The September 2007 goal will be to enroll 3,000 MRC members in the USPHS Auxiliary.

N. Action (HSC 6.1.2.7): HHS, in coordination with DHS, DOD, VA, and the USA Freedom Corps and Citizen Corps programs, will prepare guidance for local

Medical Reserve Corps coordinators describing the role of the Medical Reserve Corps during a pandemic. (Also see chapter 7, Pillar One [HSC 6.1.2.7].)

Timeframe: Within 3 months.

Measure of Performance: Guidance materials developed and published on Medical Reserve Corps website (http://www.medicalreservecorps.gov).

Step 1: Develop guidance based on existing documents (from HHS agencies and others), and with input from MRC regional coordinators and local MRC leaders.

Step 2: Publish materials at http://www.medicalreservecorps.gov.

O. Action (HSC 7.1.1.1): HHS, in coordination with DHS, DOD, and DOI, and will support USDA in its efforts (in partnership with State and tribal entities, animal industry groups, and [as appropriate] the animal health authorities of Canada and Mexico) to establish and exercise animal influenza response plans.

Timeframe: Within 6 months.

Measures of Performance: Plans in place at specified Federal agencies and exercised in collaboration with states believed to be at highest risk for an introduction into animals of an influenza virus with human pandemic potential.

Step 1: Assist USDA in defining avian influenza preparedness gaps, priorities, capabilities, and performance benchmarks.

Step 2: Assist USDA in developing avian influenza planning guidance documents for IHS and tribal health care facilities.

Step 3: Set the expectation in emergency preparedness cooperative agreements and grants that at least one exercise per year will include State Health and State Wildlife/Agriculture sectors.

P. Action (HSC 7.1.2.2): HHS, in coordination with DOD, DHS, and DOI, will assist USDA in partnering with States and tribal entities to ensure sufficient veterinary diagnostic laboratory surge capacity for response to an outbreak of avian or other influenza virus with human pandemic potential.

Timeframe: Within 6 months.

Measure of Performance: Plans and necessary agreements to meet laboratory capacity needs for a worst case scenario influenza outbreak in animals validated by utilization in exercises detailed in HSC 7.1.1.1.

Step 1: Provide technical assistance; assist with developing lab training curriculum and conducting training courses as appropriate.

Q. Action (HSC 8.1.1.1): HHS is working with DHS to help States ensure that State pandemic response plans adequately address law enforcement and public safety preparedness across the range of response actions that may be implemented, and that these plans are integrated with authorities that may be exercised by Federal agencies and other State, local and tribal governments.

Timeframe: Ongoing.

Measure of Performance: All submitted state plans reviewed within two months of receipt.

Step 1: Provide technical assistance to DHS as needed.

Step 2: Support the Federal-level review of all submitted State pandemic influenza plans.

Step 3: Provide technical assistance and monitor their cooperative agreement recipients' completion of pandemic influenza response plans.

Step 4: Communicate the national and HHS pandemic influenza plans to the cooperative agreement recipients.

Step 5: Encourage State, local, and tribal planners to ensure planning partners and stakeholders adequately address preparedness in prisons and jails as well as law enforcement and public safety.

Step 6: Monitor projects on pandemic planning activities to ensure that State pandemic influenza response plans adequately address preparedness plans for prisons and jails as well as law enforcement and public safety workplaces.

Step 7: Provide guidance to IHS and tribal health care facilities to ensure that pandemic response plans adequately address law enforcement and public safety preparedness.

R. Action (HSC 8.1.1.2): HHS will assist DHS, in coordination with DOJ, DOL, and DOD in developing a pandemic influenza tabletop exercise for State, tribal and local law enforcement and public safety officials that they can conduct in concert with public health and medical partners, and ensuring it is distributed nationwide.

Timeframe: Within 4 months.

Measure of Performance: Percent of State, local and tribal law enforcement/public safety agencies that have received the pandemic influenza tabletop exercise.

Step 1: Provide technical assistance to DHS regarding pandemic influenza tabletop exercises.

Step 2: Disseminate the tabletop exercise through various mechanisms to include Web sites, listservs, grantee conference calls, and meetings.

Step 3: Encourage participation of key stakeholders, including businesses, education sector (private and public K–12, colleges and universities, daycare/preschool), and CBOs and FBOs.

S. Action (HSC 8.1.2.7): HHS will, in coordination with DOJ, DOD, DOT, and other appropriate Federal Sector-Specific Agencies, work with DHS in a forum for selected Federal, State, local, and tribal personnel to discuss EMS, fire, emergency management, public works, and other emergency response issues they will face in a pandemic influenza outbreak and then publish the results in the form of best practices and model protocols.

Timeframe: Within 4 months.

Measure of Performance: Best practices and model protocols published and distributed.

Step 1: Provide technical assistance to DHS as needed.

Communicating Expectations and Responsibilities

T. Action (HSC 6.1.4.2): HHS, in cooperation with DHS and DOC, will assist DOT develop model protocols for 9–1–1 call centers and public safety answering points that address the provision of information to the public, facilitate caller screening, and assist with priority dispatch of limited emergency medical services. (Also see chapter 7, Pillar One [HSC 6.1.4.2].)

Timeframe: Within 12 months.

Measure of Performance: Model protocols developed and disseminated to 9–1–1 call centers and public safety answering points.

Step 1: Provide technical assistance regarding infection control and clinical triage protocols.

Producing and Stockpiling Vaccines, Antiviral Medications, and Medical Materiel

U. Action (HSC 6.1.5.1): HHS will encourage and subsidize the development of State, territorial, and tribal antiviral stockpiles to support response activities. (Also see chapter 6, Pillar One [HSC 6.1.5.1].)

Timeframe: Within 18 months.

Measure of Performance: State, territorial and tribal stockpiles established and antiviral medication purchases made toward goal of aggregate 31 million treatment courses.

Step 1: Encourage States to take advantage of federally subsidized antiviral purchasing arrangements.

Step 2: Distribute any guidance on how States can access these arrangements through multiple sources with the States.

Step 3: Explore the feasibility of a stockpile of antiviral drugs for IHS and tribal health care facilities.

V. Action (HSC 6.1.6.4): HHS, as well as DOD, VA and the States, will maintain their antiviral and vaccine stockpiles in a manner consistent with the requirements of FDA's SLEP, and HHS will explore the possibility of broadening SLEP to include equivalently maintained state stockpiles. (Also see chapter 6, Pillar One, Action L [HSC 6.1.6.4].)

Timeframe: Within 6 months.

Measure of Performance: Compliance with SLEP requirements documented; decision made on broadening SLEP to state stockpiles.

Step 1: FDA, in collaboration with State and local health authorities, determine whether to extend Shelf Life Extension Program (SLEP) to State and local stockpiles.

Step 2: If SLEP is extended to State and local stockpiles, develop guidance.

Step 3: Disseminate guidance for compliance with SLEP requirements.

Step 4: Disseminate information on SLEP to IHS and tribal health care facilities.

W. Action (HSC 6.1.7.1): HHS, in coordination with DHS, DOJ, VA, and in collaboration with State, local and tribal partners, will determine the national medical countermeasure requirements to ensure the sustained functioning of medical, emergency response, and other front-line organizations. (Also see chapter 5, Pillar One, Action L [HSC 6.1.7.1].)

Timeframe: Within 12 months.

Measure of Performance: More specific definition of sectors and personnel for priority access to medical countermeasures and quantities needed to protect those groups; guidance provided to State, local, and tribal governments and to

infrastructure sectors for various scenarios of pandemic severity and medical countermeasure supply.

Step 1: Develop guidance to assist local planners, including IHS and tribal health care facilities, in determining the number of essential personnel.

Step 2: Require all applicable grant projects to ensure that numerically quantified lists of personnel from medical, emergency response, and other front-line health care organizations that require priority access to vaccine and antiviral medications are identified.

Establishing Distribution Plans for Medical Countermeasures, Including Vaccines and Antiviral Medications

X. Action (HSC 6.1.13.1): HHS, in coordination with DHS, DOD, VA, and DOJ, and in collaboration with State, local, and tribal partners and the private sector, will ensure that States, localities and tribal entities have developed and tested pandemic influenza countermeasure distribution plans, and can enact security protocols if necessary, according to predetermined priorities. (Also see chapter 5, Pillar One, Action P [HSC 6.1.13.1] and chapter 6, Pillar One, Action Q [HSC 6.1.13.1].)

Timeframe: Within 12 months.

Measure of Performance: Ability to activate, deploy, and begin distributing contents of medical stockpiles in localities as needed established and validated through exercises.

Step 1: Work in cooperation with States and other Federal Agencies to develop and test plans for the allocation, distribution, and administration of pandemic influenza countermeasures with security protocols according to predetermined priorities.

Step 2: Require the incorporation of the pandemic influenza countermeasure allocation, distribution, and administration plans into State-level pandemic response plans.

Step 3: Encourage the development and testing of plans for the allocation, distribution, and administration of pandemic influenza countermeasures with security protocols according to predetermined priorities at the tribal and local levels.

Step 4: Ensure that PHIN-compatible information systems are available and used to support allocation, distribution, and administration of pandemic influenza countermeasures.

Y. Action (HSC 6.1.13.2): HHS will, in coordination with DOD, VA, States, and other public sector entities with antiviral drug stockpiles, coordinate use of assets maintained by different organizations. (Also see chapter 6, Pillar One, Action G [HSC 6.1.13.2].)

Timeframe: Within 12 months.

Measure of Performance: Plans developed for coordinated use of antiviral stockpiles.

Step 1: Provide technical assistance on, facilitate the discussion of, and monitor the development of State, local, and tribal pandemic influenza plans to ensure the coordinated use of antiviral stockpiles in coordination with DOD, VA, and other public sector entities with antiviral drug stockpiles.

Z. Action (HSC 6.1.13.3): HHS will, in collaboration with state, territorial, tribal, and local health care delivery partners, develop and execute strategies to effectively implement target group recommendations.

Timeframe: Within 12 months.

Measure of Performance: Guidance on strategies to implement target group recommendations developed and disseminated to State, local, and tribal authorities for inclusion in pandemic response plans.

Step 1: Build upon resource materials already developed to assist in planning for distribution of countermeasures. Aspects specific to pandemic influenza, namely the targeting of priority groups, will be addressed specifically by convening selected State, local, and tribal planners to define strategies to effectively implement target group recommendations.

Step 2: Disseminate these strategies to State, local, and tribal planners, including IHS and tribal health care facilities.

Step 3: Provide technical assistance on the implementation of these strategies.

AA. Action (HSC 6.1.13.4): HHS will, in coordination with DOD, VA, and in collaboration with State, local and tribal governments and private sector partners, assist in development and testing of distribution plans for medical countermeasure stockpiles to ensure antiviral distribution to infected patients within 48 hours of the onset of symptoms. (Also see chapter 6, Pillar One, Action O [HSC 6.1.13.4].)

Timeframe: Within 12 months.

Measure of Performance: Distribution plans developed and tested.

Step 1: Work in cooperation with States and other Federal Agencies to develop and test distribution plans for medical countermeasure stockpiles to ensure antiviral distribution to infected patients within 48 hours of the onset of symptoms.

Step 2: Require the incorporation of the distribution plans for medical countermeasure stockpiles into State-level pandemic response plans.

Step 3: Encourage the development and testing of distribution plans for medical countermeasure stockpiles at the tribal and local levels.

Step 4: Provide guidance to IHS and tribal health care facilities on the development and testing of distribution plans for medical countermeasure stockpiles.

(Also see Chapter 6, Antiviral Drugs.)

BB. Action (HSC 6.1.13.5): HHS will, in coordination with DHS, DOS, DOD, DOL, VA, and in collaboration with State, local, and tribal governments and private sector partners, develop plans for the allocation, distribution, and administration of pre-pandemic vaccine. (Also see chapter 5, Pillar One, Action O [HSC 6.1.13.5].)

Timeframe: Within 9 months.

Measure of Performance: Department plans developed and guidance disseminated to State, local, and tribal authorities to facilitate development of pandemic response plans.

Step 1: Work in cooperation with States and other Federal Agencies to develop and test plans for the allocation, distribution, and administration of pre-pandemic vaccine.

Step 2: Require the incorporation of the plans for the allocation, distribution, and administration of pre-pandemic vaccine into State-level pandemic response plans.

Step 3: Encourage the development and testing of plans for the allocation, distribution, and administration of pre-pandemic vaccine at the tribal and local levels.

(Also see chapter 6.)

CC. Action (HSC 6.1.13.6): HHS will work in coordination with DHS, State, local, and tribal officials and other EMS stakeholders , to support DOT development of suggested EMS pandemic influenza guidelines for statewide adoption that

address: clinical standards, education, treatment protocols, decontamination procedures, medical direction, scope of practice, legal parameters and other issues. (Also see chapter 4, Pillar One, Action B [HSC 6.1.2.4].)

Timeframe: Within 12 months.

Measure of Performance: Plans developed, tested and incorporated into Department- and State-level pandemic response plans.

Step 1: Provide technical expertise to DOT as needed.

Step 2: Where applicable, disseminate any guidelines that are developed and encourage the participation of key stakeholders.

DD. Action (HSC 6.1.13.7): HHS, in coordination with DHS, DOT, DOD, and VA, will work with State, local, tribal and private sector partners to develop and test plans to allocate and distribute critical medical material (e.g., ventilators with accessories, resuscitator bags, gloves, face masks, gowns) in a health emergency. (Also see chapter 4, Pillar One, Action F [HSC 6.1.13.7].)

Timeframe: Within 6 months.

Measure of Performance: Plans developed, tested, and incorporated into department plan and disseminated to State and tribes for incorporation into their pandemic response plans.

Step 1: Work in cooperation with States, tribes, and other Federal Agencies to develop and test plans for the allocation and distribution of critical medical material in a health emergency.

Step 2: Require the incorporation of the plans for the allocation and distribution of critical medical material in a health emergency into State-level pandemic response plans.

Pillar Two: Surveillance and Detection

The following Pillar Two activities where State and local jurisdictions play a role but the HSC actions are covered in detail in other chapters include Chapter 2, Domestic Surveillance (HSC 6.2.1.1, 6.2.1.2, 6.2.1.3, 6.2.2.3, 6.2.2.5, and 6.2.2.10); Chapter 3, Public Health Interventions (HSC 5.2.1.1, 5.2.4.2, 5.2.4.5, 5.2.4.6, 5.2.4.7, 5.2.4.8, and 5.2.4.10); and Chapter 7, Communications (HSC 5.2.4.10).

Ensuring Rapid Reporting of Outbreaks

A. Action (HSC 6.2.1.4): HHS, along with all other Federal, State, local, tribal, and private sector medical facilities, will ensure that protocols for transporting influenza specimens to appropriate reference laboratories are in place. (Also see chapter 2, Pillar One, Action L [HSC 6.2.1.4].)

Timeframe: 3 months.

Measure of Performance: Transportation protocols for laboratory specimens detailed in HHS, DOD, VA, State, territorial, tribal, and local pandemic response plans.

Step 1: Monitor pandemic planning activities to ensure that protocols for the transportation of laboratory specimens to appropriate reference laboratories are detailed in State, territorial, tribal, and local pandemic response plans.

Step 2: Work with key stakeholders to encourage private sector medical facilities training in the protocols for transporting influenza specimens to appropriate reference laboratories.

B. Action (HSC 6.2.2.8): HHS, in coordination with DHS, DOD, and VA, and in collaboration with State, local, and tribal authorities, will be prepared to assist State, local, and tribal authorities in collecting, analyzing, integrating, and reporting information about the status of hospitals and health care systems, health care critical infrastructure, and medical material requirements. (Also see chapter 3, Pillar Two, Action F [HSC 6.2.4.2] and chapter 4, Pillar One, Action B [HSC 6.1.2.4].)

Timeframe: Within 12 months.

Measure of Performance: Guidance provided to States and tribal entities on the use and modification of the components of the HAvBED system for implementation at the local level.

Step 1: Provide subject-matter experts to work with HHS and other relevant stakeholders in the development of guidelines and modification to the HAvBED system.

Step 2: Disseminate the guidelines to all applicable grant programs through various methods that include Web sites, conference calls, meetings, and program letters.

Step 3: The Interagency Advisory Committee, composed of HHS and DHS staff, will ensure these guidelines are disseminated across all Federal preparedness guidance documents.

Step 4: Provide guidance to IHS and tribal health care facilities to collect, analyze, integrate, and report information about the status of IHS and tribal hospitals and health care systems, health care critical infrastructure, and medical material requirements. (Also see chapter 2, Pillar Two, Action R [HSC 6.2.4.1].)

C. Action (HSC 6.2.2.11): State, local, and tribal public health departments should provide weekly reports on the overall level of influenza activity in their States or localities, with assistance from CDC epidemiologists and field officers posted within each State health department in collecting and reporting these data.

Timeframe: Ongoing

Measure of Performance: Influenza activity reports provided weekly during a pandemic.

Step 1: Assist State, local, and tribal public health departments, as requested, in providing weekly reports on the overall level of influenza activity in their jurisdictions during a pandemic.

D. Action (no HSC item): Assist State, local, and tribal entities in tracking non-hospital beds.

Step 1: Explore infrastructure capabilities to assist State Survey Agencies in standardizing real-time tracking and reporting.

Step 2: Assist States with the development and design of an information system with key elements to track and report provider status to CMS.

Step 3: Solicit input from other State Survey Agencies in broadening knowledge of the key elements of disaster tracking systems.

E. Action (HSC 6.2.3.5): State, local, and tribal public health departments should acquire and deploy rapid diagnostic tests that are specific and sensitive for pandemic influenza strains, as soon as those tested are available.

Timeframe: Ongoing

Measure of Performance: diagnostic tests, if found to be useful, are accessible to federally funded health facilities, via state public health departments.

Step 1: Assist State, local, and tribal public heath departments in acquiring and deploying rapid diagnostics tests for use at HHS-funded hospitals and clinics (e.g., IHS, NIH clinical center, USPHS hospitals).

Pillar Three: Response and Containment

The following Pillar Three activities where State and local jurisdictions play a role but the HSC actions are covered in detail in other chapters include Chapter 3, Public Health Interventions (HSC 6.3.2.2, 6.3.2.5, 6.3.2.7, 6.3.3.2, and 8.3.1.1); Chapter 4, Federal Medical Response; Chapter 6, Antivirals (HSC 6.3.5.2 and 6.3.4.1); and Chapter 7, Communications (HSC 6.3.5.2, 6.3.2.7, and 6.3.3.2).

Leveraging National Medical and Public Health Surge Capacity

A. Action (HSC 6.3.4.2): HHS will work in collaboration with DHS, DOD, and VA to assist major medical societies and organizations in developing and disseminating protocols for changing clinical care algorithms in settings of severe medical surge. (Also see chapter 3, Pillar Three, Actions L and M [HSC 6.3.2.7 and 6.3.3.1] and chapter 7, Pillar Three, Actions D and E [HSC 6.3.2.6 and 6.3.2.7].)

Timeframe: Within 6 months.

Measure of Performance: Guidance and protocols developed and disseminated.

Step 1: Provide personnel to participate in discussions with the above stakeholders and aid in the development of strategies and protocols for expanding hospital and home health care delivery capacity.

Step 2: Disseminate strategies and protocols through various mechanisms to include funding guidance documents, Web sites, grantee conference calls, and meetings as applicable.

Step 3: Provide guidance to IHS and tribal health care facilities on strategies and protocols for expanding hospital and home health care delivery capacity.

B. Action (HSC 6.3.4.3): HHS will work with State Medicaid and SCHIPs to ensure that Federal standards and requirements for reimbursement or enrollment are applied with the flexibilities appropriate to a pandemic, consistent with applicable law. Enrollment, payment, and related matters under the Medicare, Medicaid and SCHIP programs are applied with the flexibilities appropriate to a pandemic, consistent with applicable law.

Timeframe: Preliminary strategies will be developed within 6 months.

Measure of Performance: Draft policies and guidance developed concerning emergency enrollment in and reimbursement through State Medicaid and SCHIP programs during a pandemic.

Step 1: With respect to Medicaid and SCHIPs:

- Identify existing flexibilities States may immediately use to respond
- Determine relevant legal authorities, including whether new or amended authority would be required
- Develop necessary program policies and submit for approval
- Develop mechanisms to implement approved policies
- Identify means to ensure improved health care standards for providers surveyed by CMS or its agents to address disaster preparedness

Step 2: With respect to Medicare:

- Identify potential payment, coverage, and related initiatives
- Develop mechanisms to implement initiatives for which legal authority is clear
- Determine, for other initiatives, relevant legal authorities, including whether new or amended authority would be required
- Develop program policies for other initiatives and submit for approval
- Develop mechanisms to implement remaining approved initiatives

C. Action (HSC 7.3.3.1): HHS will assist USDA, in coordination with DOS, in USDA efforts to partner with appropriate international, Federal, State, and tribal authorities, and with veterinary medical associations, including the American Veterinary Medical Association, to reduce barriers that inhibit veterinary personnel from crossing State or national boundaries to work in an animal influenza outbreak response.

Timeframe: Within 9 months.

Measure of Performance: Agreements or other arrangements in place to facilitate movement of veterinary practitioners across jurisdictional boundaries.

Step 1: Provide technical assistance to USDA regarding safe disposal of animal carcasses.

D. Action (HSC 7.3.1.1): USDA, in coordination with DHS, HHS, DOI and the EPA, will partner with State and tribal entities, animal industries, individual animal owners, and other affected stakeholder to eradicate any influenza outbreak in commercial or other domestic birds or domestic animals caused by a virus that has the potential to become a human pandemic strain, and to safely dispose of animal carcasses.

Timeframe: Ongoing

Measure of Performance: at least one incident management team form USDA on site with in 24 hours of detection of such an outbreak.

Step 1: Facilitate participation by State, local, and tribal public health authorities in USDA-coordinated efforts to eradicate animal influenza, as needed.

E. Action (HSC 7.3.1.2): USDA will coordinate with DHS and other Federal, State, local, and tribal officials, animal industry, and other affected stakeholders during an outbreak in commercial or other domestic birds and animals to apply and enforce appropriate movement controls on animals and animal products to limit or prevent spread of influenza virus.

Timeframe: Ongoing

Measure of Performance: initial movement controls in place within 24 hours of detection of an outbreak.

Step 1: Facilitate participation by State, local, and tribal authorities, as needed, in USDA-coordinated efforts to apply movement controls on animals and animal products to limit or prevent spread of influenza virus during an animal influenza outbreak.

F. Action (HSC 8.3.2.2): HHS will work in coordination with DHS, DOJ, DOD, DOT, and other appropriate Federal Sector-Specific Agencies, to support DHS engagement in contingency planning and related exercises to ensure they are prepared to sustain EMS, fire, emergency management, public works, and other emergency response functions during a pandemic.

Timeframe: Within 6 months.

Measure of Performance: Completed plans (validated by exercise(s)) for supporting EMS, fire, emergency management, public works, and other emergency response functions.

Step 1: Provide technical assistance to DHS as needed.