

## Cities Readiness Initiative

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**Q: Must the USPS Plan cover all jurisdictions as defined by the MSA or may the USPS Plan identify select zip codes? (6/30/05)**

**A:** *An incremental approach is acceptable and may be the best fit for the resources available to implement the USPS Plan. Preparedness is not served well if we let the perfect be the enemy of the good. As a general rule, HHS recommends that implementation of the USPS plan begin with the most densely populated zip codes. These parts of the MSA most likely will present the greatest challenge if circumstances ever require rapid provision of antibiotics to everyone within a geographical area that includes one or more of these zip codes. The long-term target would be the extension of the USPS Plan to most, if not all jurisdictions, to ensure the success of the MSA in meeting the requirements of the CRI.*

**Q: Security is a barrier to USPS Planning. How does HHS/CDC recommend we address this issue? (6/30/05)**

**A:** *The security requirement connected to the USPS Plan is demanding. The jurisdiction may not be able to align sufficient security resources to match the needs of a 100 percent implementation of the USPS Plan and can take an incremental approach as identified above. In addition to considering the local law enforcement assets that might be made available, the jurisdiction should explore the use of mutual aid agreements with the law enforcement entities of nearby jurisdictions; work within the local incident command system to procure the needed security resources, explore the use of retired law enforcement officers; and, in collaboration with State authorities, the potential roles of the State Police and National Guard. Further, the jurisdiction should look to armored car/truck companies and private security officers with appropriate credentials to assist in implementing perimeter security at postal facilities during this one-day portion of the CRI.*

*Jurisdictions should be aware that HHS and its federal partners are exploring ways in which federal government assets might be brought to bear to assist in meeting the security requirements of the CRI overall. However, security assets from the federal government most likely could not muster and move to the affected area rapidly enough to be a realistic part of the USPS plan. That certainly will be true if the USPS plan is used in its potentially most effective mode – i.e., a “quick-strike” at the onset of the response, delivering antibiotics to every residence in the at-risk area within one day while a network of Points of Dispensing is being set up to provide prophylaxis for the at-risk community for as many of the subsequent days or weeks as the incident dictates.*

**Q: During the Pilot, the USPS Plan was introduced as an option and now it is required, why? (6/30/05)**

**A:** *The requirements of the CRI contained within the guidance document for 2005 are based in part on the lessons learned during the pilot year (2004). Working with each of the 21 cities has indicated that few, if any, are prepared as yet to meet the demands of the CRI mission. The USPS Plan provides access to a federal asset that already is in place in the community and well practiced at residential delivery. Moreover, as representatives of the USPS carrier unions and USPS management have noted on several occasions, USPS employees are members of the affected community and thus have a stake in protecting their families, friends, and neighbors.*

*The requirement therefore is to ensure that appropriate planning among the jurisdiction, HHS, and USPS occurs well in advance of an incident so that the USPS Plan is fully integrated with the rest of the CRI planning and ready for use if the jurisdiction needs it. Pre-event planning is imperative; the lead time for putting a USPS plan in place is too long for HHS and USPS to do so once an incident is underway*

*HHS recognizes that the demands of any given incident may be such that the jurisdiction will not have reason to request that the USPS plan be invoked. But, if the demands of the incident exceed local response capabilities (as easily could be the case following a wide-area outdoor release of spores of the anthrax organism), invoking the USPS plan could be the only way to save thousands of lives. HHS and USPS will not be able to help the jurisdiction via the USPS plan unless the jurisdiction has collaborated with HHS and USPS to put the plan in place.*

**Q: The SNS Guidance V10 was released this week and there is a new goal that DHHS recommends that all planners work toward having system in place to provide prophylaxis to the entire affected population within 48 hours. Do we include this goal in the grant application? (6/23/05)**

**A:** *SNS Guidance V10 is still in draft and was sent out for review and comment. The concept that providing prophylaxis as rapidly as possible makes sense from a response perspective and all project areas are encouraged to continue working in this direction. If projects wish in their narrative to describe that they will work toward 48 hour distribution, they can do so.*

**Q: Given the complex nature of the SNS program and its goals and objectives can you give us some background as to the perplexing placement and of the Critical Task for SNS literally being buried under the goal of mass dispensing and vaccination? (6/23/05)**

**A:** *The guidance is drafted under the framework of CDC's Preparedness Goals and the DHS Target Capabilities. The placement of the SNS activities best fit under the Mass Prophylaxis Outcome. Mass Prophylaxis is also one of the 7 priorities under the National Preparedness Goal and therefore is a very important*

*component of the program. At this time we have not weighted the measures and while it may appear all measures and tasks are equal we know that some of them take much more effort than others.*

**Q: Can non-CRI states/cities purchase Inventory Management Systems with Public Health Emergency Preparedness funds? (6/8/05)**

**A:** *The guidance only specifies IMS purchase by CRI areas. However, DSNS will be providing RITS gratis to all jurisdictions, including CRI. Independently purchased IMS should be RITS compatible (RITS appears to be PHINS compatible; this is currently being verified).*

**Q: When will the DSNS Inventory Management System, RITS be available? (6/8/05)**

**A:** *RITS deployment is planned for October 2005.*

**Q: On the CRI call, the terminology Group I, Group I Expansion, and Group II was used. Can you clarify who falls into which group? (June 7, 2005)**

**A:** *Group I: The original 21 CRI Pilot Cities  
Group I Expansion: CRI expanded geographic (collar) areas (i.e. MSA) identified in Appendix 3, Table I of the cooperative agreement guidance and further defined in the MSA attachment sent out via email. These areas were not included in the Pilot  
Group II: New cities described in Appendix 3, Table II of the cooperative agreement guidance. These cities are being funded for planning.*

**Q: Can States expand CRI to adjoining jurisdictions not defined by the MSA? (6/7/05)**

**A:** *Jurisdictions not included in the defined MSA can only be included in CRI if the preparedness of the defined MSA is at an acceptable level.*

**Q: Can States select to not include jurisdictions as defined by the MSA? (6/7/05)**

**A:** *No, but States can place an immediate emphasis on the principle cities and core counties within the MSA while planning and setting reasonable timeframes for expanding to the entire MSA. These plans should be submitted to CDC for approval.*

**Appendix III Clarification:  
(6/7/05)**

*As not to contradict the ability to purchase Public Health First Responder Caches, the Program Budget section's highlighted text should read, "...medications and medical supplies for the **general public and/or dispensing operations** may not be purchased."*

**Q: The Appendix III Introduction states "...several possible types of catastrophic terrorist attacks" Please define the possible types included as part of CRI.**

*A: The planning premise for CRI activities is based on a covert outdoor release of aerosolized Bacillus anthracis, the organism that causes anthrax, over a large geographic area (i.e. downtown areas with heavy pedestrian activity, sporting venues and other areas where large numbers of persons may congregate). Planning for Bacillus anthracis is sufficient to cover other Category A agents.*

**Q: Please explain the following statement in the Program Outcome section: "The Local SNS Plan should be designed so that it can accommodate an influx of federal government assets- especially the United States Postal Service..." (6/7/05)**

*A: As part of the National Response Plan each level of government has specific roles. Federal assets are available to assist state and local assets. With advance planning, the United States Postal Service can be used by CRI cities to distribute medication to residential mailboxes. Local CRI plans should include preparations for using this resource.*

**Q: Will the CRI cities/MSAs be funded directly by CDC? (6/7/05)**

*A: Only the CRI cities that are directly funded by CDC through the Public Health Emergency Preparedness Cooperative Agreement - Chicago, Los Angeles, New York City, and Washington D.C.*

**Q: How was funding calculated for CRI? (6/7/05)**

*A: For Group I existing cities, the funding is the same as last year. For Group I Expansion, funding was calculated based on the population of the MSA. For those MSA's that cross State boundaries, the funding was calculated based on the proportion of the MSA that falls within the State. For Group II Cities, \$200,000 was awarded to the city for coordinating planning efforts with bordering states/local areas within the MSA.*

**Q: How much of the funding allocated for CRI can be retained by the State? (6/7/05)**

*A: This will vary by Project Area based on local area needs, CRI assessments, and submission of a reasonable budget.*

**Q: What can be done to expedite funding to local CRI jurisdictions? (6/7/05)**

**A:** *States must submit a CDC-approved budget  
State internal fiscal requirements and barriers must be readily addressed  
DSNS SMEs will monitor local receipt of funding and report findings to DSLR  
POs  
Receipt of local funding will be added to DSNS assessment process*

**Q: What is the assessment process? (6/8/05)**

**A:** *DSNS assessment process is currently being revised. Until the final revision is completed, the current assessment process will be used.*

**Q: What is meant by the statement “Exceptions to this requirement may be granted by the Division of Strategic National Stockpile in collaboration with the Centers for Disease Control and the Department of Health and Human Services”?**

**A:** *If USPS Postal Plan is not included as a dispensing option, Project Areas must have plans for a viable alternative to ensure its dispensing capability of prophylaxis to 100% of its population within 48 hours.*

**Q: What is the approval process for USPS Plan exceptions?**

**A:** *Plans must be submitted to the DSRL POs for approval by DSNS and DHHS staff.*

**Q: Must the USPS Plan cover all jurisdictions as defined by the MSA or may the USPS Plan identify select zip codes?**

**A:** *CDC will work with HHS to answer this question.*

**Q: Security is a barrier to USPS Planning. How does HHS/CDC recommend we address this issue?**

**A:** *CDC will work with DHHS to answer this question.*

**Q: For security planning purposes, in jurisdictions where the MSA crosses state lines, do USPS delivery routes cross state lines?**

**A:** *CDC/DHHS will work with USPS to answer this question.*

**Q: What specifically can be purchased? (6/8/05)**

**A:** *Prophylaxis and PPE can be purchased for Public Health First Responders Cache.*

**Q:** **Please define Public Health First Responder**

**A:** *Public Health First Responders include the staff and volunteers that have active roles in a mass prophylaxis campaign.*

**Q:** **What documentation will DSLR and DSNS require to justify/approve the purchase of a Public Health First Responder Cache’?**

**A:** *A description and number of the Public Health First Responders and the method used for calculating cost per person.*

**Q:** **Can Group II Cities purchase Public Health First Responders caches?**

**A:** *Group II Cities cannot purchase Public Health First Responder cache specifically for CRI. However, Public Health First Responder cache can be purchased for overall preparedness.*

**Q:** **Can non CRI jurisdictions purchase Public Health First Responders caches?**

**A:** *Yes, Public Health First Responder cache can be purchased by all jurisdictions for overall preparedness.*

**Q:** **What is meant by “Jurisdiction” in a Jurisdiction wide self-assessment? What is our definition of Jurisdiction?**

**A:** *The geographic area that is covered in a Metropolitan Statistical Area (MSA)*

**Q:** **Ref: page 24 6E “Mass Prophylaxis and Vaccination” para. 1(b) “Achieve and maintain the Strategic National Stockpile (SNS) preparedness functions described in the current version of the SNS guide for planners” – Is there a requirement to include the SNS assessment tool?**

**A:** *Yes*

**Q:** **CRI - "Periodic meetings" are mentioned. Who is paying for these and who does SNS expect to attend?**

**A:** *Meeting attendance may be paid for with Bioterrorism Cooperative Agreement (BTCA) funds. Projects should work with their SNS Consultant and DSLR Project Officer regarding meeting attendees.*

## **Hazard and Vulnerability Analysis (HVA)**

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**Q:** Can you provide more info on Outcome 2B? Don't know the intent.

**A:** *The intent of Outcome 2B is that public health should access existing hazard and vulnerability assessments (typically done on a routine basis by emergency management) or participate in a the process where one does not exist to ensure that the impact on human health, consequences, both in terms of legality of the agents and the amount of population exposed is examined. Public health should prioritize the HVA and make recommendations to minimize or mitigate some of those hazards. Plans to control or contain those hazards or vulnerabilities that cannot be minimized or mitigated will have to be developed.*



## Public Health Information Network

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**Q:** There is a lot of confusion on what is expected for the tracking system for vaccinating in an event/incident. Should projects report on tracking folks who have already been vaccinated (i.e. Smallpox) or should projects set up a system for tracking during a pandemic?

**A:** *Tracking folks vaccinated during an event.*

**Q:** We have several electronic reporting pathways for laboratory test results reporting to and from the sentinel labs and the confirmatory lab. Currently, the reporting of suspected or confirmed communicable diseases to Local Health Departments and the State is mandated. However - the reporting of "orders" data is not required under current Public Health Law. Therefore, although the functional capability is present that would allow this information to be submitted and shared electronically, we cannot mandate submission of orders.

**A:** *The PHIN Functional Requirements for CLS require laboratories to have the ability to send and receive lab results messages and send and receive lab order messages. Outbreak Management must be able to send lab order messages and receive lab result messages. This would enable, for example, the health department to send a lab test order to the lab and then be able to receive the test results and link them to the subject. While pre-diagnostic data has been considered as a viable data source, it is not required that laboratory test order messages be sent to Early Event Detection Systems.*

**Q:** We maintain and actively document all necessary chain of custody information when a sample/specimen is submitted under such criteria (i.e. environmental samples suspected of containing a biological/chemical threat, any samples/specimens with a potential role in a criminal investigation). However, many specimens are submitted to us for confirmation of select agents in which chain of custody is not required because they are related to a naturally occurring outbreak or an intentional event has not been recognized. In addition, chain of custody is maintained through the rigorous documentation of possession/responsibility of the sample/specimen. To be upheld in a court of law, this chain of custody form must physically accompany the sample/specimen at all times. Rarely would chain of custody documentation through an electronic route be acceptable. Therefore, more clarification must be given as to what the "maintenance of chain of custody" through an electronic means would entail.

**A:** *The PHIN Preparedness Functional Requirements document for Connecting Laboratory Systems does not specify how chain of custody is maintained and it is recognized that COC functionality may be managed by a solution that includes paper and electronic components. In addition, the COC section differentiates requirements for routine specimens/samples from what is required for forensic and select agent samples:*

## Laboratory Capacity

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**Q: When applying for Level 1 Lab status, where can we find that section in SDN? (6/8/05)**

**A:** *From the application summary screen, click on the preferences page.. At the bottom of the page there is a question about whether or not you would like to apply for Level 1 chemical lab funding. Only projects that are considered Level 2 (by CDC) have the ability to apply for Level 1 (those are the only ones that will see that option on preference page). If you select "yes", a Level 1 tab will appear on both the Workplan and budget.*

**Q: Can states compete for funds available to establish Level I Labs? Is there additional funding available for this purpose?**

**A:** *No additional funding is available. States that have existing Level II labs may choose to compete for Level I status with their existing funds.*

## **Top Secret/Secret Clearances**

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**Q:** Due to the lengthy process involved in obtaining secret clearance for staff, are there any recommendations that CDC can give us in terms of speeding this process up? (6/7/05)

**A:** *CDC is working through this process with DHHS.*

**Q:** **Top Secret/Secret clearance - who does CDC envision having them?**

**A:** *Secret and/or Top Secret clearance should be maintained for the State health official, priority local health officials, and preparedness directors to ensure access to sensitive information about the nature of health threats and intelligence information.*

## **Goals/Outcomes/Critical Tasks/Evaluation/Reporting**

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**Q: G 6 (Control), outcome 6B, Critical Task 1-c: what is meant by simultaneously handling phone calls from at least 1% of the jurisdictions population? (6/24/05)**

**A:** *The intent of this critical task is to ensure that plans are being developed to accommodate a surge of calls to the Agency's public information line, as can be expected during an emergency, without resulting in calls going unanswered or shutting down the phone system. This does not imply that each call must be answered by a human being but rather indicates that some response should be given either by a person, in pre-recorded information, or through some other means.*

*This is an example of where it depends on how the state handles their public information lines. If they are centralized at the state then they need to plan for that volume of calls in a short time period (e.g., when it hits the media the phones will start ringing). If they handle calls at the local level then the required surge would be for 1% of the population of each local jurisdiction.*

**Q: Goal 2 (Prevent), outcome 2A, Critical Task 1-d: can we receive a listing of where these devices (ie. BioWatch) exist in our state. (6/7/05)**

**A:** *State and local officials that have BioWatch devices in their jurisdiction have access to this information.*

**Q: Goal 2 (Prevent), outcome 2B, Critical Task 2: Could CDC clarify the intent of this task? Are you expecting our state health department to be able to track a cloud of Triple-Ethyl Death? (6/7/05)**

**A:** *This will be traditional Epidemiology work in collaboration/coordination with your local environmental and HAZMAT partners.*

**Q: Goal 4 (Detect/Report), outcome 4A, Critical Task 1: Can you expand upon what is meant by this task? (6/7/05)**

**A:** *Building relationships with veterinarians, vet labs, poison control centers, etc.*

**Q: Could CDC describe how we should be responding to outcomes? (6/7/05)**

**A:** *All outcomes should be addressed by describing the role and capability needed to respond to a public health emergency.*

**Q: Do projects need to associate the funding for each allocation to specific goals, outcomes, or critical tasks from the workplan section of the application? (6/8/05)**

**A:** *Budget line items should be linked outcomes.*

**Q: How much detail is CDC looking for per critical task? Do you have any examples or a format that you would like us to use when describing our capacities and in putting together our work plan?**

**A:** *Projects should provide sufficient detail on each of their activities to ensure that they fully address the critical tasks and enable a grantee to achieve an outcome.*

**Q: Are the work activities just supposed to address the next 12 months?**

**A:** *Activities should cover the performance period from 8/31/05 to 8/30/06.*

**Q: Is there a restriction as to how much information can be put into a box?**

**A:** *There are character limitations in MIS. The grantee activity and current capacity fields have a 5,000 character limit; the evaluation field has a 2,048 character limit.*

**Q: The guidance states that the evaluation should be of the critical task, but on the SDN, the evaluation is an "activity" evaluation. How do we proceed? Do we need evaluation plans just for each critical task or for each activity?**

**A:** *Activities are the means to achieving a critical task. So, the evaluation piece is really both. How will you know when you have completed these activities and, therefore, improved your ability to achieve a critical task? We do not need great detail on the evaluation of every activity but we do need some specificity around the activities that are directly related to performance measures, particularly if a performance metric is currently not being measured. We need to have detailed information that assures us that it will be measured and reported on in the first semi-annual report.*

## Antiviral

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**Q: Could we have more information surrounding the issue of purchasing antivirals and what determines an authorized purchase?**

**A:** *The Division of State and Local Readiness (DSLRL) will work with the Center for Infectious Diseases (CID), National Immunization Program (NIP), and the National Vaccine Program Office to provide more information as it becomes available concerning antivirals for influenza. Purchase for other prophylaxis would be determined on an individual basis.*

**Q: Under outcome 6E, #2, "decrease time to provide prophylactic protection and/or immunization to all responders, included non-governmental personnel supporting relief efforts", does this mean we should plan on using CDC funds to build sufficient cache to cover "other" first responders?**

**A:** *No, CDC funds used to purchase antivirals are intended for public health responders and their families, as well as volunteers identified in your response plan. Other traditional first responders (i.e. fire, police, etc.) should be covered under the states emergency management plan.*

**Q - Further clarification for providing support for continuity of operations. To whom are we referring? Government overall? Public Health Teams?**

**A –** *Continuity of operations is for public health services.*

**Q: Page 20 4A "Health Intelligence Integration and Analysis" #6 "Increase number of local sites using BioSense for early event detection" – Is there a requirement to utilize as prescribed in task #6?**

**A:** *Yes, it is a required critical task*

**Q: Should syndromic surveillance occur at the city or state level?**

**A:** *Plans for syndromic surveillance should be coordinated between the state and local health officials.*

## Training

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**Q: ICS Training – Does CDC have a training standard and is only public health to be targeted? Homeland Security has been conducting a lot of training courses, and many public health personnel have already received ICS training.**

**A:** *This is for public health staff that has a role in response, which could include all health department personnel, volunteer and/or other persons that would be involved in a response. Everyone would have to have the courses listed in the guidance. CDC/HHS will work with DHS to get more information on what it means to be NIMS compliant.*

## Exercises

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**Q:** After Action Report: Is the expectation to make changes AND implement changes for After Action Reports? DHS just requires submitting changes within 60 days, not submitting and implementing.

**A:** *This requirement indicates “Time needed to implement corrective actions and integrate changes into plans (Target: 60 days after identification of deficiency)”. This means that corrective actions are taken on identified deficiencies within 60 days of identification.*

**Q:** Do states need to redo their plans based on the scenarios?

**A:** *Plans should be in place to address public health’s response role during an event as described in the 15 DHS planning scenarios.*



## Other Requirements

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**Q:** Will CDC develop a redirection form? (6/22/05)

**A:** Yes, but this will not be in place until the new budget period starts.

**Q:** In the past, we were told to track expenditures by focus area if we could not do it by benchmark, since there are no longer focus areas, what is CDC's recommendation for tracking expenses? (6/7/05)

**A:** *Projects will be required to submit their FSR(s) to CDC for base funding, EWIDS, CRI, and Level 1 chemical laboratories. Budget submissions must be submitted with line items attached to outcomes.*

**Q:** Regarding concurrence for projects that have tribes, what is the mechanism for reporting on tribal concurrence? (6/7/05)

**A:** *Go to the "Local Health" screen (selectable from the top of the Application Summary screen), underneath the Local Public Health section you will find an open text box for you to use to talk about Tribal concurrence.*

**Q:** Do metropolitan projects that receive are directly funded via the 2005 CDC Cooperative Agreement (i.e., Chicago, Washington, D.C., Los Angeles, and New York City) need to comply with the concurrence requirements listed in section #9? (6/8/05)

**A:** *No (applies to State projects only). Metropolitan projects are expected to work closely with their State and local partners on the development and implementation of activities.*

**Q:** Where does CDC intend for the state to find Epidemiology volunteers? Are we saying the state needs to provide additional training to current employees who are not epidemiologists, or find retired epidemiologists to be on response teams?

**A:** *States may consider any number of approaches including cross-training existing staff, recruiting volunteers from Medical Reserve Corp., Retired medical personnel in their area, medical, public health and nursing schools, etc.*

**Q:** What are we supposed to use for "Organizational ID" on the budget template? Is that our Grant number?

**A:** *The Organization ID is not the grant number; it is an optional field (10 digit alpha numeric field) for your internal use only. The Organizational ID is unique to your jurisdiction and allows you to enter information that you may later want to pull out*

*in a separate report, or to track information (i.e. individual budget line items). This field was added as a result of user requests.*