

**Pandemic Influenza Guidance Supplement to the
2006 Public Health Emergency Preparedness
Cooperative Agreement
Phase II**

Date: July 10, 2006

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Supplemental Guidance for Pandemic Influenza

I. Availability of Funds: Approximately \$225,000,000 is available to fund pandemic influenza preparedness activities specifically intended to develop and exercise pandemic influenza plans. Applicants should submit a letter requesting the amount indicated on the attached pandemic influenza supplement funding table with their PHEPCA continuation applications on July 15. Funds will be added to the PHEPCA continuation and 20% may be obligated or expended by your agency pending receipt of a request for redirection of the pandemic influenza Phase II funds as part of this application which is due August 31, 2006

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

II. Purpose: This document provides supplemental guidance for recipients of federal funding through the *Public Health Preparedness and Response Cooperative Agreement* (Cooperative Agreement AA154) for the purpose of furthering pandemic influenza preparedness and response.

Congress appropriated \$350,000,000 in emergency supplemental funding for pandemic influenza preparedness activities specifically intended to foster developing and exercising pandemic influenza plans. Specifically, the *Congressional Record* states, “The conference agreement includes bill language designating \$350,000,000 for upgrading State and local response capacity, particularly the planning and exercising of pandemic response plans by State and local officials. Section 8116 of the Senate bill proposed \$600,000,000 for this activity. The conferees are aware that any successful response to a pandemic influenza must include an effective response at the State and local levels. This will require pre-established partnerships and collaborative planning by public health officials, law enforcement officials, hospital administrators, and community leaders, who have considered a broad range of scenarios and participated in realistic response exercises. These planning and response exercises should enable public health and law enforcement officials to establish procedures and locations for quarantine, surge capacity, diagnostics, and communication. The conferees intend that most of these funds be put toward planning and exercises. The conferees intend that these funds be provided accompanied by established benchmarks and that a portion of the funding be

made available based on meeting performance objectives at both the State and local levels.”

This funding supports key elements of the *National Strategy for Pandemic Influenza*, the *Implementation Plan for the National Strategy* and the *HHS Pandemic Influenza Plan*.

Funding is being awarded in phases. In Phase I, \$100,000,000 was awarded to recipients on March 8, 2006. Recipients were required to use assessment tools developed by the Centers for Disease Control and Prevention (CDC) to identify gaps in their pandemic influenza planning and establish an approach for filling those gaps. The remaining \$250,000,000 is being divided into a \$225,000,000 formula award and a \$25,000,000 competitive award. This announcement (for Phase II) provides \$225,000,000 to recipients contingent upon sufficient responses to certain program requirements discussed below. The balance -- \$25,000,000 – will soon be awarded competitively to eligible recipients.

Projects supported by this cooperative agreement should be fully prepared to respond to and control a pandemic influenza outbreak by the end of three budget years, beginning with the initial funding under this supplement, but accelerated if epidemiologic information suggests the need to implement a cohesive response prior to that time. CDC endorses capabilities-based disaster planning and exercising consistent with the Homeland Security Exercise and Evaluation Program (HSEEP) – a national exercise program coordinated by the Department of Homeland Security (DHS).

In addition to the intent of the Congressional conference report, Secretary Leavitt has articulated in his Pandemic Influenza summits across the country that medical care providers will be on the front lines of the pandemic to provide care to the population. A component of this Pandemic Influenza Supplement should be used to augment the funding provided by the Health Resources and Services Administration (HRSA) National Bioterrorism Hospital Preparedness Program (NBHPP) to fill the gaps identified in the NBHPP Pandemic Influenza Scenario to address healthcare infrastructure preparedness and medical surge needs. This tiered healthcare system, detailed in the FY06 NBHPP Cooperative Agreement Guidance¹, should then be exercised in coordination with public health, emergency management, homeland security, and other response partners to ensure that gaps are adequately addressed.

Activities proposed for funding under this guidance, and undertaken via approved applications, are to be coordinated by the Senior Advisory Committee which is uniformly described in the CDC-PHEP, HRSA-NBHPP, and Homeland Security Grant Program (HSGP) guidance documents².

¹ <http://www.hrsa.gov/bioterrorism/>

² The membership of the Senior Advisory Committee must, at a minimum, include the following State officials directly responsible for the administration of Office of Grants and Training grants and CDC and

Recipients are reminded that any continuation of funding under this cooperative agreement is contingent upon responsiveness to the program guidance, successful completion of the activities submitted in the application in response to Critical Tasks, measured progress in meeting the Performance Measures, and proper stewardship of these congressionally-appropriated funds. Progress on actual tasks proposed in the application will be routinely assessed by the project officers and subject matter experts, and formal Progress Reports will be required twice in the budget year. In addition to the six pandemic influenza-specific Performance Measures in this document, data will be collected on the 23 Performance Measures that are described in the base Public Health Emergency Preparedness Cooperative Agreement (PHEPCA). Performance Measures are macro indicators that the public health system's response is improving in flexibility, scalability, and effectiveness. The completion of Critical Tasks as described in the application will facilitate community efforts to implement various interventions to combat an influenza pandemic. Incomplete or otherwise inadequate plans, as determined by CDC subject matter experts, will result in funding restrictions at the time of award until the flaws are remedied.

III. Background: Earlier this year, U.S. Department of Health and Human Services (HHS) Secretary Michael O. Leavitt and the nation's Governors led a series of State Pandemic Influenza Summits. The objectives were to enhance awareness of about the likely consequences of an influenza pandemic, to emphasize how seriously under-prepared the United States is at all levels of government and throughout the private sector, to improve understanding of the unique but necessarily limited roles that the Federal Government can play in countering a pandemic, and to stimulate community-wide preparedness initiatives by governments, individuals, businesses, and community organizations. The Summits were uniformly successful in sparking calls to action to improve pandemic preparedness across the nation. The challenge now is to use the momentum from the Summits to energize local-, tribal-, territorial-, and state-level initiatives to undertake those preparedness tasks that communities must do themselves.

To that end, the influenza-specific supplemental funds that are the subject of this guidance provide state, territorial, and local public health officials substantial new financial resources with which to spearhead and catalyze pandemic preparedness initiatives throughout their jurisdictions while they continue to create and sustain

HRSA cooperative agreements: the State Administrative Agency (SAA), HRSA Program Director, HRSA Bioterrorism Hospital Coordinator, and CDC Program Director. In addition, program representatives from the following entities should be members on the committee: State Homeland Security Advisor (if this role is not also the SAA); State Emergency Management Agency Director; State Public Health Officer; State Public Safety Officer (and SAA for Justice Assistance Grants, if different); State Court Official; State EMS Director; State Trauma System Manager; State Citizen Corps POC; United States Coast Guard Area Command or Captain of the Port; Senior Members of the Regional Transit Security Working Group, Senior Security Officials from Major Transportation Systems; and the Adjutant General.

emergency-ready public health agencies. HHS looks to state, territorial, tribal, and local public health officials to follow the examples of their respective Governors and Secretary Leavitt and demonstrate leadership in moving all facets of their communities toward pandemic influenza preparedness.

As with the base PHEPCA, this supplement organizes Critical Tasks under a series of Capabilities. Capabilities are combinations of people, equipment, and supplies which, through proper planning, equipping, training, organizing, and exercising, can perform Critical Tasks at expected levels of proficiency to achieve desired Outcomes in response to national disasters. The nation has defined 37 Target Capabilities as an element in Homeland Security Presidential Directive 8 – National Preparedness guidance implementation. These Capabilities, in varying degrees of aggregation, are brought to bear to accomplish the necessary tasks to prevent, protect against, respond to and recover from catastrophic events.

Public health is primarily responsible for, or has significant interest in, at least two thirds of the Target Capabilities. Because some events occur rarely, drills and exercises are required to maintain response proficiency. Routine public health activities provide opportunities for practice, but large-scale disasters involve multitudes of responders interacting in non-typical ways. Drills and exercises permit individuals and organizations to carry out their normal duties and relate to each other under unusual circumstances in simulated environments that are far less costly and threatening than real events. CDC's Coordinating Office of Terrorism Preparedness and Emergency Response (COTPER) will evaluate awardees' preparedness through drills and exercises.

Preparedness begins with plans to control hazards and reduce vulnerabilities ("Hazards and Vulnerability Analysis"-HVA) that cannot be eliminated entirely. Emergency response plans ("plans") describe what well-trained, equipped, and supplied responders ("capacity") must be able to do ("capability") to minimize injuries, deaths, and damage from uncontained hazards. Discussion-based exercises (e.g., tabletop exercises) help identify "gaps" in the plan (i.e., partners [Note: Important given the example below.], policies, protocols, processes, and procedures) which are overlooked or not sufficiently addressed in the plan. Such gaps must be filled before expensive, resource-intensive operations-based drills and exercises are conducted. For example, how children will be educated at home if schools are closed should be determined before a full-scale exercise. As responders practice the plan through exercising, they learn which aspects of response do not "go as planned." After the exercise, responders debrief ("hot wash") and create an After-Action-Report (AAR). It is not enough to record the lessons learned from the exercises. Responders must also describe corrective actions to fix response problems, including who is responsible for fixing what by when ("Corrective Action Plan"). Proposed solutions must be re-tested to ensure that they adequately correct the response problem. If the solutions are good, the plan is amended to incorporate the new information. The result is improved ability to respond to hazards that can become uncontrolled, or new knowledge

that reduces the risk posed by the hazard. Sometimes discoveries made during exercises result in strategies that eliminate hazards altogether or render populations invulnerable to them, which shortens the Hazards and Vulnerability list.

This supplement to the Public Health Emergency Preparedness cooperative agreement strives to improve understanding of 1) Target Capabilities, 2) Tasks deemed critical by science and expert opinion under each Capability, 3) Performance Measures for Tasks that require monitoring, and 4) Actions that detail steps that should be implemented to accomplish a Task. (See Attachment C.)

The Phase I Pandemic Influenza Supplement assessment tools provided states, cities, and territories with an opportunity to identify their pandemic influenza planning gaps based on 60 Critical Tasks. These tasks are organized under nine of the 37 Target Capabilities identified by the DHS. An updated, refined version of these Critical Tasks is Attachment B (List of Critical Tasks Organized by Pandemic Flu Goals, Target Capabilities). Because of the comprehensive nature of pandemic influenza planning and response, the range of possible Critical Tasks necessary to fill gaps may exceed those listed on the assessment tools. Recipients should work from the current, refined list of Critical Tasks (See Attachment B) and may develop additional Critical Tasks to best address the gaps unique to their pandemic influenza planning status.

For the year 2006-2007, recipients must address a total of five Target Capabilities. These are linked to the four high level priorities that are identified in this (Phase II of the Pandemic Influenza Emergency Supplemental) guidance document: State and Local Pandemic Influenza Preparedness Assessments, Pandemic Influenza Exercise Program, Antiviral Drug Distribution Plan, and State Pandemic Influenza Preparedness Plan. These priorities fall within four Target Capabilities: Planning, Medical Surge, Mass Prophylaxis, Isolation and Quarantine. A fifth Target Capability, Communications, is tied to a performance measure on the Public Health Information Network (PHIN). Thus this year recipients must address a total of five Target Capabilities and relevant Critical Tasks based on gaps (see Attachment B)

As part of their application, recipients should also prioritize the remaining four Target Capabilities (Epidemiological Surveillance and Investigation, Public Health Laboratory Testing, Emergency Public Information and Warning, and Community Preparedness and Participation) based on the number and severity of gaps identified under each Target Capability.

In year two, recipients should prioritize in the same manner all remaining Critical Tasks under the remaining four Targeted Capabilities, provide a detailed work plan for the next two highest priority Target Capabilities, and implement the work plan.

In year three, recipients should prioritize by number and severity of gaps the two remaining Target Capabilities, develop a work plan for the Critical Tasks with gaps and implement the work plan.

Attachment C displays a logical framework demonstrating how recipients can work towards achieving their priority Target Capabilities. To achieve a CDC Goal, recipients must attain at least one Target Capability. Each Target Capability in turn, has at least one Critical Task associated with it. To accomplish the Critical Task, the recipient should conduct at least one or more Action Items. Each Action Item will be associated with Outputs as well as targets and measures. This sets up a logical framework to attain progress.

Historically, recipients have described their Action Items (activities) using a process driven (or narrative) approach. This made it difficult to track and monitor while assessing the ultimate impact of recipient efforts on Critical Tasks and Target Capabilities. In the absence of a logical framework that linked recipient efforts to CDC Goals, the achievement of these Goals was essentially a “leap of faith.” The proposed approach addresses these limitations by allowing recipients to deductively and inductively think through and develop their work plan using a framework which starts with a CDC Goal and ends with a set of Action Items and associated Outputs.

More specifically, the framework allows recipients to describe and monitor their work using predefined descriptive elements (what, when, where, who, how) in conjunction with self-defined, discrete Output measures. These measures are collectively referred to as Success Factors. Note that while the framework describes a way to link Action Items to both Outcome and Output measures, Grantees are only required to provide Output measures for each of their Action Items.

Attachment D provides a template that recipients should fill out to demonstrate this logical relationship in the context of their work plan. The attachment also provides two examples of what a work plan might look like for the Mass Prophylaxis Target Capability. If the Target Capability is linked to a Standard CDC Performance Measure (Attachment A), the measure should be specified when filling out the template.

IV. Application Content and Required Activities:

Recipients must submit a jurisdiction-wide work plan to address the requirements in this announcement and comply with all of the requirements for Phase I as well as the 2006 Public Health Preparedness Cooperative Agreement. Activities should be carried out by the recipient in collaboration with community partners such as DHS-funded Metropolitan Medical Response System (MMRS) Steering Committees and Urban Area Security Initiative (UASI) Working Groups (for

communities so situated)³, as well as Medical Reserve Corps, private businesses, schools, Citizen Corps/ community citizens, hospitals and other healthcare entities and coordinated by the Pandemic Influenza Coordinating Committee.

Work Plan Development:

As part of this application, recipients will develop work plans using the framework outlined in Attachment C for all Action Items targeting the five priority Target Capabilities. It is mandatory for recipients to address Target Capabilities 1-4 because they correspond to the three priorities as highlighted in the Phase II Pandemic Influenza Guidance noted above. In addition, it is mandatory for recipients to address the Target Capability for Communication because it ties in directly with the Performance Measure that relates to PHIN standards/certification.

As part of the 2006 work plan, recipients must also prioritize the remaining four Target Capabilities (Epidemiological Surveillance and Investigation, Public Health Laboratory Testing, Emergency Public Information and Warning, and Community Preparedness and Participation) based on the number of gaps identified under each Target Capability.

In year two, recipients should prioritize Critical Tasks for the next two highest priority Target Capabilities (as identified by recipients) and implement the work plan to address gaps.

In year three, recipients should prioritize the Critical Tasks for the two remaining Target Capabilities, develop a work plan for Critical Tasks with gaps and implement the work plan.

Please refer to Attachment D for step by step instructions on how to develop the work plan.

Reporting Progress:

During the course of the year, recipients will report on the progress made for Action Items falling under the five Target Capabilities as part of their midyear and end-of-year progress reports. Progress reports will comprise updates on the extent to which Output Targets are achieved and a brief description of barriers encountered in achieving these targets.

In years two and three, recipients will implement Action Items for the remaining Target Capabilities. In addition, as part of the mid year and end of year progress reports, they will report on the progress made in achieving the Output Targets.

³ The FY06 Homeland Security Grant Program guidance is available at <http://www.ojp.usdoj.gov/odp/docs/fy2006hsgp.pdf>

1. Priority: State and Local Pandemic Influenza Preparedness Assessments (Target Capability: Planning)

- a. Objectives for the budget period (08/31/06-08/30/07): Work with colleagues in homeland security and emergency management, healthcare and community partners to develop and implement a jurisdictional work plan to address gaps – beginning with those which are high priorities – in community-wide pandemic influenza preparedness; conduct a follow-up assessment (utilizing Phase I assessment tools: Attachment 4a, Self Assessment –State Public Health, Attachment 4b, Self Assessment—Local Public Health, and Attachment 4c, Self Assessment—Local Public Health Totals) to determine progress and create a new priorities list to direct future work.

Application content: Each of the three items below is required to constitute a sufficient application.

i. Assessment results:

1. Describe and analyze the results of the state pandemic influenza assessment data and local pandemic influenza assessment data;
 2. Present a prioritized list of the gaps identified by the results of the data analyses noted above, and identify how and why each gap was selected as a priority.
- ii. A work plan (with timelines) for addressing the highest priority gaps—as identified under the nine Target Capabilities—in community pandemic influenza preparedness; and,
- iii. Associated budget, utilizing Attachment C, Critical Tasks, to inform the activities required to address each identified priority gap.

b. Post-award milestones and deadlines:

- i. April 15, 2007: First progress report due
- ii. July 30, 2007: Follow-up assessment and data analysis complete
- iii. November 30, 2007: Final progress report due

2. Priority: Pandemic Influenza Exercise Program (Target Capabilities: Isolation and Quarantine, Medical Surge, and Mass Prophylaxis)

Objectives for the budget period (08/31/06-08/30/07): Develop and implement a pandemic influenza preparedness exercise program to include (at least) the three priority pandemic influenza preparedness exercises prescribed below. The exercises should be conducted throughout the budget period and involve community partners. Wherever feasible, these

exercises should be combined with already scheduled exercises directed by homeland security, emergency management, or other officials, to minimize the total burden on exercise planners and participants. Where appropriate CDC and HRSA will collaborate to provide subsequent guidance including objectives, suggested participants, format, process, data to be gathered, reporting, and after action steps.

- i. Non-pharmacological interventions and a community containment plan to help contain the spread of pandemic influenza – with emphasis on school closing decisions and discouragement of large public gatherings;
- ii. Medical surge to accommodate influenza victims; and,
- iii. Seasonal influenza vaccination clinics to exercise mass prophylaxis capabilities, including points-of-dispensing (PODs).

b. Application content: A 12-month timeline for the envisioned exercise program (The pandemic influenza exercise program plan should include the budget period objectives, anticipated participants, format, data to be gathered, and plan to create an after-action report and implement recommendations.

c. Post-award milestones and deadlines:

- i. Fall 2006: Conduct exercises with seasonal influenza vaccination clinics;
- ii. November 30, 2006: Submit the community containment plan and accompanying exercise to be used to test the plan
- iii. February 15, 2006: Complete 50% of the other envisioned exercises.

3. Priority: Antiviral Drug Distribution Plan (Target Capability: Mass Prophylaxis)

- a. Objectives for the budget period (08/31/06-08/30/07): Develop and test an antiviral drug distribution plan describing the receipt, intrastate distribution, storage, security, monitoring, allocation, and administration of antiviral drugs provided by the Strategic National Stockpile (SNS) or state stockpiles, as appropriate. Ensure that the dispensing of local/metropolitan regional caches (especially those funded by the HRSA NBHPP, CDC-PHEP, and Homeland Security Grant Program [particularly the MMRS and UASI components]) is taken into account. The Public Health Information Network- (PHIN-) compatible information systems should be available and used to support allocation, distribution and administration of pandemic influenza countermeasures. Ensure that plans address distribution from the site of SNS delivery to the

terminal foci in or near healthcare settings identified in Phase I of the pandemic influenza supplemental emergency funds. Antivirals from the SNS that are distributed to states for hospitals are intended for the care of hospital personnel, patients and family members only. Hospital facilities are not to be considered as points of dispensing (PODs).

A model work scope between states and private distribution contractors to perform the intrastate distribution of antiviral drugs will be sent to awardees within a week of the release of this guidance document. This is meant to provide one model for states, and is not meant to be prescriptive; however, it does highlight many of the Critical Tasks involved in the process of intrastate distribution of antiviral drugs.

- b. Application content: A summary and timeline of planned steps to develop the antiviral drug distribution plan, including the community partners who will be involved in assuring distribution and administration to the terminal foci in or near healthcare settings.
- c. Post-award milestones and deadlines:
 - i. November 30, 2006: Complete antiviral drug distribution plan
 - ii. August 30, 2007: Updated antiviral drug distribution plan as necessary based on lessons learned and retests after incorporating the lessons learned throughout budget period.

4. Priority: State Pandemic Influenza Preparedness Plan⁴ (Target Capability: Planning)

- a. Objectives for the budget period (08/31/06-08/30/07): Complete and submit a state pandemic influenza response plan. [Note: This should be the entire plan, not just the health chapter.] In November 2005, the White House published the *National Strategy for Pandemic Influenza*, followed by the *National Strategy for Pandemic Influenza Implementation Plan* in May 2006. The *Implementation Plan* tasks federal departments (HHS and DHS) to work together to review and approve the state pandemic influenza response plans by May 2007 to ensure that various topics (e.g., non-pharmacological interventions, countermeasure distribution, public safety) are adequately addressed.
- b. Application content: Timeline of events to accomplish plan completion and submission by February 1, 2007.

⁴ Applies only to 50 U.S. states and the District of Columbia

c. Post-award milestones and deadlines:

February 1, 2007: Submit state pandemic influenza response plan (e.g. countermeasure distribution, public safety, non-pharmaceutical interventions, transportation).

5. Continuation of Prior Requirements

Recipients are expected to comply with all of the requirements listed in the Pandemic Influenza Emergency Supplement: Phase I (published March 14, 2006) as well as the PHEPCA (published June 1, 2006). Please refer to previously released guidance documents.

V. Additional Requirements:

1. Funds to Local Public Health and Healthcare Entities:

- a. Due to the pervasive nature of an influenza pandemic, local communities/jurisdictions should take a leading role in preparedness and response, rather than relying solely on substantial outside aid, mutual support, or federal assistance. The local level is where the effects of the pandemic will be felt and where the response needs to occur. Therefore it is expected that the majority of these funds will be distributed to and utilized at the local level. Where the state health department serves as the provider of local public health services in areas not covered by a local health department, funds should be dispersed commensurate with that effort.
- b. CDC requires that the cooperative agreement application describes how the State health department engages local health departments to reach consensus, approval, or concurrence for the proposed use of non-earmarked cooperative agreement funds. The description should bear evidence that local health department officials have been engaged in the cooperative agreement process and at least a majority, if not the total, approves or concurs with the application itself. This evidence may be demonstrated by:
 - i. Consensus of a majority of local health officials whose collective jurisdictions encompass a majority of the State's population;
 - ii. Recommendation of the President of the State Association of County and City Health Officials (SACCHO) if a majority of local health officials whose collective jurisdictions encompass a majority of the State's population agree with the SACCHO's decision; OR

- iii. Any other alternative method agreed to by the State Health Official and a majority of local health officials whose collective jurisdictions encompass a majority of the State's population.

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

2. **Cost Sharing or Matching:** Matching funds are not required for this program.
3. **Tribes:** CDC requires documentation with this cooperative agreement application that describes the process used by the applicant to engage American Indian tribal governments, Tribal organizations representing those governments, tribal epidemiologic centers, or Alaska Native Villages and Corporations located within their boundaries in reaching consensus, approval, or concurrence for the proposed use of non-earmarked cooperative agreement funds for pandemic influenza preparedness
4. **Allowable Costs**

Many additional Critical Tasks that are relevant to pandemic influenza planning, exercise and response may be found in the greater PHEPCA and NBHPP cooperative agreements. New supplies and equipment such as personal protective equipment, safety syringes, ventilators, etc., are allowable purchases. Costs associated with Pandemic Influenza Summits conducted prior to the award are allowable expenses and should be coordinated with the NBHPP to avoid duplication and costs. While these funds may be used to either retain staff or expand staff resources, applicants are reminded that these are emergency supplemental funds.
5. **Unallowable Costs**
 - Purchase of antiviral drugs, seasonal influenza vaccine, or pneumococcal vaccine is not allowed from this supplemental allocation. PHEPCA and NBHPP funds may be used to establish pharmaceutical caches which can include prophylaxis, antibiotics, and antivirals⁵. PHEPCA-funded caches for public health first responders and their families.
 - The state, territorial, or local government is responsible for assuring that any local affiliate does not engage in research. For the definition of research, please see the CDC web site at the following Internet address: <http://www.cdc.gov/od/ads/opspoll1.htm>

⁵ See page 10 of the 2006 PHEPCA at <http://www.bt.cdc.gov/planning/coopagreement/#fy06>

- Purchase of vehicles of any kind is not allowed.
- Pandemic Influenza Supplemental funds may not be used to purchase incentive items.

6. Supplantation: Cooperative agreement funds cannot supplant any current State or local expenditures. The Public Health Service Act, Title I, Section 319C (e) (42 USC 247d-3(e)) specifically states: "SUPPLEMENT NOT SUPPLANT. -- Funds appropriated under this section shall be used to supplement and not supplant other Federal, State, and local public funds provided for activities under this section." Therefore, the law strictly and expressly prohibits supplantation.

7. Financial Management Systems Requirements

A state, territory or local health agency must expend and account for grant funds in accordance with State laws and procedures for its own funds. 45 CFR Part 92.20.

8. Grants Subcontracting that Spans Budget Periods: The Procurement and Grants Office (PGO) has provided guidance for contracts let by recipients that span budget periods under grants or cooperative agreements. This guidance may be found at

http://pgo.cdc.gov/pgo/webcache/Regulations/GIL_06004_Grant_Contracting_that_Spans_Budget_Periods2.pdf

V. CDC Responsibilities:

In a cooperative agreement, the CDC staff is substantially involved—beyond routine monitoring—in program oversight and support. CDC activities for this pandemic influenza cooperative agreement supplement are as follows:

1. Fulfill federal-level obligations to achieve CDC’s Draft Pandemic Influenza Preparedness Goals (e.g., “Increase use and development of clinical, non-pharmaceutical, and risk communications interventions known to minimize the spread of influenza”).
2. Ensure that all of CDC’s pandemic influenza activities that support local, tribal, territorial, and state jurisdictions’ pandemic influenza activities are coordinated internally (within CDC) and externally (with other federal agencies and departments and non-government entities).
3. Provide pandemic influenza preparedness and response technical assistance including, but not limited to:
 - a. Developing, piloting, and evaluating standardized, valid drills and exercises and/or requirements and instructions for conducting such drills and exercises;

- b. Conducting evaluations (e.g., cost-effectiveness, Outcome) of local, tribal, territorial, and state pandemic influenza preparedness activities and identifying and disseminating results and promising practices;
 - c. Integrating/coordinating federal funding for local, tribal, territorial, and state pandemic influenza preparedness; and,
 - d. Disseminating subject matter expertise on pandemic influenza and related preparedness activities including evaluation, laboratory testing, epidemiology and surveillance, continuous quality improvement, communications, training, stockpile preparedness, and information systems and informatics.
4. Evaluate the technical assistance (under Responsibility 3) and program assistance (i.e., that provided by Project Officers) delivered to local, tribal and state jurisdictions.
 5. Develop appropriate performance goals, science-based standards and measures, and valid and reliable assessment and evaluation instruments.
 6. Provide guidance on, and in some cases, conduct drills and exercises, consistent with HSEEP, including objectives, suggested participants, format, process, data to be gathered, reporting, and after action steps. Where appropriate, CDC and HRSA will collaborate to create guidance and provide technical assistance.
 7. Review critically, using CDC and non-CDC subject matter (e.g., operations, logistics, influenza, evaluation, laboratory) experts, the applications to include a critique narrative, assessments, year-long exercise plan, antiviral drug distribution plan, the budget to support the three priorities and related five Target Capabilities for this pandemic influenza supplement. Incomplete or otherwise inadequate plans will result in funding restrictions at the time of award and until the deficiencies are remedied.
 8. Review critically, using CDC and non-CDC subject matter experts, progress reports to ensure technically acceptable and timely performance, program spending to ensure fiscal accountability, amount of local-level spending, and swift use of emergency supplemental funds, and recipients' evidence demonstrating that all Critical Tasks are being implemented, monitored, and evaluated on an on-going basis. Continuation of funding under this cooperative agreement is contingent upon responsiveness to the program guidance, measured progress in meeting the Performance Measures, and proper stewardship of these congressionally-appropriated funds.

9. Facilitate the inclusion of tribal, military, international, and federal (e.g., DHS) activities into national pandemic influenza preparedness efforts.

VII. Submission Information

A. Electronic applications using the CDC-provided template are due on August 31, 2006 11:59 pm EST. Note: The budget and work plan template will be made available under the “File Download” section of the MIS homepage. Guidance on submitting the budget and work plan will follow the release of this supplemental.

B. Required Forms (The following forms should be submitted to PGO by email with a copy to the appropriate DSLR Project Officer.

- Form PHS 5161-1 is available from the CDC Procurement and Grants office at the following Internet address: <http://www.cdc.gov/od/pgo/forminfo.htm>
- Application budget preparation guidance is also available at: <http://www.cdc.gov/od/pgo/funding/budgetguide2004.htm>
- Forms SF-424 (Cover page) and SF-424B (Assurances) are available from the Office of Management and Budget: http://www.whitehouse.gov/omb/grants/grants_forms.html
- Form SF-424A can also be obtained at the following Internet address: http://www.whitehouse.gov/omb/grants/grants_forms.html
- Cover letter signed by Principal Investigator/Project Director of Public Health Preparedness Cooperative Agreement and representative of the business office.
- Detailed Budget and Justification, using the provided Excel spreadsheet under the “File Download” section of the MIS homepage.
- Detailed Work Plan using the blank MS Word template provided under the “File Download” section of the MIS homepage

C. Technical Review: Applications will be reviewed for technical acceptability by the Division of State and Local Readiness and HRSA BHPP Project Officers and other CDC subject matter experts to determine:

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

D. Intergovernmental Review of Applications: Applications are subject to Intergovernmental Review of Federal Programs, as governed by Executive Order (EO) 12372. This order sets up a system for State and local governmental

review of proposed federal assistance applications. Contact your State single point of contact (SPOC) as early as possible to alert the SPOC to prospective applications, and to receive instructions on your State's process. Click on the following link to get the current SPOC list:

<http://www.whitehouse.gov/omb/grants/spoc.html>

E. Technical Reporting Requirements For Supplemental Funding

Semi Annual Progress Reports for the Budget Period must be submitted through the DSLR MIS. CDC has amended the requirements for technical reporting changing from quarterly to semiannual progress reports (see technical reporting requirements; VI Section E in 2006 PHEP CA). CDC will provide templates for these reports to assess program outcomes related to activities undertaken in the Budget Period. In addition, recipients may be required to submit information upon request based on changing threat status or national security priorities. Progress reports for activities undertaken, as well as special topics related to the goals and objectives are due on:

- **April 15, 2007**
- **November 30, 2007**

Financial Status Reports (FSR): Due to separate accounting requirements please submit both a summary and an individual FSR addressing supplemental pandemic influenza activities. An original and two copies must be submitted in hard copy to CDC's PGO and are due on:

- **May 30, 2007** A mid-year estimated FSR.
- **November 30, 2006** A final FSR is due 90 days after the end of the budget period.

Please submit the hard copies of financial status reports (FSRs) to:

Attn: Sharon Robertson
Grants Management Specialist—Regions 1, 2, 3, 4, 10
Acquisition and Assistance Branch VI
Procurement and Grants Office
Centers for Disease Control and Prevention (CDC)
2920 Brandywine Road
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Agency Contacts

DSLR Project Officers –see Appendix 9 of the 2006 PHEP Cooperative Agreement

For general questions, contact:

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Attachment A

Performance Measures for FY 2006 Pandemic Influenza Emergency Supplemental Funding

Measure 1: Medical Surge

Target Capability: Medical Surge. Use BioSense data to determine available beds that could be used for medical surge.

CDC Preparedness Goal	Proposed Measure	Jurisdictional Target	Definitions and Other Guidance	Instructions	Jurisdictional Measurement Level	Data Collection and Submission Methods
CDC Goal 6: Control 6A: Target Capability: Medical Surge	Percent of HRSA National Bioterrorism Hospital Preparedness Program (NBHPP) awardee hospitals that transmit hospital utilization data in near-real time to BioSense.	90% of HRSA NBHPP awardee hospitals.	Definitions: <u>Hospital utilization data</u> : BioSense Data Elements of Interest: Includes number of beds available by facility unit. <u>Near real-time</u> : bed-count data is submitted at least once every 24 hours.	Numerator: Number of HRSA NBHPP awardee hospitals that transmit hospital utilization data to BioSense. Denominator: Number of HRSA NBHPP awardee hospitals in the jurisdiction.	State	Numerator data: DSLR retrieves data from CDC BioSense databases to determine which jurisdiction hospitals transmit to BioSense Denominator data: Pandemic Supplemental funding awardees declare to DSLR which hospitals in their jurisdiction are NBHPP awardees.

- Department of Homeland Security: Target Capabilities. Version 2.0 available at emergency responder password protected website: www.llis.gov
- Justification: CNA Corporation. Medical Surge Capacity and Capability: A Management System for Integrating Medical and Health Resources during Large-Scale Emergencies. Virginia, CNA. Under U. S. Department of Health and Human Services Contract # 233-03-0028. 2004. Page 8-6. Available at: http://www.cna.org/documents/mscc_aug2004.pdf Accessed June 9, 2006.

Measure 2: Seasonal Flu Clinic

Target Capability: Mass Prophylaxis. Use computer modeling to estimate patient throughput and compare to actual throughput during annual influenza vaccination clinic (“flu clinic”).

CDC Preparedness Goal	Proposed Measure	Jurisdictional Target	Definitions and Other Guidance	Instructions	Jurisdictional Measurement Level	Data Collection and Submission Methods
CDC Goal 6: Control 6C: Target Capability: Mass Prophylaxis	Percent of estimated patient throughput actually achieved for each shift during mass vaccination clinic.	For each work shift: Meet or exceed estimated patient throughput for inputs entered into specified computer model.	<u>Specified computer model</u> : Use mass vaccination clinic operations model available at URL cited below.	Numerator: # of persons vaccinated during each shift. Denominator: # of persons expected to be vaccinated during a	State and local	Data will be collected during real event seasonal flu clinics. Clinic staff inputs will vary from shift to shift

Shift: To generate model estimates the number of staff working per shift is assumed constant throughout the shift. The duration of each shift is at the discretion of the public health agency (e.g., 8 hours, 12 hours, etc).

shift, according to model.

depending on the number of staff available to work the shift. As inputs vary, estimates generated by the model will differ.

Note:
observed vaccinated/
expected to be vaccinated.

Inputs entered:
Parameters entered into the model to estimate throughput. For example: 200 clinic and administrative staff working in a flu clinic configured per the model are expected to vaccinate 4 patients per minute.

Example:
Shift #1:
observed vaccinated is 2 patients per minute
expected vaccinated per the model is 4 patients per minute.

$O/E = 2/4 = 1/2$
To get percent: $1/2 \times 100 = 50\%$ of estimate achieved

- Throughput estimates: Department of Homeland Security (DHS) Target Capabilities require capacity (throughput) estimates for determining burden of work to manage standardized planning scenarios.
- Specified mass vaccinations clinic operations model: Model is funded by CDC and developed jointly by Montgomery County, Maryland, Advanced Practice Center for Public Health Emergency Preparedness and Response and The Computer Integrated Manufacturing Laboratory of the Institute for Systems Research at the University of Maryland. Model available at <http://www.isr.umd.edu/Labs/CIM/projects/clinic/> Accessed June 11, 2006.

Measure 3: Seasonal Flu Clinic.

Target Capability: Mass Prophylaxis. AGE AND RISK GROUPS – INFLUENZA VACCINATION. Exceed the influenza vaccination target coverage levels.

CDC Preparedness Goal	Proposed Measure	Jurisdictional Target	Definitions and Other Guidance	Instructions	Jurisdictional Measurement Level	Data Collection and Submission Methods
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<p>CDC Goal 6: Control</p> <p>6C: Target Capability: Mass Prophylaxis</p>	<p>Influenza vaccination coverage levels for each age and risk group.</p>		<p><u>Better than the best:</u> Jurisdiction exceeds the highest coverage level reported in the most recently published dataset.</p> <p>“Better than the best” is borrowed from HP 2010, which employs the concept as a target-setting method.</p>			<p>DSLRL retrieves data from CDC databases</p>
			<p>Target source:</p>	<p>Target tracked by:</p>		<p>Awardees’ progress toward targets is assessed using the latest survey vaccination rates available for the DSLR reporting period. Publication of survey results can lag behind current reporting period a year or more.</p>
	<ul style="list-style-type: none"> > or = 65 yr 	<p>90%</p>	<p>HP 2010</p>	<p>BRFSS</p>	<p>State</p>	<p>BRFSS does not ask about influenza vaccination for Health-care workers with patient contact every year. If this group is not queried in a particular year, the rate will be “N/A” for that year.</p>
	<ul style="list-style-type: none"> 18-64 yr with high-risk conditions 	<p>60%</p>	<p>HP 2010</p>	<p>BRFSS</p>	<p>State</p>	
	<ul style="list-style-type: none"> Health-care workers with patient contact 	<p>Better than the best</p>	<p>BRFSS (In vaccine shortage season: Years 2004 – 05, the national level estimate was 36%)</p>	<p>BRFSS</p>	<p>State</p>	
	<ul style="list-style-type: none"> 18-64 yr – Non-priority group 	<p>Better than the best</p>	<p>BRFSS (In non-shortage season: Years 2003-04, the national estimate was 24%)</p>	<p>BRFSS</p>	<p>State</p>	
<ul style="list-style-type: none"> 6-23 months 	<p>Better than the best</p>	<p>NIS</p>	<p>NIS</p>	<p>State and Local</p>		

- MMWR: *Estimated Influenza Vaccination Coverage Among Adults and Children –United States, September 1, 2004—January 31, 2005*. MMWR. April 1, 2005 54 (12); 304-307. Available at: <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5412a3.htm> Accessed: June 9, 2006.
- MMWR: *Prevention and Control of Influenza. Recommendations of the Advisory committee on Immunization Practices (ACIP)*. June 28, 2006 /55 (Early Release); 1-41. Available at: <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr55e628a1.htm> Accessed July 3, 2006.
- Influenza Vaccination Coverage Levels. Available at: <http://www.cdc.gov/flu/professionals/vaccination/coveragelevels.htm> Accessed July 3, 2006.
- BRFSS is Behavioral Risk Factor Surveillance System. Available at: <http://www.cdc.gov/BRFSS/> Accessed July, 3 2006.
- NIS is National Immunization Survey. Available at: <http://www.cdc.gov/nis/> Accessed July 3, 2006.
- HP 2010 is Healthy People 2010. Target setting methods available at: http://www.healthypeople.gov/Document/HTML/tracking/THP_PartA.htm#TargetSetting Immunization coverage levels available at: <http://www.healthypeople.gov/Document/HTML/Volume1/14Immunization.htm#Toc494510240> Accessed July 3, 2006.

Measure 4: Non-Pharmacological Public Health Interventions: Social Distancing.

Target Capability: Planning

CDC Preparedness Goal	Proposed Measure	Jurisdictional Target	Definitions and Other Guidance	Instructions	Jurisdictional Measurement Level	Data Collection and Submission Methods
CDC Goal 1: Prevent 1A: Target Capability: Planning	Public health officials recommend school closure when pandemic influenza case counts reach pre-determined levels.	Jurisdictions pre-determine case count levels that “trigger” school closure.	Jurisdictions are expected to be hyper-vigilant about the introduction of pandemic influenza in their communities. Pre-event, jurisdictions determine how many cases infected with H5, or another novel subtype, of influenza will prompt them to recommend school closure. Pandemic influenza cases: When disease prevalence is low, laboratory testing should be confirmatory (as opposed to presumptive).		State and local	Drill or exercise

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- School District (K-12) Pandemic Influenza Planning Checklist. Available at: <http://www.pandemicflu.gov/plan/schoolchecklist.html> Accessed June 18, 2006.
 - Heymann A, Chodick G, Reichman B, Kokia, E, Laufer J, *Influence of school closure on the incidence of viral respiratory diseases among children and on health care utilization*. *Pediatr Infect Dis J*. 2004 Jul; 23 (7): 675-7.
 - HHS Pandemic Influenza Plan, US Dept of Health and Human Services. November 2005. Available at: www.panflu.gov Accessed June 21, 2006.

Measure 5: Isolation

Target Capability: Isolation and Quarantine. During drills and exercises make timely decisions to seek court order for isolation or release detained patient.

CDC Preparedness Goal	Proposed Measure	Jurisdictional Target	Definitions and Other Guidance	Instructions	Jurisdictional Measurement Level	Data Collection and Submission Methods
CDC Goal 6: Control 6B: Target Capability: Isolation and Quarantine	Time an individual (s) is detained for medical evaluation while determining need for isolation.	< 12 hours	<p><u>Detain:</u> Restrict movement by preventing individual from leaving the designated area while he/she is medically evaluated.</p> <p>This measure includes time to obtain presumptive laboratory results.</p> <p>This measure does not include time to get a judge or magistrate to sign the order, which can take considerably longer.</p> <p>This measure also does not include evaluations for quarantine.</p>	<p>Date and Start time: Date and time public health authority first detains individual(s).</p> <p>Date and Stop time: Any one of the following:</p> <ul style="list-style-type: none"> • Date and time on petition for court order. • Date and time patient is placed under voluntary isolation. • Date and time patient is released after deemed not in need of isolation. 	State and local	<p>Data collected for each individual detained for evaluation.</p> <p>In the case of mass isolation data is collected for the cohort.</p>

Measure 6: PHIN Compliance

Target Capability: Communications. PHIN compliance enables information technology systems to support detection and containment of pandemic influenza across all Target Capabilities.

CDC Preparedness Goal	Proposed Measure	Jurisdictional Target	Definitions and Other Guidance	Instructions	Jurisdictional Measurement Level	Data Collection and Submission Methods
CDC Goal 4: Detect and Report 4A: Target Capability: Communications	For each PHIN Functional Area, the percent of critical functional requirements that have been achieved based on either the Functional Self Assessment Tool or the PHIN certification process. The Functional Areas are: <ul style="list-style-type: none"> • <i>Connecting Laboratory Systems</i> • <i>Countermeasure/Response Administration</i> • <i>Cross-functional Components</i> • <i>Early Event Detection</i> • <i>Outbreak Management</i> • <i>Partner Communications and Alerting Functional Requirements</i> 	100% of the critical functional requirements for each Functional Area	Note: For each Functional Area cite the assessment method used to determine achievement: Self Assessment (Self-Assessment Tool) OR (Independent Assessment) PHIN Certification process.	Example: 1) Connecting Laboratory Systems has 10 critical functional requirements. The recipient using the Functional Self Assessment tool has achieved 7 of the critical functional requirements. The Connecting Laboratory Systems score is 7/10 or 70% by Functional Self Assessment Tool. 2) Countermeasure/Response Administration has 5 critical functional requirements. The recipient has achieved all 5 critical functional requirements based on the PHIN Certification process. The Countermeasure/Response Administration score is 5/5 or 100% by PHIN Certification process.	State and local	Recipient’s plan for addressing identified gaps AND either the PHIN Certification Status Letter for each Functional Area or the Summary page from the Functional Self Assessment Tool for each Functional Area

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- *Public Health Information Network (PHIN) Certification: Standards, Self-Assessment Tools and Certification process available at: <http://www.cdc.gov/phn/certification/index.html> Accessed November 16, 2005*

Attachment B

List of Critical Tasks Organized by Pandemic Flu Goals and Target Capabilities

CDC considers the Critical Tasks below to be central to a comprehensive pandemic influenza preparedness strategy. Given continued funding, CDC expects the following tasks to be implemented, monitored and evaluated on an on-going basis.

Pandemic Influenza Preparedness Goal 1: PREVENT

Increase the use and development of clinical, non-pharmaceutical, and risk communications interventions known to minimize the spread of influenza.

1A Target Capability: Planning (links to HHS State and Local Pandemic Influenza Planning Checklist, Community Preparedness, Leadership and Networking)

Critical Task(s):

1. Develop, exercise and improve operational plans for pandemic influenza at the state and local level. Plans must:
 - a) be compliant with National Incident Management System and include Incident Command System (ICS)
 - b) delineate accountability and responsibility for key local authorities and stakeholders engaged in planning and executing specific components of the operational plan (e.g., identification, isolation, quarantine, movement restriction, healthcare services, emergency care, mutual aid and school closure)
 - c) link plan activities to WHO Pandemic Influenza Phases⁶
 - d) identify which plan activities will occur at state, local, or coordinated level
 - e) define State role in providing guidance and assistance to the local, tribal and regional levels
 - f) address integration of state, local, tribal, territorial, and regional plans across jurisdictional boundaries
 - g) address the provision of psychosocial support services for the community, including parents and their families, and those affected by community containment procedures
 - h) be sufficiently flexible to adapt to the magnitude and severity of the pandemic and to available resources
 - i) identify how public health, hospitals and healthcare systems will establish systems for healthcare facility level infection control while allowing necessary personnel access to the facility
 - j) Address the needs of vulnerable/special populations⁷

⁶ See World Health Organization (WHO) Pandemic Influenza Phases at http://www.who.int/csr/resources/publications/influenza/GIP_2005_5Eweb.pdf

2. Formalize agreements that address communication, mutual aid, and other cross-jurisdictional needs with neighboring domestic and/or international jurisdictions sharing an international border with Canada or Mexico (e.g., city-state-tribal collaboration arrangements or city-state-province/state collaboration arrangements)
3. Assess and map local community; identify and build social networks; and develop community outreach information networks, pre-event, to
 - a) define, locate and reach special, at-risk and vulnerable populations and
 - b) maximize capacity to effectively disseminate public information during a pandemic.
4. Clarify and communicate to all stakeholders the process for requesting, coordinating, and approving requests for resources to state and federal agencies
5. Ensure that legal authorities for executing the operational plan, especially those relevant to case identification, isolation, quarantine, movement restriction, healthcare services, emergency care, and mutual aid, are transparent to all stakeholders ⁸
6. Develop and document schemes to activate non-pharmacological interventions, including home isolation of patients and quarantine of household contacts, social distancing measures such as closure of schools and workplaces, reduced public transport, cancellation of mass gatherings and public education on hygiene measures such as hand and respiratory hygiene. The scheme should clearly outline how and when decisions are made to implement the interventions.
7. Identify and communicate to all stakeholders the authority responsible for declaring a public health emergency at the state, local and tribal levels and for officially activating the pandemic influenza response plan
8. Identify State, local and tribal law enforcement personnel who will maintain public order and help implement control measures
9. Exercise operational plan in cooperation with animal health sectors (including but not limited to industry, veterinary diagnostic laboratories, state departments of agriculture), to prevent, detect and respond to reports of disease in animals as a early warning of threat to human health including:
 - a) education of and risk communication to the poultry owning public, poultry farmers and vendors, especially small operations
 - b) a plan for surveillance in birds
 - c) disease reporting and data sharing
 - d) triggers for action to contain disease within the animal sector
 - e) triggers to perform heightened surveillance to detect human illness
10. Train to and exercise the operational elements of the jurisdictional plan including plan activation, incident command, integration with partner agencies; integration with and assistance to hospitals and healthcare systems particularly regarding surge capacity, assisting persons with special needs, coordination with schools

⁷ See the Public Health Workbook to Define, Locate and Reach Special, Vulnerable and At-Risk Populations in an Emergency at www.bt.cdc.gov/workbook

⁸ See Appendix E, Legal Authorities of DHHS Pandemic Influenza Plan, <http://www.hhs.gov/pandemicflu/plan/pdf/part2.pdf>

11. Conduct at least one exercise per year jointly with HHS and DHS funded pandemic influenza responders through exercises, drills, tabletop exercises, etc.
12. Assign responsibilities and resources to complete, update and execute the plan. Assure that the plan includes timelines and Outcomes to be achieved as well as back-up systems for each part of the plan

Measure(s):

1. Public health agency has primary and secondary staff identified for core functional roles delineated in the Incident Command System (ICS) for public health
2. Public health officials recommend school closure when pandemic influenza case counts reach pre-determined levels.

Pandemic Influenza Preparedness Goal 3: DETECT AND REPORT

Decrease the time needed to detect and report an influenza outbreak with pandemic potential.

3A Target Capability: Epidemiological Surveillance and Investigation (links to HHS State and Local Pandemic Influenza Planning Checklist, Surveillance)

Critical Task(s):

1. Recruit and maintain a group of healthcare providers that report influenza-like illness (ILI) regularly, year-round, to the influenza sentinel provider surveillance network
2. Develop the ability to rapidly provide healthcare providers, clinics, and hospitals with updated information on case definitions and sample collection requests and protocols
3. Establish a system for healthcare providers to contact public health authorities about suspect cases or outbreaks
4. Develop an electronic system for rapid reporting of deaths and contributing causes of death (i.e. pneumonia and influenza-related) occurring in the state
5. Improve capacity for rapid identification of unusual influenza strains by working with federal partners to enhance laboratory-based monitoring of seasonal influenza subtypes
6. Ensure that tribal entities such as local Service Units, tribal health facilities and Area IHS review mechanism for influenza case reporting and identify local surveillance coordinators, thereby assuring linkage of local surveillance activities with federal, state and local systems
7. Inventory and maintain tribal and IHS supplies of influenza rapid diagnostic tests
8. Coordinate protocols for influenza testing with tribal entities and establish means of transportation for respiratory specimens to State public health laboratories when necessary
9. Develop protocols to enhance surveillance activities for early detection of influenza-like illness (ILI) among patients and health care workers at Tribal/IHS facilities.

Measure(s):

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

3B Target Capability: Public Health Laboratory Testing (links to HHS State and Local Pandemic Influenza Planning Checklist, Public Health and Clinical Laboratories)

Critical Task(s):

1. Maintain the ability to test for influenza viruses year-round
2. Perform Polymerase Chain Reaction (PCR) testing for rapid detection and subtyping of influenza viruses
3. Electronically exchange specimen-level data among clinical laboratories, the state public health lab, and CDC
4. Institute surveillance for influenza-like illness (ILI) among laboratory personnel working with novel influenza viruses
5. Develop and exercise an operational plan to augment the capacity of public health and clinical laboratories to meet the needs of the jurisdiction during an influenza pandemic
6. Assess all public health and clinical laboratory influenza diagnostic testing proficiency and adherence to biosafety containment and biomonitoring protocols at least annually
7. Test the knowledge and competency of frontline clinicians and laboratory personnel with regard to:
 - a) Protocols for safe specimen collection and testing
 - b) How and to whom a potential case of novel influenza should be reported
 - c) Mechanism for submitting specimens to referral laboratories
8. Determine how hospitals and health care systems will use systems and communications tools to report information to public health and response partners with an emphasis on regional hospital coordination

Measure(s)

1. Time from presumptive identification to confirmatory identification of select agents by Laboratory Response Network (LRN) reference lab
2. Time to have a knowledgeable LRN reference laboratorian answer a call during non-business hours

Pandemic Influenza Preparedness Goal 4: DETECT AND REPORT

Improve the timeliness and accuracy of communications regarding the threat posed by an influenza outbreak with pandemic.

4A Target Capability: Communications (links to HHS State and Local Pandemic Influenza Planning Checklist, Public Health Communications.)

1. Support exchange of essential information before and during an influenza pandemic. Coordinate procurement and placement of technology communication systems that, based on a gap analysis of requirements versus existing capabilities, are compliant with PHIN Preparedness Functional Area *Partner Communication and Alerting*.
2. Have or have access to interoperable information systems that support the initial identification and that provide situational awareness of possible pandemic influenza

- outbreak in compliance with PHIN Preparedness Functional Area *Early Event Detection*.
- a) Receive, triage and send case or suspect case disease reports 24/7/365.
 - b) Receive health related data from multiple data sources to monitor, quantify and localize aberrations to normal data patterns (e.g., veterinary systems, school absenteeism reports, hospital utilization data, nurse call lines, over-the-counter drug sales, poison control center reports).
3. Have or have access to interoperable information systems to capture and manage data associated with the investigation and containment of an outbreak (e.g., pandemic influenza) or public health emergency in compliance with PHIN Preparedness Functional Area *Outbreak Management*.
 4. Have or have access to interoperable information systems for electronic exchange of laboratory related information with public health partners (e.g. to support laboratory surveillance and electronic reporting in a pandemic) in compliance with PHIN Preparedness Functional Area *Connecting Laboratory Systems*.
 5. Have or have access to interoperable information systems that comply with PHIN Preparedness Functional Area *Countermeasure and Response Administration* to allocate, manage and track measures taken to contain or provide protection against an actual or possible outbreak or event.
 - a) Deliver prophylaxis and manage isolation and quarantine.
 - b) Monitor adverse events and follow-up of patients.
 6. Have or have access to interoperable information systems that span PHIN functional areas by adhering to standards and specifications for public health system and data architecture requirements (e.g., secure message exchange, terminology standards and public health directory) in compliance with PHIN Preparedness Functional Area *Cross Functional Components*.
 7. Develop plans to address gaps in achieving PHIN certification.

Measure(s):

1. For each PHIN Functional Area, the percent of critical functional requirements that have been achieved based on either the Functional Self Assessment Tool or the PHIN certification process. The Functional Areas are:
 - Connecting Laboratory Systems
 - Countermeasure/ Response Administration
 - Cross-functional Components
 - Early Event Detection
 - Outbreak Management
 - Partner Communications and Alerting Functional Requirements

Pandemic Influenza Preparedness Goal 5: INVESTIGATE

Decrease the time to understand modes of transmission, risk groups and risk factors, and appropriate interventions.

5A Target Capability: Epidemiological Surveillance and Investigation (links to HHS State and Local Pandemic Influenza Planning Checklist, Surveillance)

Critical Task(s):

1. Conduct year-round surveillance for seasonal influenza (e.g. virologic, outpatient visits, hospitalization, and mortality) preferably through the use of electronic reporting
2. Assure capacity to implement enhanced surveillance once a pandemic is detected, to ensure recognition of the first cases of pandemic virus infection in time to initiate appropriate containment protocols
3. Link animal and human health surveillance systems and routinely share information
4. Develop systems to obtain and track numbers and rates of these Outcomes daily during an influenza pandemic on:
 - a) the numbers of newly hospitalized persons with influenza or pneumonia
 - b) the numbers of newly isolated and quarantined persons, and
 - c) hospitals with pandemic influenza cases
 - d) the number of pneumonia or influenza-associated deaths

Measure(s):

1. Time for State/territory public health agency to notify local public health agency, or local to notify State, following receipt of a call about an event that may be of urgent public health consequence

Pandemic Influenza Preparedness Goal 6: CONTROL

Decrease the time needed to implement rapid outbreak response actions and provide other countermeasures, including personnel, risk communications, and health interventions and guidance to those at risk of pandemic influenza

6A Target Capability: Medical Surge (link to HHS State and Local Pandemic Influenza Planning Checklist, Healthcare and Public Health Partners)

Critical Task(s):

1. Before March 31, 2007, coordinate with the HRSA Bioterrorism coordinator to detail the gaps identified in the HRSA NBHPP program Pandemic Influenza Scenario and a plan for how funds from this Supplement would be used to augment funding provided by the HRSA NBHPP program.
 - a) In concert with public health partners, ensure that healthcare entities (primary care, community health centers, rural health programs, and hospitals) are a key component in the exercising of state, local and tribal plans that address:
 - i. maintenance of essential hospital support functions
 - ii. severe shortages of health care workers

- iii. adequate personnel and staffing needs based on CDC's FluSurge software
 - iv. use of the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) to obtain volunteer health care workers
 - v. ensuring real-time situational awareness of patient visits, hospital bed and intensive care needs, medical supply needs and medical staffing needs.
 - vi. the purchase and storage of beds, equipment, supplies, pharmaceuticals needed to treat influenza patients
 - vii. mass fatalities and maximizing morgue capabilities
- b) Exercise communication systems, plans and procedures to ensure that hospitals, health care systems and public health inform the community about the operating status of hospitals and the triggers for sending a person to the hospital
 - c) Exercise vaccination and prophylaxis plans to cover healthcare staff and patients
 - d) Exercise triage and admission plans that would serve to minimize stress on the hospital system and maintain control of the situation
 - e) Hospitals and health care systems in conjunction with public health partners identify the location, set-up, staffing and operation of alternate care sites during a pandemic. Focus for sites should be within metropolitan areas with plans that can support the sub-state region in which the metropolitan area is contained. States should make firm logistical arrangements for the selection, set-up (beds, medical supplies and equipment, personal protective equipment, pharmaceuticals, etc) staffing and operation (to include food, fuel and water) of alternate care facilities to meet the needs during the peak period of a pandemic wave (2-3 weeks).
 - f) Identify how public health, hospitals and healthcare systems will establish systems for healthcare facility level infection control while allowing necessary personnel access to the facility

Measure(s):

1. Percent of HRSA National Bioterrorism Hospital Preparedness Program (NBHPP) awardee hospitals that transmit hospital utilization data in near-real time to BioSense.

6B. Target Capability: Isolation and Quarantine (Link to HHS State and Local Pandemic Influenza Planning Checklist, Infection Control and Clinical Guidelines, and Community Disease Control and Prevention)

Critical Task(s):

1. Develop and exercise an operational plan for community mitigation of pandemic influenza using non-pharmacological, including home isolation of patients and quarantine of household contacts, social distancing measures such as closure of schools and workplaces, reduced public transport, and cancellation of mass

- gatherings, and public education on hygiene measures such as hand and respiratory hygiene.
2. Conduct multiple municipal or regional tabletop exercises regarding the decision-processes associated with school closure and the use of other non-pharmacologic interventions.
 3. Develop and exercise a plan to communicate to healthcare providers about infection control guidelines and for communication about containment measures at the State, local and tribal level
 4. Exercise and improve the ability to implement infection control guidelines and public health measures at the State, local and tribal levels
 5. Disseminate information from public health sources on:
 - a) routine infection control (e.g., hand hygiene, cough/sneeze etiquette)
 - b) pandemic influenza fundamentals (e.g., signs and symptoms of influenza, modes of transmission)
 - c) personal and family protection and response strategies (e.g., guidance for the at-home care of ill students and family members)
 6. Develop and exercise an operational plan for isolation and quarantine that delineates the following:
 - a) the criteria for isolation and quarantine
 - b) the procedures and legal authorities for implementing and enforcing these containment measures, and
 - c) the methods that will be used to support, service, and monitor those affected by these containment measures in healthcare facilities, other residential facilities, homes, community facilities, and other settings
 7. Develop and exercise an operational plan to implement various levels of movement restrictions within, to, and from the jurisdiction
 8. Inform citizens in advance what community mitigation measures may be used in the jurisdiction (e.g. tabletop exercises)
 9. Develop and exercise an operational plan for implementing social distancing measures in a jurisdiction that addresses school and workplace closures and cancellation of public gatherings
 10. Implementation in sub-populations where non-pharmacological interventions may pose particular challenges
 11. Providing support and services to help counteract the secondary impact of such measures
 12. monitoring compliance with non-pharmacological interventions including tracking persons in quarantine

Measure(s)

1. The time to issue an isolation or quarantine order
2. Time an individual is retained for medical evaluation while determining need for isolation

3. Public health officials recommend school closure when pandemic influenza case counts reach pre-determined levels.

6C Target Capability: Mass Prophylaxis (link to HHS State and Local Pandemic Influenza Planning Checklist, Vaccine Distribution and Use, and Antiviral Drug Distribution and Use)

Critical Task(s):

1. Describe the receipt, distribution, storage, security, monitoring and administration of pandemic influenza vaccines including plans for limited vaccine availability and prioritization of population groups. Take into account potential for administration of **vaccines subject to** Investigational New Drug (IND) or Emergency Use Authorization (EUA)
2. Collaborate in mass prophylaxis planning and exercising with community-wide partners, bordering jurisdictions, IHS and tribal nations
3. Maintain PHIN compliant information systems for tracking vaccine distribution and administration

Measure(s):

1. Adequacy of State and local plans to receive and dispense medical countermeasures as demonstrated through assessment by the Strategic National Stockpile/Cities Readiness Initiative (CRI)
2. Percent of estimated patient throughput actually achieved for each shift during mass vaccination clinic
3. Influenza vaccination coverage levels reported by BRFSS for each age and risk group.

6D Target Capability: Emergency Public Information and Warning (links to HHS State and Local Pandemic Influenza Planning Checklist, Public Health Communications.)

Critical Task(s):

1. Exercise communication plans with an emphasis on:
 - a) coordination with response partners and tribal nations
 - b) rapid provision of public health risk information and recommendations
 - c) addressing stigmatization, rumors and misperceptions in real time
 - d) surge capacity for public information, media operations and spokespersons
 - e) procedures to secure resources to activate the public information and media operation during a public health emergency around the clock if needed for a minimum of 10 days
2. Prepare supporting materials for public health issues that are unique to an influenza pandemic such as issues of isolation, social distancing, and public health law
3. Establish a contact list of additional spokespersons and persons outside the state health department who can be available as subject matter experts on pandemic health

- issues to respond as surge capacity to meet demands for speakers or interviewees from the media, civic organizations and others
4. Identify additional and nontraditional vehicles of information dissemination to the public, partners and stakeholders

Measure(s):

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

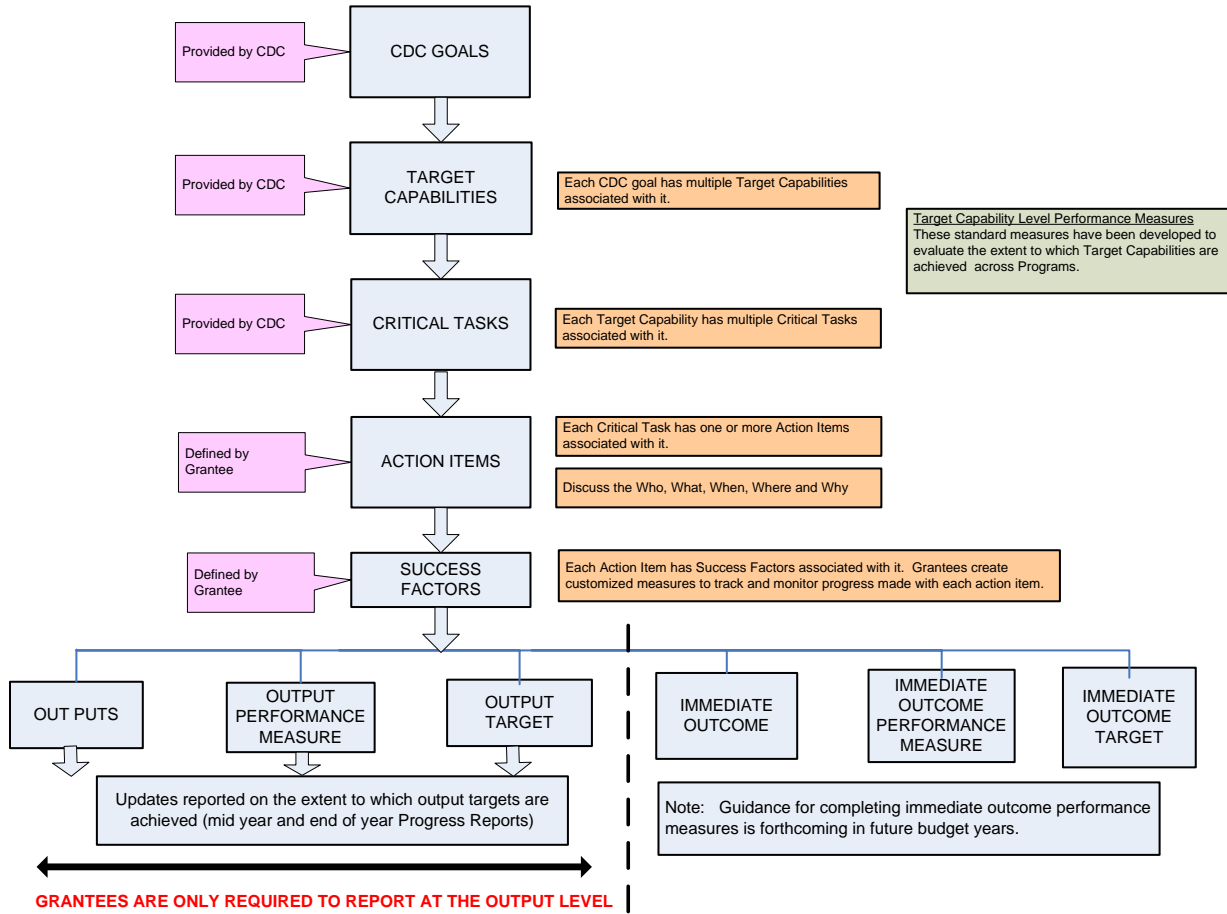
6F Target Capability: Community Preparedness and Participation (link HHS State and Local Pandemic Influenza Planning Checklist, Workforce Support: Psychosocial Considerations and Information Needs)

Critical Task(s):

1. Develop and exercise a continuity of operations plan for essential department services that includes:
 - a) contingency planning for increasing public health workforce in response to absenteeism among health department staff and stakeholder groups that have key responsibilities under a community's response plan
 - b) ensuring availability of psychosocial support services (including educational and training materials) for employees who participate in or provide support for the response to public health emergencies such as influenza pandemics

Attachment C

PANDEMIC INFLUENZA WORK PLAN LOGIC MODEL



2006 Pandemic Influenza Work Plan Guidance

Attachment D

Work Plan Template for Pandemic Flu Guidance

GRANTEES SHOULD FILL OUT A SEPARATE TEMPLATE FOR EACH ACTION ITEM

<p>CDC Goal: Each Goal can have multiple Target Capabilities associated with it.</p> <ul style="list-style-type: none"> • CDC goals form the framework for public health activities surrounding preparedness 		
<p>Target Capability: Each Target Capability can have multiple Critical Tasks associated with it.</p> <ul style="list-style-type: none"> • Capabilities are combinations of people, equipment, and supplies which, through proper planning, equipping, training, organizing, and exercising, can perform critical tasks at expected levels of proficiency to achieve desired Outcomes in response to national disasters. 		
<p>Associated CDC Performance Measure: Indicate if this Target Capability relates to a CDC Performance Measure (Attachment A).</p> <ul style="list-style-type: none"> • Performance measure are leading indicators that allow a national snapshot to show how preparedness and response activities and their associated resources aid in making a public health system that responds more quickly and comprehensively in a public health emergency. 		
<p>Critical Task: Each Critical Task can have multiple Action Items associated with it.</p> <ul style="list-style-type: none"> • Tasks deemed critical by science and expert opinion for each Capability to execute its mission. 		
<p>Action Item: The program efforts conducted to achieve the critical tasks that result in the creation of a product or service.</p>		
Description		
What	Purpose of the Action Item	What is the problem, or what is the opportunity, to be addressed by this Action Item?
Who	Target audience	What sectors are you trying to change or influence? (list all that apply):
	Stakeholders critical to success of the project	Stakeholders who are critical to the success of the project and are in the best position to contribute to the solution (agents of change); (no acronyms please)
	Who is responsible for the Outputs	Recipient and Agents of Change from above
When	Time period of project	From mm/yyyy to mm/yyyy (maximum of 12 months)
Where (addresses reach)	Venue, location, etc.	Venue – Where interventions occur Location – Geographic (list all that apply from the following): neighborhood/community, urban, rural, suburban, county, region/district, statewide
Why	Rationale	What evidence do you have to support the proposed intervention/course of action/Outcome for this Action Item? (Use experience if no data available) What is the capacity of the recipient to deal this problem/opportunity?

		Why does this Action Item deserve the recipient's attention now? (Concisely summarize the above information.)
Success Factors for Action Item		
Outputs	What does this action item produce?	Direct products or services produced by the action item that lead to the intended Immediate Outcomes.
Output Performance Measure	Measures the quantity or quality of the Output.	Output Performance Measures are indicators used to gauge the Quantity (i.e. How much was produced) and/or the Quality (How well an Output is produced/delivered) of the Output produced as a result of the Action Item.
Output Target	Pre established value (number or percentage) that the program is trying to reach at the Output level.	Targets are the quantifiable or otherwise measurable characteristics (e.g. number or percentage) that tell how well a program must accomplish a performance measure.
Immediate Outcome*	Describe the intended result that will occur from one or more Outputs?	Intended result that will occur from one or more Outputs.
Immediate Outcome Performance Measure*	Measures the effectiveness of the Immediate Outcome.	Immediate Outcome Performance Measures are indicators that gauge how successful Outputs are at producing Immediate Outcomes.
Outcome Target*	Pre established value (number or percentage) that the program is trying to reach at the Outcome level.	Targets are quantifiable or otherwise measurable characteristics (e.g. number or percentage) that tell how well a program must accomplish a performance measure.
Progress Report- To be Reported Mid Year and End of Year		
Progress Report- Outputs	Provide updates (quantifiable) regarding the achievement of	Extent to which the target Outputs have been achieved. Reported in the form a quantifiable or measurable characteristic.

	Output performance measures	
Progress Report- Barriers	Barriers/problems faced in achieving Outputs	Briefly explain if any barriers were encountered in achieving the target Outputs.

Note: *Grantees only need to report on Outputs, Output Performance Measures and Output Targets. They are not required to report Immediate Outcomes, Outcome Performance Measures and Outcome Targets.

Examples in the use of the Work Plan Template

Example 1		
CDC Goal: Pandemic Influenza Preparedness Goal 6: Control		
Target Capability: Mass Prophylaxis		
CDC Performance Measure: Measure 2, Seasonal Flu Clinic: Percent of estimated patient throughput actually achieved for each shift during mass vaccination clinic.		
Critical Task: Describe the receipt, distribution, storage, security, monitoring and administration of pandemic influenza vaccines including plans for limited vaccine availability and prioritization of population groups.		
Name of Action Item: Identification of vaccination clinic locations (when public health is responsible for vaccination).		
What	Purpose of the Action Item	Identifying and securing seasonal influenza vaccination clinic sites to exercise mass prophylaxis capabilities, including points of dispensing (PODs).
Who	Target audience	Utilizing current Advisory Committee on immunization practices guidelines for distribution/delivery of seasonal influenza vaccines, target audiences will be identified.
	Stakeholders critical to success of the project	State health departments, local health jurisdictions, clinic volunteers, security/law enforcement, media, local politicians, state homeland security agency, health care sector and other partners selected from the Pandemic Influenza Planning Committee Roster.
	Who is responsible for the Outputs	Local and State Public Health departments
When	Time period of project	From late September 2006 thru April 2007
Where (addresses reach)	Venue, location, etc.	Sites in three high density and two rural local public health jurisdictions
Why	Rationale	To test capabilities to deliver vaccines to the general population in a manner consistent with mass vaccination including points of dispensing (PODS)
Success Factors		
Outputs	A list of local clinics located in three high density and two rural public health jurisdictions	

Outputs	
Output Performance Measure	# of clinics located in three high density and two rural public health jurisdictions that agree to implement the mass prophylaxis campaign
Output Target	5 clinics located in three high density and two rural public health jurisdictions that agree to implement the mass prophylaxis campaigns
Immediate Outcome *	Increase capacity of clinics to implement mass prophylaxis campaigns Each site Identifies weaknesses in exercise planning and implementation efforts and takes corrective
Immediate Outcome Performance Measure*	Each site Identifies weaknesses in exercise planning and implementation efforts and takes corrective actions
Immediate Outcome Target*	Corrective action taken for at least 2 weaknesses identified during the exercise
Progress Report- To be Reported Mid Year and End of Year	
As of	2/15/2007
Updates on Output Measures	3 clinics located in three high density jurisdictions agree to implement the mass prophylaxis campaigns
Barriers	Difficulty in collaborating with 2 clinics located in rural public health jurisdictions due to challenges in the availability of communication technology available to reach out to these areas.

Note: *Grantees only need to report on Outputs, Output Performance Measures and Output Targets. They are not required to report Immediate Outcomes, Outcome Performance Measures and Outcome Targets.

Example 2
CDC Goal: Pandemic Influenza Preparedness Goal 6: Control
Target Capability: Mass Prophylaxis
CDC Performance Measure: Measure 2, Seasonal Flu Clinic: Percent of estimated patient throughput actually achieved for each shift during mass vaccination clinic.

Critical Task: Develop and test an antiviral drug distribution plan describing the receipt, intrastate distribution, storage, security, monitoring, allocation, administration and use of antiviral drugs provided via the Strategic National Stockpile (SNS) or state stockpiles as appropriate.		
Name of Action Item: Develop a plan for receipt and intrastate distribution of antiviral drugs provided.		
What	Purpose of the Action Item	Develop a scalable plan for receipt and intrastate distribution of antiviral drugs to health care settings provided via SNS or state stockpile
Who	Target audience	Health care settings including hospitals, skilled nursing facilities, community health centers and pharmacies.
	Stakeholders critical to success of the project	State health departments, local health jurisdictions, security/law enforcement, state homeland security agency, health care sector and other partners selected from the Pandemic Influenza Planning Committee Roster.
	Who is responsible for the Outputs	State and local health departments
When	Time period of project	From late September 2006 thru September 2007
Where (addresses reach)	Venue, location, etc.	State health department will develop an intrastate distribution plan that covers atleast 2 metropolitan statistical areas
Why	Rationale	To ensure that local public health jurisdictions are better prepared to coordinate activities associated with the distribution of anti-virals in the event of a influenza pandemic
Success Factors		
Outputs	A scalable action plan that outlines how antivirals will be distributed from the state public health department to health care facilities including hospitals, skilled nursing facilities, community health centers and pharmacies.	
Output Performance Measure	% of stakeholders that agree to and sign off on the finalized plan	
Output Target	80 % of stakeholders agree and sign off on the finalized plan.	
Immediate Outcome *	Increase capacity of state public health department to distribute anti-virals to local health care facilities including hospitals, skilled nursing facilities, community health centers and pharmacies.	

Immediate Outcome Performance Measure*	# of external stakeholder groups with expertise in planning that approve its feasibility
Immediate Outcome Target*	At least 2 external stakeholder groups with expertise in planning approve the plan's feasibility.
Progress Report- To be Reported Mid Year and End of Year	
As of	2/15/2007
Updates on Output Measures	50 % of stakeholders have signed off on the finalized plan
Barriers	Difficulty in setting up meetings with the remaining 30% stakeholders due to scheduling conflicts and change in leadership/point of contact at a number of these settings.

Note: *Grantees only need to report on Outputs, Output Performance Measures and Output Targets. They are not required to report Immediate Outcomes, Outcome Performance Measures and Outcome Targets.

Attachment E

The following table outlines Step by Step Instructions for developing 2006 Pandemic Influenza Work Plan

#	STEP	DESCRIPTION
1.	Pandemic Influenza Planning Self Assessment	Conduct a follow up self assessment in Pandemic Influenza Planning (utilizing Phase 1 assessment tools: Attachment 4a, Self Assessment- State Public Health, Attachment 4b, Self Assessment-Local Public Health, and Attachment 4c- Self Assessment-Local Public Health Totals).
2.	Analyzing results from the Assessment	Synthesize the results of updated state Pandemic Influenza Assessment data and local Pandemic Influenza Assessment data.
3.	Identifying Gaps in Critical Tasks	For each of the nine Target Capabilities, develop a list of gaps as identified by the results of the data synthesis.
4.	Prioritizing Work Plan Content	<p>Develop a Work Plan for addressing Critical Tasks identified as ‘gaps’ in Step 1 for the following Target Capabilities:</p> <ol style="list-style-type: none"> 1. Planning 2. Medical Surge 3. Mass Prophylaxis 4. Isolation and Quarantine 5. Communication <p>It is mandatory for Recipients to address Target Capabilities (1-4) because they correspond to the three priorities as highlighted in the Pandemic Flu Guidance outlined below. In addition, it is mandatory for Recipients to address the Target Capability for Communication because it ties in directly with the Performance Measure that relates to PHIN standards/certification.</p>

		<table border="1" data-bbox="730 298 1419 786"> <thead> <tr> <th data-bbox="737 303 1073 370">Priorities for Pandemic Flu Guidance</th> <th data-bbox="1073 303 1413 370">Target Capability</th> </tr> </thead> <tbody> <tr> <td data-bbox="737 370 1073 508">State and Local Pandemic Influenza Preparedness Assessments,</td> <td data-bbox="1073 370 1413 508">Planning</td> </tr> <tr> <td data-bbox="737 508 1073 610">Pandemic Exercise Program,</td> <td data-bbox="1073 508 1413 610">Medical Surge Mass Prophylaxis Isolation and Quarantine</td> </tr> <tr> <td data-bbox="737 610 1073 712">Antiviral Drug Distribution Plan.</td> <td data-bbox="1073 610 1413 712">Mass Prophylaxis</td> </tr> <tr> <td data-bbox="737 712 1073 782">PHIN Performance Measure</td> <td data-bbox="1073 712 1413 782">Communication</td> </tr> </tbody> </table> <p data-bbox="730 824 1640 889">Prioritize the four remaining Target Capabilities based on the number of gaps identified in the assessment done in Step 1.</p> <table border="1" data-bbox="730 922 1383 1105"> <thead> <tr> <th data-bbox="737 927 1377 964">Target Capability</th> </tr> </thead> <tbody> <tr> <td data-bbox="737 964 1377 1002">Epidemiological Surveillance and Investigation</td> </tr> <tr> <td data-bbox="737 1002 1377 1039">Public Health Laboratory Testing</td> </tr> <tr> <td data-bbox="737 1039 1377 1076">Emergency Public Information and Warning</td> </tr> <tr> <td data-bbox="737 1076 1377 1105">Community Preparedness and Participation</td> </tr> </tbody> </table>	Priorities for Pandemic Flu Guidance	Target Capability	State and Local Pandemic Influenza Preparedness Assessments,	Planning	Pandemic Exercise Program,	Medical Surge Mass Prophylaxis Isolation and Quarantine	Antiviral Drug Distribution Plan.	Mass Prophylaxis	PHIN Performance Measure	Communication	Target Capability	Epidemiological Surveillance and Investigation	Public Health Laboratory Testing	Emergency Public Information and Warning	Community Preparedness and Participation
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Community Preparedness and Participation																	
5.	Developing Work Plan Content and Success Factors	<p data-bbox="730 1117 1656 1279">Attachment D provides a framework that inductively describes measurable and time phased Action Items which lead to the completion of Critical Tasks which in turn lead to the attainment of the Target Capabilities. This attachment also provides examples of how this framework can be used to develop work plans for two sample Action Items.</p> <p data-bbox="730 1317 1650 1416">This framework requires that Recipient Action Items be defined such that they are time phased and measurable using Outputs. This facilitates the tracking and monitoring of progress in achieving Action Items and their associated</p>															

		<p>Critical Tasks and Target Capabilities.</p> <p>Using this approach, Recipients will develop one or more Action Items for Critical Tasks (with gaps) that fall under one of the five Target Capabilities identified in Step 4, (five priority Capabilities). Each Action Item includes a description of its purpose, target audience, major stakeholders/partners, time period, venue/location and rationale. In addition, each Action Item is associated with a set of success factors at the Output level (Note: While the framework provides Immediate Outcome measures, Grantees are only required to provide measures at the Output level). While multiple Action Items may be required to address a Critical Task in its entirety, Recipients are only required to define one Action Item for each Critical Task where a gap has been identified.</p> <p>Recipients will submit in their applications, a prioritized list of the remaining four Target Capabilities not included in the selections above.</p>
6.	Implementing the Work Plan	<p>In year 1, Recipients will implement Action Items described in their Work Plan for the five Target Capabilities identified above.</p> <p>In year 2 recipients will prioritize all Critical Tasks for the next two priority Target Capabilities, create a work plan and implement Action Items as described in the work plan for the next two priority Target Capabilities (in addition to any pending work remaining from year 1).</p> <p>In year 3 recipients will prioritize all Critical Tasks for the remaining two Target Capabilities, create a work plan and implement Action Items as described in the work plan in addition to any pending work remaining from years 1 and 2.</p> <p>All Action Items and associated Critical Tasks and Target Capabilities will need to be accomplished within three years; with ongoing maintenance required.</p>
7.	Reporting Progress	<p>For each Action Item described in the Work Plan, Recipients will provide</p> <ul style="list-style-type: none"> • Updates regarding the extent to which Output measures have been

		<p>achieved (as part of their mid year and end of year progress reports).</p> <ul style="list-style-type: none"> • Barriers encountered in achieving the Action Item.
8.	Reporting Standard Performance Measures ⁹	Recipients will indicate progress made towards achieving Target Capabilities by submitting standard Performance Measures as outlined in Attachment A.

⁹ Standard Performance Measures are developed by CDC to consistently track the attainment of Target Capabilities across recipients.

