

The following sections of the PHEP Budget Period 10 guidance have been updated for the Budget Period 10 Extension Period.

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**Instructions for Preparing and Submitting
Budget Period 10 **Extension** Funding Applications**

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Introduction

This guidance document is designed to assist awardees with developing a comprehensive **Budget Period (BP10) Extension** funding application and to act as a reference guide for fiscal, programmatic, and administrative requirements of the Public Health Emergency Preparedness (PHEP) cooperative agreement. This document also provides guidance on prioritizing program activities (see Key Elements of PAHPA below) in alignment with the PHEP authorizing legislation, **Section 319C-1 of the Public Health Service (PHS) Act, as amended by the Pandemic and All-Hazards Preparedness Act (PAHPA) (P.L. 109-417)**.

The purpose of this program is to develop emergency-ready public health departments by upgrading, integrating and evaluating state and local public health jurisdictions' preparedness for and response to public health emergencies with federal, state, local, and tribal governments, the private sector, and nongovernmental organizations (NGOs). Examples of public health emergencies may include terrorism, infectious disease outbreaks including influenza pandemics, food-borne disease outbreaks and other food security issues, natural disasters, and biological, chemical, nuclear, and radiological threats. These emergency preparedness and response efforts are intended to support the National Response Framework and the National Incident Management System (NIMS).

Prioritizing Public Health Preparedness Functions

CDC and its partners have held intensive discussions on the advisability of prioritizing public health preparedness functions in an environment when it may be necessary to trim or even eliminate many longstanding functions. To help our awardees determine the most critical functions to maintain, CDC has developed a summary of the PAHPA requirements that may help awardees make these difficult decisions. Many of these requirements are not new, so please be aware that appropriate activities may already be in place in many jurisdictions.

Key Elements of PAHPA (Appendix 1)

Awardees should use the elements listed below, as stated in PAHPA, to help determine priorities:

- 1) National Preparedness and Response, Leadership, Organization, and Planning
 - 1) Distribution of qualified countermeasures and qualified pandemic or epidemic products
 - 2) Distribution of the Strategic National Stockpile
 - 3) Logistical support for medical and public health aspects of federal responses to public health emergencies
 - 4) Addressing the needs of at-risk individuals
- 2) Public Health Security Preparedness
 - 1) Evidence-based benchmarks and objective standards
 - 2) State pandemic influenza plan
 - 3) Matching requirements
 - 4) Near-real-time electronic nationwide public health situational awareness capability through an interoperable network of systems
 - 5) Tracking distribution of influenza vaccine in an influenza pandemic
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 - 7) Assessment and evaluation of laboratory capacity

- 3) All-Hazards Medical Surge Capacity
 - 1) Analysis of community health care facilities
 - 2) Adequate supply of volunteer health professionals
 - i. National verification of licenses and credentials via a single interoperable network
 - ii. Waiver of licensing requirements in an emergency
 - 3) Curriculum and training for core health and medical response workers

A summary of all BP10 Extension PHEP cooperative agreement requirements, including PAHPA-related requirements, performance measures, administrative requirements, exercise requirements, and other reporting requirements can be found in Appendix 6.

Instructions for Preparing and Submitting Budget Period 10 **Extension Funding Applications**

Narrative answers must be in English and may not exceed **3,500** characters. This is approximately **one** page of 12-point, Times New Roman text, using left/right margins of 1 inch and top/bottom margins of 1.25 inches per answer. Detailed instructions for submitting your **Budget Period 10 (BP10) Extension** funding application are available through a download in PERFORMS (<https://sdn.cdc.gov>).

There are two components required for a complete **BP10 Extension** funding application submission:

- Component 1: **Budget Period 10 (BP10) Update** (formerly known as the Interim Progress Report)
- Component 2: **Budget Period 10 (BP10) Extension Application for Funding**

Component 1 - Budget Period 10 (BP10) Update (formerly known as Interim Progress Report)

Component 1 includes an update on the progress made during **BP10** on PHEP activities, priority projects, performance measures, and financial status reports. Additional details are provided below.

Information on **BP10** PHEP activities and priority projects is pre-populated in PERFORMS and should be updated in the **BP10 Extension** funding application if any additional changes have occurred. CDC's Division of State and Local Readiness (DSLRL) project officers and subject matter experts will use this information to identify strengths and weaknesses to update **work/consultation** plans and to establish priorities for site visits and technical assistance. Answers that do not clearly demonstrate compliance with PHEP activities may result in the restriction of funds until additional documentation is provided.

A. Progress on PHEP Activities

Review the **BP10** narrative responses describing plans to address PHEP activities. Update these responses with progress made **during the first six months of BP10**, making sure to highlight successes, describe barriers to overcome and/or those yet to be addressed, and request assistance where needed.

B. Progress on Priority Projects

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

Since this is a closeout year for PHEP Program Announcement AA154, CDC expects no major changes in priority projects for the **BP10 Extension**. While awardees are free to make adjustments to or add new priority projects they believe are needed, CDC expects the **BP10 Extension** to represent a period of continued progress on priorities and maintenance of essential public health emergency response and recovery infrastructure. In addition, priority projects must support the intent of the original PHEP Program Announcement AA154.

Review the **BP10** priority projects in PERFORMS. In the response boxes provided,

describe the progress made since the BP10 mid-year progress report, making sure to highlight successes, describe barriers overcome and/or those yet to be addressed, and request assistance where needed. Pay particular attention to updating priority project outputs, which may be rewritten at this time.

C. Performance Measures

Performance measures are an important tool for awardees to demonstrate essential public health emergency preparedness and response capabilities. Through the annual submission of performance measure data, awardees demonstrate functional public health capabilities such as incident management, crisis and emergency risk communication and laboratory reporting. Specific guidance on data collection and reporting requirements for the BP10 performance measures is available to awardees via the PHEP cooperative agreement website (<http://emergency.cdc.gov/cdcpreparedness/coopagreement/index.asp>). Awardees are expected to report on each measure according to this detailed guidance document. As always, awardees are encouraged to request clarification from CDC as needed. The deadline for submitting BP10 performance measures data is November 9, 2010.

In 2009, the PHEP “incident management- staff assembly” performance measure was chosen as a high priority performance goal (HPPG) for preparedness by the U.S. Department of Health and Human Services. To ensure a timely and effective response to an incident, public health agencies must demonstrate their capability to immediately, with no advanced notice, assemble public health staff with senior incident management roles. The ability to quickly notify and assemble such staff is a critical first step in initiating or activating a public health response regardless of the scale of the incident or event. The high priority performance goal is to increase to 90% the percentage of state public health agencies that can convene within 60 minutes of notification a team of trained staff that can make decisions about appropriate response and interaction with partners. The target date for reaching the 90% goal is November 2011. Budget Period 9 performance measure data indicate that 70% of awardees reported meeting this goal.

The incremental goal for this measure is that 80% of state awardees will meet the target of 60 minutes by November 2010, with progress measured using BP10 performance measure data submitted in November 2010. While awardees are not required to submit HPPG performance measure data until November 2010, CDC will conduct a mid-year status check on progress to date in achieving this staff assembly goal via the BP10 mid-year progress report. CDC will develop and provide training and focused technical assistance to awardees to support their efforts to meet the HPPG performance measure.

D. BP10 Financial Status Report (FSR)

Estimated unobligated funds should be reported separately by component (PHEP base, CRI, chemical laboratory and EWIDS). Both outlays and obligations must be estimated to the end of the budget period, August 9, 2010. Provide detailed actions to be taken to spend estimated unobligated funds. If insufficient funds are anticipated, provide detailed justification of the shortfall and list the actions taken to bring the obligations in line with the authorized funding level.

Component 2 - Budget Period 10 (BP 10) Extension Application for Funding

Component 2 includes program requirements, budget requirements, administrative requirements, and PAHPA requirements.

A. Program Requirements

Awardees should describe plans to address programmatic activities including the requirements noted below during the upcoming closeout year. The awardees should refer to the hyperlinks provided to ensure they are addressing all requirements, through a combination of responses in the **BP10** mid-year progress report and the **BP10 Extension Application for Funding** submission.

1) Comply with Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) guidelines.

PHEP awardees are required to describe how they work with their state Hospital Preparedness Program to continue adopting and implementing the *Interim ESAR-VHP Technical and Policy Guidelines, Standards, and Definitions (ESAR-VHP Guidelines)* (Appendix 8).

2) Ensure interoperable systems are consistent with the Public Health Information Network (PHIN).

Describe plans for implementing interoperable systems that demonstrate capabilities consistent with current PHIN requirements and that support the following functions:

- Identification of events/conditions of public health incidents through biosurveillance, including clinical data exchange with hospitals, urgent care centers, health information exchanges, laboratories, etc.
- Analysis of data about public health incidents, including outbreak management and integration of public health and clinical data.
- Communication of data about public health incidents including dissemination of alerts and secure sharing of preliminary information about suspected events.
- Intervention in public health incidents, including countermeasure and response administration.

Documentation for awardee compliance may be accomplished by providing detail regarding:

- **Planning** – Brief description of each project or activity, including their timelines and major milestones (with percent complete, if applicable). Awardees are encouraged to describe completed tasks or those in progress from the corresponding project plan.
- **Achievements in PHIN** – Listing of PHIN certifications that have been awarded or a detailed explanation as to why the target dates were not met. (Details regarding PHIN certification and target dates may be found at: <http://www.cdc.gov/phin>.)

Additional information (optional) may also be included:

- **Success Stories** – Examples of how PHIN applications or systems, currently in production, were used to identify, analyze, communicate, or intervene during a public health event.

- Innovation – Description of projects or implementations that extend the use and capacity of PHIN infrastructure. Work may involve CDC or other partners within public health.

- 3) Engage the State Office for Aging or equivalent office in addressing the emergency preparedness, response, and recovery needs of the elderly.
Describe the activities the awardee will undertake during the **BP10 Extension period** to further work with this resource on behalf of the elderly in awardee communities.
- 4) Solicit public comment on emergency preparedness plans and their implementation, including the establishment of an advisory committee or similar mechanism to ensure ongoing public comment.
Describe the activities the awardee will undertake during the **BP10 Extension period** to address this requirement.
- 5) Collaborate with Accredited Schools of Public Health to Include all Those Funded by CDC’s Office of Public Health Preparedness and Response (OPHPR).

Awardees should describe plans during the BP10 Extension period to work with CDC/OPHPR-funded Accredited Schools of Public Health to develop, deliver, and evaluate competency-based training and education programs based on identified needs of state, local, territorial, and tribal agencies for building workforce preparedness and response capabilities. Remember to include any Accredited Schools of Public Health contracts in budget requests (Appendix 12).

In addition, awardees are encouraged to begin or to continue collaborating with any of CDC’s nine Preparedness and Emergency Response Research Centers (PERRCS). The PERRCs are conducting public health systems research to enhance the usefulness of training; improve timely emergency communication; create and maintain sustainable response systems; and generate criteria and metrics for the effectiveness of preparedness and response activities. The PERRCs are listed in Appendix 13 and additional information about ongoing research in these centers is available at <http://emergency.cdc.gov/cdcpreparedness/science/research/PERRC.asp>

- 6) Obtain Local Health Department Concurrence.
The awardee should show evidence that at least a majority, if not all, of local health departments within the awardee’s jurisdiction approves or concurs with the approaches and priorities described in this application. In addition, state awardees will be required to provide signed letters of concurrence upon request. Documentation for local health department concurrence will be accomplished by:
 - Attaching a list in PERFORMS (<https://sdn.cdc.gov>) noting the consensus of a majority of local health officials whose collective jurisdictions encompass a majority of the state's population; or
 - Attaching in PERFORMS (<https://sdn.cdc.gov>) the statement of the president of the State Association of County and City Health Officials (SACCHO) that a majority of local health officials whose collective jurisdictions encompass a majority of the state's population agree with the SACCHO's decision.

7) Obtain Tribal Concurrence.

The awardee should show evidence that a majority, if not all, of American Indian/Alaska Native tribes within the jurisdiction approves or concurs with the approaches and priorities described in this application. Documentation for tribal concurrence will be accomplished by:

- Attaching in PERFORMS (<https://sdn.cdc.gov>) a letter of concurrence from the Indian Health Board representing the tribes within the awardee's jurisdiction; or
- Attaching individual letters of concurrence from the American Indian/Alaska Native tribes within the jurisdiction.

Awardees who are unable to gain 100% concurrence, despite good-faith efforts to do so, should attach in PERFORMS a Word document describing the reasons for lack of concurrence and the steps the state has taken to address them.

8) Continue the Development of Mass Prophylaxis and Countermeasure Distribution and Dispensing Operations.

Countermeasure distribution and dispensing is defined in the Homeland Security Presidential Directive 21 (HSPD-21), issued October 18, 2007, as a critical component of public health and medical preparedness. While much has been done to address this critical component of preparedness, existing plans and procedures must be tested to demonstrate state and local operational capability. In accordance with the requirements of HSPD-21, HHS must work with current cooperative agreement programs to demonstrate specific capabilities in tactical exercises and establish procedures to gather performance data from state and local participants on a regular basis to assess readiness. Consequently, CDC has included this mass prophylaxis section and the specified exercise requirements below in the **BP10 Extension** guidance.

a) Statewide

- Based on the state's public health preparedness planning infrastructure, describe the actions that will be taken during the **BP10 Extension period** to ensure that within each planning/local jurisdiction medical countermeasures can be rapidly dispensed to the affected population.
- Describe actions that will be taken during the **BP10 Extension period** to ensure that critical medical supplies and equipment are appropriately secured, managed, distributed, and restocked in a timeframe appropriate to the incident. Include a brief discussion of plans to exercise statewide medical supplies management, distribution plans, and personnel, and submit the resulting exercise after action report(s) and improvement plan(s) to CDC's Division of Strategic National Stockpile (DSNS) Program Preparedness Branch (PPB) mailbox (sns_ppb@cdc.gov) by November 9, 2011. Note that all scheduled exercises and documents also should be posted to LLIS or the National Exercise Schedule (NEXS) (if access is available).

b) Cities Readiness Initiative (CRI)

- Describe the actions that will be taken by the planning/local jurisdiction(s)

within a CRI metropolitan statistical area (MSA) during the **BP10 Extension period** to achieve the point of dispensing (POD) standards provided by DSNS.

- Describe plans to ensure that each planning/local jurisdiction within a CRI MSA and the four directly funded cities conducts at least three different drills from the range of eight possible drills and submits the appropriate documentation no later than November 9, 2011.
- Describe plans to conduct at least one full-scale or functional exercise that tests key components in mass prophylaxis/dispensing plans in each CRI MSA (including the four directly funded cities) that includes all pertinent jurisdictional leadership and emergency support function leads, planning and operational staff, and all applicable personnel. Submit the resulting applicable exercise data collection worksheet(s) and after action report(s), to the DSNS PPB mailbox (sns_ppb@cdc.gov) by November 9, 2011. All scheduled exercises and documents should be posted to LLIS or NEXS (if access is available).
- In an annual scheduling process between the DSNS program consultants and the state and local coordinators, DSNS is responsible for reviewing 25% of the CRI MSA planning/local jurisdictions, and the state is responsible for reviewing 75% of the CRI MSA planning/local jurisdictions by August 9, 2011, using the DSNS Local Technical Assistance Review tool.

Please note the following activity should be conducted in coordination with the awardee's state and local immunization programs.

- 9) Continue the Countermeasure and Response Administration (CRA) System Data Collection Project (Previously called "Biosurveillance Exercises").
Using a sample of seasonal influenza vaccination clinics, each awardee will report to CDC aggregate data on vaccine doses administered based on guidance from CDC's Immunization Services Division. The performance period for this activity is October 1, 2010, through December 31, 2010. **Note: H1N1 vaccination clinics meet this requirement for the BP10 Extension period and no further reporting is necessary.**

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

- 10) Continue Early Warning Infectious Disease Surveillance (EWIDS) Efforts.
The U.S. Department of Health and Human Services (HHS) Assistant Secretary for Preparedness and Response (ASPR) continues to provide supplemental funds for the purpose of developing and enhancing cross-border early warning infectious disease surveillance efforts for states sharing a common border with Mexico or Canada. Awardees should adhere to the guidance on EWIDS-related critical tasks found in Appendix 9.

The purpose of the EWIDS project is to enhance coordination among neighboring states along the U.S. borders with Mexico and Canada to:

- Improve early warning epidemiological surveillance capabilities at the state/province, local, and tribal level;
- Strengthen capacity for cross-border detection, reporting, and prompt investigation

- of infectious diseases outbreaks;
- Explore mechanisms to create interoperable systems to share surveillance (including laboratory) data; and
- Develop the public health workforce to undertake these activities.

11) Continue Level 1 Chemical Laboratory Surge Capacity Activities

The 10 funded awardees should describe plans for the **BP10 Extension** period to address objectives related to chemical emergency response surge capacity, including staffing and equipping the lab, training and proficiency testing for staff, and participating in local, state, and national exercises. Also describe how to increase laboratory capabilities and capacities consistent with the Laboratory Response Network for chemical terrorism program objectives, including the addition of new high-throughput sample preparation and analysis techniques and analytical capability for new threat agents (Appendix 7).

12) Assurances

CDC's Procurement and Grants Office (PGO) considers that the awardee's acceptance of the **BP10 Extension** funding award constitutes assurance of compliance with the other requirements listed below. No narrative response or attachment in PERFORMS is necessary for this submission.

Awardees must assure that they will:

- Submit as required: at mid-year, a progress report and an estimated FSR; and at the end of the year, a final progress report, performance data (including PAHPA benchmarks), and a final FSR.
- Submit an independent audit report every two years to the Federal Audit Clearinghouse within 30 days of receipt of the report.
- Conduct at least two preparedness exercises annually, developed in accordance with Homeland Security Exercise and Evaluation Program (HSEEP) standards. After action reports/improvement plans for these exercises must be submitted to DSLR project officers no later than the following year's funding application submission deadline. Required exercises may be pandemic influenza-related exercises.
- In coordination with the Hospital Preparedness Program, inform and educate hospitals in the jurisdiction on their role in public health emergency preparedness.
- Address the public health and medical needs of at-risk individuals¹ in the event of a public health emergency.
- Have in place fiscal and programmatic systems to document accountability and improvement.
- Meet National Incident Management System (NIMS) compliance requirements.

B. Budget Requirements

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

Funding applications must include the following budget requirements.

1) Detailed Line Item Budget and Justification

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

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

- Name(s) of contractor(s);
- Method of selection (competitive or sole source; less than full and open competition must be justified);
- Period of performance;
- Description of activities;
- Method of accountability; and
- Itemized budget with narrative justification.

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

2) Funding Amounts by Category

The funding amounts available for the categories below are shown in Appendices 2 and 3.

Base Funding. As described in the original PHEP Program Announcement AA154 (<http://emergency.cdc.gov/planning/guidance05/pdf/annoucement.pdf>), the distribution of funds among the awardees is calculated using a formula established by the HHS Secretary that includes a base amount for each awardee plus a population-based calculation.

Cities Readiness Initiative (CRI). All 50 state awardees and the four directly funded cities receive CRI funding using a population-based calculation. The BP10 Extension funding formula is calculated using a per capita of **\$0.33** based on the U.S. Census 2008 population estimates with three exceptions. One exception covers those project areas that would have received less than \$200,000 based on the BP10 Extension formula. These areas were increased to \$200,000. The second exception covers those project areas that would have received a greater than 25% reduction in funding based on the BP10 Extension formula. These areas were allocated 75% of their original fiscal year 2004 funding levels plus an additional 3%. The third exception covers the metropolitan statistical areas that did not receive funding increases under the first two exceptions. These areas received additional funding calculated using a per capita of **\$0.006339013** based on 2008 U.S. Census data.

Early Warning Infectious Disease Surveillance (EWIDS). States situated at the United

States' borders with Canada or Mexico (AK, AZ, CA, ID, IL, IN, ME, MI, MN, MT, NH, NM, NY, ND, OH, PA, TX, VT, WA and WI) are eligible for EWIDS funding. Additional guidance for this program is included in Appendix 9.

Level 1 Chemical Laboratory Surge Capacity. Ten awardees (CA, FL, MA, MI, MN, NM, NY, SC, VA and WI) receive funding to support Level 1 chemical laboratory surge capacity personnel, equipment, and/or activities. Additional guidance is included in Appendix 7.

3) Requests to Carry Over Unobligated Funds

According to the Section 319C-1 of the Public Health Service (PHS) Act, as amended by the Pandemic and All-Hazards Preparedness Act (PAHPA) (P.L. 109-417), for each fiscal year, funds may be carried over to the succeeding fiscal year. **Awardee requests to carry forward unobligated funds should be submitted to CDC by June 4, 2010,** to allow time for PGO to process the requests and the awardees time to obligate the funds by August 9, 2010.

All requests to carry forward unobligated funds should be based on a one-time, nonrecurring need as there is no guarantee new funds will be available to continue activities in the succeeding budget period(s). CDC encourages awardees to spend dollars in the year in which they are awarded and to identify legitimate nonrecurring activities which previously unobligated dollars could support as early in the year as possible. See Appendices 1 and 5 for additional information.

Carry-over requests should include at a minimum:

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

4) Maintaining State Funding (MSF)

Awardees are required to document MSF as part of their BP10 Extension funding applications. MSF is defined as ensuring that awardee expenditures for public health security are maintained at a level not less than the average of such expenditures for the previous two years. This definition includes:

- Appropriations specifically designed to support public health emergency preparedness as expended by the entity receiving the award; and
- Funds not specifically appropriated for public health emergency preparedness activities but which support public health emergency preparedness activities, such as personnel assigned to public health emergency preparedness responsibilities or supplies or equipment purchased for public health emergency preparedness from general funds or other lines within the operating budget of the entity receiving the award.

Expenditures for one-time expenses to support public health preparedness and response,

such as purchases of antiviral drugs, do not count toward MSF.

See Appendix 4 for additional guidance.

5) Matching of Federal Funds

PHEP cooperative agreement funding must be matched by nonfederal contributions beginning with the distribution of FY 2009 funds (BP10). Nonfederal contributions (match) may be provided directly or through donations from public or private entities and may be in cash or in-kind donations, fairly evaluated, including plant, equipment, or services. Amounts provided by the federal government, or services assisted or subsidized to any significant extent by the federal government, may not be included in determining the amount of such nonfederal contributions. Awardees will be required to provide matching funds as described:

- For FY 2009 (BP10), not less than 5% of such costs (\$1 for each \$20 of federal funds provided in the cooperative agreement); and
- For any subsequent fiscal year of such cooperative agreement, not less than 10% of such costs (\$1 for each \$10 of federal funds provided in the cooperative agreement).

The match requirement for the BP10 Extension period is 10%.

Please refer to 45 CFR § 92.24 for match requirements, including descriptions of acceptable match resources. Documentation of match must follow procedures for generally accepted accounting practices and meet audit requirements. Beginning with FY 2009 (BP10), the HHS Secretary may not make an award to an entity eligible for PHEP funds unless the eligible entity agrees to make available nonfederal contributions in full as described above. CDC will require each eligible entity to include in its **BP10 Extension** mid-year progress report a plan describing the methods and sources of match that the eligible entity agrees to pursue in FY 2011. See Appendix 4 for additional guidance.

6) Direct Assistance

Awardees planning to request direct assistance (DA) in lieu of financial assistance should have completed the DA request form and submitted it no later than **May 31, 2010**. Note that DA may only be requested in the form of public health advisors or Career Epidemiology Field Officers. No equipment or maintenance agreements will be supported through DA for the **BP10 Extension period**.

7) Attendance at Meetings

Participation in CDC-sponsored training, workshops, and meetings is essential to the effective implementation of the PHEP cooperative agreement. Awardees are reminded that the annual budget should include **required** travel for appropriate staff to attend PHEP-related meetings. The following meetings are MANDATORY for the state, local, or territorial PHEP director and/or other awardee staff:

- one business meeting for three days in Atlanta, Georgia;
- one program meeting for two days in a regional location;
- for Level 1 and 2 chemical laboratories one three-day, hands-on training for two analysts in Atlanta for state, local, or territorial chemical laboratory staff;
- one SNS training for three days in Atlanta for state, local, or territorial SNS

- coordinators and other SNS staff; and
- one PHIN conference for the PHIN coordinator and/or appropriate staff.

Attendance at the following partner-sponsored meetings is strongly recommended and may be funded through the PHEP cooperative agreement:

- one ASTHO- or NACCHO-sponsored program meeting such as the annual Public Health Preparedness Summit;
- one ASTHO- or NACCHO-sponsored business meeting such as the annual meeting for public health preparedness directors;
- Laboratory Response Network national meeting for chemical and biological laboratories;
- Association of Public Health Laboratories national meeting; and
- other appropriate meetings sponsored by national professional organizations.

C. **Administrative Requirements**

Awardees are required to submit twice a year progress reports on activities and financial performance. The information contained in the reports, which are outlined below, is considered public information and may be published.

1) Mid-year Reports

On April 30, 2011, awardees must submit progress reports for the performance period August 10, 2010, through February 28, 2011. The mid-year report should include updates on program activities/projects and an estimated FSR.

2) End-of-year Reports

On November 9, 2011, awardees must submit end-of-year progress reports including updates on program activities/projects for the performance period March 1, 2011, through August 9, 2011; performance measures data; and a final FSR.

3) Audit Requirements

Each awardee shall, not less than once every two years, audit its expenditures from amounts received from the PHEP cooperative agreement. Such audits shall be conducted by an entity independent of the agency administering the PHEP cooperative agreement in accordance with Office of Management and Budget Circular A-133, Audits of States, Local Governments, and Non-Profit Organizations. Audit reports must be submitted to the Federal Audit Clearinghouse. Failure to conduct an audit or expenditures made not in accordance with PHEP cooperative agreement guidance and grants management policy may result in a requirement to repay funds to the federal treasury or the withholding of future funds.

4) Terms and Conditions

Awardees should familiarize themselves with the terms and conditions of the award. They are the legal requirements imposed by the awarding office (CDC) on awardees, whether included in whole or in part in full text or incorporated by reference. Documents impacting the program include:

- 45 Code of Federal Regulation (CFR) 92, Uniform Administrative Requirements for

- Grants and Cooperative Agreements to State, Local and Tribal Governments;
- OMB Circulars: A-87, Cost Principles for State, Local and Indian Tribal Governments; A-102, Grants and Cooperative Agreements with State and Local Governments;
- A-133, Audits of States, Local Governments, and Non-Profits Organizations.

More information is available at <http://www.hhs.gov/asrt/og/aboutog/grantsnet.html>.

5) Employee Certifications

PHEP awardees are required to adhere to all applicable federal laws and regulations, including OMB Circular A-87 and semiannual certification of employees who work solely on a single federal award. Per OMB Circular A-87, compensation charges for employees who work solely on a single federal award must be supported by periodic certifications that the employees worked solely on that program during the certification period.

These certification forms must be prepared at least semiannually and signed by the employee or a supervisory official having firsthand knowledge of the work performed by the employee. Awardees must be able to document that the scope of duties and activities of these employees are in alignment and congruent with the intent of the PHEP cooperative agreement to build public health response capacity and to rebuild public health infrastructure in state and local public health agencies.

These certification forms must be retained in accordance with 45 Code of Federal Regulation, Part 92.42.

D. **PAHPA Requirements That Affect Fiscal Year 2012 Funding Decisions**

CDC has identified **five benchmarks** to be used as a basis for withholding **fiscal year 2010** funding for PHEP awardees. The benchmarks were selected because they:

- Reflect fundamental preparedness activities (e.g., incident management, influenza pandemic preparedness planning, and countermeasure delivery);
- Capture a range of complexity and level of effort (e.g., development of plans, maintaining organizational capacity, demonstrating operational capability through exercise and drills); and
- Can be modifiable from year to year to demonstrate progress in PHEP performance.

Following are descriptions of the benchmarks.

1) Demonstrated capability to notify primary, secondary, and tertiary staff to cover all incident management functional roles during a complex incident (Elements 1-2 in Table 1).

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

the staff notification system is critical for an efficient response, especially when the notification is unannounced and occurs outside of regular business hours. To demonstrate capability, public health departments must:

- a. Test the notification system twice a year, with at least one test being unannounced and occurring outside of regular hours. The test can be a drill or an exercise, or it may be demonstrated by a response to a real incident.

2) Demonstrated capability to receive, stage, store, distribute, and dispense material during a public health emergency (Elements 3-4 in Table 1).

Health departments must be able to provide countermeasures to 100% of their identified population within 48 hours after the decision to do so. To achieve this standard, health departments must maintain the capability to plan and execute the receipt, staging, storage, distribution, and dispensing of material during a public health emergency. To demonstrate capability, public health departments must comply with the following requirements:

- a. The 50 states must obtain a score of **89** or higher on the DSNS state Technical Assistance Review (TAR) during the performance period August 10, **2010**, through August 9, **2011**.
- b. The four directly funded cities must obtain a score of **89** or higher on the DSNS local TAR during the performance period August 10, **2010**, through August 9, **2011**.
- c. The U.S. Associated Pacific Islands, the U.S. Virgin Islands, and Puerto Rico must obtain a score of **60** or higher on the DSNS Island TAR during the performance period August 10, **2010**, through August 9, **2011**. Use of either of the DSNS State and/or Local TAR tool is optional, depending upon governmental structure and organization.
- d. A DSNS Local TAR must be conducted within each planning/local jurisdiction within a CRI MSA during the performance period August 10, **2010**, through August 9, **2011**.
- e. Within each CRI MSA, each planning/local jurisdiction and the four directly funded cities must conduct a minimum of three **different** (types of drill performed; not the same drill performed three times) drills during the performance period of August 10, **2010**, to August 9, **2011**.

There are two suites (eight separate drills) of simple, cost effective, and modular drills available from which to choose the three different drills. The three required drills may be chosen from any of the eight available drills across both suites.

Documentation of the three required drills must be submitted no later than November 9, **2011**, to the DSNS PPB mailbox (sns_ppb@cdc.gov) and consists of an after action report for any drill performed from the first suite of drills and a standardized data collection matrix for any drill performed from the second suite of drills. However, awardees are strongly encouraged to submit after action reports for any drills completed from the second suite by November 9, **2011**.

The first suite consists of drills that address decision-making processes: 1) resource

allocation game; 2) distribution tool intended to be used as a tabletop exercise; and 3) decision-making evaluation tool. Since a set of standardized data collection matrices are not available for this suite of drills, after action reports for any drills conducted from this suite should be submitted no later than November 9, 2011. This suite of drills will be released later in calendar year 2010.

The second suite of drills include staff call down, site activation, facility set-up, pick-list generation, and dispensing and/or modeling of throughput. This suite of drills is accompanied by a standardized set of data collection matrices. The matrices for any drills conducted from this suite should be submitted no later than November 9, 2011. Updated versions of the data collection matrices will be released later in calendar year 2010.

3) Submit pandemic influenza plans (Element 5 in Table 1).

Guidance and evaluation criteria for the pandemic influenza operational plan assessments, which are due on July 31, 2011, will be released by the CDC Influenza Coordination Unit no later than March 31, 2011. That review will impact withholding of PHEP funding for fiscal year 2012.

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

	Benchmark Measure	Yes	No	Reporting Mechanism	Possible % Withholding
1	Did the awardee test the notification system twice during the performance period of August 10, 2010, to August 9, 2011?			BP10 Extension end-of-year progress report	2.5%
2	Was at least one of the tests of the notification system referenced in #1 above conducted <i>unannounced and outside normal business hours</i> during the performance period of August 10, 2010, to August 9, 2011?			BP10 Extension end-of-year progress report	
3	Did each planning/local jurisdiction within each CRI MSA ² conduct a minimum of three different (types of drill performed; not the same drill performed three times) drills during the performance period of August 10, 2010, to August 9, 2011?			PPB mailbox (sns_ppb@cdc.gov)	
4	Did the awardee (50 states and four directly funded jurisdictions) receive a DSNS TAR score of 89 during the performance period of August 10, 2010, to August 9, 2011? Did the awardee (six Pacific Island jurisdictions, Puerto Rico, and the U.S. Virgin Islands) receive a DSNS TAR score of 60 during the performance period of August 10, 2010, to August 9, 2011?			DSNS TAR documents	2.5%

² The six Pacific Island jurisdictions, Puerto Rico, and the U.S. Virgin Islands are exempt from this requirement in the BP10 Extension period.

5	Pandemic Influenza Plan (Public Health Component Meets Standards)			Report to CDC Influenza Coordination Unit	5.0%
Total Potential Withholding Percentage					10.0%

Scoring Criteria

For the first three benchmarks, one point will be given for every measure that an awardee successfully completes. All measures are weighted the same, so the maximum number of points an awardee can receive is 3. Failure to meet two out of three benchmarks may result in withholding of up to 2.5% of the PHEP base award in **fiscal year 2012**.

For the fourth benchmark, failure to achieve a TAR score of **89** for the 50 states and four directly funded jurisdictions or a TAR score of **60** for the six Pacific Island jurisdictions, Puerto Rico, and the U.S. Virgin Islands may result in withholding of up to an additional 2.5% of the **fiscal year 2012** PHEP base award.

More information on withholding and repayment can be found in Appendix 5.

Submission Requirements and Application Review

BP10 Extension applications for funding are **due to CDC no later than 11:59 p.m. ET on Friday, June 25, 2010**, in the PERFORMS database maintained by DSLR. The direct link to PERFORMS is <https://sdn.cdc.gov>. Both principal investigators and business office officials must sign the completed **BP10 Extension** funding applications. **BP10 Extension** funding applications must be submitted on time and in English. Late or incomplete submissions may result in a delay in the award and/or reduction in funds.

PGO and DSLR will review the **BP10 Extension** funding applications for completeness. PGO will analyze the financial/business documentation, and DSLR and CDC subject matter experts will analyze the technical/programmatic documentation. Based on this analysis, the availability of funds, and the best interest of the government, PGO and DSLR will decide jointly whether to award extension funding. Following the initial budget review, CDC staff will coordinate calls with PHEP program directors to collect additional information and correct errors that may affect the final award conditions. After the calls, budgets will be finalized and CDC will prepare Notices of Award. CDC may withhold awards due to delinquent reports, inadequate stewardship of federal funds, or failure to meet the terms and conditions of the awards.

Any programmatic questions regarding the submission should be directed to the appropriate DSLR project officer (Appendix 10). For grants management questions, including budget questions, please contact the appropriate PGO grants management specialist (Appendix 11).

Appendix 1

Pandemic and All-Hazards Preparedness Act (PAHPA)

Summary of Requirements

Authorizing Legislation

Building on the lessons learned from the terrorist attacks of September 11, 2001, the anthrax attacks in the fall of 2002, SARS, Hurricanes Katrina and Rita in 2005, and other public health emergencies, the Pandemic and All-Hazards Preparedness Act (PAHPA) was enacted in December 2006 to improve the nation's public health and medical preparedness and response capabilities for emergencies, whether deliberate, accidental, or natural.

PAHPA amended and added new sections to the Public Health Service Act. Examples of these changes include identifying the Secretary of HHS as the lead official for all federal public health and medical responses to public health emergencies and other incidents covered by the National Response Framework; establishing the position of the Assistant Secretary for Preparedness and Response (ASPR), who will lead and coordinate HHS public health and medical preparedness and response activities, advise the Secretary of HHS during an emergency, and lead the coordination of public health and medical emergency preparedness and response efforts between HHS and other federal agencies; consolidating federal public health and medical response programs under the renamed ASPR; requiring the development and implementation of the National Health Security Strategy; and reauthorizing the Public Health and Emergency Preparedness (PHEP) cooperative agreements administered by the CDC and the Hospital Preparedness Program (HPP) cooperative agreements administered by ASPR. In addition to reauthorizing these two programs, the PAHPA amended these cooperative agreement programs to add certain new requirements that awardees must meet.

The Secretary of HHS is required under section 319C-1(g) of the PHS Act, **as amended by PAHPA**, to develop and require application of measurable benchmarks and objective standards that measure levels of preparedness with respect to PHEP activities. The Secretary shall withhold funds beginning in FY 2009 from PHEP awardees who fail to meet the applicable benchmarks for the immediately preceding fiscal year and/or who fail to meet accepted criteria for a pandemic influenza operations plan. Thus, PHEP awardees will have funds withheld from their **BP10** Extension (**FY 2010**) awards if they fail to meet the benchmarks described in the **BP10** continuation guidance or to submit a pandemic influenza operations plan that meets accepted criteria.

In addition, there are other requirements that are subject to enforcement actions including repayment of funds or withholding of future funds based on failure to meet certain provisions (e.g., independent audits, carryover limits) that went into effect with the distribution of BP10 (FY 2009) funding. Please note these and respond accordingly as insufficient responses shall adversely affect funding.

Section 319C-1 requires that awards be extended for activities to achieve the following preparedness goals of the National Health Security Strategy³:

(1) INTEGRATION- Integrating public health and public and private medical capabilities with other first responder systems, including through--

³ Section 319C-1(d)(1) of the PHS Act (42 USC §247d-3a(d)(1))

- (A) the periodic evaluation of Federal, State, local, and tribal preparedness and response capabilities through drills and exercises; and
- (B) integrating public and private sector public health and medical donations and volunteers.
- (2) PUBLIC HEALTH- Developing and sustaining Federal, State, local, and tribal essential public health security capabilities, including the following:
 - (A) Disease situational awareness including detection, identification, and investigation.
 - (B) Disease containment including capabilities for isolation, quarantine, social distancing, and decontamination.
 - (C) Risk communication and public preparedness.
 - (D) Rapid distribution and administration of medical countermeasures.
- (3) AT-RISK INDIVIDUALS
 - (A) Taking into account the public health and medical needs of at-risk individuals in the event of a public health emergency.
 - (B) The term ‘at-risk individuals’ means children, pregnant women, senior citizens and other individuals who have special needs in the event of a public health emergency.
- (4) COORDINATION- Minimizing duplication of, and ensuring coordination between, Federal, State, local, and tribal planning, preparedness, and response activities (including the State Emergency Management Assistance Compact). Such planning shall be consistent with the National Response Plan, or any successor plan, and National Incident Management System and the National Preparedness Goal.
- (5) CONTINUITY OF OPERATIONS- Maintaining vital public health and medical services to allow for optimal Federal, State, local, and tribal operations in the event of a public health emergency.

PAHPA also requires that applications for funding include⁴:

- (A) an All-Hazards Public Health Emergency Preparedness and Response Plan which shall include--
 - (i) a description of the activities such entity will carry out under the agreement to meet the goals identified under section 2802 [of the PHS Act]⁵;
 - (ii) a pandemic influenza plan consistent with the requirements of paragraphs (2) and (5) of subsection (g)⁶;
 - (iii) preparedness and response strategies and capabilities that take into account the medical and public health needs of at-risk individuals in the event of a public health emergency;

⁴319C-1(b)(2)(A) of the PHS Act (42 USC § 247d-3a(b)(2)(A))

⁵ Section 2802 of the PHS Act describes the goals of the National Health Security Strategy. Those relevant to the PHEP program are stated immediately above.

⁶ (2) CRITERIA FOR PANDEMIC INFLUENZA PLANS.—

(A) IN GENERAL.—Not later than 180 days after the date of enactment of the Pandemic and All-Hazards Preparedness Act, the Secretary shall develop and disseminate to the chief executive officer of each State criteria for an effective State plan for responding to pandemic influenza.

(B) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to require the duplication of Federal efforts with respect to the development of criteria or standards, without regard to whether such efforts were carried out prior to or after the date of enactment of this section.

(5) WITHHOLDING OF AMOUNTS FROM ENTITIES THAT FAIL TO ACHIEVE BENCHMARKS OR SUBMIT INFLUENZA PLAN.—Beginning with fiscal year 2009, and in each succeeding fiscal year, the Secretary shall--

(A) withhold from each entity that has failed substantially to meet the benchmarks and performance measures described in paragraph (1) for the immediately preceding fiscal year (beginning with fiscal year 2008), pursuant to the process developed under paragraph (4), the amount described in paragraph (6); and

(B) withhold from each entity that has failed to submit to the Secretary a plan for responding to pandemic influenza that meets the criteria developed under paragraph (2), the amount described in paragraph (6).

- (iv) a description of the mechanism the entity will implement to utilize the Emergency Management Assistance Compact or other mutual aid agreements for medical and public health mutual aid; and
- (v) a description of how the entity will include the State Unit on Aging in public health emergency preparedness;
- (B) an assurance that the entity will report to the Secretary on an annual basis (or more frequently as determined by the Secretary) on the evidence-based benchmarks and objective standards established by the Secretary to evaluate the preparedness and response capabilities of such entity under subsection (g);
- (C) an assurance that the entity will conduct, on at least an annual basis, an exercise or drill that meets any criteria established by the Secretary to test the preparedness and response capabilities of such entity, and that the entity will report back to the Secretary within the application of the following year on the strengths and weaknesses identified through such exercise or drill, and corrective actions taken to address material weaknesses;
- (D) an assurance that the entity will provide to the Secretary the data described under section 319D(d)(3) as determined feasible by the Secretary;
- (E) an assurance that the entity will conduct activities to inform and educate the hospitals within the jurisdiction of such entity on the role of such hospitals in the plan required under subparagraph (A);
- (F) an assurance that the entity, with respect to the plan described under subparagraph (A), has developed and will implement an accountability system to ensure that such entity make satisfactory annual improvement and describe such system in the plan under subparagraph (A);
- (G) a description of the means by which to obtain public comment and input on the plan described in subparagraph (A) and on the implementation of such plan, that shall include an advisory committee or other similar mechanism for obtaining comment from the public and from other State, local, and tribal stakeholders; and
- (H) as relevant, a description of the process used by the entity to consult with local departments of public health to reach consensus, approval, or concurrence on the relative distribution of amounts received under this section.

Under section 319D (d) of the PHS Act, as amended by PAHPA, HHS is responsible, in collaboration with state, local, and tribal public health officials, to establish a near-time electronic nationwide public health situational awareness capability through an interoperable network of systems to share data and information to enhance early detection of, rapid response to, and management of potentially catastrophic infectious disease outbreaks and other public health emergencies that originate domestically or abroad. Such a network shall be built on existing state situational awareness systems or enhanced systems that enable such connectivity. The recently developed National Biosurveillance Strategy for Human Health is the first step in a long-term effort to improve a nationwide capability to manage health-related data and information. (See Appendix 14.)

NOTE: HHS defines situational awareness as “a common operating picture of the situation requiring a response.” This common operating picture is the context for crisis decision-making to mitigate negative health impacts. A report prepared recently for HHS further describes this common operating picture as having “incorporated a threat and vulnerability assessment and resource availability and included the process of making sense of the current state of affairs and projecting

into the future.”⁷ As such, the components of situational awareness are:

- Nature of the incident (e.g., agent or cause, response timeline, severity),
- Personnel (e.g., volunteers, paid staff),
- Non-personnel resources (e.g., medical materiel, facilities),
- Projections about future changes (e.g., severity, skill sets required).

Improved situational awareness also increases the effectiveness and efficiency of these activities and resources by allowing for better targeting of their use during an incident (i.e., cyclic quality improvement). They include:

1. Infrastructure, technical and clinical requirements and administrative provisions of triage, diagnosis, consultation, treatment, support, compensation, administration, and education relating to Information Technology (IT) and Telemedicine objectives,
2. Biosurveillance systems that might identify and facilitate investigation of a threat,
3. Logistical and dynamic operational need and asset requirements and support of an ongoing theater of activity.

As indicated above, awardees are required to include an assurance in their applications that they will provide to CDC the data generated in this network.

Maximum Amount of Carryover

As required by PAHPA, CDC must determine the maximum amount of unobligated funds that can be carried over into the succeeding budget period, beginning with the BP10 Extension period, which starts August 10, 2010. **The maximum percentage of carry-over funds for the BP10 Extension will be set at 100%.**

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

CDC recognizes that there may be justifiable causes (e.g., state hiring freezes, inefficiencies on the part of the awarding agency) or unjustifiable causes (e.g., ineffective management infrastructure at the state level, irregularities in contracting or payment of debt) for dollars to remain unobligated at the end of the budget period even after a robust execution of plans. Unjustifiable unobligated balances will be determined by using the awardee’s spend plan and financial status and progress/performance reports. (See Appendix 5 for additional information.) Therefore, during the budget period the awardee must immediately communicate with the DSLR project officer events occurring between the scheduled spend plan and progress/performance report date which have significant impact upon the cooperative agreement. This ongoing communication will enable the awardee’s project officer to provide the appropriate technical assistance to help address identified issues.

⁷ Parker, A., Nelson, C., Shelton, S., Dausey, D., Lewis, M., Pomeroy, A., Leuschner, K. Measuring Crisis Decision-Making for Public Health Emergencies, WR-577-DHHS, October 2008. Working Paper Prepared for the U.S. Department of Health and Human Services Office of the Assistant Secretary for Preparedness and Response.

Appendix 2
Budget Period 10 Extension (FY 2010) Funding

Awardee	FY 2010 Total Base Plus Population Funding	FY 2010 Cities Readiness Initiative Funding	FY 2010 Level 1 Chemical Laboratory Funding	FY 2010 EWIDS Funding	FY 2010 Total Funding Available*
Alabama	\$9,522,688	\$375,896	\$0	\$0	\$9,898,584
Alaska	\$4,800,000	\$200,000	\$0	\$15,000	\$5,015,000
American Samoa	\$390,413	\$0	\$0	\$0	\$390,413
Arizona	\$12,063,333	\$1,440,170	\$0	\$394,168	\$13,897,671
Arkansas	\$6,999,076	\$244,729	\$0	\$0	\$7,243,805
California	\$40,258,503	\$6,471,305	\$1,176,433	\$935,497	\$48,841,738
Chicago	\$8,978,646	\$1,660,875	\$0	\$0	\$10,639,521
Colorado	\$9,882,118	\$843,077	\$0	\$0	\$10,725,195
Connecticut	\$7,884,813	\$684,993	\$0	\$0	\$8,569,806
Delaware	\$4,621,861	\$378,139	\$0	\$0	\$5,000,000
District of Columbia	\$5,825,307	\$641,175	\$0	\$0	\$6,466,482
Florida	\$28,691,962	\$3,431,705	\$898,167	\$0	\$33,021,834
Georgia	\$16,523,564	\$1,808,255	\$0	\$0	\$18,331,819
Guam	\$545,470	\$0	\$0	\$0	\$545,470
Hawaii	\$4,795,383	\$304,399	\$0	\$0	\$5,099,782
Idaho	\$5,130,096	\$200,000	\$0	\$15,000	\$5,345,096
Illinois	\$16,930,758	\$2,400,864	\$0	\$15,000	\$19,346,622
Indiana	\$11,908,450	\$922,407	\$0	\$15,000	\$12,845,857
Iowa	\$7,175,093	\$240,355	\$0	\$0	\$7,415,448
Kansas	\$6,900,919	\$479,102	\$0	\$0	\$7,380,021
Kentucky	\$8,979,488	\$476,360	\$0	\$0	\$9,455,848
Los Angeles	\$18,752,555	\$3,316,992	\$0	\$0	\$22,069,547
Louisiana	\$9,207,602	\$641,856	\$0	\$0	\$9,849,458

Awardee	FY 2010 Total Base Plus Population Funding	FY 2010 Cities Readiness Initiative Funding	FY 2010 Level 1 Chemical Laboratory Funding	FY 2010 EWIDS Funding	FY 2010 Total Funding Available
Maine	\$4,840,299	\$200,000	\$0	\$68,768	\$5,109,067
Marshall Islands	\$388,143	\$0	\$0	\$0	\$388,143
Maryland	\$10,890,953	\$1,679,598	\$0	\$0	\$12,570,551
Massachusetts	\$12,124,995	\$1,563,781	\$1,080,994	\$0	\$14,769,770
Michigan	\$16,948,393	\$1,488,338	\$1,049,437	\$196,866	\$19,683,034
Micronesia	\$450,174	\$0	\$0	\$0	\$450,174
Minnesota	\$10,293,987	\$1,063,809	\$1,063,730	\$30,118	\$12,451,644
Mississippi	\$7,100,104	\$277,182	\$0	\$0	\$7,377,286
Missouri	\$11,306,065	\$1,116,278	\$0	\$0	\$12,422,343
Montana	\$4,800,000	\$200,000	\$0	\$16,198	\$5,016,198
Nebraska	\$5,484,915	\$241,473	\$0	\$0	\$5,726,388
Nevada	\$6,647,675	\$713,948	\$0	\$0	\$7,361,623
New Hampshire	\$4,843,341	\$341,015	\$0	\$15,000	\$5,199,356
New Jersey	\$15,081,045	\$2,784,616	\$0	\$0	\$17,865,661
New Mexico	\$5,770,526	\$284,514	\$1,067,226	\$61,340	\$7,183,606
New York	\$18,484,556	\$2,083,221	\$1,617,584	\$286,788	\$22,472,149
New York City	\$16,663,132	\$3,939,750	\$0	\$0	\$20,602,882
North Carolina	\$15,895,060	\$507,380	\$0	\$0	\$16,402,440
North Dakota	\$4,800,000	\$200,000	\$0	\$21,860	\$5,021,860
Northern Mariana Islands	\$377,263	\$0	\$0	\$0	\$377,263
Ohio	\$19,075,811	\$1,856,716	\$0	\$15,000	\$20,947,527
Oklahoma	\$8,081,566	\$405,673	\$0	\$0	\$8,487,239
Oregon	\$8,275,353	\$595,971	\$0	\$0	\$8,871,324
Palau	\$328,877	\$0	\$0	\$0	\$328,877
Pennsylvania	\$20,523,708	\$2,119,963	\$0	\$15,000	\$22,658,671
Puerto Rico	\$8,514,449	\$0	\$0	\$0	\$8,514,449

Awardee	FY 2010 Total Base Plus Population Funding	FY 2010 Cities Readiness Initiative Funding	FY 2010 Level 1 Chemical Laboratory Funding	FY 2010 EWIDS Funding	FY 2010 Total Funding Available
Rhode Island	\$4,646,579	\$353,421	\$0	\$0	\$5,000,000
South Carolina	\$9,279,791	\$318,013	\$976,849	\$0	\$10,574,653
South Dakota	\$4,800,000	\$200,000	\$0	\$0	\$5,000,000
Tennessee	\$11,702,270	\$859,158	\$0	\$0	\$12,561,428
Texas	\$36,892,153	\$4,728,791	\$0	\$1,423,595	\$43,044,539
Utah	\$6,803,260	\$375,251	\$0	\$0	\$7,178,511
Vermont	\$4,800,000	\$200,000	\$0	\$43,078	\$5,043,078
Virgin Islands (U.S.)	\$453,195	\$0	\$0	\$0	\$453,195
Virginia	\$13,870,661	\$1,798,642	\$933,795	\$0	\$16,603,098
Washington	\$12,156,340	\$1,271,477	\$0	\$153,724	\$13,581,541
West Virginia	\$5,530,827	\$217,361	\$0	\$0	\$5,748,188
Wisconsin	\$10,847,661	\$617,692	\$1,336,085	\$15,000	\$12,816,438
Wyoming	\$4,800,000	\$200,000	\$0	\$0	\$5,000,000
TOTAL FY 2010 PHEP FUNDING	\$611,341,225	\$61,965,686	\$11,200,300	\$3,752,000	\$688,259,211

* Funding aligns with a 12-month budget cycle

Appendix 3
Budget Period 10 Extension Cities Readiness Initiative Funding

Awardee	CRI City	2008 Census Population	BP10 Extension Awardee Totals
Alabama	Birmingham	1,117,608	\$ 375,896
Alaska	Anchorage	364,701	\$ 200,000
Arizona	Phoenix	4,281,899	\$1,440,170
Arkansas	Little Rock	675,069	\$244,729
Arkansas	Memphis	52,554	
California	Los Angeles	3,010,759	\$6,471,305
California	Riverside	4,115,871	
California	Sacramento	2,109,832	
California	San Diego	3,001,072	
California	San Francisco	4,274,531	
California	San Jose	1,819,198	
California	Fresno	909,153	
Chicago	Chicago	2,853,114	
Colorado	Denver	2,506,626	\$843,077
Connecticut	Hartford	1,190,512	\$684,993
Connecticut	New Haven	846,101	
Delaware	Philadelphia	529,641	\$378,139
Delaware	Dover	155,415	
Florida	Miami	5,414,772	\$3,431,705
Florida	Orlando	2,054,574	
Florida	Tampa	2,733,761	
Georgia	Atlanta	5,376,285	\$1,808,255
Hawaii	Honolulu	905,034	\$304,399
Idaho	Boise	599,753	\$200,000
Illinois	Chicago	5,849,587	\$2,400,864
Illinois	St Louis	693,998	
Illinois	Peoria	372,487	
Indiana	Chicago	702,458	\$922,407
Indiana	Indianapolis	1,715,459	
Indiana	Cincinnati	79,101	
Indiana	Louisville	245,469	
Iowa	Des Moines	556,230	\$240,355
Iowa	Omaha	119,982	
Kansas	Wichita	603,716	\$479,102
Kansas	Kansas City	829,823	
Kentucky	Louisville	999,227	\$476,360
Kentucky	Cincinnati	417,079	

Awardee	CRI City	2008 Census Population	BP10 Extension Awardee Totals
Los Angeles	Los Angeles	9,862,049	\$3,316,992
Louisiana	Baton Rouge	774,327	\$641,856
Louisiana	New Orleans	1,134,029	
Maine	Portland	514,065	\$200,000
Maryland	Baltimore	2,667,117	\$1,679,598
Maryland	Washington D.C	2,226,715	
Maryland	Philadelphia	99,926	
Massachusetts	Boston	4,103,594	\$1,563,781
Massachusetts	Providence	545,823	
Michigan	Detroit	4,425,110	\$1,488,338
Minnesota	Fargo	55,767	\$1,063,809
Minnesota	Minneapolis	3,107,137	
Mississippi	Jackson	537,285	\$277,182
Mississippi	Memphis	229,474	
Missouri	St. Louis	2,146,682	\$1,116,278
Missouri	Kansas City	1,172,224	
Montana	Billings	152,005	\$200,000
Nebraska	Omaha	717,943	\$241,473
Nevada	Las Vegas	1,865,746	\$713,948
New Hampshire	Boston	419,264	\$341,015
New Hampshire	Manchester	402,042	
New Jersey	New York City	6,367,843	\$2,784,616
New Jersey	Philadelphia	1,316,710	
New Jersey	Trenton	364,883	
New Mexico	Albuquerque	845,913	\$284,514
New York	Albany	853,919	\$2,083,221
New York	Buffalo	1,124,309	
New York	New York City	4,215,581	
New York City	New York City	8,363,710	\$3,939,750
North Carolina	Charlotte	1,484,351	\$507,380
North Carolina	Virginia Beach	24,183	
North Dakota	Fargo	139,918	\$200,000
Ohio	Cincinnati	1,658,957	\$1,856,716
Ohio	Cleveland	2,088,291	
Ohio	Columbus	1,773,120	
Oklahoma	Oklahoma City	1,206,142	\$405,673
Oregon	Portland	1,771,935	\$595,971
Pennsylvania	Philadelphia	3,892,194	\$2,119,963
Pennsylvania	Pittsburgh	2,351,192	
Pennsylvania	New York City	59,664	

Awardee	CRI City	2008 Census Population	BP10 Extension Awardee Totals
Rhode Island	Providence	1,050,788	\$353,421
South Carolina	Columbia	728,063	\$318,013
South Carolina	Charlotte	217,448	
South Dakota	Sioux Falls	232,930	\$200,000
Tennessee	Nashville	1,550,733	\$859,158
Tennessee	Memphis	1,003,704	
Texas	Dallas	6,300,006	\$4,728,791
Texas	Houston	5,728,143	
Texas	San Antonio	2,031,445	
Utah	Salt Lake City	1,115,692	\$375,251
Vermont	Burlington	208,460	\$200,000
Virginia	Richmond	1,225,626	\$1,798,642
Virginia	Virginia Beach	1,634,109	
Virginia	Washington D.C	2,487,967	
Washington	Seattle	3,344,813	\$1,271,477
Washington	Portland	435,527	
Washington D.C	Washington D.C	591,833	\$641,175
West Virginia	Charleston	303,944	\$217,361
West Virginia	Washington D.C	51,615	
Wisconsin	Chicago	164,465	\$617,692
Wisconsin	Milwaukee	1,549,308	
Wisconsin	Minneapolis	122,741	
Wyoming	Cheyenne	87,542	\$200,000
TOTAL Cities Readiness Initiative Funding		173,310,492	\$61,965,686

Appendix 4

Matching Funds and Maintaining State Funding Guidance

Matching Funds

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

Beginning in fiscal year 2009 (BP10), CDC may not award a cooperative agreement under this program unless the **awardee state (or consortium)** agrees that with respect to the amount of the cooperative agreement awarded by CDC that the **awardee state (or consortium)** will make available (directly or through donations from public or private entities) nonfederal contributions in an amount equal to –

- (i) for the first fiscal year of the cooperative agreement, not less than 5% of such costs (\$1 for each \$20 of federal funds provided in the cooperative agreement and
- (ii) for any second fiscal year of the cooperative agreement, and for any sequent fiscal year of such cooperative agreement, not less than 10% of such costs (\$1 for each \$10 of federal funds provided in the cooperative agreement).

Administrative Requirement

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

Source of Funds

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

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

Exceptions to Matching Funds Requirement

- **Matching does not apply** to the political subdivisions of New York City, Los Angeles County, and Chicago.
- Title 48 U.S.C. 1469a (d) requires HHS/CDC to waive matching fund requirements for American Samoa, Guam, the U.S. Virgin Islands, and the Commonwealth of the Northern Mariana Islands up to \$200,000.

Matching Funds and Unobligated Funds

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

Maintaining State Funding (MSF)

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

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

Administrative Requirement

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

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

Appendix 5

Withholding and Repayment Guidance

Procedural Consideration

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

Pandemic and All-Hazards Preparedness Act (PAHPA) Requirements for the PHEP Cooperative Agreement

PAHPA requires the withholding of amounts from entities that fail to achieve benchmarks and objective standards or to submit an acceptable pandemic influenza operations plan, beginning with fiscal year 2009 and in each succeeding fiscal year:

A. Benchmarks and Statewide Pandemic Influenza Operations Plan

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

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

- (2) Enforcement Action:
 - Withhold funds – BP12 (FY 2011) is for the purpose of evaluation to determine the amount to be withheld from the year immediately following year of failure. Additionally, each failure is to be treated as a separate failure for the purposes of the penalties described below:
 - Initial failure - withholding in an amount equal to 10% of funding per failure
 - Two consecutive years of failure - withholding in an amount equal to 15% of funding per failure
 - Three consecutive years of failure - withholding in an amount equal to 20% of funding per failure
 - Four consecutive years of failure - withholding in an amount equal to 25% of funding per failure
 - Reallocation of amount withheld – according to [Section 319C-1\(g\)\(7\)](#) any funds withheld from the PHEP or the Hospital Preparedness Program will be reallocated to the Healthcare Facilities Partnership program.

- Preference in reallocation – according to **Section 319C-1(g)(7)**, any funds withheld from the PHEP or the Hospital Preparedness Program will be reallocated to the Healthcare Facilities Partnership program in the same state.

B. Audit Implementation

- (1) Enforcement Condition: Awardees who fail to submit the required audit or spend amounts in noncompliance.
- (2) Enforcement Action: Grants management officer disallows costs and requests payment via standard audit disallowance process or temporarily withholds funds pending corrective action.

C. Carryover

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

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

The Department of Health and Human Services (HHS) permits awardees to appeal to the Departmental Appeal Board (DAB) certain post-award adverse administrative decisions made by HHS officials (see 45 CFR Part 16). CDC has established a first-level grant appeal procedure that must be exhausted before an appeal may be filed with the DAB (see **42 CFR § 50.402**). CDC will assume jurisdiction for any of the above adverse determinations.

Appendix 6
Budget Period 10 (BP10) Extension Reporting Requirements
All Awardees

This is a summary document for the CDC PHEP Cooperative Agreement Budget Period 10 (BP10) Extension reporting requirements. The reporting requirements are summarized in five tables:

TABLE 1: Requirements that affect Fiscal Year 2012 funding decisions per PAHPA

TABLE 2: Additional reporting requirements

TABLE 3: Performance measurement requirements

TABLE 4: Administrative requirements

TABLE 5: All requirements (Tables 1-4) in chronological order by due date

Many of the reporting requirements in this document may be achieved by conducting exercises, responding to real incidents, or a combination of both real incidents and exercises. Exercises can be developed to test multiple functions at both the state and local levels; therefore multiple requirements in this document may be fulfilled in one exercise.

All due dates in this summary document are subject to change and awardees should continue to consult with their DSLR project officers.

TABLE 1: Requirements That Affect Fiscal Year 2012 Funding Decisions per PAHPA¹

Requirement	Jurisdictional Level	Reporting Tool	Performance Period	Due Date	Reference to Guidance
2 Staff Notifications ²	All Awardees	BP10 Extension End-of-year Progress Report (PERFORMS)	08/10/10-08/09/11	11/09/2011	
SNS TAR Score 89 or higher 89 or higher 60 or higher	-States -Directly Funded Localities -USAPI, VI, PR	DSNS Technical Assistance Review Tool	08/10/10-08/09/11	11/09/2011	
3 DSNS Drills ³	-Each Planning/Local Jurisdiction within Each CRI MSA -Directly Funded Localities	1 st Suite - AAR Submission (sns_ppb@cdc.gov) 2 nd Suite - DSNS Worksheet (sns_ppb@cdc.gov)	08/10/10-08/09/11	11/09/2011	
Pandemic Influenza Plan (Public Health Component Meets Standards)	All Awardees	Submission of Pandemic Influenza Operational Plan, PH Component	N/A	07/31/2011	

¹ The Pandemic and All-Hazards Preparedness Act (PAHPA), passed in December, 2006, amended and added new sections to the Public Health Service Act, including section 319C-1, which authorizes the Public Health Emergency Preparedness Cooperative Agreement Program. Section 319C-1 requires awardees to meet certain benchmarks described in this guidance. Awardees will be scored based upon the degree to which they complete these benchmarks and will be notified of their scores by early spring 2011. Failure to meet the benchmarks may result in withholding of FY 2012 funding.

² Staff notifications may occur during either operations-based exercises (drill, functional, or full-scale) or real incidents. At least 1 staff notification must be unannounced and outside normal business hours for the performance period. The requirement may be completed anytime within the performance period.

³ May be chosen from a set of 8 possible DSNS drills: first drill suite includes resource allocation, decision making or distribution; second drill suite includes staff call down (or notification), site activation, facility set-up, dispensing throughput or pick-list generation. Drills may be incorporated into other functional or full-scale exercises.

TABLE 2: Additional Reporting Requirements

Requirement	Jurisdictional Level	Reporting Tool	Performance Period	Due Date	Reference to Guidance
1 Exercise Schedule (See Below)	All Awardees	Exercise Schedule (DSL Channel on LLIS.gov)	08/10/10-08/09/11	12/31/2010	
2 State-level Preparedness Exercises ¹	All Awardees	AARs (DSL Channel on LLIS.gov)	08/10/10-08/09/11	11/09/2011	
Conduct local TAR (by DSNS & state planners) CRI TAR Score 69 or Higher	100% of Planning/Local Jurisdictions within Each CRI MSA	DSNS Will Provide Reports from Reviews For 25% of the CRI MSA planning/local jurisdictions State Will Provide Automated Score Sheets & Reports from Reviews to DSNS Consultant for 75% of the CRI MSA planning/local jurisdictions	08/10/10-08/09/11	11/09/2011	
1 Functional or Full-Scale Exercise testing key components of mass prophyl/ dispensing plans	Participation from: -Each Planning/Local Jurisdiction in CRI MSA -Directly Funded Localities	AAR and Any Associated DSNS Worksheet or Exercise Evaluation Guide (EEG) (sns_ppb@cdc.gov)	08/10/10-08/09/11	11/09/2011	
Countermeasure & Response Administration Data Collection Project (Biosurveillance)	All Awardees 8 Seasonal Influenza Clinics (Mixture of Urban, Suburban, Exurban & Rural Areas)	Immunization Information System Data Exchange OR Countermeasure and Response Administration (CRA) Web-based System Entry	H1N1 vaccination clinics were used to meet this requirement; no further reporting is needed.	N/A	
1 Medical Supplies Management & Distribution Plan Exercise	States	AAR and Any Associated DSNS Worksheet or EEG (sns_ppb@cdc.gov)	08/10/10-08/09/11	11/09/2011	

¹ ANY public health exercise led by the state or an exercise in which the state participates that is conducted between 08/10/10 and 08/09/11 will count toward the 2 annual preparedness exercises requirement. Evidence of completing the exercise will be demonstrated through submission of AARs. Draft AARs are ideally submitted 60 days after the completion of the exercise consistent with current Homeland Security Exercise and Evaluation Program (HSEEP) documentation (Volume I: HSEEP Overview and Exercise Program Management, February 2007).

TABLE 3: Performance Measurement (PM) Requirements

Requirement	Jurisdictional Level	Reporting Tool	Performance Period	Due Date	Reference to Guidance
Best Demonstration of Incident Management – Staff Notification (Operations-based Exercise or Real Incident)	All Awardees	BP10 Extension Performance Measures	08/10/10-08/09/11	11/09/2011	BP10 Extension Performance Measures Guidance
Best Demonstration of Incident Management – Staff Assembly (Operations-based Exercise or Real Incident)	All Awardees	BP10 Extension Performance Measures	08/10/10-08/09/11	11/09/2011	BP10 Extension Performance Measures Guidance
Best Demonstration of Incident Management – Incident Action Plan (Operations-based Exercise or Real Incident)	All Awardees	BP10 Extension Performance Measures	08/10/10-08/09/11	11/09/2011	BP10 Extension Performance Measures Guidance
Best Demonstration of Incident Management – After Action Report and Improvement Plan (Tabletop or Operations-based Exercise or Real Incident)	All Awardees	BP10 Extension Performance Measures	08/10/10-08/09/11	11/09/2011	BP10 Extension Performance Measures Guidance
Best Demonstration of Crisis and Emergency Risk Communication with the Public (Operations-based Exercise or Real Incident)	All Grantees	BP10 Extension Performance Measures	08/10/10-08/09/11	11/09/2011	BP10 Extension Performance Measures Guidance
Biosurveillance Measures (Epidemiology, Surveillance & Investigation, and Laboratory) TBD ¹	TBD	BP10 Extension Performance Measures	03/01/11-08/09/11	11/09/2011	BP10 Extension Performance Measures Guidance ¹

¹ Biosurveillance performance measures (including epidemiology, surveillance and investigation, and laboratory capabilities) are currently in development. The performance period for these newly developed performance measures will be based on the release and distribution date of these performance measures and related guidance. **It is anticipated that the BP10 Extension Performance Measures Guidance will be available 11/2010.**

TABLE 4: Administrative Requirements

Requirement	Jurisdictional Level	Reporting Tool	Performance Period	Due Date	Reference to Guidance
Direct Assistance Request	Awardees Requesting Direct Assistance	Direct Assistance Request Form (Email to DSLR Project Officer)	N/A	05/31/2010	
Budget Carry-over Request	Awardees Requesting Budget Carry-over	Budget Carry-over Request (PERFORMS)	N/A	06/04/2010	
BP10 Extension Application for Funding	All Awardees	BP10 Extension Application for Funding (PERFORMS)	N/A	06/25/2010	
Mid-year Progress Report	All Awardees	BP10 Extension Mid-year Progress Report (PERFORMS)	08/10/10-02/28/11	04/30/2011	
Estimated Financial Status Report (FSR)	All Awardees	Estimated FSR (SF#269)	08/10/10-02/28/11	04/30/2011	
End-of-year Report	All Awardees	BP10 Extension End-of-year Progress Report (PERFORMS)	08/10/10-08/09/11	11/09/2011	
Final FSR	All Awardees	Final FSR (SF#269)	08/10/10-08/09/11	11/09/2011	

TABLE 5: All Requirements (Tables 1-4) in Chronological Order by Due Date

Requirement	Jurisdictional Level	Reporting Tool	Performance Period	Due Date
Direct Assistance Request	All Awardees	Direct Assistance Request Form	N/A	05/31/2010
BP10 Extension Funding Application	All Awardees	BP10 Extension Application for Funding	N/A	06/25/2010
Pandemic Flu Plan - Satisfactory	All Awardees	Submission of Pandemic Influenza Plan	N/A	07/31/2011
1 Exercise Schedule	All Awardees	LLIS.gov/DSLChannel & NEXS If Available	08/10/10 - 08/09/11	12/31/2010
Mid-year Progress Report	All Awardees	BP10 Extension Mid-year Progress Report	08/10/10 - 02/28/11	04/30/2011
Estimated (FSR)	All Awardees	B10 Extension Mid-year Progress Report	08/10/10 - 02/28/11	04/30/2011
2 Staff Notifications	All Awardees	BP10 Extension End-of-year Progress Report	08/10/10 - 08/09/11	11/09/2011
SNS TAR Score \geq 89	State & Localities	DSNS Technical Assistance Review	08/10/10 - 08/09/11	11/09/2011
SNS TAR Score \geq 60	USAPI, VI, PR	DSNS Technical Assistance Review	08/10/10 - 08/09/11	11/09/2011
3 DSNS Drills	Each planning/ local jurisdictions in CRI MSA & Localities	AAR Submission or DSNS Worksheet (sns_ppb@cdc.gov)	08/10/10 - 08/09/11	11/09/2011
Conduct Local TAR	Each planning/local jurisdictions in CRI MSA	DSNS and State Planners	08/10/10 - 08/09/11	11/09/2011
1 FE or FSE – Key Components of Mass Prophy/Dispensing Plans	Each planning/local jurisdictions in CRI MSA & localities participate	AAR and Any Associated DSNS Worksheet or EEG (sns_ppb@cdc.gov)	08/10/10 - 08/09/11	11/09/2011
1 Medical Supplies Management & Distribution Plan Exercise	State	AAR and Ay Associated DSNS Worksheet or EEG (sns_ppb@cdc.gov)	08/10/10 - 08/09/11	11/09/2011
2 Preparedness Exercises	All Awardees	Submit AARs to DSLR Channel of LLIS.gov	08/10/10 - 08/09/11	11/09/2011
Best Demo- Staff notification	All Awardees	BP10 Extension Performance Measures to be Released	08/10/10 - 08/09/11	11/09/2011
Best Demo- Staff Assembly	All Awardees	BP10 Extension Performance Measures to be Released	08/10/10 - 08/09/11	11/09/2011
Best Demo- Incident Management	All Awardees	BP10 Extension Performance Measures to be Released	08/10/10 - 08/09/11	11/09/2011
Best Demo- AAR/IP	All Awardees	BP10 Extension Performance Measures to be Released	08/10/10 - 08/09/11	11/09/2011
Best Demo- CERC	All Awardees	BP10 Extension Performance Measures to be Released	08/10/10 - 08/09/11	11/09/2011
Biosurveillance Measures	All Awardees	BP10 Extension Performance Measures to be Released	03/01/11 - 08/09/11	11/09/2011
End-of-year Progress Report	All Awardees	BP10 Extension End-of-year Progress Report	08/10/10 - 08/09/11	11/09/2011
Final FSR	All Awardees	BP10 Extension End-of-year Progress Report	08/10/10 - 08/09/11	11/09/2011
CRA Data Collection Project	All Awardees	Immunization Information System Data Exchange OR (CRA) Web-based System Entry	H1N1 vaccination clinics meet this requirement for the BP10 Extension period.	N/A

Requirements that affect funding

Additional requirements

Performance measurement requirements

Administrative requirements

Exercise Schedules

All PHEP awardees must submit **BP10 Extension** state public health exercise schedules, which will be used to create a national calendar of public health exercises on the CDC DSLR secure channel of the LLIS.gov system. This national public health exercise calendar, along with an aggregate review of after-action reports from required exercises, will allow DSLR to create an annual national summary of PHEP awardees' preparedness capabilities, corrective actions accomplished, and areas needing additional resources.

Instructions for Submitting Exercise Schedules

- Submit your BP10 Extension state public health exercise schedule by December 31, **2010** on the DSLR channel of LLIS.gov. This should be a high-level summary of all planned state-level public health exercises. All listed exercises should include the exercise name, date, point of contact, scope, type, DHS capability and previous related exercises. For your two annual preparedness exercises, also specify applicable PHEP requirement (if any), the exercise sponsor, exercise objectives and planning conference dates. Although exercise schedules may be submitted in the format of your choice, a template example is provided below for your convenience.
- Scheduled exercises should also be submitted to NEXS if you have access to NEXS; CDC will accept copies of the NEXS exercise detail summaries or NEXS-generated custom reports for your public health exercises as evidence of your exercise schedule.

(Insert Awardee Name) Exercise Schedule **Budget Period 10 Extension (August 10, 2010 – August 9, 2011)**

This is an example of a table that captures a high-level summary of planned state public health exercises, including the required fields (unshaded fields on the left). At a minimum, schedules must also include more detailed information for the **two** required preparedness exercises, to the extent known, using the additional required fields (shaded on the right).

Exercise Name	Exercise Dates	Point of Contact and Contact Information	Scope ¹	Type ²	DHS Target Capabilities ³	Previous Related Exercises & Dates	Supports PHEP Requirement ⁴	Sponsor	Objectives ⁵	Planning Conferences & Dates ⁶

¹The scope represents the level of government or private sector participation in exercise play. Select all that apply

Local Regional State International
 Federal Private Sector Intrastate Nongovernmental/Volunteer Organization

²Select type of exercise Seminar Workshop TTX Drill FE FSE

³Select target capabilities from the DHS Target Capabilities List (<http://www.ojp.usdoj.gov/odp/assessments/hspd8.htm>)

⁴Select PHEP CA requirement supported

Public Health Emergency Cooperative agreement requirement is supported by this exercise

⁵Write objectives based on your capabilities and associated tasks (max 875 characters)

⁶ Planning Conferences

After Action Conference (AAC) Concepts & Objectives (C&O) Meeting Other
 Final Planning Conference (FPC) Initial Planning Conference (IPC)
 Mid-term Planning Conference (MPC) MSEL Conference

Appendix 7

Federal Guidance to Assist States in Improving Public Health Laboratory Emergency Response Capability and Capacity

Key Outcomes

Chemical, radiological, and biological agents causing or having the potential to cause widespread illness or death are rapidly detected and accurately identified by the public health laboratory within the jurisdiction or through network collaboration with other appropriate federal, state, and local laboratories. The public health laboratory, working in close partnership with public health epidemiology, environmental health, law enforcement, agriculture, and veterinary officials, hospitals, and other appropriate agencies, produces timely and accurate data to support ongoing public health investigations and the implementation of appropriate preventive or curative countermeasures.

Capabilities

For all public health laboratories:

- Prepare/update/maintain a lab continuity of operations plan (COOP) for chemical, radiological, biological and select agents consistent with federal guidelines.
- Develop, maintain, and evaluate a plan to rapidly identify radiological, chemical, and biological agents which may be involved in a public health emergency.
- **Continue to work toward attaining/maintaining LRN membership and register all relevant laboratories.**
- Maintain network awareness and state-of-the-art organizational understanding by sending at least one chemistry and one biology representative to national Laboratory Response Network (LRN) and Association of Public Health Laboratories (APHL) meetings.

For biological laboratories:

- Evaluate capabilities and capacity for identification of biological agents in clinical (human and animal) specimens and environmental samples by ensuring the jurisdiction can:
 1. Ensure availability of at least one operational Biosafety Level 3 (BSL-3) laboratory in the jurisdiction (or have formal arrangements in place for this capacity to be acquired).
 2. Identify all biological sentinel laboratories in the jurisdiction and coordinate for training and logistics in specimen handling, packaging, and shipping.
 - Maintain a current database of all identified LRN sentinel laboratories. Refer to the (LRN Joint Leadership (Council) Committee definition, available on the secure LRN website and the APHL website, of sentinel clinical laboratories for more information on these types laboratories).
 - Maintain and exercise a system to provide routine and emergency communication to all identified LRN sentinel laboratories within the jurisdiction.
 - Provide training in the American Society for Microbiologists (ASM)/LRN sentinel laboratory protocols, such as rule out and referral; packaging and shipping; and other training relevant to public health emergencies to identified sentinel laboratories within the jurisdiction.
 3. Maintain and test the competencies of the bioterrorism laboratory coordinator or designee to advise on proper collection, packaging, labeling, shipping, and chain of custody procedures for biological samples. **This requirement may be met by response to actual events.**

4. Test the competency of biological sentinel laboratories to properly rule out and refer, notify, and send samples to the appropriate LRN reference laboratory in the region. This requirement may be met by response to actual events.
5. Comply with the CDC/LRN requirements and Select Agent Regulations by assuring all security and regulatory requirements are in place to maintain a valid select agent registration number. Develop and disseminate operational plans and protocols for:
 - Specimen collection, transport, handling, and storage
 - Laboratory safety, to include emergency response operations
 - Training of laboratory personnel in biosafety
 - Compliance with federal biosecurity and biosafety regulations, including the maintenance of a United States Department of Agriculture/Animal and Plant Health Inspection Service/Veterinary Services (USDA/APHIS/VS) permit
6. Maintain or enhance capability and capacity to provide LRN reference level testing using rapid and classical methods. Develop and maintain plans and protocols for:
 - Training of laboratory personnel in LRN-deployed rapid testing and classical methods
 - Triage samples and coordination with epidemiologists, hazardous materials teams, and other first responders
 - Maintaining inventory for adequate reagents and other supplies and equipment necessary for bioterrorism response efforts
 - Conducting periodic review and addressing any gaps that may have been identified in surge capacity for biological incidents
 - Maintaining capability and capacity to test for or rule out for orthopox virus in both human and environmental samples. Laboratories that wish to perform variola testing must meet additional special CDC requirements.
 - Complying with all requirements for the LRN proficiency testing program for biological agents
 - Participating in an LRN-approved training course by at least one laboratorian
 - Sending at least one staff person to national meetings, such as the LRN national meeting
7. When a Homeland Security Exercise and Evaluation Program (HSEEP)-compliant, operations-based exercise(s) that public health personnel participate in or conduct includes a laboratory element, ensure that the exercise includes conducting and evaluating critical laboratory functions including sample and/or specimen collection, triage, accessioning, testing, notification and data messaging of results to the sending entity.
8. Collaborate with the LRN chemical staff to **engage** with appropriate partners such **as** local law enforcement, hazardous materials teams, civil support teams (CST), and Federal Bureau of Investigation regional offices for screening and triage procedures for mixed environmental samples (to include chemical, biological, radiological, and explosive materials).
9. Maintain supply levels and equipment necessary for bioterrorism response efforts and high throughput considerations for pandemic influenza.
10. Ensure proper and timely reporting of proficiency testing results to the CDC Emergency Operations Center (CDC EOC) when required and when significant results warrant, as well as participate in LRN-sponsored exercises.

For laboratories testing for chemical threat agents:

Level 3 Laboratories:

- Conduct outreach to hospitals and conduct clinical chemical specimen collection, packaging, and shipping training.
- Demonstrate competence in sample collection, packaging, and shipping by successfully participating in at least one LRN-C sample collection, packaging, and shipping (SCPaS) exercise.
- Establish/maintain a working relationship with poison control centers who can act as sentinel resources for obscure chemical exposure incidents, such as food poisoning.
- Collaborate with LRN biological staff to establish/maintain a working relationship with first responders (police, fire, hazardous materials teams) and CSTs who can be sentinel resources for identifying overt mass chemical exposure incidents
- Stock sample collection and shipping supplies for a minimum of 500 patient samples.
- Send at least one person to all LRN national meetings

Level 2 Laboratories:

- Meet all Level 3 requirements.
- **Pursue CLIA certification for the clinical chemistry laboratory.**
- Successfully complete at least one emergency response exercise (Pop PT).
- Collaborate with LRN biological staff to conduct outreach activities to first responders, such as hazardous materials teams and CSTs, to establish a technical link between CSTs and the public health chemistry lab with respect to field analysis of unknown samples.
- Stock materials and supplies for the analysis of at least 500 patient samples for each qualified analysis method.
- Staff and cross-train to operate 24/7 for three days
- Attain/maintain LRN-C PT Program Qualified status for:
 - Cyanide in blood by GC-MS
 - Nerve agent metabolites in urine by GC-MS (or LC-MS/MS)
 - VOCs in blood by GC-MS
 - Multi-element in urine by ICP-MS (or ICP-DRC-MS)
 - As/Se in urine by ICP-DRC-MS
 - Blood Cd/Hg/Pb by ICP-MS
 - Tetramine in urine by GC-MS
 - Ricinine/Abrine in urine by LC-MS/MS
- This may require sending two people to hands-on analysis method training at CDC.

Level 1 Laboratories:

- Meet all Level 2 and 3 requirements.
- Maintain LRN-C PT Program Qualified status for all Level 1 and Level 2 analysis methods.
- Attain LRN-C PT **Program Qualified status** for each new analysis method transferred by CDC.
- Maintain an adequate supply of materials and supplies for the analysis of 1,000 patient samples for each analysis method.
- Staff and cross-train to operate 24/7 for 14 days.
- Successfully participate in all surge capacity exercises.
- Send at least two representatives to each Level 1 Surge Capacity Laboratory meeting

For laboratories testing for radiological threats:

- Evaluate, maintain, or increase as needed the capability and capacity for identification of radioactive material in clinical samples.
 1. Maintain and test the competency of the analytical or radio analytical laboratory coordinator to advise on proper collection, packaging, labeling, shipping, storage and chain-of-custody of clinical (urine and nasal swab) samples.
 2. Develop and execute plans and protocols to properly collect, store, package, label, ship, coordinate routing, and maintain chain-of-custody of clinical samples to laboratories that can test for radioactive materials.
 3. Develop a system to triage radiological containing clinical samples and collaborate with the biological and chemical components of the LRN as necessary.
 4. Maintain supply levels and equipment necessary for response to radiological incidents.
 5. Identify and address gaps in surge capacity for radiological incidents.

For laboratories without capability to test for radiological threats:

- Develop a plan to address the identification of radioactive material in environmental (and possibly food, animal and clinical) samples by collaborating with the state radiation control program.
 1. Maintain and test the competency of the analytical laboratory coordinator to advise on proper collection, packaging, labeling, shipping, storage and chain of custody of clinical (urine and nasal swab) samples.
 2. Develop and execute plans and protocols to properly collect, store, package, label, ship, coordinate routing, and maintain chain of custody of clinical samples to laboratories that can test for radioactive materials and coordinate with the biological and chemical components of the LRN as necessary.
 3. Maintain supply levels and equipment necessary for response and radiological incidents.
 4. Identify and address gaps in surge capacity for radiological incidents
- Maintain compliance with federal and/or state regulations regarding use and shipment of radioactive materials and laboratory and worker safety.
- Coordinate and/or collaborate with local law enforcement and Federal Bureau of Investigation regional offices for screening and triage procedures for mixed clinical or environmental samples (to include chemical, biological, radiological and explosive materials).

Appendix 8

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

The draft ESAR-VHP compliance requirements identify capabilities and procedures that State⁸ ESAR-VHP programs must have in place to ensure effective management and inter-jurisdictional movement of volunteer health personnel in emergencies. Each state must meet all of the compliance requirements. All states must report progress toward meeting these compliance requirements on mid-year and end-of-year progress reports for the PHEP program.

ESAR-VHP Electronic System Requirements

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

These systems must:

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

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

- a) Each state must collect and verify the credentials and qualifications of the following health professionals. Beyond this list of occupations, a state may register volunteers from any other occupation it chooses. The standards and requirements for including additional occupations are left to the states.
 - 1) Physicians (Allopathic and Osteopathic)
 - 2) Registered nurses, including advanced practice registered nurses (APRNs). APRNs include nurse practitioners, certified nurse anesthetists, certified nurse-midwives, and clinical nurse specialists.
 - 3) Pharmacists
 - 4) Psychologists
 - 5) Clinical social workers

⁸ For purpose of this appendix, state refers to states, territories, cities, counties, the District of Columbia, commonwealths, or the sovereign nations of Palau, Marshall Islands, and Federated States of Micronesia.

- 6) Mental health counselors
 - 7) Radiologic technologists and technicians
 - 8) Respiratory therapists
 - 9) Medical and clinical laboratory technologists and technicians
 - 10) Licensed practical nurses and licensed vocational nurses
- b) Six (6) months after end of the Budget Period 8 (FY 2007) budget period, each state must expand its electronic registration system to include the remaining professions identified in the *ESAR-VHP Guidelines*.
 - c) States must add additional professions to their systems as they are added to future versions of the *ESAR-VHP Guidelines*.
2. Each electronic system must be able to assign volunteers to all four ESAR-VHP credential levels. Assignment will be based on the credentials and qualifications that the state has collected and verified with the issuing entity or appropriate authority.
 3. Each electronic system must be able to record ALL volunteer health professional/emergency preparedness affiliations of an individual, including local, state, and federal entities.

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

4. Each electronic system must be able to identify volunteers willing to participate in a federally coordinated emergency response.
 - a) Each electronic system must query volunteers upon initial registration and/or re-verification of credentials about their willingness to participate in emergency responses coordinated by the federal government. Responses to this question, posed in advance of an emergency, will provide the federal government with an estimate of the potential volunteer pool that may be available from the states upon request.
 - b) If a volunteer responds “Yes” to the federal question, states may be required to collect additional information (e.g., training, physical and medical status, etc.).
5. Each state must be able to update volunteer information and reverify credentials every six months.

Note: ASPR will review this requirement regularly for possible adjustments based on the experience of the states.

ESAR-VHP Operational Requirements

6. Upon receipt of a request for volunteers from any governmental agency or recognized emergency response entity, all states must: 1) within 2 hours query the electronic system to

generate a list of potential volunteer health professionals to contact; 2) contact potential volunteers; 3) within 12 hours provide the requester an initial list of willing volunteer health professionals that includes the names, qualifications, credentials, and credential levels of volunteers; and 4) within 24 hours provide the requester with a verified list of available volunteer health professionals.

7. All states are required to develop and implement a plan to recruit and retain volunteers.

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

8. Each state must develop a plan for coordinating with all volunteer health professional/emergency preparedness entities to ensure an efficient response to an emergency, including but not limited to Medical Reserve Corps (MRC) units and the National Disaster Medical Systems (NDMS) teams.
9. Each state must develop protocols for deploying and tracking volunteers during an emergency (mobilization protocols):
 - a) Each state is required to develop written protocols that govern the internal activation, operation, and timeframes of the ESAR-VHP system in response to an emergency. Included in these protocols must be plans to track volunteers during an emergency and for maintaining a history of volunteer deployments. ASPR may ask for copies of these protocols as a means of documenting compliance. ASPR will include protocol models in future versions of the *ESAR-VHP Guidelines*.
 - b) Each state ESAR-VHP program is required to establish a working relationship with external partners, such as the local and/or state emergency management agency and develop protocols outlining the required actions for deploying volunteers during an emergency. These protocols must ensure 24-hour/7-days-a-week accessibility to the ESAR-VHP system. Major areas of focus include:
 - 1) Intrastate deployment: States must develop protocols that coordinate the use of ESAR-VHP volunteers with those from other volunteer organizations, such as the Medical Reserve Corps (MRC).
 - 2) Interstate deployment: States must develop protocols outlining the steps needed to respond to requests for volunteers received from another state. States that have provisions for making volunteers employees or agents of the state must also develop protocols for deployment of volunteers to other states through the state emergency management agency via the Emergency Management Assistance Compact (EMAC).

Each state must have a process for receiving and maintaining the security of volunteers' personal information sent to them from another state and procedures

for destroying the information when it is no longer needed.

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

ESAR-VHP Evaluation and Reporting Requirements

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

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

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

Appendix 9

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

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

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

Awards for EWIDS are co-funded by the Assistant Secretary for Preparedness and Response in accordance with section 301 of the Public Health Service Act and CDC in accordance with section 319C-1 of the Public Health Service Act. In accordance with their authorizing legislation, U.S. Border States EWIDS funds are intended strictly for the support of surveillance and epidemiology-related activities to address bioterrorism and other outbreaks of infectious diseases with the potential for catastrophic consequences (including novel influenza viruses with pandemic potential). U.S. Border States EWIDS funds are not to be used to support noninfectious disease surveillance or broader border activities in terrorism preparedness. Consequently, these funds may not be used to finance any chemical, radiological, nuclear, or other emergency preparedness activities. EWIDS funds cannot be used to supplant surveillance and/or epidemiological activities already supported by other funding sources. However, U.S. Border States EWIDS funds can be used to enhance coordination and integration with other existing cross-border infectious disease surveillance and epidemiology activities including, but not limited to, pandemic influenza preparedness and response.

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

CDC Preparedness Goal 2: DETECT AND REPORT

Decrease the time needed to classify health events as terrorism or naturally occurring in partnership with other agencies.

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

Critical Task(s):

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

- immediately notifies the agency-designated public health professional 24/7/365;
 - has the agency-designated public health professional promptly respond to immediately notifiable condition or emergency public health threat reports 24/7/365; and
 - receives reportable disease reports 24/7/365.
- 8) Conduct joint, cross-border assessments of information technology capabilities essential to infectious disease surveillance.
 - 9) Collaborate with public health officials in border jurisdictions to identify how infectious disease outbreak information can be most rapidly and effectively shared across the border. Together, border jurisdictions should explore the interoperability of information technology systems, i.e., the ability of different types of computers, networks, operating systems, and applications to work together effectively. Jurisdictions on both sides of the border should work toward ensuring the connectivity and interoperability, both vertically and horizontally, of their surveillance and epidemiology relevant information technology (IT) systems.
 - 10) Working with jurisdictions across the border, establish a secure, Web-based communications system that provides for rapid and accurate reporting and discussion of disease outbreaks and other acute health events that might suggest bioterrorism. Include provision for routine communications (e.g., Web, email) and contingency plans for communication systems' failure and alert capacity for emergency notification (e.g., phone, pager) of key staff of counterpart agency across the border.
 - 11) Work with states, tribes, and provinces along the international border to help train personnel regarding notifiable diseases, conditions, syndromes, and their clinical presentations, and reporting requirements and procedures, including those conditions and syndromes that could indicate a bioterrorist event.
 - 12) Conduct joint infectious disease surveillance exercises involving a broad range of appropriate participants from both sides of the international border. This exercise should involve not only border health departments but, where feasible, local hospitals, tribal, and Public Health Service health facilities, hospital laboratories, major community health care institutions, emergency response agencies, and public safety agencies to respond in a coordinated manner.

CDC Preparedness Goal 3: DETECT AND REPORT

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

3A Target Capability: Public Health Laboratory Testing

Critical Task(s):

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

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

CDC Preparedness Goal 5: INVESTIGATE

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

5A Target Capability: Epidemiological Surveillance and Investigation

Critical Task(s):

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

- contribute information directly to the public, including special populations, that explains and informs about risk and appropriate courses of action.
- 2) Continue to convene binational surveillance and epidemiology planning workshops to discuss and plan cross-border surveillance and/or epidemiology-related activities. Such activities should, where feasible, involve a collaborative and regional approach with neighboring U.S. border states and appropriate tribal nations, as well as Mexico or Canada (as appropriate).
 - 3) Conduct capable field epidemiologic investigations, rapid needs assessments, exposure assessments, and response.

Appendix 10
Division of State and Local Readiness
Project Officers

HHS Region	Awardee	Project Officer	Telephone	Email
4	Alabama	Mark Green	404-639-7268	mlg5@cdc.gov
10	Alaska	Karen Galloway	404-639-7451	klw5@cdc.gov
9	Arizona	Janice McMichael	404-639-7943	jrm6@cdc.gov
6	Arkansas	Clint Matthews	404-639-7638	div8@cdc.gov
9	California	Janice McMichael	404-639-7943	jrm6@cdc.gov
5	Chicago	Terrance Jones	404-639-7047	tcj9@cdc.gov
8	Colorado	Karen Galloway	404-639-7451	klw5@cdc.gov
1	Connecticut	Lisa Walker	404-639-7441	jmu2@cdc.gov
3	Delaware	Trevia Brooks	404-639-7613	tnb9@cdc.gov
3	District of Columbia	Trevia Brooks	404-639-7613	tnb9@cdc.gov
4	Florida	Mark Green	404-639-7268	mlg5@cdc.gov
4	Georgia	Mark Green	404-639-7268	mlg5@cdc.gov
10	Idaho	Karen Galloway	404-639-7451	klw5@cdc.gov
5	Illinois	Terrance Jones	404-639-7047	tcj9@cdc.gov
5	Indiana	Terrance Jones	404-639-7047	tcj9@cdc.gov
7	Iowa	Karen Galloway	404-639-7451	klw5@cdc.gov
7	Kansas	Karen Galloway	404-639-7451	klw5@cdc.gov
4	Kentucky	Mark Green	404-639-7268	mlg5@cdc.gov
9	Los Angeles	Janice McMichael	404-639-7943	jrm6@cdc.gov
6	Louisiana	Clint Matthews	404-639-7638	div8@cdc.gov
1	Maine	Lisa Walker	404-639-7441	jmu2@cdc.gov
3	Maryland	Trevia Brooks	404-639-7613	tnb9@cdc.gov
1	Massachusetts	Lisa Walker	404-639-7441	jmu2@cdc.gov
5	Michigan	Terrance Jones	404-639-7047	tcj9@cdc.gov
5	Minnesota	Terrance Jones	404-639-7047	tcj9@cdc.gov
4	Mississippi	Mark Green	404-639-7268	mlg5@cdc.gov
7	Missouri	Karen Galloway	404-639-7451	klw5@cdc.gov
8	Montana	Greg Smith	404-639-7703	gqs0@cdc.gov
7	Nebraska	Karen Galloway	404-639-7451	klw5@cdc.gov
9	Nevada	Janice McMichael	404-639-7943	jrm6@cdc.gov
1	New Hampshire	Lisa Walker	404-639-7441	jmu2@cdc.gov
2	New Jersey	Monica Farmer	404-639-5962	mwf7@cdc.gov
6	New Mexico	Clint Matthews	404-639-7638	div8@cdc.gov
2	New York City	Monica Farmer	404-639-5962	mwf7@cdc.gov
2	New York State	Monica Farmer	404-639-5962	mwf7@cdc.gov
4	North Carolina	Mark Green	404-639-7268	mlg5@cdc.gov
8	North Dakota	Greg Smith	404-639-7703	gqs0@cdc.gov
5	Ohio	Terrance Jones	404-639-7047	tcj9@cdc.gov

6	Oklahoma	Clint Matthews	404-639-7638	div8@cdc.gov
HHS Region	Awardee	Project Officer	Telephone	Email
10	Oregon	Karen Galloway	404-639-7451	klw5@cdc
3	Pennsylvania	Trevia Brooks	404-639-7613	tnb9@cdc.gov
2	Puerto Rico	Monica Farmer	404-639-5962	mwf7@cdc.gov
1	Rhode Island	Lisa Walker	404-639-7441	jmu2@cdc.gov
4	South Carolina	Mark Green	404-639-7268	mlg5@cdc.gov
8	South Dakota	Greg Smith	404-639-7703	gqs0@cdc.gov
4	Tennessee	Mark Green	404-639-7268	mlg5@cdc.gov
6	Texas	Clint Matthews	404-639-7638	div8@cdc.gov
8	Utah	Greg Smith	404-639-7703	gqs0@cdc.gov
1	Vermont	Lisa Walker	404-639-7441	jmu2@cdc.gov
2	Virgin Islands	Monica Farmer	404-639-5962	mwf7@cdc.gov
3	Virginia	Trevia Brooks	404-639-7613	tnb9@cdc.gov
10	Washington	Karen Galloway	404-639-7451	klw5@cdc
3	West Virginia	Trevia Brooks	404-639-7613	tnb9@cdc.gov
5	Wisconsin	Terrance Jones	404-639-7047	tcj9@cdc.gov
8	Wyoming	Greg Smith	404-639-7703	gqs0@cdc.gov
Pacific Islands				
9	Palau	Janice McMichael	404-639-7943	jrm6@cdc.gov
9	CNMI	Janice McMichael	404-639-7943	jrm6@cdc.gov
9	FSM	Janice McMichael	404-639-7943	jrm6@cdc.gov
9	Guam	Janice McMichael	404-639-7943	jrm6@cdc.gov
9	Hawaii	Janice McMichael	404-639-7943	jrm6@cdc.gov
9	Marshall Islands	Janice McMichael	404-639-7943	jrm6@cdc.gov
9	American Samoa	Janice McMichael	404-639-7943	jrm6@cdc.gov

Appendix 11
Procurement and Grants Office
Grants Management Specialists

Grant #	Awardee	Specialist
516966	Illinois	Angela Webb Phone: (770) 488-2784 Email: aqw6@cdc.gov
516983	Ohio	
517008	Chicago	
517018	Michigan	
517024	Indiana	
617001	Texas	
617005	Louisiana	
916012	Los Angeles	
916969	Hawaii	
917016	California	
016977	Alaska	
017007	Oregon	
017010	Washington	
020290	Idaho	
416976	South Carolina	
416978	Alabama	
417015	Kentucky	
416986	Mississippi	
716833	Iowa	
716971	Missouri	
716975	Nebraska	
716985	Kansas	
816827	Colorado	
816832	Montana	
816965	Utah	
816984	Wyoming	
816973	South Dakota	
817000	North Dakota	
916964	Nevada	
916987	Arizona	
917003	Guam	
921818	Commonwealth of the Northern Mariana Islands	
921819	Marshall Islands	
921820	Palau	
921821	Federated States of Micronesia	
921822	American Samoa	

117009	Rhode Island	Kaleema McLean Phone: (770) 488-2742 Email: fy3@cdc.gov
316980	Delaware	
416968	Tennessee	
516981	Minnesota	
116970	Vermont	Pamela Baker Phone: (770) 488-2689 Email: fxz7@cdc.gov
116972	Maine	
117011	New Hampshire	
217004	New Jersey	
316998	West Virginia	
317014	Virginia	
317023	Maryland	
517002	Wisconsin	
616974	Arkansas	
616982	Oklahoma	
616999	New Mexico	
116996	Connecticut	Sharon Robertson Phone: (770) 488-2748 Email: sqr2@cdc.gov
116997	Massachusetts	
216988	New York State	
221298	New York City	
221823	Virgin Islands	
221876	Puerto Rico	
316831	District of Columbia	
316967	Pennsylvania	
416979	North Carolina	
417006	Florida	
417013	Georgia	

Appendix 12

Accredited Schools of Public Health

State	43 Accredited Schools of Public Health
Alabama	University of Alabama, Birmingham
Arizona	University of Arizona
Arkansas	University of Arkansas for Medical Sciences
California	University of California, Berkley
	San Diego State University
	University of California, Los Angeles
	Loma Linda University
Connecticut	Yale University
District of Columbia	George Washington University
Florida	Florida International University
	University of Florida
	University of South Florida
Georgia	Emory University
	University of Georgia
Illinois	University of Illinois, Chicago
Iowa	University of Iowa
Kentucky	University of Kentucky
	University of Louisville
Louisiana	Tulane University
Maryland	Johns Hopkins University
Massachusetts	Boston University
	Harvard University
	University of Massachusetts Amherst
Mexico	National Institute for Public Health
Michigan	University of Michigan
Minnesota	University of Minnesota
Missouri	Saint Louis University
New Jersey	University of Medicine and Dentistry of New Jersey
New York	Columbia University
	State University of New York, Albany
	State University of New York, Buffalo
North Carolina	University of North Carolina, Chapel Hill
Ohio	Ohio State University
Oklahoma	University of Oklahoma
Pennsylvania	Drexel University
	University of Pittsburgh
Puerto Rico	University of Puerto Rico
South Carolina	University of South Carolina

Tennessee	East Tennessee State University
Texas	Texas A & M Health Science Center
	University of North Texas Health Science Center
	University of Texas, Houston
Washington	University of Washington

The Accredited Schools of Public Health are funded through a cooperative agreement with the Centers for Disease Control and Prevention and managed in partnership with the Association of Schools of Public Health (ASPH).

CDC	http://emergency.cdc.gov/cdcpreparedness/cphp/index.asp
ASPH	http://www.asph.org/

Appendix 13 Preparedness and Emergency Response Research Centers (PERRCs)

State	9 Centers for Preparedness and Emergency Response Research (PERRCs)
California	University of California, Berkley
	University of California, Los Angeles
Georgia	Emory University
Maryland	Johns Hopkins University
Massachusetts	Harvard University
Minnesota	University of Minnesota
North Carolina	University of North Carolina, Chapel Hill
Pennsylvania	University of Pittsburgh
Washington	University of Washington

The PERRCs are funded through a cooperative agreement with the Centers for Disease Control and Prevention and managed in partnership with the Association of Schools of Public Health (ASPH).

CDC	http://emergency.cdc.gov/cdcpreparedness/science/research/PERRC.asp
ASPH	http://www.asph.org/

Appendix 14 Resources

Awardees are responsible for maintaining progress in each of the preparedness areas described in PHEP Program Announcement AA154. To access that document, as well as the subsequent continuation guidance documents for the PHEP program including information on expected laboratory capabilities and outcomes, click on the following link and scroll to the document you wish to review: <http://www.emergency.cdc.gov/planning/coopagreement> . Awardees must ensure that they are working toward the capacities and capabilities described. This commitment should be reflected in line item budget justifications and their linkage to outcomes, as well as in responses to requirements and descriptions of priority projects.

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

Awardees should continue to follow the Homeland Security Exercise and Evaluation Program's (HSEEP) approach to selecting preparedness, response, or recovery objectives. Awardees should use those objectives as a foundation for planning and training and demonstrate capability to reach those objectives by conducting a mix and range of exercises that, in turn, provide information for program improvements. Following the HSEEP strategy also facilitates awardees' demonstration of progress in the core preparedness activities that are overarching and ongoing. More information is available at https://hseep.dhs.gov/pages/1001_HSEEP7.aspx.

The National Biosurveillance Strategy for Human Health is the first step in a long-term effort to improve **and integrate our** nationwide **biosurveillance** capability. CDC published the strategy **in February 2010**. It includes six priority areas as defined by federal, state, local, tribal, and territorial partners. They are: **Electronic Health Information Exchange, Electronic Laboratory Information Exchange, Unstructured Data, Integrated biosurveillance Information, Global Disease Detection and Collaboration, and Biosurveillance Workforce of the Future**. The strategy's foundation is Homeland Security Presidential Directive-21 (HSPD-21), *Public Health and Medical Preparedness*, which named biosurveillance as one of four critical priorities for improving public health preparedness. The strategy, **along with other information about biosurveillance**, is available at http://www.cdc.gov/osels/ph_surveillance/bc.html.

Appendix 15
CDC Procurement and Grants Office
Assistance Award Closeout Requirements

Submit the following required reports to CDC within 90 days after the project completion date as specified in terms and conditions of the award/agreement and 45 CFR Part 74 and 92:

- a) **Final Performance/Progress Report** – the narrative of the final report should include information to fulfill any specific reporting requirements in the Notice of Award, a summary statement of progress toward the achievement of the originally stated goals, and a list of the results considered significant (whether positive or negative).
- b) **Final Financial Status Report (SF 269 or 269A)** – the final report should not show any unliquidated obligations and must indicate the exact balance of the unobligated funds. The final FSR should agree with the final expenditures reported to HHS, PMS. If not, the recipient will be required to update the reports (SF 272 and FSR 269) so they agree.

Link: www.whitehouse.gov/omb/grants/grants_forms.html

- c) **Equipment Inventory List** – An inventory list should include the description of the item, manufacturer serial and/or identification number, acquisition date and cost, percentage of federal funds used in the acquisition of the item. When equipment acquired with CDC funds is no longer needed on the grant, the equipment may be used for other activities in accordance with the following standards: Equipment with a fair market value of \$5,000 or more may be retained for other uses provided compensation is made to CDC. These requirements do not apply to equipment which was purchased with non-federal funds. Equipment no longer needed shall be disposed following instructions requested from and provided by CDC/PGO. If no equipment was acquired under this grant/cooperative agreement a negative report is required.
- d) **Invention Statement Certification:** This statement using Form HHS 568 (<http://grants.nih.gov/grants/hhs568.pdf>) must include all inventions which were conceived or put into practice within the entire project period.