HEALTH SERVICES DEPARTMENT

PUBLIC HEALTH DIVISION

Healthy People Living in Healthy Communities throughout El Dorado County

Daniel Nielson, M.P.A., Acting Director / Olivia C. Kasirye, M.D., M.S., Public Health Officer

931 Spring Street, Placerville, CA 95667 (530) 621-6156 / Fax (530) 626-4713

September 9, 2011

California Department of Public Health
Public Health Preparedness
1615 Capitol Avenue, MS 7002,
P.O. Box 997377
Sacramento, CA 95899-7377

To Whom It May Concern:

Enclosed please find the El Dorado County Health Services Department application for 2011-12 CDC Public Health Emergency Preparedness (PHEP), State General Fund (GF) Pandemic Influenza, HHS Hospital Preparedness Program (HPP) Funding.

Submittal of this application is subject to approval by the El Dorado County Board of Supervisors and cannot be considered binding until the Director's signature on the application is ratified. Approval to submit the funding application and ratification of the Director's signature is scheduled to go before the El Dorado County Board of Supervisors on September 27, 2011. A certified minute order will be forwarded once the Board of Supervisors formally approves submittal of the application and ratifies the Director's signature.

Sincerely,

Daniel Nielson, M.P.A., Acting Director
Health Services Department

Enclosure

2011-12 Application Guidance for Local Health Departments and Local Hospital Preparedness Program Entities for:

Centers for Disease Control and Prevention
Public Health Emergency Preparedness Program
CDC CFDA # 93-069

State General Fund Pandemic Influenza Planning Program

U.S. Department of Health and Human Services
Assistant Secretary for Preparedness and Response
Hospital Preparedness Program
HPP CFDA # 93.889

BE PREPARED CALIFORNIA

August 15, 2011

California Department of Public Health

CDPH

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SECTION ONE

OVERVIEW OF LOCAL REQUIREMENTS FOR 2011-12 FUNDS

This guidance describes the 2011-12 application process for local health departments (LHD) and Local Hospital Preparedness Program (HPP) Entities to apply for funds available through the 2011-12 Public Health Emergency Preparedness (PHEP) cooperative agreement, Hospital Preparedness Program Cooperative Agreement (HPP), and State General Fund Pandemic (GF Pan Flu) Influenza allocation.

Authority

- The CDC PHEP Cooperative Agreement number is CFDA # 93-069
- The HPP Cooperative Agreement number is CFDA # 93.889
- Chapter 33 of the State of California 2011 Budget Act

Funding Source Purpose

The funding sources and intended purposes are:

- PHEP all-hazards funds awarded to California by CDC for CDPH and LHDs to develop and maintain public health preparedness

  The PHEP cooperative agreement begins a new five year grant cycle with the 2011-12 grant year. The 2011-2016 PHEP cooperative agreement addresses 15 public health preparedness capabilities and provides a structure for state and local health departments to meet them. Implementation of these capabilities will be the focus of the PHPE grant for the next five years.

- HPP funds awarded to California by the Assistant Secretary for Prevention and Response (ASPR) for health care facilities and emergency medical services (EMS) to develop and maintain disaster preparedness. The 2011-12 grant year is the final year of the current HPP three year grant cycle. HPP required activities largely focus on completing development activities of this cycle and remain the same as in the prior two years.

- Local GF Pan Flu planning funds appropriated from the State general fund for LHDs to develop and maintain preparedness for pandemic influenza.

Comprehensive Agreement

In order to ensure greater coordination of separate funding streams and maximize integration of funds, CDPH is issuing a single combined guidance and a Comprehensive Agreement for all funding sources. However, PHEP, HPP and GF Pan Flu each require a separate work plan and budget. Funds from each funding source must be tracked separately.

LOCAL ALLOCATIONS:

PHEP: State statute requires allocation of 70% of the CDC PHEP Base grant award to LHDs. The CDC PHEP Base award for Grant Year 2011-12 is $33.6 million in which $23.5 million is allocated to LHDs. Of this, $20.3 million is allocated to LHDs as the Base allocation; $2.8 million is earmarked for public health laboratories; and $.4 million is earmarked for lab training and lab assistance awards. The CDC PHEP Base allocation of $20.2 million is distributed to LHDs according to a funding formula of a $100,000 base, plus a population based share of the remaining funds. An additional $5.0 million is allocated to LHDs identified as CRI jurisdictions.

HPP: CDPH allocated $16.2 million directly to Local HPP Entities in 2011-12. The HPP funding formula allocates a base award of $135,000 (which includes a base of $85,000 plus $50,000 to support a Local HPP Coordinator) and a population based share of the remaining funds.

GF Pan Flu: The 2011-12 State budget includes $4.96 million for distribution to LHDs. The funds are distributed according to a funding formula of $60,000 base plus a population based share of the remaining funds.

Allocations for each LHD or Local HPP Entity by funding source are displayed in the CDC and HPP Allocation Table (See Attachment 1).

For each funding stream, the following terms apply:

FUNDING SOURCE	**2011-12 FUNDING CYCLE**	
	BEGIN DATE	**END DATE**
PHEP (including Reference Laboratories and Cities Readiness Initiative (CRI))	August 10, 2011	August 9, 2012
HPP	July 1, 2011	June 30, 2012
State GF Pan Flu	July 1, 2011	June 30, 2012

Completing the 2011 - 12 Application

Completed applications are comprised of the signed Comprehensive Agreement, Work Plan, Budget, and required Attachments, and for HPP, letters of support, as indicated in the Checklist below (pages 13 and 14).

Comprehensive Agreement

The Comprehensive Agreement between CDPH and the LHD or Local HPP Entity contains operational information that includes:

1. Administrative information necessary for successful grant administration, and
2. Payment provisions
3. The requirement to obtain pre-approval for subcontracts that exceed $5,000 before the contract is executed (if the sub-contract is not available at time of submission, please submit statement of work and budget when available) and
4. Submission of mid-year and year-end progress reports

CDPH will send a customized Comprehensive Agreement by e-mail to each LHD and Local HPP Entity applicant. The e-mail will be addressed to each Local Health Executive, Local Health Officer, Local PHEP Coordinator, Local Pandemic Influenza Coordinator, and Local HPP Coordinator. Applicants who do not receive their official Agreement within one week of receiving this guidance should contact their CDPH Regional Project Officer immediately.

Regional Project Officer contact information is provided below:

Region	Name	Phone	E-Mail
1	William Porter	(916) 650-0423	William.porter@cdph.ca.gov
2	Stacy Sher	(916) 346-0765	Stacy.sher@cdph.ca.gov
3	Dan Nichols	(530) 589-4209	Dan.nichols@cdph.ca.gov
4	Tom Hoffman	(916) 346-0771	Tom.hoffman@cdph.ca.gov
5	Armando Arroyo	(916) 440-7154	Armando.arroyo@cdph.ca.gov
6	Edward Soto	(916) 650-6453	Edward.soto@cdph.ca.gov

Instructions for Counties in which Local HPP Entities are not LHDs:

In counties where the Local HPP Entity is not the LHD, the Local HPP Entity and LHD must coordinate the HPP and CDC work plans and budgets. The LHD must also provide the Local HPP Entity with a Letter of Support which the Local HPP Entity must include in its application.

Instructions for Los Angeles, Long Beach, and Pasadena:

Since the federal government directly funds Los Angeles County, CDPH will send Los Angeles, Pasadena and Long Beach Health Departments an application package, including an agreement that only includes GF Pan Flu planning funds.

Timeline for Application Submission

Local Guidance Release Date	August 15, 2011
Application Submission Due Date	September 16 , 2011
Funds Withdrawn (all grants) if Application not Submitted	September 30, 2011
All Work Plans and Budgets Approved	November 15, 2011
Funds Withdrawn if Signed Agreement not Submitted	November 15, 2011

- Completed applications including Budgets, Work Plans and Attachments must be submitted electronically to CDPH on or before September 16, 2011. If complete application documents have not been submitted prior to September 30, 2011, funds will be withdrawn and reallocated to other LHDs/Local HPP Entities.
- Completed applications (all grants) must be approved by CDPH by November 15, 2011. If Work Plans and Budgets have not been approved by November 15,, 2011, funds will be withdrawn and reallocated to other LHDs/Local HPP Entities. In order to meet this

date, LHDs/Local HPP Entities must work expeditiously with CDPH in responding to requests for additional information.

- Local applicants must submit the signed Agreement, Non-Lobbying Statement, and Non-Supplantation Statement by November 15, 2011. A customized agreement will be provided within one week of issuance of this guidance to each LHD/Local HPP Entity. Failure to meet this critical deadline will result in re-allocation of funds to other LHDs/Local HPP Entities.

Application Process and Review Period

LHDs/Local HPP Entities are expected to submit work plans, budgets, attachments and Comprehensive Agreements at the specified due dates.

CDPH will review all completed applications in the order in which they are received. The review process will follow the timeframes set forth in this guidance. CDPH will notify LHDs/Local HPP Entities the results of the review.

Application Requirements

In order to be considered complete, LHD/Local HPP Entity applications must meet the following criteria:

- All required components of the application are submitted by the identified due dates
    - CDPH will initiate review of applications when all PHEP, HPP and Pan Flu Work Plans, budgets and required attachments are submitted (exceptions will be made when the Local HPP Entity is not the LHD). Incomplete applications will be returned to the LHD/Local HPP Entity.
- Work plans address all required areas and are clear, specific, and responsive to requested information.
- Budgets support the activities in the Work Plans, balance to the allocation, are well documented and justified, and match to the requirements of each funding stream.

Means of Avoiding Delayed Approval

Attention to the following items may allow LHDs/Local HPP Entities avoid delay in application approval:

Cause of Delay	Means of Avoiding Delay
All funds – Application and/or budget proposes using funds for items inconsistent with grant purposes.	LHDs/Local HPP Entities must ensure that funds are budgeted for allowable activities under the grant and are tied to the activities in the submitted Work Plan.
PHEP/HPP/PF funds – Budgets have incomplete documentation to support travel, purchases of supplies and equipment, and contracts.	LHDs/Local HPP Entities must provide sufficient detail to explain basis for budgeted funds
PHEP/HPP/GF Pan Flu funds – Budgeted indirect costs exceed 10% of salaries and benefits.	LHDs/Local HPP Entities need to accurately calculate indirect rates based on salaries and benefits. Budget application requires accurate computation and failure to correctly budget indirect costs will result in “Not Approved” budget status.

Cause of Delay	Means of Avoiding Delay
PHEP/HPP/GF Pan Flu funds – Applications propose large expenditures on purchase of supplies and equipment.	All expenditures on supplies and equipment must be justified in terms of meeting specific CDC/HPP capabilities. • LHDs and Local HPP Entities are held to a 40% cap for supplies and equipment utilizing CDC and HPP base funds. Exceptions to this policy may be granted for the following criteria: ▪ An applicant's Work Plan demonstrates commitment from health care facilities to participate fully in planning, training and exercises ▪ New partners recruited into the coalition require equipment or supplies to achieve parity ▪ Outdated or expired equipment or supplies need to be replaced or updated There is no cap on the amount that can be spent on supplies and equipment for GF Pan Flu funds.
PHEP/HPP/PF funds – LHD/Local HPP Entities do not provide justification or explanation of need and explanation of expenditures for electronic or communications equipment, Information Technology (IT) services or IT software. IT forms are not provided or do not contain enough supporting detail.	LHDs/Local HPP Entities must submit IT Justification Forms for all IT or communications purchases or services with detailed responses for all fields in the form, and any supporting material (quotes, invoices, etc). The budget must include a description of the existing IT or communications equipment, software, or services and a statement of how the requested purchase will complement existing systems.
PHEP/HPP/ GF Pan Flu funds – Budgets include incentive items.	No incentive items are allowed.
PHEP/HPP/ GF Pan Flu funds – Fiscal staff have not participated in preparation of budgets, resulting in fiscal errors.	LHDs/Local HPP Coordinators and fiscal staff need to work together in development of budgets.
PHEP funds – Capability Plan includes CDC Tier 1 optional activities when not all of the Tier 1 activities are addressed.	CDC Tier 1 – If all required Tier 1 items are addressed, LHDs may undertake additional CDC Tier 1 public health capabilities, functions and resource elements.
PHEP funds – CDC Tier 2 activities are included in the Capability Plan without completing all Tier 1 public health preparedness capabilities with associated functions and priority resource elements and/or providing sufficient justification.	CDC Tier 2 public health preparedness capabilities will not be funded during 2011-12 unless: • A LHD has completed all CDC identified Tier 1 public health preparedness capabilities including all associated functions and priority resource elements OR • A LHD has a strong justification of the need and can show how they will meet all of the CDC Tier 1 public health preparedness capabilities including the associated functions and priority resource elements by the end of the 2011-12 budget year, <u>AND</u> A LHD is currently using PHEP funds for these activities and will maintain them in 2011-12.
PHEP funds – Budget includes line items for activities listed in the Capabilities Plan as "No Goal."	Budget line items must link to a public health preparedness capability that supports a function goal of Build, Sustain, or Scale Back. Funds cannot be budgeted against a "No Goal"

Training and Exercise Plan

Beginning with the 2011-12 grant year, training and exercise activities for PHEP and HPP grants are no longer submitted together on the same attachment. All entities should continue to plan and execute these exercises together. Please see Section 2 of this guidance that references the Demonstration Plan for the CDC PHEP grant and Section 4 for HPP grant requirements.

Budgets

LHDs/Local HPP Entities must complete a budget for each funding stream. LHDs/Local HPP Entities must ensure that allocated funds are expended in accordance with the requirements outlined in the guidance and local agreement and are consistent with the activities identified in their work plan. See Attachments 3 (CDC PHEP), 15 (HPP), and 5 (GF Pan Flu) for Budget Instructions and Templates.

LHDs must link budget line items by percentage to one or more of the public health preparedness capabilities. Budget line items must link to a public health preparedness capability that supports a function goal of Build, Sustain, or Scale Back. Funds cannot be budgeted against a "No Goal".

Work Plans

A separate work plan must be submitted for PHEP, HPP and State General Fund Pan Flu. Work plan templates are provided for each of the three funding streams. In addition to the description of the work being completed, LHDs/Local HPP Entities must include a summary of deliverables and an estimated completion date for these deliverables. [Workplan templates are located in Attachments 2 (PHEP), 4 (GF Pan Flu) and 14 (HPP)]

- The PHEP work plan has two components: a Capabilities Plan and a Demonstration Plan, LHDs are required to provide the current status and goal for each function and priority resource element associated the public health preparedness capabilities. LHDs will select one of the drop-down menu options and provide a narrative that describes their activities for each current status and goal.

- Required grant activities for the HPP and Pan Flu grants are listed in the work plan templates. LHDs/Local HPP Entities must address each work plan item. The work plan templates provide space below each required task for the LHD/Local HPP Entity to enter a description of the intended activities.

Audits

- Federal Audit Regulations

  The following Federal Regulations apply to the PHEP and HPP grants:

  Title 31 - Money and Finance, Subtitle V - General Assistance Administration, Chapter 75 - Requirements for single audits, Section 7502 - Audit Requirements;
  Exemption (f)(2) Each pass-through entity shall:
  (d) Provide the sub recipient program names (and any identifying numbers) from which such assistance is derived, and the Federal requirements, which govern the use of such awards and the requirements of this chapter.

- 2005-06 LHD Audits - Fiscal Audit Corrective Action Plan (CAP)

  For those LHDs/HPP Entities 2005-06 audits that resulted in findings are required to submit a fiscal audit corrective action plan (CAP) on the areas identified in the letter transmitting the final audit documents. A template to complete the CAP is provided as an Attachment to the grant application as well as a chart identifying the LHDs/HPP Entities that must submit the CAP with their application. (Attachment 24)

Subcontract Approval Process

- Subcontracts equal to or greater than $5,000 must be approved by CDPH prior to the contractor starting work.
- To the extent possible, subcontracts should be submitted with the application so that they can be reviewed and approved concurrent with the LHLD/ Local HPP Entity's budget and workplan.
- If a complete subcontract is not available at the time of application, LHDs/local HPP entities should provide as complete as possible Scope of Work (SOW) in the justification portion of the budget. Approval of the budget without submittal of a complete contract will be enhanced if the following language is provided: *"A complete contract will be provided to EPO for approval at a later date. When the contract is ultimately signed by both parties, a copy will be sent to EPO."*
- Although CDPH can approve workplans and budgets without subcontract approval, approval by CDPH of the full subcontract, including the SOW and associated budget, must occur before the contractor may start work.
- CDPH will approve contracts without signatures from both parties provided that the contract that is ultimately signed is the same as that approved by CDPH.
- LHLD/local HPP entities submitting subcontracts after submission of the application should be sent via email to LHBTPROG@cdph.ca.gov with a copy to the Regional Project Officer.
- Any subcontract not preapproved by EPO is in violation of the signed agreement and the invoice for those services can be rejected and not reimbursed.

In State Travel

LHDs/local HPP entities are reminded that the annual National Association of County and City Health Officials will hold the 2012 Public Health Preparedness Summit from Tuesday, February 21, 2012 to Friday, February 24, 2012 in Anaheim.

Out of State Travel

Out of state travel (OST) restrictions exist for each funding stream and are outlined below.

PHEP Base
OST is limited to one trip for one person.

CRI Base
OST is limited to one trip for one person to attend the annual Strategic National Stockpile Summit.

PHEP Lab Base

OST will be allowed for one PHEP-funded laboratory position to attend an LRN-sponsored laboratory training workshop; OST is approvable for the following three workshops:

1. "LRN Conventional Methods" course sponsored by CDC
2. "LRN Rapid Methods Training" course sponsored by CDC
3. "Train the Trainer – Designing and Conducting Training for the Sentinel Laboratory Workshop" sponsored by NLTN/APHL

Allowable expenses include airfare, meals, and lodging.

HPP

OST is limited to one trip for one person.

Pan Flu

No OST is allowed.

Application Submission

Completed Work Plans, Budgets, HPP Letters of Support and Attachments must be submitted electronically to CDPH at LHBTPROG@cdph.ca.gov.

The Signed Agreement, Lobbying Certificate, and Non-Supplantation Form with original signatures must be submitted in hard copy to the mailing address below if sent by US Postal Service or the physical address below if sent by courier. CDPH requires only one signed original. LHDs/local HPP entities requesting signed originals to be returned to them must submit extra copies equal to the number requested.

Mailing Address (US Postal Service):
California Department of Public Health
Emergency Preparedness Office
Local Management Unit
Attn: CDC/HPP Application 2010/11
P.O. Box 997377, Suite 73.373, MS 7002
Sacramento, CA 95899-7377

Overnight Mail Address (Courier):
California Department of Public Health
Emergency Preparedness Office
Local Management Unit
Attn: CDC/HPP Application 2010/11
1615 Capitol Ave. Suite 73.373 MS 7002
Sacramento, CA 95814

Application Approval by CDPH

Reviewing and approving the application Work Plans and Budgets is an interactive process between LHDs/Local HPP Entities and CDPH. When CDPH receives the LHD/Local HPP Entity application, it is assigned to Regional Project Officers and appropriate subject matter experts, including laboratory, epidemiology, and pharmacy experts, to review the Work Plan for completeness and the Budget for support of the Work Plan. CDPH Emergency Preparedness Office (EPO) Local Management Unit (LMU) Fiscal Analysts review the Budget documents for computational accuracy and compliance with federal guidance documents. The timeline for CDPH review is as follows:

Activity	Number of Days
Upon initial submission of a complete application, CDPH will review Work Plans and Budgets and provide written comments to LHDs/Local HPP Entities within 14 days.	14
If additional information is needed, LHDs/Local HPP Entities will be requested to respond within 5 days of receipt of electronic comments from CDPH. If no comments are received within 5 working days, CDPH will send a follow-up letter to the Local Health Officer and Local Health Executive. The letter will emphasize the importance of submitting the comments and restate the consequences of not having an approved Work Plan and Budget by November 15, 2011.	5
CDPH will review additional information provided by the LHD/ Local HPP Entity and provide formal written comments to the LHD/Local HPP Entity within 5 days of receipt.	5

Progress Reports

Mid-year and year-end progress reports are required in 2011-12 and the due dates are noted below. Instructions on submission of progress reports may be found in the directions immediately preceding the work plan and budget documents.

HPP and State General Fund Pan Flu			
	Begin Date	End Date	Report Due Date
2011-2012 Mid-Year Report Period	July 1, 2011	December 31, 2011	April 2, 2012
2011-2012 Year-End Report Period	July 1, 2011	June 30, 2012	November 1, 2012

PHEP (Base, Labs, CRI, Risk Based)			
	Begin Date	End Date	Report Due Date
2011-2012 Mid-Year Report Period	August 10, 2011	February 29, 2012	April 2, 2012
2011-2012 Year-End Report Period	August 10, 2011	August 9, 2012	November 1, 2012

After Action Reports

After Action Reports including Improvement Plans must be submitted within 90 days of an exercise or actual response. For specific reporting information, please refer to the relevant program section.

Trust Fund Accounts

As stated in Exhibit B of the Comprehensive Agreement, the LHD/Local HPP Entity shall deposit advance federal fund payments received from CDPH into separate Trust Funds (hereafter called Federal Fund), established solely for the purposes of implementing the activities described in the LHD's and/or Local HPP Entity's approved Work Plan and Budget and Agreement before transferring or expending the funds for any of the uses allowed. CDPH requires that the LHD and/or Local HPP Entity set up separate Federal Funds for PHEP and HPP funds. A trust fund account is not required for the GF Pan Flu funds.

Maintaining Documentation

The Comprehensive Agreement requires that LHDs/Local HPP Entities maintain supporting documents for the expenditure of funds for a minimum of 10 years.

CHECKLIST
REQUIRED DOCUMENTS AND DEADLINES

Checklist	Document
	Due: September 16, 2011
	Application for CDC PHEP Funds
	CDC PHEP 2011-12 Work Plan for (Attachment 2)
	CDC PHEP Budget (Attachment 3)
	Information Technology Justification (embedded in budget)
	2010-11 Annual A-133 Audit
	Fiscal Audit Corrective Action Plan (if there were findings) (Attachment 24)
	PHEP Lab Base (applicable for LRN labs)
	California Sentinel Labs Training Record
	Current Select Agent Certificate of Registration
	Current USDA Permit for Importation and Transportation of Controlled Materials and Organisms and Vectors
	Public Health Microbiologist Training Stipends (if applying)
	CDPH Laboratory Field Services (LFS) trainee approval letter for each trainee
	Lab Trainee Training Plan
	Confirmation of Lab Trainee Hire Dates
	Laboratory Consortium Training Assistance Awards for Sentinel Public Health Laboratories (if applying)
	Letter of Support from Each Participating Laboratory in the Consortium
	Application for HPP Funds
	Training, Drills and Exercise Form (Attachment 12)
	Surge Bed Capacity Form (one combined submission with GF) (Attachment 13)
	HPP 2011-12 Work Plan (Attachment 14)
	HPP Budget (Attachment 15)
	Information Technology Justification (embedded in budget)
	Participating Health Care Facilities (Attachment 16)
	HPP Data Elements Form (Attachment 19 Tab 1 for each Hospital and Attachment 19 Tab 2)
	Letters of Support from partners (Including LHD, Hospital, Clinic, LEMSA, and Skilled Nursing Facility)

	Surge Bed Capacity Form (one combined submission with HP) (Attachment 13)
	Information Technology Justification (embedded in budget)
	2010-11 Annual A-133 Audit
	Fiscal Audit Corrective Action Plan (if there were findings) (Attachment 24)
	Application for GF Pan Flu Funds
	State GF Pan Flu 2011-12 Work Plan (Attachment 4)
	State GF Pan Flu 2011-12 Budget (Attachment 5)
	Information Technology Justification (embedded in budget)
	2010-11 Annual A-133 Audit
	Comprehensive Agreement (all funding streams)
	Signed Agreement (Attachment 23) (Exhibits A-E)

SECTION TWO: GUIDANCE FOR PUBLIC HEALTH EMERGENCY PREPAREDNESS

This section provides guidance to assist Local Health Department (LHDs) in completing their 2011-12 application for the Public Health Preparedness Program (PHEP). The guidance includes foundational knowledge to assist LHDs understand the new PHEP federal requirements, strategic planning for California, and specific 2011-12 PHEP requirements.

Defining National Standards for State and Local Planning

In preparation for the new five-year PHEP cooperative agreement, the Centers for Disease Control and Prevention (CDC) implemented a systematic process for defining a set of public health preparedness capabilities to assist state and local health departments with their strategic planning. The resulting *Public Health Preparedness Capabilities: National Standards for State and Local Planning* creates national standards for public health preparedness capability-based planning and will assist state and local planners in identifying gaps in preparedness, determining the specific jurisdictional priorities, and developing plans for building and sustaining capabilities.

These standards support the accomplishment of the 10 Essential Public Health Services and were developed in concert with Presidential Homeland Security Strategies, the federal Pandemic and All-Hazards Preparedness Act (PAHPA), the federal Homeland Security Target Capabilities and the National Health Security Strategy. The National Standard for State and Local Public Health Preparedness was developed in coordination with the federal Hospital Preparedness Program (HPP) Cooperative Agreement.

CDC developed the following 15 public health preparedness capabilities in six domains as the basis for state and local public health preparedness.

Biosurveillance
- Public Health Laboratory Testing
- Public Health Surveillance and Epidemiological Investigation

Community Resilience
- Community Preparedness
- Community Recovery

Countermeasures and Mitigation
- Medical Countermeasure Dispensing
- Medical Materiel Management and Distribution
- Non-Pharmaceutical Interventions
- Responder Safety and Health

Incident Management
- Emergency Operations Coordination

Information Management
- Emergency Public Information and Warning
- Information Sharing

Surge Management
- Fatality Management
- Mass Care
- Medical Surge
- Volunteer Management

Public Health Preparedness Capabilities

Each public health capability includes a definition of the capability and list of the associated functions, performance measures, tasks, and resource considerations.

Public Health Preparedness Capabilities Structure

Capability Definition	Defines the capability as it applies to state, local, tribal, and territorial public health
Function	Describes the critical elements that need to occur to achieve the capability.
Performance Measure	CDC-defined performance measures associated with a function.
Task	Steps that need to occur to complete the function
Resource Element	Resources a jurisdiction needs to have or have access to (via an arrangement or agreement with a partner organization etc.) to successfully perform a function and the associated tasks within a capability. Resource elements are organized into three categories, 1) planning, 2) skills and training, and 3) equipment and technology. Priority Resource Elements are the most critical of the resource elements and are the "minimum standards" for state and local preparedness.

Detailed information specific to each public health preparedness capability can be found in the Capabilities Plan, *Public Health Preparedness Capabilities: National Standards for State and Local Planning March 2011* found at: http://www.cdc.gov/phpr/capabilities/index.htm.

Federal Requirements

The 2011-2016 PHEP Cooperative Agreement requires state and local health departments to establish a capabilities-based approach to better prepare state and local health departments to respond to public health emergencies and incidents. All 15 public health preparedness capabilities must be addressed within the five-year grant cycle; however, jurisdictions are not required to work on all 15 capabilities each year.

CDC strongly recommends that state and local health departments prioritize the order of the public health preparedness capabilities in which they intend to invest based upon: 1) their jurisdictional risk assessments, 2) an assessment of current capabilities and gaps, and 3) CDC's recommended tiered strategy for public health preparedness capabilities.

CDC's tiered strategy for public health preparedness capabilities is designed to place emphasis on the Tier 1 public health capabilities as these capabilities provide the foundation for public health preparedness. State and local public health are required to build the priority resource elements in the Tier 1 public health preparedness capabilities prior to making significant or comprehensive investments in Tier 2 capabilities. Some of the Tier 2 public health preparedness capabilities are priorities under the Hospital Preparedness Program (HPP) agreement.

CDC's Tiered Strategy

Tier 1 Capabilities	Tier 2 Capabilities
Community Preparedness	Community Recovery
Emergency Operations Coordination	Fatality Management
Emergency Public Information and Warning	Mass Care
Information Sharing	Medical Surge
Medical Countermeasure Dispensing	Non-Pharmaceutical Interventions
Medical Materiel Management and Distribution	Volunteer Management
Public Health Laboratory Testing	
Public Health Surveillance and Epidemiological Investigation	
Responder Safety and Health	

State and local health departments are required to report on a range of capability-based performance measures developed by CDC that focus on both program accountability and program improvement. Performance measures provide critical information needed to evaluate and report on how well PHEP funding improves the nation's ability to prepare for and respond to public health emergencies. While not all performance measures will be required every year, state and local health departments will be required to report data on select performance measures annually. Currently there are not performance measures associated with each public health preparedness capability; however, CDC will continue their development. Further information on performance measures and reporting requirements for 2011-12 will be distributed as they become available.

California's Strategic Planning for Public Health Preparedness Capabilities

To establish a strategy and identify priorities for California's public health preparedness capabilities over the next five years, CDPH convened a local and State workgroup. The Local Public Health Emergency Preparedness (PHEP) Framework Workgroup was established in conjunction with the California Conference of Local Health Officers (CCLHO) and County Health Executives Association of California (CHEAC) and an intradepartmental workgroup for each Domain and its corresponding public health preparedness capabilities. Program experts from across CDPH programs assessed California's current preparedness status under each capability, function, and priority resource element.

The following key principles were identified to enable California to successfully implement the public health preparedness capabilities over the next five years in order to prepare for and respond to public health emergencies.

- Maintain essential activities to respond to public health emergencies.
- Ensure sufficient capacity within the state to respond to all hazards.
- Focus on activities that lay the foundation for others, creating a natural progression of activities.
- Allow local flexibility while providing statewide standardization in key areas.
- Focus first on core public health and overarching public health preparedness capabilities while LHDs and CDPH obtain a baseline assessment of their current status across all capabilities to develop priorities for future grant years.
- Acknowledge that real events may dictate a refocus on specific public health capabilities.

A key element in public health preparedness strategic planning is an assessment of current capabilities. Two assessment activities will be undertaken in 2011-12. First is the development of a standardized tool for LHDs to conduct a public health focused Risk Assessment. CDPH will work with State and local representatives to issue a standardized tool that all LHDs will use to conduct a Public Health Risk Assessment as part of their 2011-12 requirements. In addition to the Public Health Risk Assessment, LHDs are required to complete an assessment of all fifteen public health preparedness capabilities as part of their mid-year progress report. These activities will assist CDPH and local public health leadership identify gaps and prioritize public health preparedness capabilities based on the greatest public health needs in California.

Table 2.1 outlines three priority levels established by CDPH and the local workgroup to prioritize implementation of public health preparedness capabilities. The levels indicate the order in which CDPH and LHDs plan to undertake efforts over the five-year grant cycle. These priorities may change in subsequent grant years based on progress made and new information obtained during 2011-12.

Table 2.1: California Priority Levels for Public Health Preparedness Capabilities

Level I	Level II	Level III
Public Health Surveillance & Epidemiologic Investigations*	Responder Safety*	Community Recovery**
Public Health Laboratory Testing*	Non-Pharmaceutical Interventions**	Fatality Management**
Emergency Operations Coordination*	Volunteer Management**	Mass Care**
Emergency Public Information and Warning*		Medical Surge**
Information Sharing*		
Community Preparedness*		
Medical Countermeasures Dispensing*		
Medical Materiel Management & Distribution*		

*****CDC Tier 1 Public Health Preparedness Capability
**CDC Tier 2 Public Health Preparedness Capability

2011-12 LHD Required Activities

For 2011-12, LHDs will place priority on maintaining core public health preparedness capabilities essential for preparedness and overarching public health preparedness capabilities to ensure consistency across jurisdictions. These priority public health preparedness capabilities for 2011-12 are:

- Core Public Health: 1) Public Health Surveillance and Epidemiologic Investigations and 2) Public Health Laboratory Testing

- Overarching: 1) Emergency Operations Coordination, 2) Emergency Public Information and Warning, 3) Information Sharing, 4) Community Preparedness, 5) Medical Countermeasures Dispensing and 6) Medical Materiel Management and Distribution

Within these public health preparedness capabilities, the functions selected for 2011-12 activities enable California to maintain essential public health capability to respond to public health emergencies. Functions requiring expansion beyond current capabilities are not required in 2011-12 and are deferred for future years.

Table 2.2 lists the public health preparedness capabilities and functions that LHDs will address during 2011-12. All of the priority resource elements included for each required function must be met unless otherwise indicated. Attachment 27, 2011-12 Required Capabilities, Functions, Priority Resource Elements and Performance Measures provides a complete list of the functions and priority resource elements associated with each required public health preparedness capability.

Table 2.2: California's Public Health Emergency Preparedness 2011-12 Activities

Capability	Required Functions
Public Health Surveillance & Epidemiologic Investigations	Function 1: Conduct public health surveillance and detection Function 2: Conduct public health and epidemiological investigations Function 3: Recommend, monitor, and analyze mitigation actions
Public Health Laboratory Testing	Function 2: Perform sample management Function 3: Conduct testing and analysis for routine and surge capacity Function 4: Support public health investigations
Emergency Operations Coordination	Function 1: Conduct preliminary assessment to determine need for public activation Function 2: Activate public health emergency operations Function 3: Develop incident response strategy Function 4: Manage and sustain the public health response
Emergency Public Information and Warning	Function 1: Activate the emergency public information system Function 2: Determine the need for a joint public information system Function 3: Establish and participate in information system operations Function 4: Establish avenues for public interaction and information exchange Function 5: Issue public information, alerts, warnings, and notifications
Information Sharing	Function 1: Identify stakeholders to be incorporated into information flow. Function 3: Exchange information to determine a common operating picture
Community Preparedness	Function 1: Determine risk to the health of the jurisdiction **(Priority Resource Element # 2 only, jurisdictional risk assessment)** Function 3: Engage with community organizations to foster public health, medical, and mental/behavioral health social networks
Medical Countermeasure Dispensing	Function 1: Identify and initiate medical countermeasure dispensing strategies Function 2: Receive medical countermeasures Function 3: Activate dispensing modalities Function 4: Dispense medical countermeasures to identified population Function 5: Report adverse event
Medical Materiel Management and Distribution	Function 1: Direct and activate medical materiel management and distribution Function 3: Maintain updated inventory management and reporting system **<u>Additional Functions required for CRI jurisdictions:</u>** Function 2: Acquire medical materiel Function 4: Establish and maintain security Function 5: Distribute medical materiel Function 6: Recover medical materiel and demobilize distribution operations

2011-12 LHD Optional Activities

If all required items are addressed, LHDs may undertake additional CDC Tier 1 public health preparedness capabilities, functions and resource elements.

CDC Tier 2 public health preparedness capabilities will not be funded during 2011-12 unless:

- A LHD has completed all CDC identified Tier 1 public health preparedness capabilities including all associated functions and priority resource elements

  OR

- A LHD has a strong justification of the need and can show how they will meet all of the CDC Tier 1 public health preparedness capabilities including the associated functions and priority resource elements by the end of the 2011-12 budget year, AND

- A LHD is currently using PHEP funds for these activities and will maintain them in 2011-12.

Other funding sources such as HPP should be considered to fund CDC Tier 2 public health preparedness capabilities for 2011-12.

2011-12 Application Requirements

1. Capabilities Plan

   LHDs must complete a Capabilities Plan that describes the current status and goal for each function and priority resource element identified as a 2011-12 required activity and any additional functions and priority resource elements the LHD elects to undertake. For each function and priority resource element, LHDs are required to write a narrative description of the current status and an explanation of the goal.

   The following information must be completed for each of the required public health preparedness capabilities:

   Functions

   - A description of each required function using one of the four options below that best describes the LHD's current status of the function:
     - Infrastructure Fully in Place – Function Fully Evaluated and Demonstrated
     - Infrastructure Fully in Place – Function Not Fully Evaluated and Demonstrated
     - Infrastructure Partially in Place
     - No Infrastructure in Place

   - A narrative explanation that supports the chosen description. For example, if "fully in place, fully evaluated and demonstrated" is chosen, provide the date and means by which the function was demonstrated (exercise, real incident etc.). *The demonstration date must be within the past 24 months.*
     - The narrative description for the function should include a roll up of the associated priority resource elements and what activities have been completed towards that function. Narratives should be concise and include all components listed as requirements.

   - The LHD's goal for each function, using one of the options below to describe the goal for each function:
     - Build
     - Sustain
     - Scale Back

- No Goal *(Funds cannot be budgeted against a "No Goal")*

- A narrative explanation that supports the goal. The narrative explanation for the goal must include which activities the LHD plans to undertake to enable the LHD perform that function. Include any current or planned contracts, training, exercises that will be undertaken in 2011-12. If a chosen goal is not accomplished by the end of the 2011-12 budget year LHDs may continue the activity into the next budget year, but must provide what progress was made in the end-year report.

- A narrative of the planned funding type to be used to achieve a function, using one of the following funding types:
  - PHEP
  - Partial PHEP
  - Other Funding Sources (a drop menu is available with other funding types)
  - No Funding

<u>Priority Resource Elements</u>

- A description of the current status for each priority resource element. LHDs must have or have access to priority resource elements associated with each function to perform a function and its associated tasks. Select the description using one of the following three options:
  - Fully in Place
  - Partially in Place
  - Not in Place

- A narrative explanation that explains the current status for each requirement listed. The narrative explanation must address each of the requirements listed in the priority resource element. For example, if the priority resource element requires having a plan that includes five components, the narrative should list the status of the plan and which components the LHD has or has access to.

- The LHD's goal for each priority resource element using one of the three options below. The chosen goal should indicate the goal for the status at the end of the 2011-12 budget period.
  - Fully in Place
  - Partially in Place
  - Not in Place

- A narrative description that indicates the activities planned for 2011-12 that supports the chosen goal. If a chosen goal is not accomplished by the end of the 2011-12 budget year LHDs may continue the activity into the next budget year, but must provide what progress was made in the end-year report.

2. Demonstration Plan

LHDs are required to complete a Demonstration Plan that includes exercises, performance measures and functions that will be demonstrated in 2011-12. Demonstration Plans must include:

- All required exercises (e.g. Statewide Medical and Health Exercise)
- All required performance measures (see below)

- A detailed description Functions and Public Health Preparedness Capabilities to be demonstrated during 2011-12.

Functions can be demonstrated by any of the four following demonstration types:

- Routine public health activity;
- Planned event;
- Real incident; and
- Exercise

Each exercise, planned event, real incident or routine public health activity may include the demonstration of multiple functions.

LHDs are required to collect and report select performance measures for 2011-12 within the following public health preparedness capabilities.

- Public Health Surveillance and Epidemiological Investigation
- Public Health Laboratory Testing (jurisdiction specific)
- Emergency Operations Coordination
- Emergency Public Information and Warning

For a listing and description of the required reporting elements, see Attachment 27: *Required Public Health Preparedness Capabilities with Associated Functions, Priority Resource Elements and Performance Measures.* CDC is currently developing additional performance measures that will be required in subsequent years.

3. Budget

LHD budgets must meet the following budget requirements:

- LHDs must link budget line items to one or more of the public health preparedness capabilities. Budget line items must link to a public health preparedness capability that supports a function goal of Build, Sustain, or Scale Back. Funds cannot be budgeted against a "No Goal".
- If the line item is considered cross-cutting across all public health preparedness capability or is not specific to a capability such as program administration, it may be budgeted to a general category called Program Management. Program Management activities include cross-cutting and general program administrative activities that are not specific to a public health preparedness capability. For example, the LHD PHEP Coordinator may have overall responsibility for PHEP activities and may be budgeted in Program Management.
- Personnel justification must include one or more functions the individual will be primarily working on. For example, the budget for an epidemiologist linked to the Public Health Surveillance and Epidemiology Investigations Capability must describe the functions within that capability their activities will focus on.
- A percentage of effort being applied to one or more of the 15 public health preparedness capabilities must be entered for each line item. (Percent field column must add up to 100 percent.)

4. Capabilities Assessment

   LHDs are required to complete a Capabilities Assessment for all 15 public health preparedness capabilities as part of their mid-year progress report. The Capabilities Assessment will include a narrative describing the LHD's current status for each function and priority resource element including any progress made for the required functions and priority resource elements.

Additional Requirements

LHDs also must describe the activities they plan to undertake in 2011-12 that comply with the following requirements. Requirements are tied to one or more of the public health preparedness capabilities. LHDs should address the requirements in the narrative sections of the Capabilities Plan associated with the listed public health preparedness capabilities.

5. Identify the organizations the LHD will work with to address the public health needs of at-risk populations in public health preparedness activities. (See Capabilities Plan: Community Preparedness, Emergency Public Information and Warning, and Public Health Surveillance and Epidemiological Investigation Capabilities.)

6. Engage Tribal entities in public health emergency preparedness efforts. (See Capabilities Plan: Community Preparedness and Information Sharing Capabilities.)

7. Ensure CAHAN is operational within the jurisdiction. (See Capabilities Plan Information Sharing Capability, Function 1: Identify stakeholders to be incorporated into information flow, and Function 2: Identify and develop rules and data elements for sharing.)

   - Identify a primary and backup CAHAN Coordinator.
   - Describe activities the LHD will undertake to identify, register, and retain public health partners in CAHAN.
   - Describe activities the LHD will undertake to assess the quality and accuracy of its User, Role, and Role Group Directories (to occur at least once per fiscal year).
   - Maintain CAHAN roles and ensure all participants in the jurisdiction are kept current and properly trained.
   - Identify drills and exercises that will verify the quality and accuracy of the LHD's User, Role, and Role Group Directories in CAHAN. Provide detailed information about how CAHAN will be used during such drills and exercises.
   - Update and maintain the LHD's County Facility Report to reflect health care facility enrollment status (as demonstrated in the LHD's User and Role Directories).
   - Ensure the primary or backup HAN Coordinator for the LHD maintains a minimum of 50 percent attendance on the monthly All-Jurisdiction Conference Call over the course of the fiscal year.

8. Complete a Public Health Risk Assessment for 2011. CDPH will issue a standardized tool for all LHDs to use to complete their public health focused risk assessment. The standardized tool will be developed by State and local representatives. (See Capabilities Plan: Community Preparedness Capability, Function 1: Determine risks to the health of the jurisdiction.)

- The Public Health Risk Assessment must include a matrix that describes and ranks/prioritizes the public health threats and risks within the jurisdiction based on a local mitigation planning.
- Public Health Risk Assessments are due within 120 days of receiving the standardized tool provided by CDPH.
- Jurisdictions participating in the Risk-Based Pilot Project will complete this activity as part of this initiative.

9. Maintain a TAR score of 70% or higher for 2011-12 on Strategic National Stockpile or Cities Readiness Initiative. LHDs must complete a self-assessment of local medical countermeasure distribution and dispensing program using the current edition of the CDC's Local Technical Assistance Review Tool (TAR) and Automated Self Scoring Sheet. Both documents must be posted on CAHAN no later than February 15, 2012. CRI jurisdictions may use their last formal CDC or CDPH CRI review (if completed in 2011) in place of the self-assessment. (See Capabilities Plan: Medical Countermeasure Dispensing and Medical Materiel Management and Distribution Capabilities.)

10. Participate in the four phases of the annual Statewide Medical and Health Exercise.

    - At minimum, participation in Phase 4, Functional Exercise, shall include **submitting at least one completed situation report** as detailed in the *California Public Health and Medical Emergency Operations Manual* (See Capabilities Plan Information Sharing Capability, Function 3, Exchange information to determine a common operating picture.)
    - Complete and submit an After Action Report and Improvement Plan AAR/IP in compliance with Homeland Security Exercise and Evaluation Program (HSEEP) to lhbtprog@cdph.ca.gov no later than 90 days after completion of the exercise.
    - Complete the template for the statewide exercise demonstration in the Demonstration Plan.

11. Within the five-year grant cycle from 2011-16, participate in a minimum of one local, regional or State exercise on LHD CHEMPACK Plans with appropriate partners (e.g., law enforcement, fire, EMS, emergency services, emergency room departments, health care providers). (See Capabilities Plan: Medical Materiel Management and Distribution Capability.)

    - The activity must include procedures for requesting, activating, deploying and receiving CHEMPACK assets.
    - The exercise can be conducted as a tabletop, drill, or full-scale exercise. For more information or assistance in please contact Dr. Dana Grau at dana.grau@cdph.ca.gov.

12. Submit an H1N1 After Action Report Improvement Plan Progress Report for 2011. The H1N1 AAR/IP Progress Report for 2011 will provide a summary status update of the key improvement plan items from the LHD's H1N1 AAR/IP following the 2009-2010 H1N1 influenza pandemic response. LHDs are required to submit H1N1 AAR/IP Progress Reports to CDPH, using the template provided in Attachment 25, by **September 30, 2011.**

13. Develop or maintain mutual aid agreements or memoranda of understanding for regional/state collaborations for expansion of surveillance and epidemiology capacities; and/or identify surge capacity for epidemiology response within the jurisdiction and/or geographical region (See Public Health Surveillance and Epidemiological Investigations Capability.)

14. Assure that all data exchange, including electronic exchange of personal health information meets state and federal standards for privacy (See Public Health Surveillance and Epidemiological Investigations Capability.)

Requirements for Laboratory Response Network (LRN) - B Laboratories

LHDs with LRN-B Laboratories must comply the following requirements:

1. Subscribe to the CAP-LPX proficiency test sets;
2. Provide Sentinel training updates to clinical/hospital laboratories in the jurisdiction or service area as feasible and maintain a record, in the CDPH standardized Excel spreadsheet, of trainings. (Contact Will Probert at Will.Probert@cdph.ca.gov for a copy of the Excel spreadsheet to be used in tracking these trainings);
3. LRN Reference Laboratories will submit an EXCEL spreadsheet of their "Bio Facility Capabilities" (agent, sample type, test name) as listed under their "Facility Profile" on the LRN website. The list will be submitted to CDPH MDL to Dr. Will Probert (will.probert@cdph.ca.gov) with the mid-year and year-end progress reports;
4. Maintain a 24/7 contact list for sentinel laboratories in the jurisdiction and provide the contact list to CDPH MDL (submit to will.probert@cdph.ca.gov) with the mid-year and year-end progress reports;
5. If the laboratory is registered under the Select Agent Act, provide copies of the laboratory's current registration certificate and current USDA APHIS transport permit with the mid-year and year-end progress reports; and
6. Have plans for influenza testing, including:
    - Cross-training of staff to provide adequate trained personnel a available to perform influenza typing and subtyping by PCR;
    - Stockpiling and procurement of reagents and specimen collection materials; and
    - Data management capabilities to handles processing of a large number of specimens and reporting of results.

Cities Readiness Initiative (CRI) – For CRI funded Jurisdictions

To align with the PHEP cooperative agreement's capabilities-based approach, CRI requirements support the Medical Countermeasure Dispensing and the Medical Materiel Management and Distribution Capabilities. As described in those capabilities, CRI supports medical countermeasure (MCM) distribution and dispensing for *all-hazards events*, which includes the ability of jurisdictions to develop capabilities for U.S. cities to respond to a large-scale biologic attack, with anthrax as the primary threat consideration.

Medical countermeasure distribution and dispensing for all-hazard events is a change in scope from previous local guidance in that the CRI scenario planning was specific to an anthrax scenario only. CDC recognizes that jurisdictions need to improve all-hazards planning capabilities and has broadened the CRI criteria to support this activity.

Seventeen California LHDs outside Los Angeles County are designated as CRI jurisdictions:

California CRI Counties/Cities	
Alameda	Sacramento
City of Berkeley	San Benito
Contra Costa	San Bernardino
El Dorado	San Diego
Fresno	San Francisco
Marin	San Mateo
Orange	Santa Clara
Placer	Yolo
Riverside	

All LHDs receiving CRI funds must complete the work plan identified for CRI jurisdictions as part of this application. CRI jurisdictions are required to address all functions and priority resource elements for Medical Countermeasure Dispensing and Medical Material Management and Distribution Capabilities. In addition to the work plan, CRI jurisdictions are required to complete a demonstration plan that includes the following:

RAND Drills

- All LHDs receiving CRI funds must complete a minimum of three different RAND drills (not the same drill performed three times) during 2011-12. The three required drills may be chosen from any of the eight available drills on the DSNS Extranet website at: https://www.orau.gov/snsnet/default.htm.

- Drill data and/or HSEEP AAR/IP for applicable drills must be submitted to lhbtprog@cdph.ca.gov no later than June 30, 2012.

- Real events can substitute for drills and exercises provided that target capabilities are sufficiently tested and documented.

- Questions concerning the RAND Corporation drills or for the DSNS Extranet Logon ID and Password should be directed to Alan Hendrickson (alan.hendrickson@cdph.ca.gov) or Anne Bybee (anne.bybee@cdph.ca.gov).

Full-Scale Exercise

- All LHDs receiving CRI funds must participate in a full-scale exercise involving all LHDs across the CRI Multiple Statistical Area (MSA) that tests and validates medical countermeasures distribution and dispensing plans within the 2011-16 PHEP project period. CRI MSA dispensing exercise must include all pertinent jurisdictional leadership and emergency support function leads, planning and operational staff, and all applicable personnel.

- Complete and submit an After Action Report and Improvement Plan AAR/IP in compliance with HSEEP to lhbtprog@cdph.ca.gov no later than 90 days after completion of the exercise.

Risk-Based Pilot Project– Applicable to Risk-Based Initiative Funded Jurisdictions

Seven California LHDs outside Los Angeles County are designated as Risk-Based Pilot Project jurisdictions:

California Risk-Based Pilot Project Counties/Cities	
Alameda	San Francisco
City of Berkeley	Marin
Contra Costa	San Mateo
Orange	

This funding is intended to promote and accelerate the development of strategies that mitigate the public health risks associated with high population areas. Guidance on work plans and budgets for the pilots will be provided separately.

SECTION THREE:

GUIDANCE FOR GENERAL FUND PANDEMIC INFLUENZA FUNDS

State General Fund Pandemic Influenza funds (GF Pan Flu) shall enhance the LHD's preparedness for an influenza pandemic.

Required Activities

- Maintain Pandemic Influenza Coordinator and define the role and functions of the coordinator in pandemic influenza response.

- Improve Pandemic Influenza Operational Response Plans
  - Utilizing the 2008/09 CDPH feedback received on your LHD pandemic plan , the LHD 2009 H1N1 pandemic influenza after action plan, and the LHD 2010 AAR Progress report, evaluate the current status of your jurisdiction's operational pandemic influenza plan. Identify remaining gaps and areas for improvement in the current pandemic influenza operational response plan.
  - Develop a corrective action plan for 2011-12 prioritizing critical activities needed to improve your LHD pandemic influenza operational response plan.
  - Submit H1N1 AAR/IP Progress Report to CDPH, using the template provided in Attachment 25, by September 23, 2011.

- Meet Pandemic Influenza Reporting Requirements
  Describe how the following influenza reporting requirements are being or will be met:
    - The mechanism for transmitting (e.g., by electronic means or fax) case report forms of severe cases (ICU and fatal) of confirmed influenza (all types and subtypes, including seasonal) in persons under 65 years of age in a timely manner year-round.
    - The mechanism to report (e.g., by electronic means or fax) laboratory confirmed influenza during a pandemic, with results additionally classified by categories specified by CDPH, such as by influenza type/subtype, hospitalization or other outcome status.
    - Be able to identify whether specimens tested are from inpatients, outpatients, or fatal cases.
    - Have a pre-existing plan in place for disseminating guidelines on who should be tested for influenza (e.g. hospitalized and fatal cases, outbreaks, health care workers).

- Maintain and Strengthen Government-Authorized Alternate Care Sites
  - Maintain, strengthen, and test operational plans in meeting surge targets at the acute level of care.
  - Collaborate with Local HPP Entities, and community/regional/geographical partners for the operation of the Alternate Care Sites
  - Purchase of surge supplies and equipment for Government-Authorized Alternate Care Sites.

- Develop plans for integration of Alternate Care Sites within the continuum of care from existing health care facilities to expansion of health care facilities to Government-Authorized Alternate Care Sites including details on planned patient triage, movement, and mass fatality.

- Maintain Local Disaster Healthcare Volunteers (DHV) Program. Support and promote the DHV program for registration and credential verification of volunteer medical and health professionals, including Medical Reserve Corps members. All Medical Reserve Corps receiving State General Fund Pan Flu funds are required to register in DHV.

- Coordinate with Preparedness Activities for At-Risk Populations. Assist and collaborate with the Local HPP Entity with their preparedness activities concerning access to medical care for at-risk populations.

Optional Activities:

The following activities may be addressed during 2011-12 after all required activities have been met:

- Purchase pneumococcal vaccine for a vaccination exercise. Costs for this activity cannot exceed 10% of the GF pandemic influenza allocation. This exercise activity must:

  - Apply Homeland Security Exercise and Evaluation Program (HSEEP) guidelines for organization, management, and implementation of the vaccination clinic;
  - Include review of AAR findings related to 2009 H1N1 vaccination efforts and apply relevant recommendations into the exercise;
  - Identify high-risk and priority target groups for receipt of the vaccine;
  - Include collaboration between public health emergency preparedness and the local immunization program;
  - Include an after action/corrective action plan after completion of the vaccination clinic and submit the after action report/corrective action plan within 90 days of the event.

- Activate a mass vaccination clinic for seasonal influenza with a focus on vaccination of at-risk populations and priority target groups as identified by CDPH. Cost for this activity cannot exceed 10% of GF pandemic influenza allocation. This exercise activity must:

  - Apply Homeland Security Exercise and Evaluation Program (HSEEP) guidelines for organization, management, and implementation of the vaccination clinic;
  - Include review of AAR findings related to 2009 H1N1 vaccination efforts and apply relevant recommendations into the exercise;
  - Identify high-risk and priority target groups for receipt of the vaccine;
  - Include collaboration between public health emergency preparedness and the local immunization program;
  - Include an after action/corrective action plan after completion of the vaccination clinic and submit the after action report/corrective action plan within 90 days of the event.

- Support Warehouse Costs for maintaining and storing medical materiel received from CDPH. LHDs may utilize up to 30% of their GF pandemic influenza allocation for this purpose.

SECTION FOUR:
GUIDANCE FOR HOSPITAL PREPAREDNESS PROGRAM

The purpose of the HPP Cooperative Agreement is to maintain, refine, and enhance the capabilities of health care systems to be prepared for all-hazards events. HPP funds support hospitals and other health care facilities, including clinics, skilled nursing facilities, and emergency medical services.

The HPP 2011-12 grant year is the final year of a three-year project period that began in 2009-10. Local HPP Entities should plan their activities to ensure completion of all projects by the end of this grant cycle.

2011-12 HPP Activities

In 2011 - 12, HPP activities are structured into three categories: Overarching, Tier 1 Requirements and Tier 2 Activities. Local HPP Entities are required to document the current status of the activity and describe plans for each activity in 2011-12. Tier 2 Activities are optional and may only be undertaken after Overarching and Tier 1 Requirements are met.

Each local allocation begins with a base of $135,000 including $50,000 for a half-time HPP Coordinator to carry out program responsibilities. The Local HPP Coordinator should continue programmatic and administrative responsibilities. Programmatic activities include overseeing the development and implementation of the HPP activities across Tier 1 and 2 and Overarching capabilities and collecting required data elements from participating health care facilities. For Local HPP Entities that do not have a Partnership Coordinator, the Local HPP Coordinator shall be responsible for the local partnership deliverables. Administrative responsibilities include preparing the HPP Work Plan and budget, convening local partnership meetings, administering and tracking grant funds, preparing budget redirections and programmatic changes, submitting mid-year and year-end progress reports, and ensuring that all audit requirements are met.

Overarching Requirements

Continuing Preparedness for the Medical Needs of At-Risk Populations

At-risk populations include the medical needs of senior citizens, pregnant women, those who are disabled, developmentally disabled, mentally handicapped, homeless, have limited or no English proficiency, live in institutionalized settings; are from diverse cultures, have chronic medical disorders; and/or have pharmacological dependency.

At-risk individuals also include those who have, in addition to their medical needs, other needs that may interfere with their ability to access or receive medical care (example: supervision needs, transportation, and independence assistance). They may have additional needs before, during, and after an incident.

Local HPP Entities shall:

- Describe the following relative to at-risk populations:
  - The current status of plans/planning for at-risk populations mentioned above.
  - The current status of activities and partnerships with groups (both government and community based) that represent the at-risk populations mentioned above.

- Describe what activities are planned for this grant year for at-risk populations
- Describe what gaps at the end of this grant year will remain relative to at-risk populations.

Education and Preparedness Training:

- Local HPP Entities shall support education and training opportunities for health care personnel who respond to public health and medical emergencies. These activities should include NIMS/SEMS/HICS/NHICS training, training on emergency response plans, population based care, and other training specific to individual roles of health care facilities during emergencies.
- Local HPP entities and HPP participating health care facilities as well as LHDs are required to participate in the Statewide Medical and Health Training and Exercise.
- HPP participating healthcare facilities and Local HPP Entities are encouraged to provide staff training based on the CDPH 2010 "Preparedness for Respirator Use and Infection Prevention in Health Care Facilities". CDPH will provide written materials to assist participating agencies in developing appropriate curricula. (Contact Dr. Juan Ruiz at juan.ruiz@cdph.ca.gov for more information about the available training)

NIMS Compliance

- Local HPP Entities shall ensure that all hospitals comply with the 14 NIMS elements. The Local HPP Entity will report aggregate data on participating hospitals that have adopted all NIMS elements as outlined in the *NIMS Hospital Compliance Tracking Document* (Attachment 17) and identify which facilities are still in the process of adopting activities.

Exercises, Evaluations and Corrective Actions

Each Local HPP Entity will coordinate with participating health care facilities in conducting exercises that at a minimum tests the operational capability of the following medical surge components over the period of the grant:

- Interoperable communications
- Disaster Health Care Volunteers (DHV).
- Partnership Plans, Procedures, and Agreements.
- Fatality Management
- Medical Evacuation/Shelter in Place, and
- Tracking of Bed Availability

In addition, exercises should involve public health, local OES, emergency management, EMS, health care facilities and other responders to exercise the effective public – private interaction needed during an emergency response.

Exercise programs funded by HPP funds must be built on HSEEP guidelines. It is important all HPP-funded partners (hospitals, SNFs, LEMSAs, etc.) that participate in HPP-funded exercises to also participate in the HSEEP planning conferences including the after action process. The purpose of the After Action process is to assist the exercise coordinator in developing the After Action Report / Improvement Plan (AAR/IP) to identify activities requiring improvement that affect all exercise participants within the Operational Area. Partners participating HPP-funded exercises are encouraged to use the Attachment 18 form for this purpose. HPP partners are also encouraged to use this form their own internal After Action Report / Improvement Plan.

Local HPP Entities must submit their Statewide Medical and Health Exercise After Action Report and Improvement Plan within 90 days to 2011StatewideExercise@cdph.ca.gov.

Each Local HPP Entity shall include a training and exercise plan in its 2011-12 application. CDPH has provided an Excel spreadsheet (Attachment 12) for Local HPP Entities to document projected trainings and exercises. The Statewide Medical and Health Exercise and Training Program must be included in the Training and Exercise Plan. Exercises may be replaced with actual events if targeted capabilities are sufficiently tested.

In previous years, Attachment 12 was combined with the PHEP application. For 2011-12, training and exercise activities related to PHEP are incorporated into the PHEP application in the form of the Demonstration Plan.

Tier 1 Requirements

Partnership/Coalition Development

The foundation of California's approach to health care surge continues to be based on partnerships between health care entities and public health.

At a minimum, a partnership/coalition consists of:

- Hospitals servicing the Operational Area, at least one of which shall be a designated trauma center, if applicable
- One or more clinics (including American Indian clinics), ambulatory care centers, or primary care facilities
- Skilled nursing facilities
- Local Health Department
- Local Emergency Medical Services Agency
- Medical Health Operational Area Coordinator Program

Local partnerships should also include the following groups:

- Home health agencies
- Hospices
- Dialysis Centers
- Freestanding Surgery Centers
- Pre-hospital care providers including dispatchers
- Local OES
- Local Welfare and Social Services Departments
- Developmental Centers
- Regional Centers
- Mental Health Facilities
- Maternal and Child Health Programs
- Community Service Agencies
- Sheriffs, Coroners and/or Medical Examiners
- Amateur Radio Operators
- Community non-profit organizations
- Additional partners as determined by the partnership/coalition

Coalition development includes establishing Memoranda of Understanding that identify roles and responsibilities to share information, staff, and other resources. It is recommended that one memorandum of understanding be signed by all partners; however, multiple agreements may be

necessary to address all partner concerns. At a minimum, Local HPP Entities should ensure that a memorandum of understanding exists between the required members of the partnership.

It is expected that all health care facilities and organizations receiving HPP funding from the Local HPP Entity will participate in the local partnership.

Partnership Deliverables:

- Provide CDPH with a list of participating partners that includes the required organizations and the name of the lead participant from each partner organization
- Ensure full participation of all partners in emergency response planning efforts. Provide documentation of attendance of partners at planning sessions.
- Complete development of integrated written operational response plans that identify the processes partners will use to request and share assets, personnel and information during emergencies; including the roles and functions of all partners. Document the MHOAC role in coordinating assets and personnel.
- Develop a communications plan that addresses alerting and notification of all partners during an emergency and identify the integrated communications systems the partners will use to communicate both vertically and horizontally during a response.
- Review existing emergency response plans and procedures of each partner to identify common points of integration. This includes documentation of efforts to resolve conflicting points of integration.
- Develop Memoranda of Understanding that identify roles and responsibilities to share information, staff, and other resources.
- Train all partners in local emergency response plans.
- Ensure participation of all partnership members in one or more HSEEP exercises or drills and provide AARs with Improvement Plans. Drills and exercises must test the following:
    - Sharing information across redundant communication systems
      Meeting the target number of surge beds within the Operational Area including use of Government-Authorized Alternate Care Sites
    - Use of Evacuation/Shelter in Place decision-making process
    - Requesting and sharing of resources including use of Disaster Healthcare Volunteers
    - Meeting the 14 required NIMS Compliance elements for hospitals
    - Tracking and reporting available beds based on HAvBED Categories within 60 minutes
    - Participating in the Statewide Medical/Health Training and Exercise program.
- Ensure completion of HSEEP-compliant AARs and Improvement Plans by all partners for drills, exercises, and events. California Hospital Association Hospital Preparedness Coordinators can provide technical assistance.

LEMSA Deliverables and Allocations

Each local emergency medical services agency (LEMSA) shall designate a LEMSA Coordinator who shall participate in the activities described below.

In recognition that LEMSAs are an integral part of the local partnership, each Local HPP Entity is allocated funds for a LEMSA Coordinator. LEMSAs representing single Operational Areas will be allocated, via the Local HPP Entity, $50,000 for a half-time position or contract to participate in the local partnership, including planning and exercising. LEMSAs representing multiple Operational Areas will receive a total of $65,000 for a part-time staff person to participate in

local planning and exercising. Each Local HPP Entity within a multi-county LEMSA is allocated an equal share of the $65,000. Local HPP Entities within a regional LEMSA may agree to a different funding formula for reaching the $65,000 LEMSA funding requirement.

To strengthen regional coordination and minimize administrative processes, Local HPP Entities within a multi-county LEMSA may elect to appoint a single HPP entity to administer the partnership portion of the LEMSA contract and move the funds to that HPP entity. Upon the request of Local HPP Entities, CDPH will modify local allocations based on line-item direction to fund a single Local HPP Entity to administer the LEMSA allocation.

LEMSA Requirements

- Participate in HPP Partnership activities and Partnership planning meetings in all counties included in the LEMSA. Provide documentation of participation.
- Participate in state sponsored rollout and training on the Emergency Operations Manual.
- Modify LEMSA plans, policies and procedures that address information management and resource requesting to be consistent with the Emergency Operations Manual and integrated with Operational Area response plans.
- Clearly articulate, within emergency response plans, LEMSA roles and responsibilities for providing emergency medical services elements of the MHOAC Program.
- Participate in HAvBED data collection activities including training and exercises according to roles established in local policies and procedures. After each exercise, identify any gaps in local policies and procedures and modify plans to address the gaps.
- Participate in the Statewide Medical and Health Exercise in coordination with Operational Area exercise play.

Interoperable Communication Systems

Local HPP Entity partners shall maintain and refine operational, redundant communication systems that are capable of communicating both horizontally, between health care systems, and vertically, within the Operational Area's incident command structure.

During 2011-12 Local HPP entities should continue to strengthen communication systems that are capable of communicating both horizontally and vertically. However, all proposed communications purchases must be supported by a clear explanation of how the purchase will augment, not duplicate, functions of CAHAN, California's official public health and medical emergency alerting system, and how they will interoperate under the Project 25 (P25) standards as outlined in the SAFECOM website at www.safecomprogram.gov.

Hospital Available Beds (HAvBED) for Emergencies and Disasters

Local HPP Entities will ensure that all participating hospitals understand the process for collecting and reporting bed availability data. In 2011-12 HPP participating hospitals will demonstrate the ability to report available hospital beds within 60 minutes in at least one statewide drill/exercise; the State will not provide advance notification of the drill to Local HPP Entities.

Disaster Healthcare Volunteers

Local HPP Entities should continue to promote medical and health care volunteering and develop specific strategies for the enrollment of professional volunteers. Local HPP Entities should provide a brief outline of the identified strategies with proposed completion dates and indicate what efforts have begun to date, as well as the results of those efforts.

Local HPP Entities should utilize the Disaster Healthcare Volunteers system for registration and credential verification of volunteer medical and health professionals, including Medical Reserve Corps. All Medical Reserve Corps receiving HPP funding are required to register their members in Disaster Healthcare Volunteers.

Fatality Management

Local HPP Entities shall continue to work closely with participating hospitals, skilled nursing facilities, long term care facilities and other appropriate health care entities to ensure that fatality management plans are in place at each facility and integrated into county plans for disposition of the deceased. These plans must clearly account for the proper identification, handling and storage of remains by the health care facility. Local HPP Entities should be familiar with the county coroner's/medical examiner's mass fatality management plan.

Medical Facility Evacuation Planning/Sheltering in Place

Complete work on Medical Evacuation/Shelter in Place (SIP) plans.

- Ensure all participating health care facilities upgrade medical evacuation plan/procedures as necessary to respond to disaster scenarios that require medical evacuation. These plans should include options to evacuate beyond the boundaries of the facility and be tested in a drill or exercise.

- Ensure plans include shelter-in-place when evacuation is inappropriate or delayed. The decision making process for determining whether to evacuate or shelter in place should be clearly articulated in each facility's plan.

Expansion of Health Care Facility Surge Capacity and Planning for Government Authorized Alternate Care Sites

Local HPP Entities, LHDs, and health care facilities shall continue to develop medical surge capacity for their county in the event of a catastrophic event such as pandemic influenza, or a catastrophic earthquake. Surge plans should include movement of patients along the continuum of care from existing health care facilities to expansion of health care facilities to Government-Authorized Alternate Care Sites. California will need 58,728 surge beds during a catastrophic event. Attachment 26 displays each county's population-based proportion of surge beds during a catastrophic event. Although it is anticipated that the need for surge beds during moderate event will be met largely through the expansion of hospital beds, the surge needs of a catastrophic event will depend on the expansion of other existing health care providers, and the establishment of Government-Authorized Alternate Care Sites.

Tier 2 Activities (Optional)

The following Tier 2 activities may be addressed during 2011-2012 after Overarching and Tier 1 Requirements have been met.

Pharmaceutical Caches

The following pharmaceutical purchases are allowable for health care providers, ancillary staff, and their families; both pediatric and adult doses shall be considered. Local HPP entities may consider a phased approach for pharmaceutical purchases in the following order of precedence:

- Antibiotics for prophylaxis and post-exposure prophylaxis to biological agents for at least three days;

- Medications (except nerve agent antidotes) and vaccines needed for exposure to other threats.

Local HPP Entities may purchase, replace and rotate pharmaceuticals only if the purchases are linked to a Hazard and Vulnerability Analysis (HVA) that identifies where and why sufficient quantities do not currently exist. Caches should be placed in strategic locations based on the same HVA and stored in appropriate conditions to allow rotation of stock and maximize shelf life. Emergency contacts and contingency plans should be designated for cache access.

Health care facilities should develop procedures for storage, rotation and timely distribution of critical medications for health care providers, ancillary staff, and their families during an emergency.

Personal Protective Equipment

Local HPP Entities may continue to acquire personal protective equipment (PPE) to protect current and additional health care personnel necessary to support events of the highest risk identified through the HVA. The amount should be tied directly to the number of health care personnel needed to support bed surge capacity during a catastrophic event that requires PPE. (See Attachment 13 – Surge Bed Capacity Form which projects surge estimate for each county.) The necessary level of PPE should be established based on the HVA that identifies gaps in the amount of PPE needed to protect staff during events identified as the highest risks.

Mobile Medical Assets

Local HPP Entities may continue to develop or begin to establish plans for a mobile medical capability, working with State and local partners to ensure integration of plans and sharing of resources. Mobile medical plans must address staffing, supply and re-supply, and training of associated personnel who may function interchangeably as surge augmentation or evacuation facilitators. Mobile medical asset related activities funded during the project period must be reported in the HPP end-of-year progress report.

Decontamination

Purchase decontamination equipment (including replacing missing or broken components) and continue development of decontamination plans. Local HPP Entities may assure adequate portable or fixed decontamination system capability exists for managing adult and pediatric patients and health care personnel who have been exposed during all hazards and health and medical disaster events. The level of capability should be in accordance with the number of required surge capacity beds expected to support the events of highest risk identified through the HVA. All decontamination assets shall be based on the number of patients and providers who can be decontaminated on an hourly basis.

Medical Reserve Corps

Local HPP Entities may consider using HPP funds to support the integration of Medical Reserve Corps units with local and regional infrastructure. Local HPP Entities are also encouraged to use multiple sources of funding to establish/maintain the Medical Reserve Corps program. HPP funds may be used to:

- Support Medical Reserve Corps personnel/coordinators for the primary purpose of integrating the Medical Reserve Corps structure with the Disaster Healthcare Volunteer program;

- Include Medical Reserve Corps volunteers in trainings that are integrated with that of other local, regional, and state assets, health care facilities, or volunteers through the Disaster Healthcare Volunteer program; and/or
- Include Medical Reserve Corps volunteers in exercises that integrate the volunteers with other local, regional, and state assets.

Telecommunications Service Priority Program (TSP)

Each Local HPP Entity can identify a minimum of one hospital or health care facility to participate in the Federal Communications Commission's (FCC) TSP that prioritizes facilities for re-establishing physical telecommunications lines affected by disaster. Facilities targeted for TSP must be those that the Local HPP Entity recognizes as critical medical surge responders during disaster, e.g., a designated trauma center that may be subject to interruption of communication capability.

LIST OF ATTACHMENTS
FY 2011 – 2012

Overview
Attachment 1 – 2011 - 12 Local Allocations, CDC, GF Pan Flu, HPP

CDC Public Health Emergency Preparedness (PHEP)
Attachment 2 – 2011 – 12 LHD PHEP Work Plan
Attachment 3 – 2011 – 12 LHD PHEP Budget
Attachment 6 – SNS RAND Drill – All Staff Call-Down Data Collection Sheet
Attachment 7 – SNS RAND Drill – Site Activation Staff Call-Down Data Collection Sheet
Attachment 8 – SNS RAND Drill - Facility Set-Up Data Collection Sheet
Attachment 9 – SNS RAND Drill – Picklist Assessment Data Collection Sheet
Attachment 10 - SNS RAND Drill - Dispensing Assessment Time Study Data Sheet
Attachment 11 – Laboratory Training Programs for Local Health Departments
Attachment 22 – Generic TAR Workplan
Attachment 27 – Required Capabilities, Functions, Priority Resource Elements and Performance Measures

State General Fund Pan Flu
Attachment 4 – State GF Pan Flu Workplan
Attachment 5 – State GF Pan Flu Budget
Attachment 25 – H1N1 AAR Improvement Plan Progress Report

Hospital Preparedness Program (HPP)
Attachment 12 – Training Drills and Exercises Form
Attachment 13 – Surge Bed Capacity Form
Attachment 14 – Local HPP Entity 2011 - 12 Work Plan
Attachment 15 – 2011 - 12 HPP Budget
Attachment 16 – 2011 - 12 HPP Participating Health Care Facilities Form
Attachment 17 – NIMS Implementation Objectives Hospital Compliance Tracking Tool
Attachment 18 – AAR Reporting Form – HPP Drills Exercises
Attachment 19 – HPP Data Elements Worksheet for Individual Hospitals – Tab1
HPP Data Elements Worksheet Aggregated by OA – Tab 2
Attachment 20 – Hospital Incident Command System Acronyms
Attachment 26 – Number of Licensed Health Care Facilities and Number of Surge Beds Required Based on Population

CDC and HPP
Attachment 21 – Allowable/Non-Allowable Expenditures and Staffing Matrix
Attachment 24 – Limited Fiscal Audit Corrective Action Plan (CAP)
Embedded in Budget Templates – Information Technology Justification

Attachment 23 - 2010 - 11 Comprehensive Agreement
Exhibit A – Scope of Work
Exhibit B – Budget Detail and Payment Provisions
Exhibit C – Additional Provisions
Exhibit D – Special Terms and Conditions including Certification Regarding Lobbying
Exhibit E – Non-Supplantation Certification Form

APPLICATION CHECKLIST					
Submit with grant application		For reference only	For use during the grant year		Attachments
CDC	HPP				
		X		Attachment 1	2011 - 12 Local Allocations
X				Attachment 2	2011 –12 LHD PHEP Work Plan
X				Attachment 3	2011 – 12 LHD PHEP Budget
X				Attachment 4	2011 – 12 State GF Pan Flu Work Plan
X				Attachment 5	2011 – 12 State GF Pan Flu Budget
			X	Attachment 6	SNS RAND Drill – All Staff Call-Down Data Collection Sheet
			X	Attachment 7	SNS RAND Drill - Site Activation Staff Call-Down Data Collection Sheet
			X	Attachment 8	SNS RAND Drill - Facility Set Up Data Collection Sheet
			X	Attachment 9	SNS RAND Drill - Picklist Assessment Data Collection Sheet
			X	Attachment10	SNS RAND Drill - Dispensing Assessment Time Study Data Sheet
		X		Attachment 11	Laboratory Training Programs for Local Health Departments
X	X			Attachment 12	Training Drills and Exercises Form
X	X			Attachment 13	Surge Bed Capacity Form
	X			Attachment 14	2011 - 12 Local HPP Entity Work Plan
	X			Attachment 15	2011 - 12 Local HPP Entity Budget
	X			Attachment 16	2011 - 12 HPP Participating Health Care Facilities Form
		X		Attachment 17	NIMS Compliance Tracking Tool
			X	Attachment 18	AAR Reporting Form - HPP Drills Exercises
				Attachment 19	HPP Data Elements Worksheet for Individual Hospitals – Tab 1
	X				HPP Data Elements Worksheet Aggregated by OA – Tab 2
		X		Attachment 20	Hospital Incident Command System Acronyms
		X		Attachment 21	Allowable Non-Allowable Items Matrix
		X		Attachment 22	Generic TAR Work Plan

APPLICATION CHECKLIST					
Submit with grant application		For reference only	For use during the grant year		Attachments
CDC	HPP	X		Attachment 23	Comprehensive Agreement (Reference Copy)
			X	Attachment 24	Fiscal Audit Corrective Action Plan (CAP)
			X	Attachment 25	H1N1 AAR Improvement Plan Progress Report
		X		Attachment 26	Number of Licensed Health Care Facilities and Number of Surge Beds Required Based on Population
		X		Attachment 27	2011 – 12 Required Capabilities, Functions, Priority Resource Elements and Performance Measures
X	X			Embedded in the budget documents	Information Technology Justification