

Dated: May 20, 2005.

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[FR Doc. 05-10538 Filed 5-25-05; 8:45 am]

BILLING CODE 4163-18-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Public Health Emergency Preparedness

Announcement Type: New.

Funding Opportunity Number:

AA154.

Catalog of Federal Domestic

Assistance Number: 93.283.

Application Deadline: July 13, 2005.

Notice of Award: August 31, 2005.

I. Funding Opportunity Description

Authority: This program is authorized under 42 U.S.C. 247d-3.

Purpose: The purpose of this program is to upgrade and integrate State and local public health jurisdictions' preparedness for and response to terrorism and other public health emergencies with Federal, State, local, and tribal governments, the private sector, and Non-Governmental Organizations (NGOs). These emergency preparedness and response efforts are intended to support the National Response Plan (NRP)¹ and the National Incident Management System (NIMS)².

In addition, the activities described in this cooperative agreement guidance are designed to develop emergency-ready public health departments in accord with the Interim National Preparedness Goal (NPG)³, the Interim Public Health and Healthcare Supplement to the NPG⁴, and the Centers for Disease Control and Prevention (CDC) Preparedness Goals (see below). Associated with the Interim NPG are two broad-gauged resources to help guide preparedness planning and implementation: A set of scenarios and the Target Capabilities List⁵. The

Department of Homeland Security (DHS) developed the Interim NPG and the associated resources in concert with the Department of Health and Human Services and other agencies of the Federal Government as well as with representatives of State and local public health departments and other stakeholders. All of these documents will be refined and extended from time to time to capture lessons learned and to introduce new concepts as appropriate.

This announcement is only for non-research activities supported by the Centers for Disease Control and Prevention/Agency for Toxic Substances and Disease Registry (CDC/ATSDR). If research is proposed, the application will not be reviewed. For the definition of research, please see the CDC Web site at the following Internet address: <http://www.cdc.gov/od/opspoll1.htm>.

This program addresses the "Healthy People 2010" focus area(s) of public health infrastructure.

Recipient Activities: CDC has developed Preparedness Goals designed to measure urgent public health system response performance parameters that are directly linked to health protection of the public. The Preparedness Goals are intended to measure urgent public health system response performance for terrorism and non-terrorism events including infectious disease, environmental and occupational related emergencies. For the purposes of this announcement urgent response is intended to indicate non-routine public health system reaction to limit possible mortality, morbidity, loss of quality of life, or economic damage. The primary intent of this cooperative agreement is to fund the active participation of awardees in the immediate establishment, use, and continuous improvement of a national system using the CDC Preparedness Goals to measure public health system response performance. The CDC Preparedness Goals are below:

Prevent: (1) Increase the use and development of interventions known to prevent human illness from chemical, biological, radiological agents, and naturally occurring health threats.

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

Detect/ Report: (3) 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.

(4) Improve the timeliness and accuracy of information regarding threats to the public's health as reported by clinicians and through electronic early event detection, in real time, to those who need to know.

Investigate: (5) Decrease the time to identify causes, risk factors, and appropriate interventions for those affected by threats to the public's health.

Control: (6) Decrease the time needed to provide countermeasures and health guidance to those affected by threats to the public's health.

Recover: (7) Decrease the time needed to restore health services and environmental safety to pre-event levels. (8) Increase the long-term follow-up provided to those affected by threats to the public's health.

Improve: (9) Decrease the time needed to implement recommendations from after-action reports following threats to the public's health.

The activities in this cooperative agreement guidance will be based on the synchronization of the Department of Homeland Security Target Capabilities List (TCL) with the CDC Preparedness Goals in order to create a preparedness framework that identifies the key needs for the public health community.

The TCL was developed under the auspices of Homeland Security Presidential Directive 8: National Preparedness (HSPD-8). It is a functional, performance-focused compendium of response activities designed to provide State and local jurisdictions with nationally accepted preparedness levels of first responder capabilities. The TCL was developed in close consultation with Federal, State, local, and tribal entities and national associations, including CDC and many of the agency's key response partners.

Additional Requirements: The activities outlined in the guidance and required for the application for funds are as follows:

1. The existence of or current efforts to establish or participate in a senior advisory committee during Fiscal Year 2005 (FY05) to coordinate funding with the U.S. Department of Health and Human Services' (HHS) Centers for Disease Control and Prevention; U.S. Department of Health and Human Services' (HHS) Health Resource and Services Administration (HRSA) hospital preparedness cooperative agreement; and FY05 Homeland Security Grant Program Department of

¹ Emergency Support Function Annexes. National Response Plan. Available at: http://www.dhs.gov/dhspublic/interapp.editorial/editorial_0566.xml.

² National Incident Management System <http://www.fema.gov/nims/>.

³ Interim National Preparedness Goal: http://www.ojp.usdoj.gov/odp/docs/InterimNationalPreparednessGoal_03-31-05_1.pdf.

⁴ Interim Public Health and Healthcare Supplement to the National Preparedness Goal: <http://www.hhs.gov/ophep/index.html>.

⁵ Target Capabilities List: Version 1.0; January 31, 2005. U.S. Department of Homeland Security Office of State and Local Government Coordination and

Preparedness (ATTN: Office for Policy, Initiatives, and Analysis) 810 7th Street, NW, Washington, DC 20531. Version 1.0 of the Target Capabilities List will be made available on the ODP Secure Portal (<https://odp.esportals.com>) and the Lessons Learned and Information Sharing network (<http://www.llis.gov>).

Homeland Security, Office for Domestic Preparedness.

2. During the award year, awardees ability to respond to events will be evaluated through assessments, site visits, drills, exercises, and responses to real events. In year one of this cooperative agreement, CDC will initiate a series of drills to test components of a comprehensive response system. In years 2–5 of this cooperative agreement, CDC will require the demonstration of a broader set of measures that are consistent with the TCLs through full-scale exercises at the State and local level. Further guidance on the development and evaluation of exercises and drills will be forthcoming from CDC. To the extent possible, public health exercises should use standards set by the DHS Homeland Security Exercise Evaluation Program (HSEEP) as well as other recognized exercise programs including those used by the Federal Emergency Management Agency (FEMA) Emergency Management Institute. These exercises should test both horizontal and vertical integration with response partners at the local, tribal, State, and federal level.

3. Awardees must ensure that funds are available to establish and maintain systems to collect and report on the performance measures described in this program announcement, including reporting on the achievement of performance measures by local public health entities.

4. Awardees are expected to address the activities and outcomes described in this announcement through the use of cooperative agreement funds and coordination with other funding sources such as the Urban Areas Security Initiative (UASI) and the Metropolitan Medical Response System (MMRS) through the Department of Homeland Security. Achievement of these outcomes will be evaluated through drills, exercises, and responses to real events whenever possible.

5. While this guidance contains instructions for CDC awardees, it also includes recipient activities that need to be integrated with those funded by the hospital preparedness cooperative agreement administered by HRSA. Further, CDC encourages applicants to coordinate activities with current relevant efforts in their jurisdictions or proposed under the various goals of this cooperative agreement.

Applicants should also coordinate activities within their jurisdictions (*i.e.*, at the State level), between State and local jurisdictions, tribes, and military installations; among local agencies; and with hospitals and major health care entities, including tribal and Public

Health Service health facilities; among jurisdictional MMRSs, and adjacent States. If applicable, awardees should coordinate with neighboring provinces, tribal/First Nations indigenous jurisdictions and States across international borders.

6. Public health agencies must support public health response functions in the context of NIMS. In accordance with HSPD–5, NIMS provides a consistent approach for Federal, State, and local governments to work effectively and efficiently together to prepare for, prevent, respond to, and recover from domestic incidents, regardless of cause, size, or complexity. As a condition of receiving Public Health Emergency Preparedness cooperative agreement funds, awardees agree to adopt and implement NIMS. In accordance with the eligibility and allowable uses of the cooperative agreement, awardees are encouraged to direct FY05 funding towards activities necessary to implement NIMS.

On September 8, 2004, the former Secretary of Homeland Security, Tom Ridge, wrote a letter to the Governors outlining the important steps that State, territorial, tribal and local entities should take during FY05 to become compliant with NIMS.⁶

In order to receive Fiscal Year 2006 (FY06) preparedness funding, the minimum FY05 compliance requirements described in the Secretary's letter must be met. Applicants will be required to certify as part of their FY06 cooperative agreement applications that they have met the FY05 NIMS requirements.

NIMS compliance activities to be accomplished during FY05 are as follows:

States and Territories

- Incorporate NIMS into existing training programs and exercises;
- Ensure that federal preparedness funding (including the National Bioterrorism Hospital Preparedness cooperative agreement) supports State, local and tribal NIMS implementation;
- Incorporate NIMS into Emergency Operations Plans (EOP);
- Promote intraState mutual aid agreements;
- Coordinate and provide NIMS technical assistance to local and tribal entities; and
- Incorporate Incident Command Systems (ICS) into public health department, hospital, and supporting health care systems.

⁶ Available at http://www.fema.gov/doc/nims/letter_to_governors_09082004.doc, accessed April 7, 2005.

State, Territorial, Local and Tribal Jurisdictions

- Complete the NIMS Awareness Course: “National Incident Management System (NIMS), An Introduction” IS 700.

This independent study course developed by the Emergency Management Institute (EMI) explains the purpose, principles, key components and benefits of NIMS. The course is available on the EMI Web page at: <http://training.fema.gov/EMIWeb/IS/is700.asp>.

- Formally recognize the NIMS and adopt NIMS principles and policies. States, territories, tribes and local entities should establish legislation, executive orders, resolutions, or ordinances to formally adopt the NIMS. Go to <http://www.fema.gov/nims> and see NIMS Resources for examples.

- Determine which NIMS requirements have already been met.

State, territorial, tribal, and local entities have already implemented many of the concepts and protocols identified in the NIMS. However, as gaps in compliance with the NIMS are identified, States, territories, tribes and local entities should use existing awards to develop strategies for addressing those gaps.

- Develop a strategy and timeframe for full NIMS implementation.

States, territories, tribes, and local entities are encouraged to achieve full NIMS implementation during FY05. To the extent that full implementation is not possible during FY05, federal preparedness assistance must be leveraged to complete NIMS implementation by FY06. By Fiscal Year 2007 (FY07), federal preparedness assistance will be conditioned by full compliance with the NIMS. States should work with tribal and local governments to develop a strategy for Statewide compliance with the NIMS.

- Incorporate Incident Command Systems (ICS) into public health department, hospital, and supporting health care systems.

All Federal, State, territory, tribal and local jurisdictions are required to adopt ICS in order to be compliant with the NIMS. See NIMS and the Incident Command System at <http://www.fema.gov/nims> under NIMS Resources.

During the FY 2005 budget period the Department of Health and Human Services will continue to work closely with the NIMS Integration Center to clarify NIMS requirements for public health and medical communities. Both HRSA and CDC will continue to provide technical assistance throughout this

process to assist to awardees in meeting 2005 requirements.

7. Competency-based education of public health workers, clinicians, and others critical to emergency response should be planned and implemented based on needs identified through assessments and/or evaluations of performance. Awardees are expected to continue to support preparedness education and training activities needed to successfully achieve targeted outcomes and preparedness goals. Development, delivery, and evaluation of competency-based preparedness education should be done in conjunction with Centers for Public Health Preparedness (CPHP), and academic experts in other schools of public health, medicine, nursing, and academic health science centers.

Prior to planning development of new preparedness education courses or training programs to meet identified needs, efforts should be taken to identify and utilize existing education programs that have been evaluated for learning effectiveness (e.g. as evidenced by measured knowledge gained through pre- and post-tests, self-assessed learner competence, and/or skill demonstrations.) Resources such as learning management systems ((e.g. TrainingFinder Real-time Affiliate Integrated Network (TRAIN)) and other preparedness educational inventories ((e.g. Centers for Public Health Preparedness (CPHP) Resource Center)) can help facilitate the identification of existing preparedness educational programs that can be accessed, adopted, and adapted for local use, which will result in less duplication and more efficient use of available funds.

8. During the award year, awardees are expected to implement capable, interoperable information systems that support public health preparedness. PHIN Preparedness defines functional requirements in the areas of Early Event Detection, Outbreak Management, Countermeasure and Response Administration, Partner Communications and Alerting, and Connecting Laboratory Systems. All awardees are expected to develop information technology systems that are compliant with PHIN and begin to initiate the PHIN Preparedness certification process (further guidance on this process can be found at <http://www.cdc.gov/phinf/certification>) during this cooperative agreement cycle. PHIN certification will ensure that systems have the capabilities necessary ("functional requirements") to share data and work together ("Key Performance Measures—KPM's") in

order to implement a national network of capable public health preparedness systems. Certification is based upon the system requirements and specification guides found at <http://www.cdc.gov/phinf>. Self-assessment tools are available for all functional areas and the alerting KPMs at <http://www.cdc.gov/phinf/certification>.

Awardees may choose to meet the system requirements and specifications by: building or enhancing their own systems, purchasing commercial solutions, or using CDC developed systems and services. The requirements documents and specification guides include the details of what needs to be implemented in grantee systems to meet these needs. Some awardees may choose to use CDC developed software and services either as their final solutions or as bridge solutions until their own systems meet the requirements and specifications and are certified. The CDC has software and services available to cover all of the PHIN Preparedness functional areas, but the CDC is committed to working with awardees to help support solutions from any viable software solutions providers. The implementation of the PHIN Preparedness functional requirements will usually require several software systems to cover all of the functional areas, but in some circumstances, awardees may implement a single system that covers more than one functional area. Each PHIN Preparedness functional area can be certified separately. While CDC systems will undergo certification themselves, if CDC software and services are used in the awardee environment some components will require certification in the environment they are implemented.

9. CDC requires documentation with the cooperative agreement application that describes the process used by the State health department to engage local health departments to reach consensus, approval, or concurrence for the proposed use of non-earmarked cooperative agreement funds. Non-earmarked cooperative agreement funds are those funds not designated for urban areas (e.g. Cities Readiness Initiative (CRI)), Early Warning Infectious Disease Surveillance (EWIDS), currently established Level 1 Chemical laboratories, or other specialty activities as defined in the guidance. The description should bear evidence that local health department officials have been engaged in the cooperative agreement application process and at least a majority, if not the total, approves or concur with the application

itself. This evidence may be demonstrated by:

a. The consensus of a majority of local health officials whose collective jurisdictions encompass a majority of the State's population;

b. The recommendation of the President of the State Association of County and City Health Officials (SACCHO) if a majority of local health officials whose collective jurisdictions encompass a majority of the State's population agree with the SACCHO's decision; or

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

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

10. CDC requires documentation with the cooperative agreement application that describes the process used by the State health department to engage the following entities in preparedness and response activities: American Indian tribal governments, Tribal organizations representing those governments, tribal epidemiologic centers, or Alaska Native Villages and Corporations located within their boundaries.

11. State awardees are expected to ensure the preparedness of major population centers within each State either through the provision of funding to the population centers to ensure their capability to perform the outcomes and activities described and/or (for those States with a centralized public health system that does not fund local health agencies) by directly achieving the performance outcomes and completing the required activities described in this cooperative agreement announcement in those population centers. State awardees are expected to report on the relevant performance measures (see Appendix 4) for the following population centers. Some of the performance measures will be reported on by each local public health agency (through the State) in the jurisdiction; others will require the local agencies to work collaboratively to develop an integrated response. In those cases, reporting will be done through the State for the region as a whole (see Appendix 4).

State	Biowatch* or UASI (05) cities	Associated MSA
Arizona	Phoenix	Phoenix-Mesa-Scottsdale, AZ
California	Anaheim	Los Angeles-Long Beach-Santa Ana, CA
	Long Beach	Los Angeles-Long Beach-Santa Ana, CA
	Los Angeles	Los Angeles-Long Beach-Santa Ana, CA
	Oakland	San Francisco-Oakland-Fremont, CA
	Sacramento	Sacramento Arden-Arcade Roseville, CA
	San Diego	San Diego-Carlsbad-San Marcos, CA
	San Francisco	San Francisco-Oakland-Fremont, CA
	San Jose	San Jose-Sunnyvale-Santa Clara, CA
	Santa Ana	Los Angeles-Long Beach-Santa Ana, CA
Colorado	Denver	Denver-Aurora, CO
Delaware	Philadelphia	Philadelphia-Camden-Wilmington, PA-NJ-DE
District of Columbia	Washington/NCR	Washington-Arlington-Alexandria, DC-VA-MD
Florida	Jacksonville	Jacksonville, FL
	Miami	Miami-Fort Lauderdale-Miami Beach, FL
	Tampa	Tampa-St. Petersburg-Clearwater, FL
Georgia	Atlanta	Atlanta-Sandy Springs-Marietta, GA
Hawaii	Honolulu	Honolulu, HI
Illinois	Chicago	Chicago-Naperville-Joliet, IL-IN-WI
	St. Louis	St. Louis, MO-IL
Indiana	Indianapolis	Indianapolis, IN
	Chicago	Chicago-Naperville-Joliet, IL-IN-WI
	Cincinnati	Cincinnati-Middletown, OH-KY-IN
	Louisville	Louisville, KY-IN
Iowa	Omaha	Omaha-Council Bluffs, NE-IA
Kansas	Kansas City	Kansas City, MO-KS
Kentucky	Louisville	Louisville, KY-IN
	Cincinnati	Cincinnati-Middletown, OH-KY-IN
Louisiana	Baton Rouge	Baton Rouge, LA
	New Orleans	New Orleans-Metairie-Kenner, LA
Massachusetts	Boston	Boston-Cambridge-Quincy, MA-NH
Maryland	Baltimore	Baltimore-Towson, MD
	Washington DC	Washington-Arlington-Alexandria, DC-VA-MD
Michigan	Detroit	Detroit-Warren-Livonia, MI
Minnesota	Minneapolis	Minneapolis-St. Paul-Bloomington, MN-WI
Missouri	Kansas City	Kansas City, MO-KS
	St. Louis	St. Louis, MO-IL
Nebraska	Omaha	Omaha-Council Bluffs, NE-IA
North Carolina	Charlotte	Charlotte-Gastonia-Concord, NC-SC
New Hampshire	Boston	Boston-Cambridge-Quincy, MA-NH
New Jersey	Jersey City	New York-Northern New Jersey-Long Island, NY-NJ-PA
	Newark	New York-Northern New Jersey-Long Island, NY-NJ-PA
	Philadelphia	Philadelphia-Camden-Wilmington, PA-NJ-DE
Nevada	Las Vegas	Las Vegas-Paradise, NV
New York	Buffalo	Buffalo-Niagara Falls, NY
	New York	New York-Northern New Jersey-Long Island, NY-NJ-PA
Ohio	Cincinnati	Cincinnati-Middletown, OH-KY-IN
	Cleveland	Cleveland-Elyria-Mentor, OH
	Columbus	Columbus, OH
	Toledo	Toledo, OH
Oklahoma	Oklahoma City	Oklahoma City, OK
Oregon	Portland	Portland-Vancouver-Beaverton, OR-WA
Pennsylvania	Philadelphia	Philadelphia-Camden-Wilmington, PA-NJ-DE
	Pittsburgh	Pittsburgh, PA
	New York	New York-Northern New Jersey-Long Island, NY-NJ-PA
South Carolina	Charlotte	Charlotte-Gastonia-Concord, NC-SC
Texas	Austin	Austin-Round Rock, TX
	Arlington	Dallas-Fort Worth-Arlington, TX
	Dallas	Dallas-Fort Worth-Arlington, TX
	Fort Worth	Dallas-Fort Worth-Arlington, TX
	El Paso	El Paso, TX
	Houston	Houston-Baytown-Sugar Land, TX
	San Antonio	San Antonio, TX

State	Biowatch* or UASI (05) cities	Associated MSA
Virginia	Washington DC	Washington-Arlington-Alexandria, DC-VA-MD
Washington	Seattle	Seattle-Tacoma-Bellevue, WA
	Portland	Portland-Vancouver-Beaverton, OR-WA
Wisconsin	Chicago	Chicago-Naperville-Joliet, IL-IN-WI
	Milwaukee	Milwaukee-Waukesha-West Allis, WI
	Minneapolis	Minneapolis-St. Paul-Bloomington, MN-WI

* Biowatch only.

12. CDC will work with awardees and partner agencies (including National Association of County and City Health Officials (NACCHO), Association of State and Territorial Health Officials (ASTHO), Council of State and Territorial Epidemiologists (CSTE), Association of Public Health Laboratories (APHL), DHS, and FEMA)) to build on these initial activities and develop performance-based metrics within the next six months that will measure all aspects of preparedness as outlined in the CDC Preparedness Goals and the TCLs. They will be developed with the understanding that wherever possible these activities can be demonstrated through performance in drills, exercises, or real events. Additional activities will include gap analysis, economic modeling, continuous improvement and data collection/evaluation from exercises and real events as well as piloting the developed metrics. Required critical tasks and performance measures will be updated in each project year as public health learns more about measuring preparedness. In addition, CDC will be developing targets for those measures that do not currently have them based on research over the coming year.

13. As Stated in the FY04 guidance, awardees should provide a copy of the complete pandemic influenza plan for the jurisdiction to HHS Office of Public Health Emergency Preparedness (OPHEP) via CDC Division of State and Local Readiness' Management Information System (DSLRS-MIS). Awardees of this cooperative agreement should collaborate with influenza programs to maximize the impact of funds and efforts, reduce duplication, and coordinate activities including drills and exercises. Detailed information concerning the development of influenza pandemic preparedness plans is available in the document *Pandemic Influenza: A Planning Guide for State and Local Officials*, version 2.1 available at <http://www.hhs.gov/nvpo/pubs/pandemicflu.htm>.

Local Caches of Antiviral Drugs

Certain antiviral drugs are efficacious in countering influenza virus and could be the sole initial medical countermeasure against a pandemic strain until an effective vaccine is available. The H5N1 avian strain currently circulating widely in Asia has been shown to infect humans and cause significant mortality and morbidity; and the virus could trigger an influenza pandemic if it were to undergo genetic changes that enhance its transmissibility from person to person. One commonly available drug, Oseltamivir, has been shown to be effective against the current H5N1 strain. Because worldwide production capacity for antiviral drugs faces significant limitations, the Department of Health and Human Services is working to create a mechanism whereby it and its State and local public health partners might acquire and pre-deploy predictable quantities of antiviral drugs during the next several years.

The Hospital Bioterrorism Cooperative Agreement of the Health Resources and Services Administration (HRSA) includes a Critical Benchmark for hospital-based pharmaceutical caches. This provision provides a means for jurisdictions to amass appropriate quantities of antiviral drugs as a first line of protection for the staff of hospitals and other healthcare entities as well as their most critically ill patients. Such action could be one of the most important steps toward maintaining an effective healthcare infrastructure during an influenza pandemic.

Hospital-based pharmaceutical caches also could house antiviral drugs to protect public health professionals, another critical part of the human resources needed to combat an influenza pandemic. Funds allocated through the CDC bioterrorism cooperative agreement could be used to acquire appropriate quantities of antiviral drugs for storage within the hospital-based caches funded by the HRSA cooperative agreement. When and as needed, the drugs could be released to the public health department

for it to dispense to its staff. This arrangement would be analogous to the way some jurisdictions have implemented the CHEMPAK program (containerized sets of nerve-agent antidotes)—i.e., using CDC funds to acquire materiel, using HRSA funds to offset costs of storing it, and planning to release the materiel when and as needed to those authorized to use it in accord with an established Concept of Operations.

Awardees requesting to use cooperative agreement funds for the purchase of antiviral drugs for these caches must specify the quantity and cost as part of the budget application.

14. Awardees participating in the FY04 CRI will continue to do so in FY05 (the second year of the pilot initiative). The guidelines for CRI can be found in Appendix 3.

Application Content: What follows is the outline to be used to develop the application for funds. It was derived from a combination of many resources: past guidance, input from State and local public health partners, subject matter expertise within technical program areas of CDC, priorities from HHS, CDC priorities, documentation from DHS's TCL, DHS's Universal Task List (UTL), and HSPD-8.

The outline is arranged in the following manner:

CDC Goals—Draft CDC Preparedness Goals that form a framework for public health activities surrounding preparedness. This cooperative agreement is one activity among many that will contribute to meeting the Preparedness Goals.

Outcomes—The outcomes are Statements that were developed with State and local input from public health and homeland security. They were created in relation with HSPD-8 and are a comprehensive description of the major roles and capabilities needed to respond to an event of significance. Version 1 of the TCL contained 36 capabilities. For year one of this guidance, we singled out those capabilities that had a significant public health component. In some cases, we added language to the capabilities to

create a public health focused outcome. A comprehensive budget where each allocation is linked to an outcome should be submitted with the application through the DSLR MIS.

Required Critical Tasks—The critical tasks were obtained from the TCL. In most cases, the public health specific critical tasks associated with an outcome were listed. Language was added or modified to make the required critical task more specific to public health. In addition, program requirements specific to CDC and this cooperative agreement were added as sub-bullets under the required critical tasks to assure that each applicant addressed plans to continue implementation of the activities in the next cooperative agreement cycle.

Performance Measures—The performance measures are defined as leading indicators that will allow a national “snapshot” to show how the preparedness and response activities, and the associated resources, aid in making a public health system that responds more quickly and comprehensively in a public health emergency.

Applicants will be required to address each critical task (using the DSLR-MIS) by providing an explanation of their current capability to perform this task and proposing activities for this budget year to enhance performance on each critical task. In addition, applicants will be asked how they currently evaluate or plan to evaluate their ability to perform each of the critical tasks.

After award, CDC Project Officers and technical experts will monitor the progress of each awardee in accomplishing the activities set forth and approved in the plan submitted.

CDC Preparedness Goal 1: Prevent

Increase the use and development of interventions known to prevent human illness from chemical, biological, radiological agents, and naturally occurring health threats.

Outcome 1A: All Hazards Planning

Emergency response plans, policies, and procedures that identify, prioritize, and address all hazards (using the 15 National Planning Scenarios^{7 8 9 10} as a

guide to identify or recognize the roles and responsibilities for each jurisdiction/agency) across all functions. All plans are coordinated at all levels of government and address the mitigation of secondary and cascading emergencies.

Required Critical Tasks: (1) Support incident response operations according to all-hazards plan

(2) Improve regional, jurisdictional, and State all-hazard plans (including those related to pandemic influenza) to support response operations in accordance with NIMS and the National Response Plan.¹¹

(a) Increase participation in jurisdiction-wide self-assessment using the National Incident Management System Compliance Assessment Support Tool¹² (NIMCAST).

(b) Agency's Emergency Operations Center meets NIMS incident command structure requirements to perform core functions: coordination, communications, resource dispatch and tracking and information collection, analysis and dissemination.

(3) Increase the number of public health responders who are protected through Personal Protective Equipment (PPE), vaccination or prophylaxis

(a) Have or have access to a system that maintains and tracks vaccination or prophylaxis status of public health responders in compliance with Public Health Information Network (PHIN) Preparedness Functional Area Countermeasure and Response Administration¹³

(4) Increase and improve mutual aid agreements, as needed, to support NIMS-compliant public health response.

(5) Increase all-hazard incident management capability by conducting regional, jurisdictional and State training to:

(a) Include the Emergency Management Independent Study Program, IS 700, “National Incident Management System: An Introduction¹⁴” in the training plan for all staff expected to report for duty following activation of the public health emergency response plan and/or staff

who have emergency response roles documented in their job descriptions.

(6) Provide support for continuity of public health operations at regional, State, tribal, local government, and agency level.

Measures: (1) Percent of public health employees who have emergency response roles documented in their job descriptions that are trained in Incident Management.

(2) Time to organize a NIMS-compliant medical and public health operations functional area¹⁵ with hospitals that supports:

- incident epidemiological profiling
- pre-hospital care
- medical care
- mental health
- hazard threat/disease containment
- mass casualty care
- (Target: 3 hours from plan activation)

(3) Time from request for mutual aid to acknowledgement that request has been approved.

(4) Time to complete the notification/alerting of the initial wave of personnel to staff emergency operations (Target: 60 minutes).

(5) Time to have initial wave of personnel physically present to staff emergency operations (Target: 90 minutes from notification).

CDC Preparedness Goal 2: Prevent

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

Outcome 2A: Information Collection and Threat Recognition

Locally generated public health threat and other terrorism-related information is collected, identified, provided to appropriate analysis centers, and acted upon as appropriate.

Required Critical Tasks: (1) Increase the use of disease surveillance and early event detection systems.

(a) Select conditions that require immediate reporting to the public health agency (at a minimum, Category A agents).

(b) Develop and maintain systems to receive disease reports 24/7/365.

(c) Have or have access to electronic applications in compliance with PHIN Preparedness Functional Area *Early Event Detection* to support:

¹⁵ The CNACorporation. Medical Surge Capacity and Capability: A Management System for Integrating Medical and Health Resources During Large-Scale Emergencies. Prepared under Contract Number 233-03-0028 for the Department of Health and Human Services. Alexandria, Virginia: August 2004. Available at: http://www.cna.org/documents/mscc_aug2004.pdf.

⁷ Frequently Asked Questions: HSPD 8/National Planning Scenarios/Targeted Capabilities List. Available at: <http://www.ojp.usdoj.gov/odp/assessments/hspd8.htm>.

⁸ Homeland Security Presidential Directive #8 <http://www.whitehouse.gov/news/releases/2003/12/print/20031217-6.html>.

⁹ Homeland Security Presidential Directive #5 <http://www.fas.org/irp/offdocs/nspd/hspd-5.html>.

¹⁰ Homeland Security Grant Program—FY 2005. Available at: <http://www.ojp.usdoj.gov/odp/docs/fy05hsgp.pdf>.

¹¹ Guide for All-Hazard Emergency Operations Planning: State and Local Guide 101. Federal Emergency Management Agency. April 2001. <http://www.fema.gov/pdf/rrr/slg101.pdf>.

¹² National Incident Management System Compliance Assessment Support Tool (NIMCAST). <http://www.fema.gov/nimcast/index.jsp>.

¹³ Public Health Information Network (PHIN) Preparedness Requirements <http://www.cdc.gov/phn/>.

¹⁴ Emergency Management Independent Study Program, IS 700, National Incident Management System, An Introduction. <http://www.training.fema.gov/EMIWeb/IS/IS700.asp>.

- Receipt of case or suspect case disease reports 24/7/365.
- Reportable diseases surveillance.
- Call triage of urgent reports to knowledgeable public health professionals.

- Receipt of secondary use health-related data and monitoring of aberrations to normal data patterns.

(d) Develop and maintain protocols for the utilization of early event detection devices located in your community (e.g., BioWatch).

(e) Assess timeliness and completeness of disease surveillance systems annually.

(2) Increase sharing of health and intelligence information within and between regions and States with Federal, local and tribal agencies.

(a) Improve information sharing on suspected or confirmed cases of immediately notifiable conditions, including foodborne illness, among public health epidemiologists, clinicians, laboratory personnel, environmental health specialists, public health nurses, and staff of food safety programs.

(b) Maintain secret and/or top secret security clearance for the State health official, local health officials, preparedness directors, and preparedness coordinators to ensure access to sensitive information about the nature of health threats and intelligence information¹⁶.

(3) Decrease the time needed to disseminate timely and accurate national strategic and health threat intelligence.

(a) Maintain continuous participation in CDC's Epidemic Information Exchange Program (Epi-X)¹⁷.

(b) Participate in the Electronic Foodborne Outbreak Reporting System (EFORS) by entering reports of foodborne outbreak investigations and monitor the quality, completeness or reports and time from onset of illnesses to report entry¹⁸.

(c) Perform real-time subtyping of PulseNet¹⁹ tracked foodborne disease agents. Submit the subtyping data and associated critical information (isolate identification, source of isolate, phenotype characteristics of the isolate, serotype, etc) electronically to the national PulseNet database within 72 to

96 hours of receiving the isolate in the laboratory.

(d) Have or have access to a system for 24/7/365 notification/alerting of the public health emergency response system that can reach at least 90% of key stakeholders and is compliant with PHIN Preparedness Functional Area Partner Communications and Alerting.

Measures: (1) Time to receive confirmed case reports of immediately notifiable conditions by public health agency (includes Biowatch and Biohazard Detection Systems (BDS)).

(2) Time for State to notify local/tribal or local/tribal to notify State of receipt of a suspicious or confirmed case report of an immediately notifiable condition (Target: one hour from receipt).

(3) Time to have a knowledgeable public health professional answer a disease report call and begin taking the report 24/7/365 (Target: 15 minutes or less).

(4) Percent of sub-typing data submitted to PulseNet within 72–96 hours of receiving isolate in the laboratory.

Outcome 2B: Hazard and Vulnerability Analysis

Jurisdiction-specific Hazards are identified and assessed to enable appropriate protection, prevention, and mitigation strategies so that the consequences of an incident are minimized.

Required Critical Tasks: (1) Prioritize the hazards identified in the jurisdiction hazard/vulnerability assessment for potential impact on human health with special consideration for lethality of agents and large population exposures within 60 days of cooperative agreement award.

(2) Decrease the time to intervention by the identification and determination of potential hazards and threats, including quality of mapping, modeling, and forecasting.

(3) Decrease human health threats associated with identified community risks and vulnerabilities (i.e., chemical plants, hazardous waste plants, retail establishments with chemical/pesticide supplies).

(4) Through partners increase the capability to monitor movement of releases and formulate public health response and interventions based on dispersion and characteristics over time.

Measures: (1) Time to recommend public health courses of action to minimize human health threats identified in the jurisdiction's hazard and vulnerability analysis (Target: 60 days from identification of risk or hazard).

CDC Preparedness Goal 3: Detect/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.

Outcome 3A: Laboratory Testing

Potential exposure and disease will be identified rapidly, reported to multiple locations immediately, and accurately confirmed to ensure appropriate preventive or curative countermeasures are implemented. Additionally, public health laboratory testing is coordinated with law enforcement and other appropriate agencies.

Required Critical Tasks: (1) Increase and maintain relevant laboratory support for identification of biological, chemical, radiological and nuclear agents in clinical (human and animal), environmental, and food specimens^{20, 21, 22}

(a) Develop and maintain a database of all sentinel (biological)/Level Three (chemical) labs in the jurisdiction using the CDC-endorsed definition that includes:

- Name.
- Contact information.
- BioSafety Level.
- Whether they are a health alert network partner.
- Certification status.
- Capability to rule-out Category A and B bioterrorism agents per State-developed proficiency testing or College of American Pathologists (CAP)²³ bioterrorism module proficiency testing.

• Names and contact information for in-State and out-of-State reference labs used by each of the jurisdiction's sentinel/Level Three labs.

(b) Test the competency of a chemical terrorism laboratory coordinator and bioterrorism laboratory coordinator to advise on proper collection, packaging, labeling, shipping, and chain of custody of blood, urine and other clinical specimens.

(c) Test the ability of sentinel/Level Three labs to send specimens to a confirmatory Laboratory Response Network (LRN) laboratory on nights, weekends, and holidays.

(d) Package, label, ship, coordinate routing, and maintain chain-of-custody of clinical, environmental, and food specimens/samples to laboratories that

¹⁶ HHS Guidance: <http://198.102.218.46/doc/Security%20Class%20Guide.doc>.

¹⁷ Epidemic Information Exchange Program (Epi-X) <http://www.cdc.gov/epix/>.

¹⁸ Electronic Foodborne Outbreak Reporting System (EFORS) http://www.cdc.gov/foodborneoutbreaks/info_healthprofessional.htm.

¹⁹ PulseNet <http://www.cdc.gov/pulsenet/>.

²⁰ CDC: Emergency Preparedness and Response—Lab Issues. <http://www.bt.cdc.gov/labissues/>.

²¹ National Lab Training Network <http://www.phppo.cdc.gov/nlt/default.aspx>.

²² Sentinel (Level A) lab protocols <http://www.asm.org/Policy/index.asp?bid=6342>.

²³ College of American Pathologists (CAP) http://www.cap.org/apps.cap.portal?_nfpb=rue&_pageLabel=home_page.

can test for agents used in biological, chemical, and radiological terrorism.

(e) Continue to develop or enhance operational plans and protocols that include:

- Specimen/samples transport and handling.
- Worker safety.
- Appropriate Biosafety Level (BSL) working conditions for each threat agent.
- Staffing and training of personnel.
- Quality control and assurance.
- Adherence to laboratory methods and protocols.
- Proficiency testing to include routine practicing of LRN validated assays as well as participation in the LRN's proficiency testing program electronically through the LRN Web site.
- Threat assessment in collaboration with local law enforcement and Federal Bureau of Investigations (FBI) to include screening for radiological, explosive and chemical risk of samples.
- Intake and testing prioritization.
- Secure storage of critical agents.
- Appropriate levels of supplies and equipment needed to respond to bioterrorism events with a strong emphasis on surge capacities needed to effectively respond to a bioterrorism incident.

(f) Ensure the availability of at least one operational Biosafety Level Three (BSL-3) facility in your jurisdiction for testing for biological agents. If not immediately possible, BSL-3 practices, as outlined in the CDC-NIH publication "Biosafety in Microbiological and Biomedical Laboratories, 4th Edition" (BMBL), should be used (see [MACROBUTTON HtmlResAnchor www.cdc.gov/od/ohs](http://www.cdc.gov/od/ohs)) or formal arrangements (*i.e.*, Memorandum of Understanding (MOU)) should be established with a neighboring jurisdiction to provide this capacity.

(g) Ensure that laboratory registration, operations, safety, and security are consistent with both the minimum requirements set forth in Select Agent Regulation (42 CFR part 73) and the U.S. Patriot Act of 2001 (Pub. L. 107-56) and subsequent updates.

(h) Ensure at least one public health laboratory in your jurisdiction has the appropriate instrumentation and appropriately trained staff to perform CDC-developed and validated real-time rapid assays for nucleic acid amplification (Polymerase Chain Reaction, PCR) and antigen detection (Time-Resolved Fluorescence, TRF).

(i) Ensure the capacity for LRN-validated testing and reporting of Variola major, Vaccinia and Varicella viruses in human and environmental

samples either in the public health laboratory or through agreements with other LRN laboratories.

(2) Increase the exchange of laboratory testing orders and results.

(a) Monitor compliance with public health agency (or public health agency lab) policy on timeliness of reporting results from confirmatory LRN lab back to sending sentinel/Level Three lab (*i.e.*, feedback and linking of results to relevant public health data) with a copy to CDC as appropriate.

(b) Comply with PHIN Preparedness Functional Areas *Connecting Laboratory Systems and Outbreak Management* to enable: (a) the linkage of laboratory orders and results from sentinel/Level Three and confirmatory LRN labs to relevant public health (epi) data and (b) maintenance of chain of custody.

Measures: (1) Percentage of LRN biologic and chemical laboratories that demonstrate proficiency in:

- Confirming Category A agents in human clinical specimens (proficiency in accordance with CDC's Laboratory Response Network (LRN) proficiency testing program)
- Confirming Category A agents in food samples.
- Confirming the identity of and further characterizing (*e.g.*, assessment of toxin production, serotyping, phage typing, and DNA "fingerprinting") *Salmonella* (including *Salmonella* Typhi), *Shigella* species, Shiga toxin-producing *E. coli* and pathogenic vibrios isolated from FOOD samples.
- Confirming Category A agents in environmental samples.
- Confirming chemical agents in human clinical specimens.

(2) Time following initiation of an epidemiological investigation to begin obtaining or directing the acquisition of samples/specimens for laboratory analysis to support epidemiological investigation, as needed (Target: 60 minutes).

(3) For clinical specimens, environmental samples and samples of potentially contaminated food collected by public health personnel in an emergency, time to:

- Send clinical specimens to a reference laboratory within the LRN when an incident may involve an infectious biological agent (Target: within 60 minutes of collection).
- Send clinical specimens to the CDC or CDC-designated State laboratory when an incident may involve a hazardous chemical agent (Target: within 180 minutes of collection).
- Send environmental samples to a reference laboratory within the LRN when the incident requires biological or chemical characterization of an incident

scene (Target: within 60 minutes of collection).

- Send potentially contaminated food samples to a reference laboratory within the LRN or coordinate with Food Emergency Response Network (FERN), as appropriate, when the incident might involve food contaminated with a biological or chemical agent²⁴ (Target: within 60 minutes of collection).

CDC Preparedness Goal 4: Detect/Report

Improve the timeliness and accuracy of information regarding threats to the public's health as reported by clinicians and through electronic early event detection in real time to those who need to know.

Outcome 4A: Health Intelligence Integration and Analysis

To produce timely, accurate, and actionable health intelligence or information in support of prevention, awareness, deterrence, response, and continuity planning operations.

Required Critical Tasks: (1) Increase source and scope of health information.

(2) Increase speed of evaluating, integrating, analyzing for, and interpreting health data to detect aberrations in normal data patterns.

(3) Improve integration of existing health information systems, analysis, and distribution of information consistent with PHIN Preparedness Functional Area Early Event Detection, including those systems used for identification and tracking of zoonotic diseases.

(4) Improve effectiveness of health intelligence and surveillance activities²⁵.

(5) Improve reporting of suspicious symptoms, illnesses, or circumstances to the public health agency.

(a) Maintain a system for 24/7/365 reporting cases, suspect cases, or unusual events consistent with PHIN Preparedness Functional Area Early Event Detection.

²⁴ Abrin, Acids and bases, Aconites, actinomycin type protein synthesis inhibitors, Adamsite, Aflatoxin, amanitin toxin (*Amanita phalloides*), Anatoxin B, Any potent carcinogens or teratogens (*e.g.* benzo[a]pyrene, accutane), Arsenic compounds, Azides, Barium salts, Cancer chemotherapeutic agents, Carbamates, cardioactive glycosides, Colchicine, Copper and arseno-copper compounds, Corrosives (permanganate, chromate, etc), Cyanides, Cycloheximide, Digoxin, Dioxin, Ergot alkaloids, Ethylene glycol, Fluoroacetate salts, Hallucinogens (PCP, LSD, myristosin, others), Ipecac/emetine, Lead compounds, Mercury compounds, Methanol, Microcystins, Nicotine, Organochlorine pesticides, Organophosphate pesticides, Paraquat, Pentachlorophenol and dinitrophenols, Ricin, Rotenone, Sodium nitrite, Strychnine, Superwarfarins, Tetramine, Tetrodotoxin, Thallium salts.

²⁵ Updated Guidelines for Evaluating Public Health Surveillance Systems <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5013A1.htm>.

(6) Increase number of local sites using BioSense for early event detection.

Measures: (1) Percent of local public health agencies using BioSense or other integrated early event detection systems.

(2) Percent of desired non-traditional public health data sources that are currently part of early event detection system (e.g., HMO encounter data, over-the-counter pharmaceutical sales).

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.

Outcome 5A: Public Health Epidemiological Investigation

Potential exposure and disease will be identified rapidly, reported to multiple locations immediately, investigated promptly, and accurately confirmed to ensure appropriate preventive or curative countermeasures are implemented. Additionally, public health epidemiological investigation is coordinated with law enforcement and other appropriate agencies including tribal and federal agencies.

Required Critical Tasks:

(1) Increase the use of efficient surveillance and information systems to facilitate early detection and mitigation of disease.

(2) Conduct epidemiological investigations and surveys as surveillance reports warrant.

(3) Coordinate and direct public health surveillance and testing, immunizations, prophylaxis, isolation or quarantine for biological, chemical, nuclear, radiological, agricultural, and food threats.

(4) Have or have access to a system for an outbreak management system that captures data related to cases, contacts, investigation, exposures, relationships and other relevant parameters compliant with PHIN preparedness functional area Outbreak Management.

Measures: (1) Time to initiate epidemiologic investigation after initial detection of a deviation from normal disease/condition patterns or a positive "hit" from an early detection device (Target: 3 hours from initial detection).

(2) Time from initial detection of a deviation from normal disease/condition patterns, initial report, or positive "hit" from an early detection device to initiation of intervention (e.g., dissemination of protective action guidance, treatment)

CDC Preparedness Goal 6: Control

Decrease the time needed to provide countermeasures and health guidance to

those affected by threats to the public's health.

Outcome 6A: Emergency Response Communications

A continuous flow of critical information is maintained among emergency responders, command posts, agencies, and government officials for the duration of the emergency response operation.

Required Critical Tasks: (1) Decrease the time needed to communicate internal incident response information.

(a) Develop and maintain a system to collect, manage, and coordinate information about the event and response activities including assignment of tasks, resource allocation, status of task performance, and barriers to task completion.

(2) Establish and maintain response communications network.

(3) Implement communications interoperability plans and protocols.

(4) Ensure communications capability using a redundant system that does not rely on the same communications infrastructure as the primary system.

(5) Increase the number of public health experts to support Incident Command (IC) or Unified Command (UC).

(6) Increase the use of tools to provide telecommunication and information technology to support public health response.

(a) Ensure that the public health agency has "essential service" designation from their telephone provider and cellular telephone provider.²⁶

(b) Ensure that the public health agency has priority restoration designation from their telephone provider.

(7) Have or have access to a system for 24/7/365 notification/alerting of the public health emergency response system that can reach at least 90% of key stakeholders and is compliant with PHIN Preparedness Functional Area Partner Communications and Alerting.

Measures: (1) Percent of key stakeholders that are notified/alerted using the public health emergency communication system (Target: 90%).

(2) Time to obtain message approval and authorization for distribution of public health and medical information to clinicians and other responders (Target: 60 minutes from confirmation of health threat).

(3) Percent of key stakeholders that are notified/alerted when electricity,

telephones, cellular telephone service, and Internet service are unavailable.

(4) Percent of Level Three/Sentinel labs that can reach a designated contact at an LRN laboratory 24/7/365 by phone within 15 minutes OR radio/satellite phone within 5 minutes.

Outcome 6B: Emergency Public Information

The public is informed quickly and accurately, and updated consistently, about threats to their health, safety, and property and what protective measures they should take.

Required Critical Tasks: (1) Decrease time needed to provide specific incident information to the affected public, including populations with special needs such as non-English speaking persons, migrant workers, as well as those with disabilities, medical conditions, or other special health care needs, requiring attention.^{27 28}

(a) Advise public to be alert for clinical symptoms consistent with attack agent.

(b) Disseminate health and safety information to the public.

(c) Ensure that the Agency's public information line can simultaneously handle calls from at least 1% of the jurisdiction's population.

(2) Improve the coordination, management and dissemination of public information.

(3) Decrease the time and increase the coordination between responders in issuing messages to those that are experiencing psychosocial consequences to an event.

(4) Increase the frequency of emergency media briefings in conjunction with response partners via the jurisdiction's Joint Information Center (JIC), if applicable.

(5) Decrease time needed to issue public warnings, instructions, and information updates in conjunction with response partners.

(6) Decrease time needed to disseminate domestic and international travel advisories.

(7) Decrease the time needed to provide accurate and relevant public health and medical information to clinicians and other responders.

Measures: (1) Time to issue information to the public that emphatically acknowledges the event;

²⁷ CDC Crisis and Emergency Risk Communication Manual http://www.orau.gov/cdcynergy/erc/content/activeinformation/resources/CERC_course_materials.htm.

²⁸ Emergency Preparedness Initiative Guide on the Special Needs of People with Disabilities for Emergency Managers, Planners, and First Responders <http://www.nod.org/resources/pdfs/epiguide2005.pdf>.

²⁶ Government Emergency Telecommunications Service. Accessed March 8, 2005 <http://gets.ncs.gov/>.

explains and informs the public about risk; provides emergency courses of action; commits to continued communication (Target: 60 minutes from activation of the response plan).

Outcome 6C: Worker Health Safety

No further harm to any first responder, hospital staff member, or other relief provider due to preventable exposure to secondary trauma, chemical release, infectious disease, radiation, or physical and emotional stress after the initial event or during decontamination and event follow-up.

Required Critical Tasks: (1) Increase the availability of worker crisis counseling and mental health and substance abuse behavioral health support.

(2) Increase compliance with public health personnel health and safety requirements.

(a) Provide Personal Protection Equipment (PPE) based upon hazard analysis and risk assessment.

(b) Develop management guidelines and incident health and safety plans for public health responders (e.g.; heat stress, rest cycles, PPE).

(c) Provide technical advice on worker health and safety for IC and UC.

(3) Increase the number of public health responders that receive hazardous material training.

Measures: (1) Percent of public health responders that have been trained and cleared to use PPE appropriate for their response roles

Outcome 6D: Isolation and Quarantine

Successful separation, restriction of movement, and health monitoring of individuals and groups who are ill, exposed, or likely to be exposed, in order to stop the spread of a contagious disease outbreak. Legal authority for these measures is clearly defined and communicated to the public. Logistical support is provided to maintain measures until danger of contagion has elapsed.

Required Critical Tasks: (1) Assure legal authority to isolate and/or quarantine individuals, groups, facilities, animals and food products^{29 30 31 32}

(2) Coordinate quarantine activation and enforcement with public safety and law enforcement.

(3) Improve monitoring of adverse treatment reactions among those who have received medical countermeasures and have been isolated or quarantined.

(4) Coordinate public health and medical services among those who have been isolated or quarantined.

(5) Improve comprehensive stress management strategies, programs, and crisis response teams among those who have been isolated or quarantined.

(6) Direct and control public information releases about those who have been isolated or quarantined.

(7) Decrease time needed to disseminate health and safety information to the public regarding risk and protective actions.

(8) Have or have access to a system to collect, manage, and coordinate information about isolation and quarantine, compliant with PHIN Preparedness Functional Area Countermeasure and Response Administration.

Measures: (1) Percentage of isolation orders that are violated.

(2) Percentage of quarantine orders that are violated.

Outcome 6E: Mass Prophylaxis and Vaccination

Appropriate prophylaxis and vaccination strategies are implemented in a timely manner upon the onset of an event, with an emphasis on the prevention, treatment, and containment of the disease. Prophylaxis and vaccination campaigns are integrated with corresponding public information strategies.

Required Critical Tasks: (1) Decrease the time needed to dispense mass therapeutics and/or vaccines.

(a) Implement local, (tribal, where appropriate), regional and State prophylaxis protocols and plans.

(b) Achieve and maintain the Strategic National Stockpile (SNS) preparedness functions described in the current version of the Strategic National Stockpile guide for planners.

(c) Ensure that smallpox vaccination can be administered to all known or

suspected contacts of cases within 3 days and, if indicated, to the entire jurisdiction within 10 days.³³

(d) Have or have access to a system to collect, manage, and coordinate information about the administration of countermeasures, including isolation and quarantine, compliant with PHIN Preparedness Functional Area Countermeasure and Response Administration.

(2) Decrease time to provide prophylactic protection and/or immunizations to all responders, including non-governmental personnel supporting relief efforts.

(3) Decrease the time needed to release information to the public regarding dispensing of medical countermeasures via the jurisdiction's JIC (if JIC activation is needed).

Measures: (1) Current rating on the SNS (or CRI for participating cities) preparedness functions based on the CDC SNS assessment tool.

(2) Time to provide prophylactic protection and/or immunizations to all responders, including non-governmental personnel supporting relief efforts.

Outcome 6F: Medical and Public Health Surge

Cases are investigated by public health to reasonably minimize morbidity and mortality rates, even when the numbers of casualties exceed the limits of the normal medical infrastructure for an affected community.

Required Critical Tasks: (1) Improve tracking of cases, exposures, adverse events, and patient disposition.

(a) Have or have access to a system that provides these capabilities consistent with PHIN Preparedness Functional Area Outbreak Management.

(2) Decrease the time needed to execute medical and public health mutual aid agreements.

(3) Improve coordination public health and medical services.

(a) Ensure epidemiology response capacity consistent with hospital preparedness guidelines for surge capacity.

(b) Participate in the development of plans, procedures, and protocols to identify and manage local, tribal, and regional public health and hospital surge capacity.

(4) Increase the proficiency of volunteers and staff performing collateral duties in performing epidemiology investigation and mass prophylaxis support tasks.

²⁹ The Model State Emergency Health Powers Act. The Center for Law and the Public's Health at Georgetown and Johns Hopkins Universities. December 21, 2001. <http://www.publichealthlaw.net/MSEHPA/MSEHPA2.pdf>.

³⁰ Public Health Emergency Legal Preparedness Checklist: Interjurisdictional Legal Coordination for Public Health Emergency Preparedness. The Center for Law and the Public's Health at Georgetown and Johns Hopkins Universities. December 2004. <http://www.publichealthlaw.net/Resources/ResourcesPDFs/Checklist%201.pdf>.

³¹ Public Health Emergency Legal Preparedness Checklist: Local Government Public Health

Emergency Legal Preparedness and Response. The Center for Law and the Public's Health at Georgetown and Johns Hopkins Universities. December 2004. Accessed January 14, 2005. <http://www.publichealthlaw.net/Resources/ResourcesPDFs/Checklist%202.pdf>.

³² Public Health Emergency Legal Preparedness Checklist: Civil Legal Liability and Public Health Emergencies. The Center for Law and the Public's Health at Georgetown and Johns Hopkins Universities. December 2004. Accessed January 14, 2005. <http://www.publichealthlaw.net/Resources/ResourcesPDFs/Checklist%203.pdf>.

³³ Smallpox Response Planning <http://www.bt.cdc.gov/agent/smallpox/response-plan/index.asp>.

(5) Increase the number of physicians and other providers with experience and/or skills in the diagnosis and treatment of infectious, chemical, or radiological diseases or conditions possibly resulting from a terrorism-associated event who may serve as consultants during a public health emergency.

Measures: (1) Percent of volunteers needed to support epidemiologic investigation that have been trained.

(2) Percent of volunteers needed to support mass prophylaxis that have been trained.

CDC Preparedness Goal 7: Recover

Decrease the time needed to restore health services and environmental safety to pre-event levels.

Outcome 7A: Economic and Community Recovery

Recovery and relief plans are implemented and coordinated with the nonprofit sector and nongovernmental relief organizations and with all levels of government. Economic impact is estimated. Priorities are set for recovery activities. Business disruption is minimized. Individuals and families are provided with appropriate levels and types of relief with minimal delay.

Required Critical Tasks: (1) Conduct post-event planning and operations to restore general public health services.

(2) Decrease the time needed to issue interim guidance on risk and protective actions by monitoring air, water, food, and soil quality, vector control, and environmental decontamination, in conjunction with response partners.

Measures: (1) Time needed to issue interim guidance on risk and protective actions during recovery.

CDC Preparedness Goal 8: Recover

Increase the long-term follow-up provided to those affected by threats to the public's health.

Required Critical Tasks: (1) Develop and coordinate plans for long-term tracking of those affected by the event.

(2) Improve systems to track cases, exposures, and adverse event reports.

(3) Increase the availability of information resources and messages to foster community's return to self-sufficiency.

Measures: (1) Percent of cases and exposed successfully tracked from identification through disposition to enable short- and long-term follow-up.

CDC Preparedness Goal 9: Improve

Decrease the time needed to implement recommendations from after-action reports following threats to the public's health.

Required Critical Tasks: (1) Exercise plans to test horizontal and vertical integration with response partners at the federal, State, tribal, and local level.

(2) Decrease the time needed to identify deficiencies in personnel, training, equipment, and organizational structure, for areas requiring corrective actions.

(3) Decrease the time needed to implement corrective actions.

(4) Decrease the time needed to re-test areas requiring corrective action.

Measures: (1) Time needed to identify deficiencies in personnel, training, equipment, and organizational structure, for areas requiring corrective actions (Target: 72 hours after a real event or exercise).

(2) Time needed to implement corrective actions and integrate changes into plans (Target: 60 days after identification of deficiency).

(3) Time needed to re-test areas requiring corrective action (Target: 90 days after identification of deficiency).

International Cross-Border Early Warning Infectious Disease Surveillance (EWIDS) Project (Selected awardees): As in the previous two years, the Office of Public Health Emergency Preparedness within the Office of the Secretary (HHS) is continuing to provide funds for early detection, identification, reporting and investigation of infectious disease outbreaks (both bioterrorist-triggered and naturally occurring) at our borders with Canada and Mexico.

This year, in recognition of the fact that States sharing a common border with a neighboring Canadian province or a Mexican State have some natural affinities and common challenges with respect to planning and implementing cross-border surveillance and epidemiological activities, the Early Warning Infectious Disease Surveillance (EWIDS) program is offering the opportunity for any two or more neighboring States to submit a joint proposal. This approach, which is strictly voluntary, may be most appealing to States that have already undertaken joint planning activities either because they share a common border with a Canadian province or Mexican State or because they wish to leverage their capabilities and resources as well as EWIDS funding. Although EWIDS funds would still be allocated on a State-by-State basis, this approach will capitalize on the synergies created by activities that a number of Border States have initiated.

States interested in this opportunity must jointly develop a common EWIDS proposal that would be broader in scope than what each State could submit on its own. Within the proposal, each of

the participating States must clearly identify the specific activities for which it would be individually responsible and accountable. For example, a coalition of four States could each submit the same proposal that they had jointly prepared. In this common proposal, each State would clearly identify a set of activities for which it would assume lead responsibility. There would be minimal duplication of effort among the States and, as a result of the synergy and resource leveraging, all four States would be able to benefit from each other's efforts. States that wish to take advantage of this opportunity must each submit a copy of the common proposal that was jointly developed. However, each State should submit its own budget reflecting not only the specific activities for which it would be responsible but also the amount of its EWIDS funds.

In accordance with their authorizing legislation, EWIDS funds are intended strictly for the support of surveillance and epidemiology-related activities to address bioterrorism and other outbreaks of infectious diseases. EWIDS funds are not to be used to support non-infectious 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. Moreover, EWIDS funds cannot be used to supplant surveillance and/or epidemiological activities already supported by other funding sources. Proposed EWIDS activities must be consistent with the laws and regulations of the United States and in harmony with existing binational agreements and guidelines.

The EWIDS guidance can be found in Appendix 2. In substance, this guidance is consistent with the guidance issued last year. However, the structure has been modified to conform to the format that has been established for the broader CDC public health emergency preparedness cooperative agreement. The DSLR MIS template provides space for responses to the EWIDS guidance for eligible applicants. These activities will be updated in the MIS as part of regular progress reports.

Collaboration across State, Tribal, Military, and International Borders: Applicants may use cooperative agreement funds to conduct necessary activities in support of cross jurisdictional planning, coordination, communications, program development, and exercises to enhance health security in the United States. In a jurisdiction that shares State, tribal, military installation or international borders, the

public health agency may use cooperative funds to jointly participate in disaster planning meetings (e.g., city-State-tribal collaboration or city-State-province/State collaboration, etc.); exchange health alert messages; exchange epidemiological data; provide mutual aid; conduct collaborative drills, exercises, and evaluate disaster scenarios. Applicants may propose relevant activities related to meeting the goals, outcomes, tasks or measures as listed above. Proposed activities must be consistent with national laws and regulations of the United States and in harmony with any pre-existing agreements and guidelines.

CDC Responsibilities: In a cooperative agreement, CDC staff is substantially involved in the program activities, above and beyond routine grant monitoring.

CDC Activities for this program are as follows:

- Technical Assistance
- Integration/Coordination of federal funding for preparedness.
- Subject matter expertise on preparedness activities (e.g., laboratory testing, epidemiology and surveillance).
- Identification of promising practices.
- Development of performance goals and standards.
- Guidance on, and in some cases, conduct, of drills and exercises.
 - Monitoring of performance.
 - Monitoring adherence to all relevant PHS, HHS, CDC rules, regulations and policies regarding cooperative agreements.
 - Facilitate tribal, military, international, DHS and other federal agency efforts into national public health preparedness efforts and coordinate the public health preparedness responsibilities of the NRP where CDC is the designated lead agency.

II. Award Information

Type of Award: Cooperative Agreement. CDC involvement in this program is listed in the Activities Section above.

Approximate Total Funding: Approximately \$862 million of fiscal year (FY) 2005 funds are available to fund budget year one of this agreement (August 31, 2005–August 30, 2006) as follows:

\$809,956,000: Base funds available for all awardees.

\$40,181,000: Urban Area focused funding (to include maintenance of CRI activities in previous 21 awardees) as described in Appendix 3.

\$5,440,000: Early Warning Infectious Disease Surveillance (EWIDS) funds available to select awardees (see Appendix 2).

\$7,200,000: Chemical Laboratories funds available to select awardees (see Appendix 1).

Each State awardee and Puerto Rico will receive a base amount of \$3.91 million, plus an amount equal to its proportional share of the national population as reflected in the U.S. Census estimates for July 1, 2003. The District of Columbia will receive a base amount of \$10 million and New York City, Los Angeles County, and Chicago will continue to receive a base amount of \$5 million. Due to their demographic characteristics and unique programmatic needs, American Samoa, the U.S. Virgin Islands, Guam, the Northern Mariana Islands, the Marshall Islands, the Federated States of Micronesia and Palau will receive \$391,000 per awardee plus a population-based allocation.

In addition to the base amount, approximately \$7,200,000 is available for Level One chemical laboratory capacity. Only Level One chemical laboratory activities may be supported with these funds. Level Two and Level Three activities should be supported by base funding.

CDC may increase the number of Level One chemical laboratories from 5 to 10 over the next five years. *However, for budget year one, applicants may only apply for Level One status using their existing funds.* Applicants who wish to apply for Level One funding must have: (a) Completed all current Level Two trainings (b) successfully completed method evaluation (c) successfully completed at least one proficiency test for each method, and (d) be in “qualified” status. New applicants for Level One chemical laboratory capacity should refer to Appendix 1.

Beginning in FY06, CDC envisions that allocation of funds among eligible entities and among preparedness priorities will be influenced increasingly by considerations of (1) the risks and likely medical consequences of various forms of terrorism and other public health emergencies when stratified across States and localities, (2) awardees’ performance in enhancing public health and healthcare emergency preparedness, and (3) the relative merits of applicants’ proposed initiatives toward selected preparedness priorities as determined by national competition.

Grantees that fail to comply with the terms and conditions of this cooperative agreement, including responsiveness to program guidance, measured progress in

meeting the performance measures, and adequate stewardship of these federal funds, may be subject to an administrative enforcement action. Administrative enforcement actions may include temporarily withholding cash payments or restricting a grantee’s ability to draw down funds from the Payment Management System until the grantee has taken corrective action.

In circumstances where the grantee is unwilling or unable to take corrective action, and in other appropriate circumstances, CDC may withhold (deny) a continuation award and require that the grantee repay any disallowed costs to the federal government from non-federal funds.

In all instances, grantees are reminded that continuation of funding under this cooperative agreement is additionally contingent upon continued availability of funds.

Anticipated Award Date: August 31, 2005.

Budget Period Length: 12 months (August 31, 2005–August 30, 2006).

Project Period Length: Year one of a five year project period.

Throughout the project period, CDC’s commitment to continuation of awards will be conditioned on the availability of funds, evidence of satisfactory progress by the recipient (as documented in required reports), and the determination that continued funding is in the best interest of the Federal Government.

III. Eligibility Information

Eligible Applicants

Eligibility is limited to those currently funded through cooperative agreement 99051 and authorized under 42 U.S.C. 247d–3.

Cost Sharing or Matching

Matching funds are not required for this program.

IV. Application and Submission Information

IV.1. Electronic Applications Via the DSLR MIS System Are Due on July 13, 2005 11:59 PM EST

See below for more details on accessing and submitting via the DSLR MIS system.

IV.2. Content and Form of Submission

CDC will provide an Internet-based system for submitting applications, including narrative and budget, electronically. This system will also enable applicants to complete most required forms electronically, which can then be signed and uploaded into the system. Applicants are required to use

this system in lieu of paper-based applications. Under separate cover, CDC will provide detailed instructions on obtaining a digital certificate to access the CDC Web portal <https://sdn.cdc.gov> and use the electronic application system. Any questions or problems concerning use of the Internet-based application should be directed to your project officer.

Cooperative Agreement Forms

- All forms will be available from the Secure Data Network (<https://sdn.cdc.gov>). In addition, Form PHS 5161-1 is available from the CDC Procurement and Grants office at the following Internet address: <http://www.cdc.gov/od/pgo/forminfo.htm>.

- Application budget preparation guidance is also available at: <http://www.cdc.gov/od/pgo/funding/budgetguide2004.htm>.

- Forms SF-424 (Cover page) and SF-424B (Assurances) are available from the DSLR MIS application site and the Office of Management and Budget: http://www.whitehouse.gov/omb/grants/grants_forms.html.

- Form SF-424A (Budget Information) will be generated and pre-populated automatically from the DSLR MIS budget application site. A blank form SF-424A can also be obtained at the following Internet address: <http://www.whitehouse.gov/omb/grants/grantsforms.html>.

Applications must include a projection of the amount of FY2004 funds that will be unobligated at the end of budget period five (*i.e.*, on August 30, 2005) and report this estimate for each focus area on a separate interim FSR form. (See Unobligated Funds, under C. Availability of Funds.)

International Cross-Border Early Warning Infectious Disease Surveillance Initiatives (Selected awardees): The DSLR MIS template provides space for responses to the International Cross-Border Early Warning Infectious Disease Surveillance (EWIDS) initiatives for eligible applicants. These cross-border issues reflect the broader Departmental goals for cross-border public health security and focus on surveillance of infectious disease outbreaks (both bioterrorist-triggered and naturally occurring) at our borders with Canada and Mexico. These activities will be updated in the MIS as part of regular progress reports.

IV.3. Submission

To submit the narrative and budget sections of the application electronically, follow the online instructions. The MIS will notify CDC that the application is ready for review

and prevent any further changes to the application by the applicant, pending any recommendations from the project officer. The electronic submission process must be completed by the application deadline (11:59 p.m. July 13, 2005 e.s.t.).

Dun and Bradstreet Data Universal Numbering System

You are required to have a Dun and Bradstreet Data Universal Numbering System (DUNS) number to apply for a grant or cooperative agreement from the Federal government. The DUNS number is a nine-digit identification number, which uniquely identifies business entities. Obtaining a DUNS number is easy and there is no charge. To obtain a DUNS number, access <http://www.dunandbradstreet.com> or call 1-866-705-5711.

For more information, see the CDC Web site at: <http://www.cdc.gov/od/pgo/funding/pubcommnt.htm>.

If your application form does not have a DUNS number field, please write your DUNS number at the top of the first page of your application, and/or include your DUNS number in your application cover letter.

Additional requirements that may require you to submit additional documentation with your application are listed in section "VI.2. Administrative and National Policy Requirements."

IV.4. Intergovernmental Review of Applications

Your application is subject to Intergovernmental Review of Federal Programs, as governed by Executive Order (EO) 12372. This order sets up a system for State and local governmental review of proposed federal assistance applications. You should contact your State single point of contact (SPOC) as early as possible to alert the SPOC to prospective applications, and to receive instructions on your State's process. Click on the following link to get the current SPOC list: <http://www.whitehouse.gov/omb/grants/spoc.html>.

IV.5. Funding Restrictions

Restrictions, which must be taken into account while writing your budget, are as follows:

- Funds may not be used for research
- Reimbursement of pre-award costs is not allowed

Use of Funds: Budget year one will begin on August 31, 2005 and extend through August 30, 2006. However, monies may be re-directed between/ among goals during the year under the following conditions: (1) Awardees

must notify the CDC Grants Office, and (2) copy their CDC Project Officer for all funding re-directions. Prior approval is required for all funding re-directions for sums greater than 25% of the total budget for BY1, or \$250,000 (whichever is less).

Vehicles: Cooperative agreement funds under this program may not be used to purchase vehicles or supplant any current State or local expenditures.

Supplantation: The Public Health Service Act, Title I, Section 319(c) specifically States: "SUPPLEMENT NOT SUPPLANT.—Funds appropriated under this section shall be used to supplement and not supplant other Federal, State, and local public funds provided for activities under this section." Therefore, the law strictly and expressly prohibits supplantation.

Unobligated Funds: Please submit interim Financial Status Reports (FSRs) estimating the unobligated balance of funds as of August 30, 2005 with the application. Please provide a summary and individual Focus Area FSRs with your application. Send the FSRs to CDC's Procurement and Grants Office (PGO). Estimated unobligated funds should also be reported in Section A—Budget Summary of Standard Form (SF) 424A.

Direct Assistance

Direct Assistance is a financial assistance mechanism, authorized by statute, where by goods or services are provided to recipients in lieu of cash. Direct assistance generally involves the assignment of Federal personnel, the provision of equipment, or the use of federally negotiated contracts. Applicants must discuss all requests for direct assistance with the Division of State and Local Readiness project officer prior to submitting an application.

Funding awarded through direct assistance is part of the total award, not an addition to the award. Direct assistance funds MUST be used in the Federal Fiscal Year (FY) in which they are appropriated. Personnel funded through direct assistance may be split between two federal fiscal years. For example, a career epidemiology field officer hired through direct assistance may be funded from August 31-September 30, 2005, with FY05 funding provided with this award and from October 1-August 30, 2006, with FY06 funding.

Requests for equipment to be purchased through direct assistance:

Direct Assistance (Contracts and Task Orders)

a. To obligate Direct Assistance funds in an amount of less than \$100,000,

each applicant must submit a Performance-based Statement of Work for each contract or task order supported by Direct Assistance Funding.

b. To obligate Direct Assistance funds in an amount greater than \$100,000, but less than \$500,000, each applicant must submit the following items for each contract or task order supported by Direct Assistance funding:

- Performance-based Statement of Work: The Division of State and Local Readiness maintains a variety of Statement of work templates available to any applicant upon request. Although performance-based Statements of work are tailored to the specifics of each project, it should contain these common elements:

- Background—general, non-technical terms and explains why the acquisition is required; its relationship to past, current, or future projects; summary of statutory and applicable program authorities and regulations;

- Project Objective—a succinct Statement of the purpose of the acquisition; outlining expected results; and anticipated benefits.

- Scope of Work—an overall, non-technical description of the work to be performed; expands upon project objectives, while avoiding going into all of the details required. Identifies and summarizes various phases of the projects; define limits in terms of specific objectives, time, special provisions, or limitations. The Scope of Work must be consistent with the detailed requirements.

- Detailed Technical Requirements—Clearly and precisely describe the work in terms of what is to be the required output rather than either how the work will be accomplished or the number of hours to be provided. Provide requirements that do not limit a contractor to providing a specific product or service, rather the contractor is provided with the objectives to be accomplished, the end goal, or the desired achievement, including all pertinent information needed for a contractor or vendor to submit a proposal. As the contractor is, being hired based upon their expertise and ability to perform, the performance-oriented requirements Statement of work places maximum responsibility for performance on the contractor. Identify any budgetary, environmental, or other constraints. Clearly and firmly define and the criteria for acceptance for all end supplies or deliverables associated with the contract.

- Reporting Schedule—Specify how the contractor shows that it has fulfilled

its obligations. Clearly identify the performance-based criteria to be used by the Government for acceptance. Define the mechanism by which the contractor can demonstrate progress and compliance with the requirements, and present any problems it may have encountered. The preparation and submission of technical and financial progress reports on a timely basis reflect on a contractor's efforts to certify satisfactory progress. Specific requirements to submit periodic financial and technical progress reports, to include format and templates will be provided by the Division of State and Local Readiness.

- Special Consideration—Include all and any information that does not fit into one of the other sections of the Statement of work.

- References—Provide a detailed list and description of any studies, reports, and other data referred to elsewhere in the Statement of work.

- Independent Government Cost Estimate: The independent government cost estimate is the government's estimate of the costs associated with a particular contract project. The cost estimate determines the amount of money that should be set aside for funding the project and the cost estimate serves as a standard to which the offeror's costs or price proposals will be compared when the offeror's proposal is evaluated. The cost estimate includes direct costs (*i.e.*, labor, material, travel, per diem, printing, consultants, etc.) and indirect costs (*i.e.*, fringe benefits, overhead, and general and administrative expense rates). For this is the government's assessment of the probable cost of the supplies or services to be acquired and serves as a basis for determining the reasonableness of an offeror's proposed costs and understanding of the Statement of work. The cooperative agreement applicant may request assistance in developing a cost estimate from their project officer in the Division of State and Local Readiness.

- Quality Assurance Surveillance Plans: These plans must recognize the responsibility of the contractor to carry out its quality control obligations and must contain measurable inspections and acceptance criteria corresponding to the performance standards contained in the original performance-based Statement of work. This plan must focus on the level of performance required by the performance-based Statement of work, rather than the methodology used by the contractor to achieve that level of

performance. The plan may also include:

- Technical progress and financial status reports (already a requirement for all direct assistance projects);
- Site visits to evaluate contract performance against scheduled or reported performance;
- Review of invoices and vouchers to assess reasonableness of costs claimed and relate the total expenditures to the physical progress of the contract, based on monitoring activities (*i.e.*, site visits, progress reports, etc.)

1. Please submit the following documents, electronically, to Gregory Lanman in the Division of State and Local Readiness at GHL2@cdc.gov:

a. Contract/Task Order less than \$100,000: Submit a performance-based Statement of work as described and outlined in this document.

b. Contract/Task Order greater than \$100,000, but less than \$500,000: Submit a performance-based Statement of work; independent cost estimate; and quality assurance surveillance plan as described and outlined in this document.

c. If you are considering a contract or task order in an amount larger than \$500,000; please contact Gregory Lanman in the Division of State and Local Readiness at (404) 639-7127 as soon as possible.

2. Upon receipt of each contract/task order package, the Division of State and Local Readiness will obtain proposals and quotes for the requested services, supplies, or equipment through federal contract vehicles. The grantee will receive the proposals for review and selection according to their technical evaluation factors. Contract/task order awards will be based upon your evaluation criteria and selection decision.

3. The Division of State and Local Readiness will obligate all Direct Assistance funding and will assume an active partnership as part of your Quality Assurance Surveillance Plan. This partnership will include oversight of the contract/task order, monitoring contract/task order expenditures and funding balances, and by coordinated site visits by the Project Officers of the Division of State and Local Readiness.

4. For additional information or if you have any questions, please contact Gregory Lanman in the Division of State and Local Readiness at (404) 639-7127 or by e-mail at GHL2@cdc.gov.

Direct Assistance (Equipment): CDC will provide a list of equipment that may be purchased through direct assistance. Generally, direct assistance equipment purchases are limited to the purchase of laboratory equipment.

Direct Assistance (Personnel): In fiscal year 2005, CDC personnel will be available to provide on-site assistance to State, territorial and local public health agencies in the form of Direct Assistance awards. Placement of these Direct Assistance personnel will be based on the needs of host agencies in a variety of public health disciplines, including public health management, laboratory science, epidemiology, health communications, and environmental health. Direct Assistance personnel assigned through this cooperative agreement will receive training in critical aspects of public health preparedness and emergency response to prepare them to respond to local, State, regional and national public health emergencies.

Deployment of Direct Assistance personnel associated with this cooperative agreement, including specific positions in the Career Epidemiology Field Officers (operated by the National Center for Health Marketing), will be coordinated with the Field Services Activity in the CDC Portfolio Management Project.

Requests for new Public Health Readiness Field Program assignees during this budget period should be discussed with the grantee's project officer *prior to* including them in the budget and budget justification sections of your annual funding application. Direct Assistance Personnel costs will be based on published pay and allowances/reimbursement rates established by the Office of Personnel Management. The value of personnel for the budget period will be deducted from the amount of financial assistance that would otherwise be made available to the recipient under the applicable allocation, formula, or other determination of award amount but will be deemed to be part of the award and to have been paid to the recipient.

Public Health Readiness Field Program personnel detailed to a recipient remain Federal employees and are subject to increases, adjustments, and any other benefits that would otherwise apply. Provision for changed costs will be negotiated with the recipient in advance as this may change the amount of financial assistance provided. Recipients will be instructed as to the process and timing for submitting travel authorizations and claims for reimbursement as well as other requests to incur costs or be reimbursed for costs related to personnel details. Recipients shall maintain documentation of payments for in-State and local travel costs and other payments on behalf of detailees as grant-related records. These records are

subject to review and audit by or on behalf of CDC.

Direct Assistance Personnel assigned through the Public Health Readiness Field Program are subject to the provisions of the existing Agreement to Detail that defines the respective responsibilities of CDC and recipients regarding Direct Assistance assignments of CDC personnel. CDC will review this agreement with recipient officials upon execution of the detail.

Recipients interested in the Direct Assistance staffing option, should contact their Division of State and Local Readiness project officer to discuss specific staffing needs and how to reflect the request for Direct Assistance personnel in your application. Be prepared to discuss the specific duties and responsibilities proposed for the Direct Assistance assignee and where the assignee would work in your organizational structure.

V. Application Review Information

V.1. Evaluation Criteria

Applications will be reviewed for technical acceptability by project officers from the Coordinating Center of Terrorism Preparedness and Emergency Response and subject matter experts through out CDC. Technical reviewers will be assessing the applications to determine:

- The applicant's current capability to perform the outcomes and critical tasks.
- That the operational plan clearly and adequately addresses the goals, outcomes, tasks, and measures.
- The extent to which the applicant clearly defines an evaluation plan that leads to continuous quality improvement of public health emergency response.
- The extent to which the applicant presents a detailed budget with a line item justification and any other information to demonstrate that the request for assistance is consistent with the purpose and objectives of the cooperative agreement.
- Where applicable, the extent to which the applicant presents an operational plan for funds for early detection, reporting and investigation of infectious disease outbreaks (both bioterrorist-triggered and naturally occurring) at our borders with Canada and Mexico.

V.2. Criteria for Level One Chemical Laboratory Capacity

New (competitive) applications for Level One chemical laboratory capacity will be evaluated according to the following criteria:

1. Description of the jurisdiction covered (10 points): the extent to which the application clearly identifies the jurisdiction(s) covered by the proposed activities.

2. Capacity (30 points): the extent to which the applicant demonstrates experience in measurements using mass spectrometry, general experience with a bench-top mass spectrometer, and experience using tandem mass spectrometry for analysis of environmental and biological samples.

3. Operational Plan (40 points): (a) The extent to which the applicant's operational plan clearly and adequately addresses all recipient activities (see Appendix 1) (b) the extent to which laboratory space plans meet or exceed the minimum requirements (c) the extent to which applicant clearly describes past experiences in application content (d) the extent to which applicant clearly describes plans for hiring or designating appropriately qualified staff.

4. Coordination (10 points): the extent to which the applicant demonstrates that the proposed activities will be coordinated with relevant activities currently underway in the applicant's jurisdiction or proposed under other sections of the cooperative agreement program. The extent to which the applicant clearly demonstrates how these activities will be coordinated within the jurisdiction (e.g., at the State level, between State and local agencies, between local agencies, with MMRS if present, and as appropriate, with other States).

5. Support (10 points): inclusion of a letter of support from the State administration agreeing to provide CDC with surge capacity in cases of emergencies. This letter should also show commitment by the State to develop this capacity in their State public health laboratory and allow their State employees to be part of the CDC response.

6. Budget (not scored): the extent to which the applicant presents a detailed budget with a line item justification and any other information to demonstrate that the request for assistance is consistent with the purpose and objectives of the cooperative agreement.

V.3. Review and Selection Process

Applications will be reviewed for completeness by the Procurement and Grants Office (PGO) staff, and for technical acceptability by the Coordinating Office of Terrorism Preparedness and Emergency Response and CDC subject matter experts. Incomplete applications and applications that are non-responsive to

the eligibility criteria will not advance through the review process. Applicants will be notified that their application did not meet submission requirements.

New applications for Level One chemical laboratory capacity will be evaluated by an objective review panel using the criteria listed in the "V.1. Criteria" section above. In addition, these applications will also be reviewed by senior federal staff taking into account the results of the independent review, program needs and relevance to national goals, geographic location, and budgetary considerations.

VI. Award Administration Information

VI.1. Award Notices

Successful applicants will receive a Notice of Grant Award (NGA) from the CDC Procurement and Grants Office. The NGA shall be the only binding, authorizing document between the recipient and CDC. The NGA will be signed by an authorized Grants Management Officer, and mailed to the recipient fiscal officer identified in the application.

Unsuccessful applicants will receive notification of the results of the application review by mail.

VI.2. Administrative and National Policy Requirements

45 CFR Part 74 and Part 92

For more information on the Code of Federal Regulations, see the National Archives and Records Administration at the following Internet address: <http://www.access.gpo.gov/nara/cfr/cfr-table-search.html>

The following additional requirements apply to this project:

- AR-7 Executive Order 12372
- AR-9 Paperwork Reduction Act Requirements
- AR-10 Smoke-Free Workplace Requirements
- AR-11 Healthy People 2010
- AR-12 Lobbying Restrictions
- AR-16 Security Clearance Requirement
- AR-21 Small, Minority, and Women-Owned Business
- AR-24 Health Insurance Portability and Accountability Act Requirements
- AR-25 Release and Sharing of Data

Additional information on these requirements can be found on the CDC Web site at the following Internet address: <http://www.cdc.gov/od/pgo/funding/ARs.htm>.

VI.3. Technical Reporting Requirements

Quarterly Progress Reports for Budget Period One—Progress reports for

activities undertaken in budget period, as well as special topics related to the goals and objectives, are due on January 15, 2006 (for activities undertaken August 31–November 30, 2005), April 15, 2006 (for activities undertaken December 1, 2005–February 28, 2006), and July 15, 2006 (for activities undertaken March 1–May 30, 2006). These reports must be submitted through the DSLR MIS. CDC will provide templates for these reports to assess program outcomes related to activities undertaken in BY 01. In addition, awardees may be required to submit information upon request based on changing threat status or national security priorities.

Financial Status Reports—A mid-year estimated financial status report is due May 30, 2006, for the period August 31, 2005–February 28, 2006. The final Financial Status Report (FSR) is due 90 days after the end of the budget period, ending on August 30, 2006. The due date for the FSR is November 30, 2006. Estimated FSRs (through August 30, 2005) are requested with your continuation application (See Unobligated Funds on page 3).

Final Reports—This cooperative agreement will end on August 30, 2006. An original and two copies of the final FSR will be due to the Grants Management Officer named below by November 30, 2006. Final project reports (for activities from June 1–August 30, 2006) should be submitted through the DSLR MIS by November 30, 2006.

Please submit the hard copy of your financial status reports to: Rebecca B. O'Kelley, Acting Chief, Attn: Sharon Robertson, Acquisition and Assistance, Branch VI, Procurement and Grants Office, Centers for Disease Control and Prevention, 2920 Brandywine Road, MS K-75, Atlanta, GA 30341-4146. Telephone: 770-488-2748. E-mail address: sqr2@cdc.gov.

Please copy your Project Officer on any electronic submissions.

VII. Agency Contacts

We encourage inquiries concerning this announcement. Programmatic technical assistance for this request may be obtained from your Project Officer.

For general questions, contact:

Sharon Robertson, Grants Management Specialist—Regions 1, 2, 3, 4, 10, Acquisition and Assistance Branch VI, Procurement and Grants Office, Centers for Disease Control and Prevention (CDC), 2920 Brandywine Road, Atlanta, Georgia 30341-4146. Telephone: 770-488-2748. E-mail address: sqr2@cdc.gov.

Angela Webb, Grants Management Specialist—Regions 5, 6, 7, 8, 9, Acquisition and Assistance Branch VI, Procurement and Grants Office, Centers for Disease Control and Prevention (CDC), 2920 Brandywine Road, Atlanta, Georgia 30341-4146. Telephone: 770-488-2784. E-mail address: aqw6@cdc.gov.

VIII. Other Information

Attachments will be available from the Secure Data Network (<https://sdn.cdc.gov>).

Appendix 1: Requirements for Level One and Level Two Chemical Laboratories.

Appendix 2: Early Warning Infectious Disease Surveillance (EWIDS) Guidance.

Appendix 3: Cities Readiness Initiative (CRI) Guidance.

Appendix 4: DRAFT Measurement Descriptions and Methods of Data Collection.

Appendix 5: Funding Table.

Dated: May 20, 2005.

William P. Nichols,

Director, Procurement and Grants Office,
Centers for Disease Control and Prevention.
[FR Doc. 05-10537 Filed 5-25-05; 8:45 am]

BILLING CODE 4163-18-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention (CDC)

National Center on Birth Defects and Developmental Disabilities

Name: National Workshop on Mild and Unilateral Hearing Loss.

Times and Dates: 1 p.m.–5 p.m., July 26, 2005. 8:30 a.m.–5 p.m., July 27, 2005.

Place: Beaver Run Resort and Conference Center, 620 Village Road, P.O. Box 2115, Breckenridge, CO 80424, Telephone: (970) 453-6000.

Status: Open to the public, limited only by the space available.

Purpose: The meeting will review and evaluate the scientific research and other data related to mild and unilateral HL to establish recommendations related to identification and appropriate intervention(s) for infants/children. In addition, the meeting will identify potential areas for future research related to mild and unilateral HL.

Matters to be Discussed: The agenda will include a review of the published and unpublished literature assessing the identification and outcomes of infants/children with mild and unilateral HL; a review of screening procedures; diagnostic protocols; follow-up practice;