Public Health Emergency Preparedness Cooperative Agreement

Follow-Up Questions and Answers: Second Set

General Questions

Q: Is CDC holding weekly telephone conferences and if so when?
A: There will be an ASTHO-sponsored call for PHEP grantees on Wednesday, June 14th at 3 PM. On Wednesday, June 21 at 3 PM, DSLR will have its regularly scheduled monthly call with the grantees.

Q: The Directly Funded Cities need clarification on MSA requirements in relation to the Performance Metrics.
A: The major metropolitan areas participating in CRI are also required to report, through the appropriate local/district public health agencies, on performance measures. Where directly funded cities are involved, CDC has no preference on whether the State or the city reports on the local/district public health agencies within the MSA. States and cities should work together to determine who should report on the local public health agencies within the MSA and jointly inform CDC of their decision. If assistance is needed to facilitate these discussions, please inform your project officer.

Q: Please clarify what the following means (from page 6): "States are likewise encouraged to examine how they are integrating preparedness activities across disciplines. In FY 2006, states must implement a cohesive planning framework that builds and implements homeland security initiatives—to include public health and medical efforts specifically—that leverage all federal (e.g., DHS, HHS) resources and resources from other sources (e.g., local governments, foundations). The Senior Advisory Committee (see Additional Requirements, 1) should serve as a key resource in integration of preparedness activities and funding sources."
A: States are receiving funding from several federal sources for preparedness activities, much of which comes through the Department of Homeland Security. States are encouraged to leverage all of the preparedness funding in the jurisdiction to ensure a comprehensive approach across all sectors—all levels and sectors of government, private corporations, not-for-profit agencies, etc. It is critical that public health and medical efforts are incorporated into homeland security efforts for events such as bioterrorism or pandemic influenza. The advisory committee is one way to engage all of the preparedness players to ensure a comprehensive integrated approach in the jurisdiction.

Q: Can we have criteria and additional information about the following statement ASAP: "Beginning in FY 2007, CDC envisions that allocation of funds among eligible entities and among preparedness priorities will be influenced increasingly by considerations of awardees' performance in enhancing public health and healthcare emergency preparedness and the relative merits of applicants' proposed initiatives toward selected preparedness priorities as determined by national competition."
A: Criteria are not available at this time. In the coming year we anticipate that there will be an increased emphasis on performance as defined by completion of the proposed activities and progress in achieving the targets for the performance measures. We also anticipate that in future years a portion of the award may become competitive as with pandemic influenza funding.

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Q: We are looking for clarification regarding what is meant by "public health responders" in Goal 1, Target Capability 1A, Critical Task 4. Does this mean people within our department, or does this refer to EMS personnel, or hospital personnel?
A: Public Health First Responders typically would be DOH personnel that are required to deploy in the wake of a PH emergency. Hospital personnel could possibly be considered PHFRs if their activity is aligned to support PH response efforts. However, EMS Responders are mostly covered through DHS. Simply put, First Responders in this context would be your DOH personnel who would be critical in the first phase of your response efforts.

Q: What is required to be uploaded as part of the grant related to local concurrence?
A: The requirements around local concurrence are the same as last year. States will be asked to list the local agencies concurring and the populations they serve.

Q: Under what authority is CDC requiring a letter of support from Sovereign Nations, and what happens if one or more Tribes refuse to sign the letter?
A: There is no Congressional and/or CDC mandate or statute (authority), requiring a letter of support. CDC is encouraging grantees to work with Tribal (Sovereign) nations on preparedness activities and requiring that grantees describe the process they are using to engage their local tribal nations. States are encouraged to obtain signed letters of concurrence (which is inherently different from the cited “letter of support”) from the Tribal (Sovereign) nations with which they are collaborating so they can demonstrate this collaboration upon request.

Q: Mid-year estimated FSRs due May 30, 2007 (for August 31, 2006 – February 28, 2007). Since the purpose of the FSRs is to provide PGO with estimates of the possible unallocated funds available at the end of the budget period, the FSRs should include information re: past budget activities (e.g., obligations, liquidations, etc.) as well as projections on future budget activities that will occur on or before August 30, 2007. Can you clarify the part in parenthesis?
A: First the states and local governments must use their accounting systems and procurement systems for estimating these figures. We understand that the numbers are estimates, at best, based on what they have actually expended and what they have obligated with the intent to expend.

FSRs should only cover the period requested. The grantees will be filing an FSR that reflects actual figures 90 days following August 30, 2006. None of the figures from this FSR should be included in the mid-year. They will be current, not past budget activities.

What they will show will be expenditures and obligations to date, unliquidated amounts for which services have been rendered but payment has not been made, and a projected amount of unobligated funds for the six month period. Again, how funds are recorded in the books of account from which this information is drawn is governed by the state or locally adopted system.

Q: We need a better definition of what constitutes "large" carryover.
A: There is no set figure or criteria for "large"; however we often reference the size of the award for comparison. The unobligated amount in relation to the base amount of the award is important. If a grantee receives $5 million per year and consistently rolls over $1 million, there is 20% of federal funds unspent yearly, which translates to the grantee performing only 80% of what it said it would achieve. Size is relative to the award, however, it is always anticipated that all monies will be spent. This is the Awarding Agency Grants Administration Manual reference :204.104B for reviewing non competing continuations:

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> "Review the most recent FSR(s) (or equivalent) and any other available financial information for indications of continuing unliquidated obligations, significant unobligated balances, or unusual expenditure patterns."

The AAGAM cites the pattern of accumulating carryover. The practice of consistently accumulating large balances is considered poor fiscal management; any amount that represents a significant component of the operation (e.g., equal to total contractual or equal to half of the personnel costs) warrants explanation.

Q: How will we load our budget request for the carry forward funds, in order to make it part of the application?
A: Carryover requests for budget year five should be submitted before July 1 using the budget change request in DSLR MIS. Carryover requests for budget year six may not be submitted until the budget period ends. CDC will not allow carryover funds to be added to the application.

Q: Is there a required format for the two Attachments (related to NIMS compliance)?
A: The following is what is required of all Grantees (and is clearly listed on the Application Summary page of MIS).

After completing your Work Plan and Budget, you can upload attachments here. You MUST attach the following documents in order to submit:

1) Signed Cover Letter for Application
2) Signed 424
3) 424A
4) Currently Approved Indirect Cost Rate Agreement
5) Certification that FY 2005 NIMS Requirements Have Been Met (submit with HRSA application)
6) Statement of Adoption of NIMS at the State/Territorial Level

Q: Under appendix 7, National Public Health Radio Network (NPRHN), guidance says for participation in the NPRHN, partners should work with CDC to receive and implement the NPRHN Operations Plan. Who do they need to contact (plus contact information)?
A: Please see the information at the end of this FAQ document for additional information about the NPHRN. The CDC Point of Contact is:
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Performance Measures, Evaluation and Reporting

Q: What completion date should we use for ongoing/continuing activities?
A: The end of the budget period (8/30/2007).

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Q: Under the Evaluation Plan tab in MIS, what is the character limit per text block?
A: The limit is 6800. Labels will be provided on the top of each box soon.

Q: Metric #5: It says that time can start from isolate of agent, but requires documentation of time sample received without time that sample isolated. Why is this so? Will time sample isolated suffice for start time?
A: Yes, the start time should be the time that the sample is isolated or the time the isolate is received.

Antiviral Contracts

Q: What is the reason for the formulary mix between Tamiflu and Relenza? (The CDC/HHS appears to be leaning heavily on Tamiflu, 40:1 ratio in the stockpile.)
A: Once all of the current Flu procurements are delivered, the SNS stockpile will reflect 85% Tamiflu and 15% Relenza. The current goal with future procurements is to bring that ratio to 80:20. Theoretically, there is less risk of resistance with Relenza compared with Tamiflu. Also, the most common Tamiflu resistant mutant is susceptible to Relenza. Thus, both Tamiflu and Relenza are being procured to ensure both of these medications are available if needed.

Q: How many regimens of antivirals will be procured at the state and federal levels?
A: The HHS goal is to have 81 million antiviral regimens available for the U.S. population. Of this 81 million, 50 million regimens will be procured and stored in the SNS. Of this 50 million, approximately 44 million regimens will be held for pandemic usage by states and 6 million reserved for domestic containment efforts. HHS will subsidize state purchases of up to 31 million treatment courses of Tamiflu and Relenza, apportioned to States based on population.

Q: How will states be subsidized?
A: HHS is working to negotiate contracts with the antiviral manufacturers to attain best pricing for state procurements and will subsidize 25 percent of the procurement costs states incur, up to 31 million doses as apportioned by State population. Additional guidance regarding state purchases will be released by HHS.

Q: Can state-owned antivirals be submitted to the Shelf Life Extension Program (SLEP)?
A: The Shelf Life Extension Program, managed by the FDA, allows for product in the Strategic National Stockpile (SNS) to receive an extended expiration date if it meets specific conditions. At this time, the SLEP is only available for federally-owned pharmaceuticals. State assets are not currently eligible for the SLEP. FDA is working with HHS and States to assess the feasibility of making State assets eligible for the extension program.

Cities Readiness Initiative

Q: In Appendix 4 about the CRI program, paragraph 3 is very confusing about the MSA requirements/expectation. Our MSA includes counties with considerably rural area and we would like to return to planning for the main activities in the more metropolitan areas. We can include the more rural counties in our general preparedness and keep them up to date but would not expect their full participation in the detail planning. Is that acceptable?
A: The selection of MSAs for each CRI city was based on U.S. Census Data and indicate the most populous jurisdictions that support the identified CRI city. While some counties are clearly urban and others rural, the focus remains the same: “Create and sustain the capacity to provide antibiotics to the MSAs entire population within 48 hours of the decision to do so”. To this end, it may be that more rural counties are supported by the more general preparedness plans of the state, but, there continues to be the

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requirement to have a detailed local plan to get medication to the identified (CRI/MSA) population. For further guidance on your CRI/MSA jurisdiction, consult with your CDC/DSNS SME and state SNS Coordinator.

Q: When the CRI crosses state lines, how do states report the data?
A: Some CRI/MSAs do cross state lines and in many cases, there are more than two states supporting a CRI city. The DSNS SME and the state SNS coordinator will perform joint assessments of 25% of the most populous jurisdictions (city, county, or region) of the identified CRI city. The state SNS coordinator(s) will conduct assessments in his/her remaining jurisdictions and will report all findings to the DSNS SME. All overall scores will be combined and averaged to form one aggregate overall score for the identified CRI/MSA. This applies to the existing CRI Recipients (Table I) only. The New CRI Recipients (Table II) will have a one time baseline assessment performed by the DSNS SME and the state SNS coordinator on the jurisdiction as defined by the state in which the city is geographically located.

The answers to these questions were developed on June 13, 2006

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National Public Health Radio Network

The National Public Health Radio Network (NPHRN) is a collaborative initiative between CDC's Coordinating Office for Terrorism Preparedness (COTPER) and the National Center for Health Marketing (NCHM). In summary, the NPHRN will provide CDC, state, territorial, and local health departments with non-infrastructure dependent redundant communications capability – a "back up" method of communication when all else fails. Utilizing specific frequencies within the High Frequency (HF) spectrum, the NPHRN provides CDC and the 50 states, Puerto Rico, the Virgin Islands, the Pacific Island Jurisdictions (American Samoa, Commonwealth of the Northern Mariana Islands, Guam, Republic of the Marshall Islands, Republic of Palau, and the Federated States of Micronesia), and the localities of Chicago, Los Angeles County, New York City, and Washington, D.C. with a wireless redundant communications capacity. When participating in the NPHRN, CDC and public health partners will have the capability to transmit and receive vital information in the event that traditional infrastructure dependent communication media (telephone, internet, cellular) are damaged, overloaded, or destroyed thus preventing effective and reliable communication. Specifically, the NPHRN will permit CDC and state, territorial, local public health departments to;

1) Provide back-up/redundant communications capacity with state and Federal agencies and a wide range of other responders during an emergency;
2) Ensure reliable long haul two-way communications in times of crises
3) Provide additional methods to gather event intelligence and situational awareness
4) Enable public health stakeholders access to redundant/secure wireless communications with public health partners/state, local EOCs, Law Enforcement and other first responders;
5) Enable public health partners to participate in National, State and Local Disaster Coordination;
6) Provision existing Non-Infrastructure Dependent Communications Assets in use by Federal/State/Local Agencies.
7) Enable CDC and partners to provide assistance to and receive assistance from other radio networks - FEMA's NECN, NCS "SHARES" Network, State/local partners (state/local EOCs, First Responders, National Guard), federal agencies, and NGOs (Amateur Radio, Red Cross, Salvation Army, etc…);
8) Allow communications on reserved frequencies for CDC and state/local health authorities.
9) Enable CDC and partners to participate in regular practice exercises with Federal/State/Local Agencies/NGOs.

Upon the installation of the standards compliant radios, CDC will issue the specific grantee a "Federal Call Sign" that will permit the grantee to operate within NPHRN, the Department of Homeland Security's Federal Emergency Management Agency's National Emergency Coordination Network (FEMA/NECN), and National Communications System's SHARES HF Network. The FEMA/NECN will provide a back-up command and control communications system to support National Response Plan (NRP) activities and other civil emergencies by providing emergency response personnel with a common HF frequency to meet on for the exchange of information, coordination of activities, and to request assistance. In the event of an

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actual emergency, this net will provide links directly to the Joint Field Office (JFO) and its Emergency Support Function (ESF) areas and headquarters FEMA. In addition, CDC and HHS will sponsor the grantee for inclusion into the National Communications System's SHARES HF Network. The SHARES HF Radio Program brings together the assets of over 1,000 HF radio stations worldwide to voluntarily pass emergency messages when normal communications are destroyed or unavailable. SHARES uses common radio operating and message formatting procedures and more than 250 designated frequencies. Participation in SHARES is open to all Federal departments and agencies and their designated affiliates on a voluntary basis. More than 90 Federal, state, and industry organizations currently contribute resources throughout the United States and in 26 countries and U.S. possessions. Additional information about NCS and SHARES can be found at www.ncs.gov/shares.

CDC grantees are expected to purchase and install standards compliant (see below) HF radio equipment before September 1, 2007. Because of possible antenna and/or space restrictions, HF radio stations can be fixed, mobile, and/or portable. The preference is a fixed station.

In order to participate in the NPHRN, all HF radios must be in compliance with:

- Military Standard 188
- NATA – STANAG 5066

For additional information on these standards and for a listing of compliant HF radios, please visit: http://jitc.fhu.disa.mil/it/cert.htm.

While planning the acquisition and installation of your HF radio, we recommend reviewing the following websites:

- http://www.ncs.gov/shares/
- http://www.fcc.gov/
- http://www.hwn.org/
- http://www.ntia.doc.gov/osmhome/osmhome.html
- http://www.asc.army.mil/mars/default.htm
- http://www.mobat-usa.com/
- http://www.qso.com/satern/sitemap.htm
- http://www.emcomm.org/

CDC Point of Contact:

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