CDC OPERATIONAL READINESS REVIEW GUIDANCE

Public Health Emergency Preparedness (PHEP) Cooperative Agreement

Budget Period 1 • July 1, 2019 - June 30, 2020

Updated March 2020

Centers for Disease Control and Prevention
Center for Preparedness and Response

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CDC OPERATIONAL READINESS REVIEW GUIDANCE

Introduction

The Centers for Disease Control and Prevention (CDC) administers the Public Health Emergency Preparedness (PHEP) cooperative agreement program to build response-ready public health systems nationwide. The PHEP program is a critical source of funding, guidance, and technical assistance for state, local, and territorial public health departments to strengthen their public health preparedness capabilities and improve their response readiness. CDC's Operational Readiness Review (ORR) is a rigorous, evidence-based assessment that evaluates PHEP program planning and operational functions.

The ORR is a tool used to measure a jurisdiction's ability to execute a large emergency response requiring medical countermeasure (MCM) distribution and dispensing. The intended outcome of this assessment is to identify strengths and challenges facing preparedness programs and to offer opportunities for improvement and technical assistance.

By June 30, 2022, all PHEP recipients and all Cities Readiness Initiative (CRI) local planning jurisdictions should be able to

- Use risk assessments to guide preparedness planning for the jurisdiction.
- Develop and update risk-based, all-hazards emergency plans.
- Conduct trainings, drills, and exercises with jurisdictional partners, including those representing people with disabilities and others with access and functional needs[1].

This document provides specific guidance on how to complete a review using the Data Collation and Integration for Public Health Event Response (DCIPHER) platform. All 62 PHEP recipients as well as CRI local planning jurisdictions are required to participate in the ORR process. State recipients are not only responsible for ensuring their statewide planning and operational function, but also for reviewing local planning jurisdictions' submitted forms within their state, and monitoring, tracking, and evaluating local activities. When states realign their local planning jurisdictions, they must ensure that initial data is entered for these new jurisdictions.

1 This document was updated to use the recommended term "people with disabilities and others with access and functional needs" instead of the less precise term, "vulnerable populations". The information collected will be the same, and the term "vulnerable populations" will remain in DCIPHER for Budget Period 1 Supplement, which starts July 1, 2018 and ends June 30, 2019. However, within this document, changes have been made to use the more appropriate terms when possible.

Overview

The ORR has three modules: 1) descriptive and demographic, 2) planning, and 3) operations. Each module collects information via specific forms. Guidance about the content collected in each form is located in the specific form chapters of this document.

In the tables below, "State" indicates one of the 50 states, "DFL" indicates a directly funded locality, "TFAS" indicates U.S. territories and freely associated states, and "CRI" indicates a Cities Readiness Initiative local planning jurisdiction.

Descriptive and Demographic Forms

Jurisdictions must submit or update the forms below as indicated to complete the demographic form section.

Table 1. The descriptive and demographic forms must be submitted before an ORR site visit is conducted.

Form	Submission Cycle*	State	DFL	TFAS	CRI
Critical contact sheet (CCS)	Every 6 months (by June 30 and by Dec 31 each year)	Yes	Yes	Yes	
Receipt, stage, store (RSS) site survey	Every 12 months	Yes	Yes	Yes	
Jurisdictional data sheet (JDS)	Every 12 months	Yes	Yes	Yes	Yes
Point of dispensing (POD)	Every 12 months	Yes (State-run open PODs only)	Yes	Yes	Yes

*NOTE: The due date for CCSs is fixed. Cycles for other forms are based on 12-month intervals from the date of the last acknowledged review

Planning Forms

Table 2. The forms below must be submitted or updated as indicated to complete the planning form section. The planning forms must be submitted before an ORR site visit is conducted.

Form	Submission Cycle*	State	DFL	TFAS	CRI
Dispensing	Every 12 months	Yes	Yes	Yes	Yes
Distribution	Every 12 months	Yes	Yes	Yes	Yes

. * NOTE: Due date cycles are based on 12-month intervals (as indicated in table above) from the date of the last acknowledged review.

Operational Forms

Table 3. The forms below must be submitted or updated as indicated to document operational performance

Form	Submission Cycle*	State	DFL	TFAS	CRI
Facility setup drill	Once a year, no later than June 30		Yes	Once every other year, no later than June 30	Yes
Staff notification and assembly drill	Once a year, no later than June 30		Yes	Yes	Yes
Site activation drill	Once a year, no later than June 30		Yes	Yes	Yes
Successful Inventory Management and Tracking System (IMATS) or Information Data Exchange (IDE) • Information is populated directly from Strategic National Stockpile (SNS) reports. No data entry is required.	Once a year, no later than June 30	Yes	Yes	Yes*	
Training and exercise planning form • To document training and exercise plan workshop (TEPW) information	Once a year, no later than June 30	Yes	Yes	At least once every 2 years	
Training and Exercise Planning Form • To document multiyear training and exercise plan (MYTEP)	Once a year (with the funding application)	Yes	Yes	Yes	Yes
PHEP, functional, or full-scale exercise (FSE) or incident • To document annual PHEP exercise (with access and functional needs partners)	Once a year, no later than June 30	Yes	Yes	At least once every 5 years	
PHEP, functional, or FSE or incident • To document emergency operations center (EOC) staff notification and assembly	At least once annually, no later than June 30	Yes	Yes	Puerto Rico only	
PHEP, functional, or FSE or incident • For all EOC activations for incidents	Each activation having a public health component	Yes	Yes	Yes	
PHEP, functional, or FSE or incident • To document joint Hospital Preparedness Program (HPP) or PHEP functional or full-scale exercise	At least once every 5 years	Yes	Yes	Puerto Rico only	

Table 3. The forms below must be submitted or updated as indicated to document operational performance (continued)

Form	Submission Cycle*	State	DFL	TFAS	CRI
Distribution FSE or incident	At least once every 5 years	Yes	Yes	FE or FSE for dispensing or distribution	
After-action report (AAR) and improvement plan (IP)	AAR must be submitted as exercise evidence; this form entry is optional				
Dispensing throughput drill • Only used to document if mass vaccination was conducted in lieu of pill dispensing	Required at least once every 5 years only if throughput not calculated during dispensing FSE		Yes	Yes	Yes
Tabletop exercise (TTX)	At least once every 5 years; TTX topics can be combined within the same exercise	Administrative Anthrax Pandemic Influenza COOP	Anthrax Pandemic Influenza COOP	Pandemic Influenza COOP	Anthrax Pandemic Influenza

* NOTE: To document compliance, American Samoa, Commonwealth of Northern Mariana Islands, Federated States of Micronesia, Guam, Republic of Palau, Republic of the Marshall Islands, and U.S. Virgin Islands may continue to submit a spreadsheet (if IMATS or IDE is unavailable) to respond to CDC inventory request. Puerto Rico must submit through IMATS or another IDE.

** NOTE: Required for states with dispensing responsibilities.

Organization of This Guidance

The specific form chapters in this guidance generally follow the structure below.

Example of Reporting Requirements Table

Completed By	Submission Timeline
States	Annual requirement
Directly funded localities	5-year requirement
U.S. territories and freely associated states	
CRI local planning jurisdictions	

Form Key Terms (refer to Appendix B)

"Completed By" column indicates which jurisdiction is responsible for completing the requirements by June 30.

"Submission Timeline" column indicates when forms are due.

- **Annual Requirement**
  - Descriptive and demographic forms must be submitted or updated at 6- or 12- month intervals (depending on the form).
  - Planning forms must be submitted or updated annually by June 30.
  - Operational forms must be submitted annually by September 30.
- **5-year requirement**
  - FSE operational forms are required every 5 years.

Why is this information collected?

This section briefly describes why the content is requested for each form.

What do you need to know about this form?

This includes tips and details about certain questions that will help the user complete the self-assessment. This section also provides tips for how the reviewer will evaluate submitted evidence.

What impacts achieving "established" status?

This describes any requirements that will contribute to eligibility for achieving an "established" status. Although the goal is for all PHEP recipients to achieve "established" status for MCM by 2022, information should be submitted as soon as available to provide up-to-date information about the status of the preparedness program.

Preparing for a PHEP Recipient ORR Site Visit Conducted by CDC

This section provides recommendations for how a jurisdiction should prepare for an ORR site visit conducted by a DSLR MCM specialist. The MCM specialist will contact PHEP recipients to schedule the ORR site visit.

A significant amount of time will be necessary to prepare for the ORR site visit. CDC encourages recipients to plan accordingly and negotiate a date that is reasonable to accommodate all stakeholders' needs. CDC will send an e-mail with the selected site visit date, the date that all forms and relevant documentation are due, and a request to confirm acceptance of the scheduled date and time for the ORR site visit.

Do not wait until the last minute to prepare for the site visit. Schedule sufficient time to collect, enter, review, and submit the data for each required form. The site visit preparation timeline should account for any internal review process that must occur before submission to CDC. Keep in mind that DCIPHER is available 24 hours a day, 7 days a week (except if otherwise notified).

All ORR forms must be submitted via DCIPHER. CDC strongly encourages that all supporting documentation be uploaded into DCIPHER. You may upload files individually or in batches using the supporting documentation tab. Use a ZIP file if the documentation is larger than 25MB. However, you may discuss with your MCM specialist if you need to use an alternative method to submit supporting documentation. For example, you may choose to grant your CDC reviewer access to documents stored on your own internal electronic system rather than uploading them to DCIPHER. If reliable Internet access is unavailable, you might need to mail a compact disc (CD) or other digital media type to your MCM specialist (particularly for U.S. TFAS).

No matter how supporting documentation is submitted, specific reference to supporting section material is required and must be entered within the associated ORR text boxes by the documentation due date (20 business days prior to scheduled ORR site visit). Include page, section, and line numbers; highlight text; and provide any detail to help the reviewer locate the supporting information.

Failure to provide specific reference citations will affect the MCM specialist's ability to verify the cited evidence. If the evidence cannot be found after a reasonable attempt to follow submitted citations, the MCM specialist will "not concur" with the evidence. This will significantly affect the ORR status for each module.

An ORR site visit should be rescheduled if unforeseen circumstances, such as a national or state emergency declaration, arise or if all parties mutually agree to reschedule the visit. If completed forms and adequate documentation are not submitted within the designated period, CDC reviewers can cancel the site visit. Failure to complete and submit required forms may result in national status reports displaying status as "early" or "non-compliant" with reporting requirements. This includes sites that submit either incomplete or none of the required forms **20 business days** prior to the ORR site visit.

Agenda Development

Prior to the site visit, the CDC MCM specialist and the jurisdiction MCM coordinator will jointly develop an agenda that outlines the purpose, goals, and objectives of the meeting. To better facilitate the ORR site visit, CDC recommends that the discussion progress from demographics to planning to operational. Exceptions to this review order can be made to accommodate the partners' availability and anticipated discussion time.

Jurisdictions are responsible for inviting stakeholders and other participants in advance of the ORR site visit and confirming that they can attend the meeting. However, CDC MCM specialists can help (if requested) to coordinate federal partner attendance, such as U.S. Marshals. The table below lists stakeholders typically involved in ORR site visits. Additional partners not listed also can be invited to participate if deemed important to the MCM response for the jurisdiction.

Figure 1. Suggested stakeholders for participation in ORR site visits.

Stakeholder	Stakeholder

• CRI MCM coordinators
• Dispensing lead
• Distribution lead
• Federal partners
  ◦ HHS regional emergency coordinators
  ◦ Unites States Marshals Service (USMS)
  ◦ CDC Career Epidemiology Field Officers (CEFOs)
  ◦ HPP field project officers (FPOs)
  ◦ Federal Executive board partners
• Health officer
• HPP coordinator
• Inventory control lead
• Law enforcement or security lead
	• MCM coordinator
	• Military installation liaison(s)
	• National Guard (if applicable)
	• PHEP director
	• Private sector partners
	• Public health, public information officer(s)
	• Receipt, stage, store (RSS) lead
	• State and local emergency management agency (EMA) representatives
	• Tactical communication lead
	• Training lead
	• Tribal partner
	• Volunteer coordinator(s)

Form Submission (via DCIPHER)

Prior to a scheduled site visit, the jurisdiction must complete and submit, at minimum, the forms listed in Table 4 on the next page. CDC will thoroughly review the forms beginning 20 business days prior to the site visit.

- Submit forms as they are completed. You do not have to submit all required forms at once. Reviewers will need time to review the information and can start this review once the first form and supporting documents are submitted.
- Use the "evidence can be found" text boxes to provide detailed information, for example, page numbers, section numbers, line numbers, or highlighted text for the reviewer about where evidence is specifically located within the referenced document. Type directly into the "evidence can be found" text box in edit mode and select <enter> once complete. Failure to provide detailed information may affect the MCM specialist's ability to conduct the ORR site visit as scheduled. Use the "comments" section in the review mode to communicate with the reviewer and provide additional clarification as needed.

Table 4. Minimum forms that must be completed and submitted prior to a scheduled ORR site visit.

Form	State	DFL	TFAS	CRI
Critical contact sheet (CCS)	Yes	Yes	Yes	
Jurisdictional data sheet (JDS)	Yes	Yes	Yes	Yes
Point of dispensing (POD)	Yes*	Yes	Yes	Yes
Distribution planning	Yes	Yes	Yes	Yes
Dispensing planning	Yes	Yes	Yes	Yes
RSS site survey	Yes	Yes	Yes	

Operational forms**	State	DFL	TFAS	CRI
Training and exercise planning form • Documents TEPW information	Yes	Yes	At least once every 5 years	
Training and exercise planning form • Documents MYTEP	Yes	Yes	Yes	Yes
Dispensing FSE or incident	Yes*	Yes	FE or FSE	
Distribution FSE or incident	Yes	Yes	FE or FSE	
PHEP, functional, or FSE or incident*** • Documents PHEP exercise (with access and functional needs partners)	Yes	Yes	At least once every 5 years	
PHEP, functional, FSE or incident*** • Documents EOC staff notification and assembly	Yes	Yes	Puerto Rico only	
PHEP, functional, FSE or incident*** • Documents joint HPP and PHEP functional or FSE	Yes	Yes	Puerto Rico only	

* NOTE: POD form and dispensing FSE or incident form are completed by states, if applicable (state maintains plans for PODs).

** NOTE: Information from previous incidents or FSEs (must not be more than 5 years old) should be submitted until incident or FSE information from the current period of performance is available (and submitted as close to real-time as feasible).

*** NOTE: Submit any completed annual exercises, including 1) any PHEP exercise involving partners representing people with disabilities and others who have access and functional needs and 2) EOC activations from any incidents where public health had a role that occurred annually. FE or FSE or incidents (must not be more than 5 years old) that involved both HPP and EMA as partners also should be submitted.

Review

Reviewers will evaluate submitted forms and supporting documentation (if provided with enough detail to identify the reference material) for accuracy and evidence of sufficient documentation. Demographic and operational forms receive overall form approval. Planning forms are evaluated element by element. Reviewers will select from standardized response options for the planning forms to promote consistency across reviews.

Standardized reviewer options are defined below. Refer to the planning forms chapter for specific information about how each distribution and dispensing element review is defined.

- **Concur** means sufficient evidence is given and no additional comments are required.
- **Insufficient evidence** means more information is needed, and reviewer comments will include what additional data are required.

- **No evidence** means nothing relevant to the element was provided, and reviewer comments will include requests for data to meet minimal standards for established.
- **Contradictory evidence** means the reviewer found inconsistent information, and comments will include requests for clarification.

A reviewer can identify a **data input error** for any item in the planning section. This will promote data integrity (documenting why data is changed) and allow the recipient to easily recognize and correct the error.

If information is determined to be incorrect or incomplete according to evidence provided, the reviewer may return the forms for correction. Failure to respond to the reviewer or update the information in a timely manner can result in "no acknowledgement" by the reviewer and may impede achieving an "established" status.

Descriptive and Demographic Form Verification

Adequate evidence to support form responses must be uploaded for reviewer verification. When "written agreements" is selected, upload the agreement document. Failure to upload evidence selected for the POD form (for example, staffing matrix or RSS site survey) can result in "no acknowledgement" by the reviewer and may impede achieving an established status.

Planning Form Verification

Specific reference to supporting evidence is required and must be entered within the associated ORR text boxes by the documentation due date (20 business days prior to scheduled ORR site visit). Include page numbers, highlight text, and provide any detail to help the reviewer locate the supporting information. Failure to provide the reviewer with necessary detail to evaluate the evidence can result in "no acknowledgement" by the reviewer and may impede achieving an "established" status.

Operational Form Verification

Operational forms are submitted to verify completion of PHEP and HPP-PHEP exercise requirements. Complete and submit the appropriate form as soon as the exercise or incident concludes. Upload data collection forms, sign-in sheets, and the related AAR as evidence of the exercise or incident as soon as available. In addition to providing the report, complete and submit the after-action report and improvement plan form. Lack of evidence for verification of participants, for example, partners representing people with disabilities and others with access and functional needs, health care coalitions, or emergency management partners may result in requests for additional evidence. Jurisdictions can fulfill program exercise requirements using the Homeland Security Exercise Evaluation Program (HSEEP) progressive exercise planning approach during an incident. For instance, inclusion of administrative preparedness components during a functional exercise or an incident meets the optional TTX recommendation.

ORR Site Visit Flow

At the beginning of the ORR site visit, the MCM specialist will reiterate the purpose, goals, and objectives for the meeting that were agreed upon prior to the site visit. The meeting should commence with an overview of the agenda and introductions. During the site visit, the MCM specialist will facilitate discussions between the jurisdiction's MCM program staff and partners to verify plans and operational implementation. The reviewer will focus on any identified issues, highlight program progress towards achieving "established" status for ORR elements, and discuss monitoring of technical assistance action plan activities. Challenges and barriers associated with those topics also will be noted.

Exit Meeting

The exit discussion is the opportunity for all stakeholders, including the recipient's leadership, to hear feedback from the reviewer about important observations, including program strengths, opportunities for improvement, and new or pending action plan recommendations. The MCM specialist will document any action items, including requests for additional evidence, prior to departing the site visit and the recipient must adequately respond no later than 5 business days from the ORR site visit date. Technical assistance may be requested by the recipient or discussed by the reviewer. All site visit stakeholders can offer areas where technical assistance might be needed. In response, the MCM and PHEP specialists will either provide requested assistance to the jurisdiction or plan to triage issues to the appropriate subject matter expert (SME).

Conducting Local CRI ORR Site Visits

This section provides recommendations to state MCM coordinators (or responsible staff) on how to conduct an ORR for a local CRI jurisdiction. To conduct an ORR for a local CRI jurisdiction, CDC recommends the state MCM coordinator (or responsible staff) assume the responsibilities and tasks outlined for the MCM specialist or reviewer in the previous section.

A significant amount of time will be necessary to prepare for the ORR site visit. The CDC regional MCM specialist is available to support and provide technical assistance for this process. CDC encourages states to plan accordingly and negotiate a date that is reasonable to accommodate all stakeholders' needs (including state review time). CDC recommends sending an e-mail with the selected site visit date, the date that all forms and relevant documentation are due, and a request to confirm acceptance of the scheduled date and time for the ORR site visit.

Do not wait until the last minute to prepare for the site visit. Schedule sufficient time to collect, enter, review, and submit the data for each required form. Your timeline should account for any internal review process that must occur before submission to DCIPHER. Keep in mind that DCIPHER is available 24 hours a day, 7 days a week (except if otherwise notified).

All ORR forms must be submitted via DCIPHER, and CDC strongly encourages all supporting documentation be uploaded into DCIPHER. CRI jurisdictions may upload files individually or in batches using the supporting documentation tab. CRI jurisdictions should use a ZIP file if the documentation is larger than 25MB. However, states may discuss alternative methods with their local CRI jurisdictions, if needed. For example, states may choose to access documents stored on your own internal electronic system rather than uploading them to DCIPHER.

No matter how supporting documentation is submitted, specific reference to supporting section material is required and must be entered within the associated ORR text boxes by the documentation due date. CDC recommends 20 business days prior to scheduled ORR site visit. Include page, section, line numbers, highlight text, and provide any detail to help the reviewer locate the supporting information.

Failure to provide specific reference citations will impact the ability to verify the cited evidence. If the evidence cannot be found after a reasonable attempt to follow submitted citations, CDC recommends that state reviewers "not concur" with the evidence. This will significantly affect the ORR status for each module.

An ORR site visit should be rescheduled if unforeseen circumstances, such as a national or state emergency declaration arise or if all parties mutually agree to reschedule the visit. If completed forms and adequate documentation are not submitted within the designated period, CDC recommends the cancellation of the site visit. Failure to complete and submit required forms may result in national status reports displaying status as "early" or "non-compliant" with reporting requirements. This includes sites that submit either incomplete or none of the required forms **20 business days** prior to the ORR site visit.

Agenda Development

Prior to the ORR site visit, the state reviewer and CRI should jointly develop an agenda that outlines the purpose, goals, and objectives of the meeting. To better facilitate the ORR site visit, CDC recommends that the discussion progress from demographic to planning, to operational. Exceptions to this review order can be made to accommodate partners' availability and anticipated discussion time.

The CRI jurisdiction is responsible for inviting stakeholders and other participants in advance of the ORR site visit and confirming that they can attend the meeting. The figure below lists stakeholders typically involved in ORR site visits. Additional partners not listed also can be invited to participate if deemed important to the MCM response for the CRI jurisdiction.

Figure 2. Suggested list of stakeholders to participate in the ORR site visit.

Stakeholder

- CRI coordinator
- Dispensing lead
- Federal partners
- Health officer
- HPP coordinator
- Inventory control lead
- Law enforcement or security lead
- MCM coordinator
- Military installation liaison(s)
- National Guard (if applicable)
- PHEP director
- Private sector partners
- Public health, public information officer(s)
- RSS lead
- State or local EMA representative
- Tactical communications lead
- Training lead
- Tribal partners
- Volunteer coordinator(s)

Form Submission (via DCIPHER)

Prior to a scheduled site visit, the CRI jurisdiction must complete and submit, at minimum, the forms listed in Table 4. Forms should be thoroughly reviewed beginning 20 business days prior to the site visit.

- Encourage CRI jurisdictions to submit the forms as they are completed. You do not have to submit all required forms at once. Reviewers will need time to review the information and can begin the review once the first form and supporting documents are submitted.
- Encourage CRI jurisdictions to use the "evidence can be found" text boxes to provide detailed information, for example, page numbers, section numbers, line numbers, or highlighted text, about where evidence is specifically located within the referenced document. CRI jurisdictions should type directly into the "evidence can be found" text box in edit mode and select <enter> once complete. Failure to provide detailed information may affect your ability to conduct the ORR site visit as scheduled. Use the "comments" section in the review mode to provide additional clarification, as needed.

Review

Reviewers should evaluate submitted forms and supporting documentation (if provided with enough detail to identify the reference material) for accuracy and evidence of sufficient documentation. Demographic and operational forms receive overall form approval. Planning forms are evaluated element by element. Reviewers will select from standardized response options for the planning forms to promote consistency across reviews.

Standardized reviewer options are generally defined as indicated below. Refer to the planning forms chapter for specific information about how each distribution and dispensing element review is defined.

- **Concur** means sufficient evidence is given and no additional comments are required.

- **Insufficient evidence** means more information is needed, and reviewer comments will include what additional data are required.
- **No evidence** means nothing relevant to the element was provided, and reviewer comments will include requests for data to meet minimal standards for established.
- **Contradictory evidence** means the reviewer found inconsistent information, and comments will include requests for clarification.

A reviewer can identify a **data input error** for any item in the planning section. This will promote data integrity (documenting why data is changed) and allows the CRI jurisdiction to easily recognize and correct the error.

If information is determined to be incorrect or incomplete according to evidence provided, the reviewer may return the forms for correction. Failure to respond to the reviewer or update the information in a timely manner can result in "no acknowledgement" by the reviewer and may impede achieving an "established" status.

Descriptive and Demographic Form Verification

CRI jurisdictions must upload adequate evidence to support form responses for reviewer verification. When "written agreements" is selected, the agreement document should be uploaded. Failure to upload evidence selected for the POD form, such as a staffing matrix, can result in "no acknowledgement" by the reviewer and may impede achieving an "established" status.

Planning Form Verification

Specific reference to supporting evidence is required and must be entered within the associated ORR text boxes by the documentation due date (20 business days prior to scheduled ORR site visit). CRI jurisdictions should include page numbers, highlight text, and provide any detail to help the reviewer locate the supporting information. Failure to provide the reviewer with necessary detail to evaluate the evidence can result in "no acknowledgement" by the reviewer and may impede achieving an "established" status.

Operational Form Verification

Operational forms are submitted to verify completion of PHEP exercise requirements. CRI jurisdictions should complete and submit the appropriate form as soon as the exercise or incident concludes. CRI jurisdictions also should upload data collection forms, sign-in sheets, and the related AAR as evidence of the exercise or incident as soon as available. In addition to providing the report, CRI jurisdictions should complete and submit the AAR and IP form. Lack of evidence for verification of participants, for example, partners representing people with disabilities and others with access and functional needs may result in requests for additional evidence. Program exercise requirements can be fulfilled using the HSEEP progressive exercise planning approach during an incident. For instance, inclusion of administrative preparedness components during a functional exercise or an incident meets the optional TTX recommendation.

ORR Site Visit Flow

At the beginning of the ORR site visit, CDC recommends that reviewers reiterate the purpose, goals, and objectives for the meeting that were agreed upon prior to the site visit. The meeting should begin with an overview of the agenda and introductions. During the site visit, the reviewers should facilitate discussions between MCM program staff and partners to verify plans and operational implementation. The reviewer will focus on any identified issues, highlight program progress towards achieving "established" status for ORR elements, and discuss monitoring of technical assistance action plan activities. Challenges and barriers associated with those topics also will be noted.

Exit Meeting

The exit discussion is the opportunity for all stakeholders, including CRI jurisdiction leadership, to hear feedback from the reviewer about important observations, including program strengths, opportunities for improvement, and new or pending action plan recommendations. The reviewer will document any action items, including requests for additional evidence, prior to departing the site visit. The recipient must adequately respond no later than 5 business days from the ORR site visit date. Technical assistance may be requested by the CRI jurisdiction or discussed by the reviewer. All site visit stakeholders can offer areas where technical assistance might be needed. In response, the reviewer will either provide requested assistance to the jurisdiction or plan to triage issues to the appropriate SME.

At-a-Glance Site Visit Facilitation for ORR Reviewers

1. Opening remarks and introductions
    a. Set expectations on meeting purpose
        i. Reiterate the goals, objectives, and purpose of the ORR site visit
        ii. Discuss the flow and allotted duration of the meeting
        iii. Establish an environment of collaboration and trust
    b. Review the agenda
        i. Start and end meeting on time
            1. Starting on time will set a positive tone
            2. Do not shortchange important discussions
        ii. Refer to the agenda frequently and be cognizant to make full use of allotted time
    c. Introductions
        i. Learn name and response role of each attendee
        ii. Acknowledge and thank participants for their work
2. Facilitate program discussion and note observations
    a. Frame conversations and observations positively and openly
    b. Ask insightful questions to increase understanding about planning and operational readiness
    c. Maintain flexibility and discuss new topics, as needed (balance with overall agenda)
3. Verify plans and operational implementation
    a. Reiterate the ORR is designed to measure ability of a CRI jurisdiction to execute plans in response to an incident, event, or exercise
    b. Note progress and any challenges or barriers presented by the jurisdiction
4. Identify follow-up action items
    a. Identify any additional documents that are required
    b. Request relevant supplemental materials no later than 5 business days from the ORR site visit

5. Technical assistance (areas needing improvement)
    a. Address any identified requests
    b. Identify areas throughout site visit
        i. Encourage all participants to contribute to the discussion
        ii. Triage to appropriate SME (including CDC regional MCM specialist) or note for follow-up action
    c. Discuss technical assistance identified or requested during the site visit
6. Exit meeting
    a. Organize your observations and recommendations
    b. Provide feedback
    c. Ensure attendees have a clear understanding of any follow-up actions required
7. Site visit promising practices
    a. Allow adequate time between scheduled site visits
        i. Don't compromise the quality of an individual review by compressing your timeline
    b. Reinforce the importance of key staff and partner attendance at the site visit
        i. Local CRI jurisdictions are the SMEs on their relevant elements
    c. Capitalize on the CDC regional MCM specialists who can
        i. Assist with DCIPHER training for the CRI coordinator
        ii. Consult on clarifying questionable evidence
        iii. Recommend appropriate technical assistance based on outcome of the site visit
    d. Query the Online Technical Resource and Assistance Center (On-TRAC) peer-to-peer module for additional resources

ORR Status

Status determination is built into DCIPHER and is calculated from the self-assessment responses and reviewer input. In the current online version, each section (demographic, planning, and operational) will display a preliminary status once all forms for each respective section are submitted. All PHEP recipients are expected to achieve "established" MCM status by June 30, 2022. Several general rules contribute to status determination.

Deadlines

Jurisdictions must meet all requirements with specific deadlines to be eligible for "established" status.

Essential Elements

Within the planning forms, multiple criteria must be addressed to be considered eligible for "established" status. The form chapters of this document detail the specific criteria as relevant for each form.

Advanced

"Advanced" status is only possible when the status for each of the descriptive, planning, and operational sections is "established." CDC will implement "advanced" status criteria with the expanded ORR.

DESCRIPTIVE AND DEMOGRAPHICS FORMS

Critical Contact Sheet (CCS)

Completed By	Submission Timeline
States	Annual requirement
Directly funded localities	Annual requirement
U.S. territories and freely associated states	Annual requirement

Form Key Terms (refer to Appendix B): department operations center (DOC), continuity of operations plan (COOP), emergency management agency (EMA), emergency operations center (EOC), materiel, preparedness, public health emergency, Public Health Emergency Preparedness (PHEP) cooperative agreement, rapid dispensing model (or nonmedical model), receipt, stage, and store (RSS) facility, Strategic National Stockpile (SNS)

Why is this information collected?

The CCS is used to maintain accurate, up-to-date information on essential personnel. For example, the Strategic National Stockpile can consult this information when they receive a request to ship materiel.

What do you need to know about this form?

Form Question	Form Hint
Primary CDC PHEP specialist	Provide the name of the current primary CDC PHEP specialist assigned to you.
Backup CDC PHEP specialist or team lead	Provide the name of the current backup CDC PHEP specialist or team lead assigned to you.
CDC MCM specialist	Provide the name of the current CDC MCM specialist assigned to you.
U.S. Marshal	Provide the name of the current U.S. Marshal assigned to you.
Backup U.S. Marshal	Provide the name of the current backup U.S. Marshal assigned to you.
Health department EOC	Provide the general contact number for the health department.
Health department EOC: 24/7 phone number	Provide the current contact number for the health department EOC or DOC.
Health department EOC: primary contact name	Provide the name for the current primary health department contact. If this is dependent on type of incident or event, provide the position title that will be responsible. Contact information for the on-call duty officer, after-hours service, or dispatch is acceptable.
Health department EOC: primary phone number	Provide the EOC contact number for the health department.

Form Question	Form Hint
COOP EOC: primary contact name	Provide the name of the current COOP primary contact; if this is dependent on type of incident or event, provide the position title that will be responsible.
EMA EOC: primary contact name	Provide the name of the current primary emergency management agency contact. If this is dependent on type of incident or event, provide the position title that will be responsible.
Health commissioner, secretary of health, state health officer (SHO), ministry of health	Provide the name of the lead health officer or health commissioner for the jurisdiction.
CHEMPACK coordinator	Select "Yes" if the CHEMPACK coordinator is the same as the MCM coordinator. If CHEMPACK coordinator is someone different, provide his or her information.
Law enforcement agencies responsible for MCM security: security contact name	Provide the name of the current law enforcement agency primary contact. If this is dependent on type of incident or event, provide the position title that will be responsible.
Law enforcement agencies responsible for MCM security: primary phone number	Provide the primary law enforcement agency current number. The agency phone number or non-emergency dispatch number should be entered if a position title (rather than person) is listed as the security contact.
Backup law enforcement agency responsible for MCM security: security contact name	Provide the name of the current backup law enforcement agency or department contact.
Distribution (RSS) lead, supervisor, or chief: name	Provide the name of the current public health department personnel that serves as the distribution planning lead. A contractor is not an acceptable entry.
Backup distribution lead: name	Provide the name of the current public health department personnel that serves as the distribution planning lead backup. A contractor is not an acceptable entry.
Influenza coordinator	Provide the name of the current public health department point of contact for the influenza program/ coordinator.
Immunization coordinator	Provide the name of the current public health department point of contact for the immunization program/ coordinator.
Laboratorian	Provide the name of the current public health department laboratory point of contact.
Epidemiologist	Provide the name of the current public health department epidemiology point of contact.

What impacts achieving "established" status?

To be eligible for this status, jurisdictions must update and submit the CCS by June 30 and again by December 31 of each year. Failure to complete each section can result in "no acknowledgement" by the reviewer and may impede achieving an "established" status.

Jurisdictional Data Sheet (JDS) – States

Completed By	Submission Timeline
States	Annual requirement

Form Key Terms (refer to Appendix B): backup point of dispensing (POD), centralized governance, Cities Readiness Initiative (CRI), closed point of dispensing (closed POD or CPOD), command staff or incident management lead roles, critical infrastructure personnel, decentralized governance, distribution assets, emergency management agency (EMA), materiel, open point of dispensing (open POD), public health emergency, Public Health Emergency Preparedness (PHEP) cooperative agreement, responder

Why is this information collected?

The JDS is used to gather information about the jurisdiction's population and staffing to support MCM distribution and dispensing

What do you need to know about this form?

Form Question	Form Hint
State population	Population will be auto-populated from Census Bureau data (https://www.census.gov). If adjustments to the population estimate are necessary to account for commuters, tourists, or other impacts, insert a modified population. Provide reasons and source(s) used to update the population in the comments.
Number of county, city, tribal, and local health departments	Provide the number of all health departments (not just CRI areas) within your state.
Number of county, city, tribal, and local health departments required to develop local mass prophylaxis plans	Provide the number of all health departments (planning jurisdictions) required to develop mass prophylaxis plans. This number should not be greater than the number of county, city, tribal, and local health departments referenced above.
Number of local CRI planning jurisdictions	Provide all CRI metropolitan statistical area (MSA) planning jurisdictions within your state. If your CRI MSA overlaps your state borders, include only the CRI planning jurisdictions that are within your state.
Number of non-CRI planning jurisdictions	Provide the number of all non-CRI MSAs (as defined by the Office of Management and Budget [OMB]) planning jurisdictions within the state borders.
Total sites that receive materiel directly from the RSS	Given worst-case scenario for your primary risk-based threat, provide the total number of sites that receive materiel directly from the RSS whether regional distribution or local dispensing sites (POD or DVC).
Total number of designated primary open (public) PODs statewide	Provide the total number of public PODs in CRI and non-CRI jurisdictions that would open to give prophylaxis to the entire population. Do not include backup PODs in this number. For the purposes of this estimate, consider drive-through PODs as open PODs, not alternate methods of dispensing.

Form Question	Form Hint
Government responsible for distribution to PODs, hospitals, health care facilities, and other entities (one question for each site type)	Designate which level of government (local, state, or a combination of both) distributes to each various dispensing site type throughout the jurisdiction.
Distribution assets identified in the state plan for use in primary and any additional RSS sites	Select the agencies or organizations (government, military, private business) that will provide personnel and assets to support RSS distribution.
Current EOC and command staff	Given a worst-case scenario for your primary risk-based threat, provide the public health staffing number for the EOC and command staff. The number should represent a 24-hour staffing operation. If the same person fills multiple positions, only count that person one time in the total. If public health staff will serve as liaisons to other agencies, such as the EMA, include them in the total.
Estimate needed EOC and command staff	Provide total EOC and command staff needed for the same scenario. If different then current staff, shortage or excess will be calculated automatically.
RSS Staff (per site)	Given a worst-case scenario for your primary risk-based threat, provide the total current staff available to conduct RSS functions, such as security, logistics, material handling, and inventory management. EOC staff located at the RSS should be included in the EOC staff totals, not the RSS staff total.
Needed RSS staff	Provide total RSS staff needed for the same scenario. If different then current staff, shortage or excess will be noted automatically.
State dispenses directly to public health responders or critical infrastructure personnel (CIP)	Select “yes” if the state dispenses through a closed POD or administers through a closed DVC. Select “no” if local staff are also used. Also, select “No” if state staff only receive MCM assets from local PODS.

What impacts achieving "established" status?

To be eligible for this status, jurisdictions must update and submit the JDS every 12 months. Failure to complete each section can result in "no acknowledgement" by the reviewer and may impede achieving an "established" status.

Jurisdictional Data Sheet (JDS) – Directly Funded Localities (DFLs)

Completed By	Submission Timeline
Directly funded localities	Annual requirement

Form Key Terms (refer to Appendix B): academic institutions, alternate dispensing methods, backup point of dispensing (POD), Cities Readiness Initiative (CRI), closed point of dispensing (closed POD or CPOD), command staff or incident management lead roles, community-based agencies, distribution assets, critical infrastructure personnel (CIP), emergency management agency (EMA), head of household (HoH), materiel, military installations, open point of dispensing (open POD), operational plans, preparedness, public health emergency, Public Health Emergency Preparedness (PHEP) cooperative agreement, regimens per hour (RPH), throughput

Why is this information collected?

The JDS is used to gather information about the jurisdiction's population and staffing to support MCM distribution and dispensing.

What do you need to know about this form?

Form Question	Form Hint
Total sites that receive materiel directly from the RSS	Given either a worst-case scenario or the actual incident or event, provide the total number of sites that receive materiel directly from the RSS and are used as a regional or local distribution sites (RDS or LDS). If you have no intermediate sites within your DFL, enter "0."
Total number of designated primary open (public) PODs DFL-wide	Provide the total number of public PODs that would open to give prophylaxis to the entire population. Do not include backup PODs in this number.
Distribution assets identified in the DFL plan for use in primary and any additional RSS sites	Select the agencies or organizations (government, military, private business) that will provide personnel and assets to support RSS distribution.
Current EOC and command staff	Given a worst-case scenario for your primary risk-based threat, provide the number of public health staffing for the EOC and command staff. The number should represent a 24-hour staffing operation. If the same person fills multiple positions, only count that person one time in the total. If public health staff will serve as liaisons to other agencies, such as the EMA, include them in the total.
Estimate needed EOC and command staff	Provide total EOC and command staff needed for the same scenario. If different then current staff, shortage or excess will be noted automatically.
RSS staff (per site)	Given a worst-case scenario for your primary risk-based threat, provide the current staff total available to conduct RSS functions, such as security, logistics, material handling, and inventory management. EOC staff located at the RSS should be included in the EOC staff totals, not the RSS staff total.
Needed RSS staff	Provide total RSS staff needed for the same scenario. If different then current staff, shortage or excess will be noted automatically.

Form Question	Form Hint
DFL dispenses directly to public health responders or CIP	Select "yes" if the DFL dispenses through a closed POD or administers through a closed DVC. Select "no" if local staff are also used. Also, select "No" if DFL staff only receive MCM assets from local PODS.
Jurisdiction population	Enter population from Census Bureau data (https://www.census.gov). If adjustments to the population estimate are necessary to account for commuters, tourists, or other impacts, insert a modified population. Provide reasons and source(s) used to update the population in the comments.
Closed PODs section	This section will collect information about types of CPODs, including health care entities, businesses, government agencies, military installations, academic institutions, and community-based agencies.
Closed PODs: population served by closed PODs (CPODs)	Provide the total number of people the type of CPOD is intended to serve. Estimate should include family and friends that will receive medications from this location.
Closed PODs: number of CPODs with written operations plans	Of the CPODs with agreements, provide the number of CPODs with written operational plans in each category. For example, if one agreement includes five CPODs, enter "5."
Closed PODs: number of plans reviewed	Of the CPODs with written operational plans in each category, enter the number of CPOD plans that underwent any review by the CRI planning jurisdiction, state, or other agency.
Closed PODs: number of CPODs exercised	Provide number of CPODS (if any) in each category that were exercised at any level (drill, FSE, or incident).
Closed PODs: number of agreements in place with dispensing sites using alternate dispensing methods	Provide a total number for any other MCM dispensing sites used to reach any individuals within the population who cannot access designated open or CPODs. For the purposes of this estimate, consider drive-through PODs as open PODs, not alternate methods of dispensing.
Remaining population to be covered by open PODs	This is auto-calculated based on individuals not included in the total closed POD population estimate. The information should be used in conjunction with the POD planning form for the worst-case scenario with the jurisdiction dispensing to the entire population.
Open PODs: total population per hour to process	This is auto-calculated based on the following formula: $\frac{\text{Remaining population to be covered by open PODs}}{\text{Hours available to complete dispensing operations}}$
Head of household (HoH) Information: maximum regimens dispensed to each HoH	Provide most realistic estimate. However, if unlimited, enter "000."
HoH information: estimated number of regimens dispensed to each HoH	Provide an estimated number of regimens to be dispensed. Estimate is used to calculate throughput.

Form Question	Form Hint
HoH information: calculated throughput if HoH available	Calculation: Total population per hour to process Estimated number of regimens This is auto-calculated based on information entered in prior questions regarding head of household and RPH calculations. The JDS should reflect the number of PODs needed to meet throughput and the POD form should reflect the number of PODs the DFL can actually staff in a worst-case scenario for your primary risk-based threat. Differences between the JDS' auto-calculated number and number of PODs reported on the POD form do not negatively affect scoring or result in punitive consequences. Information informs staffing shortage solutions.
Open PODs cont.: RPH based on model, exercise, or estimate	NOTE: Enter your throughput here, not your RPH. Question mislabeled in DCIPHER. Should be "throughput based on model, exercise, or estimate." Enter throughput-per-hour results found from model, exercise, or estimate above. This value is for auto-calculated fields below.
Open PODs cont.: actual number of open (public) PODs needed to meet the throughput	This is auto-calculated based on information entered in prior questions regarding head of household and throughput modeling calculations.
Open PODs roll-up: current number of PODs	This should be your actual number of primary PODs. If you have based the number of PODs on the actual number of PODs needed to meet throughput, the number should match the calculation in the "Actual number of open PODs needed to meet throughput."
Open PODs roll-up: current throughput	This is auto-calculated based on following calculation: RPH based on model, exercise, or estimate Current number of open PODs
Change in throughput	Calculated based on a difference between current number of PODs and estimated number of PODs. Calculated to show alternative throughput options for current PODs instead of creating additional PODs. If you have an adequate number of PODs, to meet throughput requirements, disregard.

What impacts achieving "established" status?

To be eligible for this status, jurisdictions must update and submit the JDS every 12 months. Failure to complete each section can result in "no acknowledgement" by the reviewer and may impede achieving an "established" status.

Jurisdictional Data Sheet (JDS) – Cities Readiness Initiative (CRI) Local Planning Jurisdictions

Completed By	Submission Timeline
CRI local planning jurisdictions	Annual requirement

Form Key Terms (refer to Appendix B): academic institutions, alternate dispensing methods, Cities Readiness Initiative (CRI), closed point of dispensing (closed POD or CPOD), community-based agencies, head of household (HoH), military installations, open point of dispensing (open POD), operational plans, preparedness, regimens per hour (RPH), throughput

Why is this information collected?

The JDS is used to gather information about the jurisdiction's population and staffing to support MCM dispensing.

What do you need to know about this form?

Form Question	Form Hint
Local population	Enter population from Census Bureau data (https://www.census.gov). If adjustments to the population estimate are necessary to account for commuters, tourists, or other impacts, insert a modified population. Provide reasons and source(s) used to update the population in the comments.
Closed PODs section	This section asks for information about types of CPOD, including health care entities, businesses, government agencies, military installations, academic institutions, and community-based agencies to develop an overall picture of closed POD coverage.
Closed PODs: population served by closed PODs (CPODs)	Provide the total number of people the type of CPOD serves. Estimate should include family and friends that will receive medications from this location.
Closed PODs: number of CPODs with written operations plans	Of the CPODs with agreements, provide the number of CPODs with written operations plans in each category. For example, if one agreement includes five CPODs, enter "5."
Closed PODs: number of plans reviewed	Of the CPODs with written operational plans in each category, enter the number of CPOD plans that underwent any review by the CRI planning jurisdiction, state, or other agency.
Closed PODs: number of CPODs exercised	Provide number of CPODS (if any) in each category that have been exercised at any level (drill, FSE, or incident).
Number of POD agreements with federally recognized tribal nations	Provide all dispensing types (closed PODs, open PODs, and alternate modes of dispensing) planned for persons who work or live on the reservation.
Population served by PODs within federally recognized tribal nations	Provide best estimate of total tribal nation population served by all dispensing types.
Number of PODs with written operations plans (tribal nations)	Of the tribal nation PODs with agreements, provide the number with written operational plans in each category. For example, if one agreement includes two PODs, enter "2."

Form Question	Form Hint
Number of PODs exercised (tribal nations)	Provide number of tribal nation PODS (if any) that were exercised at any level (drill, FSE, or incident).
Alternate dispensing methods: number of agreements in place with dispensing sites using alternate dispensing methods	Provide a total number for any other MCM dispensing sites used to reach any individuals within the population who cannot access designated open or closed PODs. For the purposes of this estimate, consider drive-thru PODs as open PODs, not alternate methods of dispensing.
Remaining population to be covered by open PODs	This is auto-calculated based on individuals not included in the total closed POD population estimate. The information should be used in conjunction with the POD planning form for the worst-case scenario with the jurisdiction dispensing to the entire population.
Open PODs: total population per hour to process	This is auto-calculated based on the following formula: Remaining population to be covered by open PODs Hours available to complete dispensing operations
HoH information: maximum regimens dispensed to each HoH	Provide most realistic estimate. However, if unlimited, enter "000."
HoH information: estimated number of regimens dispensed to each HoH	Provide an estimated number of regimens dispensed. Estimate used to calculate throughput.
HoH information: calculated throughput if HoH available	Calculation: Total population per hour to process Estimated number of regimens This is auto-calculated based on information entered in prior questions regarding HoH and RPH calculations. The JDS should reflect the number of PODs needed to meet throughput and the POD form should reflect the number of PODs the CRI can actually staff in a worst-case scenario for your primary risk-based threat. Differences between the JDS' auto-calculated number and number of PODs reported on the POD form do not negatively affect scoring or result in punitive consequences. Information informs staffing shortage solutions.
Open PODs cont.: RPH based on model, exercise, or estimate	NOTE: Input your throughput here, not your RPH. Question mislabeled in DCIPHER. Should be "throughput based on model, exercise, or estimate." Enter throughput-per-hour results found from model, exercise, or estimate above. This value is for auto-calculated fields below.
Open PODs cont.: actual number of open (public) PODs needed to meet the throughput	This is auto-calculated based on information entered in prior questions regarding head of household and throughput modeling calculations.
Open PODs roll-up: current number of PODs	This should be your actual number of primary PODs. If you have based the number of PODs needed on the actual number of PODs needed to meet throughput, the number should match the calculation in the "Actual number of open PODs needed to meet throughput."
Open PODs roll-up: current throughput	This is auto-calculated based on following calculation: RPH based on model, exercise, or estimate Current number of open PODs

Form Question	Form Hint
Change in throughput	Calculated based on a difference between current number of PODs and estimated number of PODs. Calculated to show alternative throughput options for current PODs instead of creating additional PODs. If you have an adequate number of PODs, to meet throughput requirements, disregard.

What impacts achieving "established" status?

To be eligible for this status, jurisdictions must update and submit the JDS every 12 months. Failure to complete each section can result in "no acknowledgement" by the reviewer and may impede achieving an "established" status.

Jurisdictional Data Sheet (JDS) – U.S. Territories and Freely Associated States (TFAS)

Completed By	Submission Timeline
U.S. territories and freely associated states	Annual requirement

Form Key Terms (refer to Appendix B): academic institutions, alternate dispensing methods, backup point of dispensing (POD), Cities Readiness Initiative (CRI), closed point of dispensing (closed POD or CPOD), command staff or incident management lead roles, community-based agencies, distribution assets, emergency management agency (EMA), head of household (HoH), materiel, military installations, open point of dispensing (open POD), operational plans, preparedness, public health emergency, Public Health Emergency Preparedness (PHEP) cooperative agreement, regimens per hour (RPH), throughput

Why is this information collected?

The JDS is used to gather information about the jurisdiction's population and staffing to support MCM distribution and dispensing.

What do you need to know about this form?

Form Question	Form Hint
Local population	Enter population from Census Bureau (https://www.census.gov). If adjustments to the population estimate are necessary to account for commuters, tourists, or other impacts, insert a modified population. Provide reasons and source(s) used to update the population in the comments.
Total number of health departments	Provide the total number of health departments, including national, state, island, and municipal health departments.
Total number of health departments required to develop local mass prophylaxis plans	Provide the number of all health departments required to develop mass prophylaxis plans. This number should not be greater than the number of health departments referenced above.
Total planning jurisdictions	Provide the number of all planning jurisdictions required to develop mass prophylaxis plans.
Total sites that receive materiel directly from the RSS	Given either a worst-case scenario for your primary risk-based threat or the actual incident or event, provide the total number of sites that receive materiel directly from the RSS and are used as a regional or local distribution sites (RDS or LDS). If you have no intermediate sites within your TFAS, enter "0."
Distribution assets identified in the TFAS plan for use in primary and any additional RSS sites	Select the agencies or organizations (government, military, private business) that will provide personnel and assets to support RSS distribution.
Current EOC and command staff	Given a worst-case scenario for your primary risk-based threat, provide the public health staffing number for the EOC and command staff. The number should represent a 24-hour staffing operation. If the same person fills multiple positions, only count that person one time in the total. If public health staff will serve as liaisons to other agencies, such as the Emergency Management Agency, include them in the total. If no public health staffing is used, enter "000."

Form Question	Form Hint
Estimate needed EOC and command staff	Provide total EOC and command staff needed for the same scenario. If different then current staff, shortage or excess will be noted automatically.
RSS staff (per site)	Given a worst-case scenario for your primary risk-based threat, provide the current staff total available to conduct RSS functions, including security, logistics, material handling, and inventory management. EOC staff located at the RSS should be included in the EOC staff totals, not the RSS staff total.
Needed RSS staff	Provide total RSS staff needed for the same scenario. If different then current staff, shortage or excess will be noted automatically.
TFAS dispenses directly to public health responders or critical infrastructure personnel (CIP)	Select "yes" if the TFAS dispenses through a closed POD or administers through a closed DVC. Select "no" if local staff are also used. Also, select "No" if TFAS staff only receive MCM assets from local PODS.
Total population	Enter population estimates. TFAS are not included in the U.S. census data, so provide the standard reference point in comments.
Closed PODs section	This section will collect information about types of CPODs, including health care entities, businesses, government agencies, military installations, academic institutions, and community-based agencies.
Closed PODs: population served by closed PODs (CPODs)	Provide the total number of people the type of CPOD is intended to serve. Estimate should include family and friends that will receive medications from this location.
Closed PODs: number of CPODs with written operations plans	Of the CPODs with agreements, provide the number of CPODs with written operations plans in each category. For example, if one agreement includes five CPODs, enter "5."
Closed PODs: number of plans reviewed	Of the CPODs with written operations plans in each category, enter the number of CPOD plans that underwent any review by the health department or emergency management agency.
Closed PODs: number of CPODs exercised	Provide number of CPODS (if any) in each category that were exercised at any level (drill, FSE, or incident).
Closed PODs: number of agreements in place with dispensing sites using alternate dispensing methods	Provide a total number for any other MCM dispensing sites used to reach any individuals within the population who cannot access designated open or CPODs. For the purposes of this estimate, consider drive-through PODs as open PODs, not alternate methods of dispensing.

Form Question	Form Hint
Remaining population to be covered by open PODs	This is auto-calculated based on individuals not included in the total closed POD population estimate. The information should be used in conjunction with the POD form to plan for the worst-case scenario with the jurisdiction dispensing to the entire population. From an estimate standpoint, the JDS should accurately reflect what is needed, and the POD form should reflect what you can actually do in the worst-case scenario. No punitive result of negative scoring implication will occur if the JDS auto-calculated number is different from the POD form scenario-based report because of staffing limitations. This information is helpful to indicate where staffing shortages exist for the worst-case scenario.
Remaining population to be covered by open PODs	This is auto-calculated based on individuals not included in the total closed POD population estimate. The information should be used in conjunction with the POD planning form for the worst-case scenario with the jurisdiction dispensing to the entire population.
Open PODs: total population per hour to process	This is auto-calculated based on the following formula: Remaining population to be covered by open PODs Hours available to complete dispensing operations
HoH information: maximum regimens dispensed to each HoH	Provide most realistic estimate. However, if unlimited, enter "000."
HoH information: estimated number of regimens dispensed to each HoH	Provide an estimated number of regimens dispensed. Estimate is used to calculate throughput.
HoH information: calculated throughput if HoH available	Calculation: Total population per hour to process Estimated number of regimens This is auto-calculated based on information entered in prior questions regarding HoH and RPH calculations. The JDS should reflect the number of PODs needed to meet throughput. The POD form should reflect the number of PODs the TFAS can actually staff in a worst-case scenario for your primary risk-based threat. Differences between the JDS' auto-calculated number and number of PODs reported on the POD form do not negatively affect scoring or result in punitive consequences. Information informs staffing shortage solutions.
Open PODs cont.: RPH based on model, exercise, or estimate	NOTE: Input your throughput here, not your RPH. Question mislabeled in DCIPHER. Should be "throughput based on model, exercise, or estimate." Enter throughput-per-hour results found from model, exercise, or estimate above. This value is for auto-calculated fields below.
Open PODs cont.: actual number of open (public) PODs needed to meet the throughput	This is auto-calculated based on information entered in prior questions regarding HoH and throughput modeling calculations.

Form Question	Form Hint
Open PODs roll-up: current number of PODs	This should be your actual number of primary PODs. If you have based the number of PODs needed on the actual number of PODs needed to meet throughput, the number should match the calculation in the "Actual number of open PODs needed to meet throughput."
Open PODs roll-up: current throughput	This is auto-calculated based on following calculation: RPH based on model, exercise, or estimate Current number of open PODs
Change in throughput	Calculated based on a difference between current number of PODs and estimated number of PODs. Calculated to show alternative throughput options for current PODs instead of creating additional PODs. If you have an adequate number of PODs to meet throughput requirements, disregard.

What impacts achieving "established" status?

To be eligible for this status, jurisdictions must update and submit the JDS every 12 months. Failure to complete each section can result in "no acknowledgement" by the reviewer and may impede achieving an "established" status.

Point of Dispensing (POD)

Completed By	Submission Timeline
States (state-run open PODs only) In centralized states complete this form only if the central headquarters operates or manages the PODs	Annual requirement
Directly funded localities	Annual requirement
U.S. territories and freely associated states (see special instructions below)	Annual requirement
CRI local planning jurisdictions	Annual requirement

Form Key Terms (refer to Appendix B): backup (secondary) point of dispensing (POD), Cities Readiness Initiative (CRI), closed point of dispensing (closed POD or CPOD), core staff, head of household (HoH), hybrid point of dispensing (POD), Inventory Management and Tracking System (IMATS), medical model (clinical) POD, preparedness, open point of dispensing (open POD), primary point of dispensing (POD), public health emergency, Public Health Emergency Preparedness (PHEP) cooperative agreement, rapid dispensing model (or nonmedical model), regimens per hour (RPH), technical assistance, tertiary point of dispensing (POD), throughput

Why is this information collected?

The intent of this form is to document POD staffing needs and to capture the estimated numbers of staff currently available across the jurisdiction to serve all primary open PODs in a worst-case scenario given your primary risk-based threat. The POD form collects current planning estimates and information about individually designated primary open POD locations, populations served, and staffing necessary to conduct dispensing activities for one shift. The aggregated POD information can be used to identify staffing shortages within the jurisdiction and opportunities for technical assistance. Using a worst-case scenario for your primary risk-based threat—meaning that the jurisdiction must dispense to the entire population, determine how many PODs could be opened and how each would be staffed.

Process for completing the POD form

Jurisdictions should enter all primary open PODs on the POD planning form by June 30, 2019. Entering POD form information promptly is recommended to provide as complete a picture as possible. Although not required, jurisdictions may enter backup POD, tertiary POD, or closed POD information to provide a complete list of PODs within their jurisdiction.

- CRI jurisdictions and DFLs complete the following sections for all primary open PODs: general POD information, facility address information, additional POD information, antibiotic dispensing operation (only if POD is used for antibiotic dispensing), or vaccine administration (if POD is used for dispensing vaccination)
- TFAS complete general POD information and facility address information sections only

Process for completing staffing sections

Provide current and needed staffing numbers per POD using your best judgment based on information available to identify your staffing types. Sections that are not applicable should be left blank and do not affect status level. Various staffing types are provided as options to

accommodate jurisdictional differences. This data will provide planners with visibility on potential staffing gaps and allow CDC to aggregate data to identify needs and garner support for national staffing efforts.

Staffing Matrix or Model

Complete the form to the extent possible for core security and core management staff assigned to specific PODs, if your jurisdiction's staffing model uses a tiered approach instead of rostering staff for all POD positions. Supporting matrix or model evidence must include a detailed description of how your jurisdiction will acquire any additional assets needed to staff necessary PODs given a worst-case scenario for your primary risk-based scenario. Submitted evidence also should describe all possible staffing sources and options, process to request and mobilize staff, use of staging (if applicable), and just-in-time training plans. PODs not included prior to your ORR site visit should be updated no later than June 30.

TFAS

In the general information section, complete the "POD used as oral antibiotic dispensing clinic and POD used as dispensing vaccination clinic" questions. In the antibiotic dispensing section, submit information for "Population served by the POD" and "Estimated population who will visit the POD." Staffing sections are not required for submission. Complete sections listed for all primary open PODs no later than June 30.

Volunteer staff definition

For the purposes of POD staffing, "volunteer" is broadly defined as an individual or group who contributes time or skills to support of the public health agency's response or is assigned responsibilities not defined in their primary job description that supports the public health agency's response, including public health, medical, and nonmedical personnel.

In jurisdictions where volunteers are not defined or used because of legal or human resource restrictions, for the first variable core medical volunteer staff, manually enter "NA" and then enter 000 for the number of current staff. This will auto-populate your total as 000 and be coded as volunteers not allowable.

What do you need to know about this form?

Form Question	Form Hint
POD name	Designate a unique name for the POD, such as "Open POD Columbus Tustin Activity Center" or "POD Walgreens30032." The name will be required on relevant operational forms that require POD drill, exercise, or real incident data.
POD planning type	Designate the PODs that could be opened as primary PODs. Although not required, jurisdictions may input POD planning data for secondary, tertiary, or closed PODs.
POD used as oral antibiotic dispensing clinic	Indicate if this POD is used to dispense oral antibiotics. Indicating "Yes" will add questions to address POD staffing and operations.
POD used as dispensing vaccination clinic	Indicate if this POD also is used to administer vaccines. Indicating "Yes" will add questions to address vaccination staffing and operations.
Facility address	Indicate physical (not mailing) address of facility.

Form Question	Form Hint
Other identifier (optional 1 and 2) facility notes	Include any notes of interest, including conversion of latitude and longitude numerical coordinates into GPS coordinates using degrees, minutes, and seconds as calculated in http://www.latlong.net.
Latitude (optional)	You may use http://www.latlong.net. If available, input number for latitude and use the link to convert to GPS coordinates. Place GPS coordinates for both in "other identifier" box above. GPS coordinates may be necessary for helicopter arrivals.
Longitude (optional)	You may use http://www.latlong.net. If available, input number for longitude and use the link to convert to GPS coordinates. Place GPS coordinates for both in "other identifier" box above.
Type of facility (select 1)	Select appropriate facility in which the POD will be set up. For K-12 schools, select academic institution.
Primarily walk-through, drive-through or combination of both (select one)	Drive-through PODs are considered open PODs instead of alternate modes of dispensing. See also JDS section.
Maximum number of dispensing stations in the POD design	Given a worst-case scenario for your primary risk-based threat, provide the maximum number of stations this POD could set up for antibiotic dispensing.
Population served by the POD	Provide the estimated total number of people expected in the geographic area who will receive their regimens from this POD. To the degree possible, calculate the total number of people within the geographic area who will receive prophylaxis (taking into consideration residential, worker, and visitor population estimates) and subtract the estimated population to be served via alternate dispensing strategies and closed PODs.
Estimated population who will visit the POD	Provide an estimate of the number of people from each geographic unit of analysis anticipated to visit a POD. If an HoH model is planned, estimate the average number of regimens the HoH will receive.
Required POD person per hour to meet the 48-hour goal	Provide the throughput number using this formula: Estimated population who will visit the POD (48-hour target time) - (distribution time)
Antibiotic dispensing staff section	Complete if applicable to this POD's staffing plans. This section will collect information about types of staff, such as security, management or lead, health department, volunteer, medical, and nonmedical, required to operate the POD for the first shift. For sections that do not apply to this POD, leave blank.
Core security staff	For security staff, enter number of staff available and designated to serve as security for this POD site. Staff used to maintain safety and security at POD. If this number cannot be provided (given a security contract), enter "000."
Total current core (security) staff	Provide the total number of staff available (actual staff in place) and ready to participate.

Form Question	Form Hint
Total needed core (security) staff	Provide the minimum number of staff needed to allow the POD to function. For security staff, it may be the number that will be requested from local EOC or law enforcement.
Total shortage or excess core (security) staff	Auto-calculated value based on the following formula: Total current core staff - Total needed core staff
Additional required security staff	Provide any additional security staff available. For sections that do not apply to this POD, leave blank.
Total current additional (security) staff	Additional staff that may be used to support POD operations. If not applicable, leave blank.
Total needed additional (security)staff	Provide the minimum number of staff needed to support POD functions. If not applicable, leave blank.
Total shortage or excess additional staff	Auto-calculated value
Note about completion of staffing types	Indicate the position types used for each staff category for a given POD. Submitting the number of current staff and needed without indicating the staffing type of each is acceptable. For example, if six core management or lead staff are available for this POD, but is dependent upon scenario need, leave staffing type blank, and enter "6" in current staff section. Continue in a likewise fashion for each type of staff. For sections that do not apply to a POD, leave blank. Avoid double counting staff to the extent possible. Rather, include staff once in the most likely role they will fill.
Core management or lead staff	POD management lead staff includes manager, operations chief, logistics chief, and other similar positions. Staff identified and needed to activate and prepare for POD functions.
Additional management or lead staff	Additional POD management lead staff may include tactical communications lead, IT leader, forms or data collection lead, staff care lead, and other similar positions. Staff that may support POD functions.
Core medical health department staff	Provide the minimum number of medical staff that will be used for core function, such as dispensing lead. Medical staff can be from any part of the health department if they will be used to support clinical POD operations. Section may be left blank if POD does not use health department staff.
Additional medical health department staff	Include any additional medical staff that would be used in a surge event. Section may be left blank if POD does not use health department staff.
Core nonmedical health department staff	Provide the minimum number of staff from any part of the health department needed to conduct non-clinical POD operations, such as dispensing station staff. Section may be left blank if POD does not use health department staff.

Form Question	Form Hint
Additional nonmedical health department staff	Provide the minimum number of staff from any part of the health department that may support non-clinical POD operations, such as extra greeters or floaters. Section may be left blank if POD does not use health department staff.
Core medical volunteer staff	Provide the minimum number of medical staff from any volunteer organizations needed to conduct clinical POD operations, such as dispensing lead. Section may be left blank if POD does not use volunteer organizations.
Additional medical volunteer staff	Provide the minimum number of medical staff from any volunteer organizations that may support clinical POD operations, such as extra medical personnel to explain adverse events. Section may be left blank if POD does not use volunteer organizations.
Core nonmedical volunteer staff	Count staff from any volunteer organizations needed to conduct non-clinical POD operations, such as dispensing station staff. Section may be left blank if POD does not use volunteer organizations.
Additional nonmedical volunteer staff	Provide the minimum number of staff from any volunteer organizations that may support non-clinical POD operations, such as extra greeters or floaters. Section may be left blank if POD does not use volunteer organizations.
Antibiotic dispensing operation – total current staff	Include current core staff across all staffing types to provide aggregate estimate for staff for this POD.
Total number of current core staff per operational shift	Total of all core staff from above. If staffing matrix provided, include approximate total core staff here.
Total number of current additional staff per operational unit	Total of all additional staff from above. If staffing matrix provided, include approximate total additional staff here.
Vaccine administration clinic	Complete items if the POD is used for vaccine administration
Maximum number of vaccination stations in the clinic design	Given a worst-case scenario for your primary risk-based threat, provide the maximum number of stations this POD clinic could set up for vaccine administration.
Estimated throughput – person per hour	Provide estimate based on maximum number of stations set up in the clinic.
Vaccine administrative staff	Complete this section as applicable using guidance from previous antibiotic dispensing staffing sections.

What impacts achieving "established" status?

To be eligible for this status, submit information for primary open PODs. All open PODs data must be updated by June 30. The POD form should be reviewed (to add or remove retired PODs) and resubmitted every 12 months. If PODs are added periodically, resubmit POD form with each addition.

For jurisdictions with only one open POD serving the entire jurisdiction, submit the POD form for the single open POD and include one backup (secondary POD).

Failure to complete each section can result in "no acknowledgement" by the reviewer and may impede achieving an "established" status.

Receipt, Stage, Store (RSS) Site Survey

Completed By	Submission Timeline
States, Puerto Rico	Every 3 years (from last site visit) or as changes occur
Directly funded localities	Every 3 years (from last site visit) or as changes occur
U.S. territories and freely associated states (TFASs require only primary RSS survey)	Every 3 years (from last site visit) or as changes occur

Form Key Terms (refer to Appendix B): after-action report (AAR), alert, cross-docking, fire suppression system, medical countermeasures (MCMs), preparedness, public health emergency, Public Health Emergency Preparedness (PHEP) cooperative agreement, rapid dispensing model (or nonmedical model), RSS facility, request, resources, Strategic National Stockpile (SNS), United States Marshals Service (USMS), voice over Internet protocol (VoIP)

Why is this information collected?

The RSS site survey provides situational awareness about potential MCM storage facilities. The information in the form is used at the time of the validation/revalidation visit to determine whether a site is appropriate to receive, store, and distribute MCM assets. Types of information collected on the RSS site survey include physical facility and surrounding area detail, security considerations, staffing information, environmental controls, and cold chain management capability.

What do you need to know about this form?

All variables in the table below are required for submission within DCIPHER.

Form Question	Form Hint
Date of visit (to include SNS and USMS)	Enter the date of the RSS validation/revalidation site visit; sites must be validated at least every three years.
Facility physical address	This is a required field. Provide street address, city, state, county, country, and zip code and any descriptive information, including major crossroads, highway exit name or number, and landmarks. This information must be provided for a site to be validated.
Dimensions or square footage of facility	This is a required field. Provide descriptive information about the site. Include any physical characteristics critical to operations. Adequate preparation requires jurisdictions identify enough space to accomplish receipt, stage, and store tasks. Jurisdictions with small spaces should develop strategies to assure fluid operations or identify larger space for potential alternate RSS site.
Facility has hard surface floors	This is a required field. "No" responses require justification for the reviewer to verify site acceptability.
Flooring surface supports modern material handling equipment	This is a required field. "No" responses require justification for the reviewer to verify site acceptability.
Facility clean and free from infestation by insects, rodents, birds, or vermin or chemical and mechanical hazards.	This is a required field. Select "Yes" if petroleum products are stored safely and kept separately from storage space used for MCMs. This is a required field. "No" responses require justification for the reviewer to verify site acceptability.

Form Question	Form Hint
Fire safety plan in place	This is a required field. "No" responses require justification for the reviewer to verify site acceptability.
Number of loading docks available at the facility for MCM operations	This is a required field. Numerical field entry. Recommendation is for two docks available for receiving and three for shipping. Enter "0" if no loading docks are available. Sites with no loading docks will have to describe how material is loaded and unloaded to assure reviewer is satisfied that the site can adequately function.
Receiving and staging area floor free of holes, doorstops, or other obstructions	This is a required field. "No" responses require justification for the reviewer to verify site acceptability.
Driveway to docks can accommodate a 53-foot trailer and 11-foot tractor with turning radius 95 feet or more	This is a required field. "No" responses require justification for the reviewer to verify site acceptability.
Multiple trucks have a secure area to wait until offload of MCM assets at the RSS site	This is a required field. "No" responses require justification for the reviewer to verify site acceptability.
Loading docks and receiving area have adequate lighting	This is a required field. "No" responses require justification for the reviewer to verify site acceptability.
If storing product long term, facility offers temperature-controlled storage for pharmaceuticals, which generally range between 68°F to 77°F (20°C to 25°C)	This is a required field. "No" responses require justification for the reviewer to verify site acceptability.
If storing product long term, facility has a working and tested temperature monitoring or logging device or service to monitor and record the temperature	This is a required field. "No" responses require justification for the reviewer to verify site acceptability.
Facility has a working and tested alarm and notification system to notify personnel if the temperature falls out of range (exceeds 104°F [40°C]) for more than 4 hours	This is a required field. "No" responses require justification for the reviewer to verify site acceptability.
Facility offers on-site refrigerated and frozen storage areas for cold chain managed items, such as vaccines	This is a required field. "No" responses will require justification for the reviewer to verify site acceptability.
Describe contingency plan for providing cold storage for pharmaceuticals (medical countermeasures) if the capability does not exist at this facility	This is a required field. If cold storage for pharmaceuticals does not exist at the facility, provide a brief explanation about contingency plans. This is a required field and "No" responses will require negotiations with the reviewer. If cold storage exists within the facility, enter **"NA/ capability exists at this facility"** in the text box in order to allow the form submission. Resource: Cold Chain Management in Receiving, Distributing, and Dispensing Strategic National Stockpile Assets: A Guide for Preparedness, Version 11.
Based on state or local law enforcement security assessment, this facility is appropriate for securely receiving, storing, and staging federal MCM assets	This is a required field. Security assessment from state or local law enforcement required every three years as part of certification. This is a required field. "No" responses will require negotiations with the reviewer.

Form Question	Form Hint
Interior has sufficient lighting to perform work required and maintain a safe workplace per OSHA standards	This is a required field. OSHA standards: physical plants, shops, machining areas, equipment and work rooms is 10 candle-feet and office areas require at least 30 candle-feet of illumination. Title 29 of the Code of Federal Regulations at section 1926.56 sets out the units or candle-feet of light required for various types of work. This is a required field. "No" responses will require negotiations with the reviewer.
Facility has eating and break areas	This is a required field. "No" responses will require negotiations with the reviewer.
Facility has drinking water fountains or access to potable water	This is a required field. "No" responses will require negotiations with the reviewer.

What impacts achieving "established" status?

To be eligible for this status, states, DFLs, and Puerto Rico must submit the required variables described above and upload the validated RSS site survey as evidence for a primary site and additional RSS sites every three years or as changes occur. All other U.S. territories and freely associated states must update and submit the RSS site survey only for a primary site (no additional or secondary site) every three years or as changes occur. For all recipients (states, DFLs, and TFAS), a site visit and certification of the RSS by **the SNS representative and the U.S. Marshal are required to validate the site** every three years.

Failure to complete each section can result in "no acknowledgement" by the reviewer and may impede achieving an "established" status.

PLANNING FORMS

Distribution Planning

Completed By	Submission Timeline
States	Annual requirement
Directly funded localities	Annual requirement
U.S. territories and freely associated states	Annual requirement
CRI local planning jurisdictions	Annual requirement

Form Key Terms (refer to Appendix B): all-hazard incidents, chain of custody, chief medical officer, Cities Readiness Initiative (CRI), closed point of dispensing (closed POD or CPOD), command staff or incident management lead roles, delivery schedule, demobilize, Drug Enforcement Administration (DEA), durable medical equipment, economically disadvantaged, emergency operations coordination, emergency operations plan (EOP), event, incident, interagency agreement (IAA), intergovernmental agreement (IGA), intermediary or intermediate distribution sites, Inventory Management System (IMS), materiel, medical countermeasures (MCMs), memorandum of agreement (MOA), memorandum of understanding (MOU), public health emergency operations plan (PHEOP), preparedness, promulgated plan, public health emergency, Public Health Emergency Preparedness (PHEP) cooperative agreement, receipt, stage, and store (RSS) facility, regional distribution site (RDS) or local distribution site (LDS), request, resources, scalability, standard operating procedure (SOP), subject matter expert (SME), vendor

Why is this information collected?

The distribution planning form provides insight about procedures for handling medical materiel management and distribution. While the primary questions address those components, additional questions from Capability 3: Emergency Operations Coordination are included for related situational awareness. Questions not specific to handling medical materiel management and distribution should be answered based on overall PHEP planning and, as applicable, to strengthen MCM plans.

How is the status for this section assessed?

Multiple criteria must be addressed to be considered eligible for "established" status within the planning form. Criteria to achieve "established" is detailed for each question and summarized at the end of each planning form. See also Appendix D: 2018–2019 ORR Status Tips.

What do you need to know about this form?

Form Question (and Hint)	Reviewer Criteria
Date of most recent preparedness plans review or update A plan should be reviewed and signed every 2 years to meet criteria toward achieving an "established" planning status.	**Concur or Sufficient Evidence** All-hazards plans that include MCM distribution and dispensing are acceptable. The document must identify the signatory authority. Any plan (draft or final) signed by the PHEP director within 2 years of the date of the review is acceptable. In lieu of the PHEP director's signature, having their designee's or a higher-level authority's signature is acceptable. **Insufficient Evidence** All-hazards plans do not include an MCM distribution and dispensing component or the date is outside of the 2-year timeframe. **No Evidence** No plan is provided. **Contradictory Evidence** The date on the plan is different from date uploaded in the DCIPHER system.
Plans include strategies to coordinate with SMEs to inform incident management decision making Plans should identify a process for including or consulting with appropriate SMEs for a particular incident to meet criteria toward achieving an "established" planning status.	**Concur or Sufficient Evidence** Written plans should include a well-defined process for identifying and consulting appropriate SMEs to develop a response strategy for a particular incident. A decision matrix that describes the functional roles needed to activate the EOC and process for consulting SMEs or evidence of a meeting with SMEs during which input on response strategies was provided also are acceptable. **Insufficient Evidence** Some, but not all, required evidence is provided. **No Evidence** None of the following evidence is provided: decision matrix, points of contact for relevant SMEs, and process for contacting SMEs. **Contradictory Evidence** Multiple pieces of evidence lack consistent information or reference to relevant documents is not available. For example, content differs between the PHEOP and SNS plans.

Form Question (and Hint)	Reviewer Criteria
Standard operating procedures for the EOC include full activation procedures, notification procedures, partial activation procedures, staff authorized to activate EOC Evidence should be provided for full or partial-activation procedures, notification procedures, and staff roles authorized to stand up the EOC to meet criteria toward achieving an "established" planning status. • EOC activation – Plans should include circumstances that would lead to an activation, such as a) who has authority and responsibility to make the decision to activate, b) what the circumstances are for activation, c) when the activation occurs, and d) how the level of activation is determined. The decision-making process for EOC activation should be documented. • Time-phased activation or similar activation determination should be presented for incidents that are expected to build over time, incidents for which a warning period is present before an emergency, and for planned events. • Levels of activation should be based on triggers (defined by actual or anticipated levels of damage) and communication with the incident commander or unified command and should be linked to jurisdiction's risk analysis. • Full activation includes all personnel. • Partial activation should include key personnel and personnel from responding agencies and monitoring to determine activation should include key personnel. • EOC should be capable of independent and 24/7 operations for at least 2 weeks (FEMA's EOC Management and Operations Resource Guide, sustainability definition). • EOC deactivation decisions will vary by jurisdiction. Deactivation usually occurs in phases similar to activation. The authority to begin full or partial deactivation should be clearly stated in EOP or other documentation.	**Concur or Sufficient Evidence** Full or partial activation procedures – Evidence should include triggers, pre-event indicators, EOC activation levels, activation processes, minimum staffing requirements based on activation levels, logistics, process for deactivation, and a plan for sustained operations. Notification procedures – Evidence should include a description of notification process, including system(s) used and how often contact information is updated. Staff authorized to activate EOC – Evidence should include functional role(s) or position(s) (as defined by the jurisdiction) with the authority to stand up the EOC. **Insufficient Evidence** Some, but not all, required evidence is provided. **No Evidence** No plan is provided. **Contradictory Evidence** Multiple pieces of evidence lack consistent information or reference to relevant documents is not available. For example, content differs between the PHEOP and SNS plans.

Form Question (and Hint)	Reviewer Criteria
Identified incident command staff include: incident commander, chief medical officer, chief science officer, epidemiologist, finance/ administration section chief, infectious disease/influenza SME, liaison officer, logistics section chief, operations section chief, planning section chief, public information officer, safety officer, other • Use the "other" category, to specify MCM specific / public health roles beyond the command and general staff level. Evidence should be provided for incident commander, finance/administration section chief, logistics section chief, operations section chief, planning section chief, and public information officer to meet criteria toward achieving an "established" planning status. Chief Medical Officer, Chief Science Officer, Epidemiologist, Infectious Disease/Influenza SME are functional roles that support command staff as needed in the event of a pandemic influenza response. While these roles are not NIMS specific, jurisdictions are encouraged to define how these experts will be used in the instance of a response.	**Concur or Sufficient Evidence** Job action sheet or other documents must outline requirements and duties, roles and responsibilities, and required qualifications or skillset per NIMS guidance (https://www.fema.gov/national-incident-management-system) for each role; staff titles might differ by jurisdiction; select the role that best matches the expected staff activities and responsibilities. Rosters or staffing matrices that indicate sufficient staff to fill primary and backup positions for a 24-hour operational period should be provided. **Insufficient Evidence** Only the name and role are provided. Excludes responsibilities of the position or qualifications or skillset required to successfully perform the role. **No Evidence** No job action sheets or other documentation are provided. **Contradictory Evidence** Multiple job action sheets do not align.

Form Question (and Hint)	Reviewer Criteria
Transportation agreements include primary transport, backup transport; operators; types of drivers or specially licensed operators; vehicles: load capacity, number available, type; vendor agreements with MOUs; procedures to maintain cold chain management; jurisdiction's response time for initial transportation requirements • CRI planning jurisdictions with responsibility for RDS or LDS transportation strategy are required to provide transportation agreements. Evidence also must include an explanation about how agreements are satisfied. • For operators, provide estimated number of available drivers for the largest planned incident or event. If agreements are in place with other agencies companies for transportation, such as United Parcel Service (UPS) or the Department of Transportation (DOT), that determine number of vehicles based on scale of incident, enter "000" and specify in the "Other" category. "Other, specify" is appropriate for evidence of agreements external to your agency or department, such as DOT or private business. • For number of available vehicles, provide estimate of how many vehicles will be available for the largest planned incident or event. • Regarding vendor agreements with MOUs, some jurisdictions will rely exclusively on the services of a vendor for their transport capability, while others will rely on a combination of public and private resources. • Response time for transport refers to the expected time for vendors to provide needed transportation assets based on scale of incident. Evidence for all items should be provided to meet criteria toward achieving an "established" planning status	**Concur or Sufficient Evidence** Primary and backup transport – Signed MOAs, MOUs, IGAs, IAAs, contracts, or a promulgated plan indicating how transportation will be procured, for example, through Emergency Support Function (ESF)-1. Draft documents also are acceptable. The documents should identify roles and responsibilities of primary and backup transport agencies, and relevant partners should acknowledge their roles and responsibilities. Operators – Evidence should include the number in the driver pool or the jurisdiction's planning estimates. Vehicles • Load capacity – Evidence should include the capacities for identified vehicles. • Number available – Evidence should include the number in a vehicle pool or the number the jurisdiction will request. • Type – Evidence should include the types of vehicles available or the types the jurisdiction will request. Vendor agreements with MOUs – Written acknowledgement in the form of a MOU or other documentation is acceptable. Procedures to maintain cold chain management – Evidence should include standard protocols, such as use of refrigerator delivery vehicles, product packaging, and bill of lading during transport. Jurisdiction's response time for initial transportation requirements – Evidence should include the expected time for vendors to provide needed transportation assets based on type or scale of incident and for the arrival of assets. **Insufficient Evidence** Some, but not all, required evidence is provided. **No Evidence** No transportation plan or agreement is provided. **Contradictory Evidence** Transportation agreements or promulgated planning documents do not align.

Form Question (and Hint)	Reviewer Criteria
States, DFLs, or TFAS **RSS staff identified – Distribution lead, primary; distribution lead, backup; logistics, primary; logistics, backup; receiving site lead, primary; receiving site lead, backup; security coordinator, primary; security coordinator, backup; current DEA registrant (identified or access to); other RSS staff** • In "Other" category, recipient should indicate if any of these positions are located at the public health EOC. • Current DEA registrant includes the DEA registrant or other individuals authorized to sign for MCMs. At a minimum, evidence for requirements of distribution lead and backup, logistics primary, receiving site lead, security coordinator, and DEA registrant should be provided to meet criteria toward achieving an "established" planning status.	**Concur or Sufficient Evidence** Job action sheet or other documents must outline requirements and duties, roles and responsibilities, and required qualifications or skillset. **Insufficient Evidence** Only the name and role are provided. Excludes responsibilities of the position or qualifications or skillset required to successfully perform the role. **No Evidence** No job action sheets or other documentation are provided. **Contradictory Evidence** Multiple job action sheets do not align.
RDS or LDS staff identified: distribution lead, primary; distribution lead, backup; logistics, primary; logistics, backup; receiving site lead, primary; receiving site lead, backup; security coordinator, primary; security coordinator, backup; current DEA registrant; other RDS or LDS staff • In "Other" category, recipient should indicate if any of these positions are located at the public health EOC. • Current DEA registrant includes the DEA registrant or other individuals authorized to sign for MCMs. • "Not applicable" applies to CRI local planning jurisdictions that do not have the responsibility for establishing and maintaining an RDS or LDS. Required for CRI planning jurisdictions that do establish and maintain an RDS or LDS. If states distribute directly to PODs or do not have responsibility for RDS or LDS staff, state may select "Not applicable" (N/A). However, if RDS or LDS do exist within the state proximity, locals must provide information on staff. In each state for which an RDS or LDS role exists, either the state or the CRI must define staffing roles. If applicable, evidence for requirements of distribution lead, logistics primary, receiving site lead, security coordinator, and DEA registrant should be provided to meet criteria toward achieving an "established" planning status. If "Not applicable" applies (and is verified), this section will not count toward status.	**Concur or Sufficient Evidence** Job action sheet or other documents must outline requirements and duties; roles and responsibilities; and required qualifications or skillset. **Insufficient Evidence** Only the name and role are provided. Excludes responsibilities of the position or qualifications or skillset required to successfully perform the role. **No Evidence** No job action sheets or other documentation are provided. **Contradictory Evidence** Multiple job action sheets do not align.

Form Question (and Hint)	Reviewer Criteria
Plans include the following elements for requesting medical materiel: assessment of local inventory and medical countermeasure caches, decision process, identification of local pharmaceutical and medical-supply wholesalers, and process for requesting medical countermeasures Evidence for all items should be provided to meet criteria toward achieving an "established" planning status.	**Concur or Sufficient Evidence** Assessment of local inventory and medical countermeasure caches – Evidence should include procedures to assess local, regional, and state inventory levels, and inventory and MCM caches available for the response. Decision process – Evidence should include appropriate jurisdictionally-defined procedures to initiate request for MCMs. Identification of local pharmaceutical or medical-supply wholesalers – Evidence should include procedures to identify sites or wholesalers that may have inventory for use in a response. Process for requesting medical countermeasures – Evidence should include appropriate jurisdictionally-defined procedures to request MCMs from entities, including local, state, regional, and federal (as applicable to the jurisdiction). **Insufficient Evidence** Some, but not all, required evidence is provided. **No Evidence** No plan is provided. **Contradictory Evidence** Multiple pieces of evidence lack consistent information or reference to relevant documents is not available. For example, content differs between the PHEOP and SNS plans.
States, DFLs, or TFAS **Security plans for primary RSS include security lead during public health emergency response, evacuation plans, exterior physical security of locations, interior physical security of location, and security breach plans** • U.S. Marshals are the SMEs who can verify RSS site-specific security plans and can provide feedback to MCM specialists and law enforcement. • If security plans are created and maintained by law enforcement partners, a trusted agent can verbally affirm to the reviewer that the security lead during a public health emergency response, evacuation plans, exterior security for location, interior security for location, and security breach procedures, or security command or management plan are clearly defined. Evidence or verification by trusted agent must be provided for all underlined elements to meet criteria toward achieving an "established" planning status.	**Concur or Sufficient Evidence** Exterior security for location – Evidence should include specialized unit needs, canine explosive ordinance disposal, unit barriers, additional lighting, staging areas for people in vehicles, identification of entrances and exits, and external crowd control. Interior security for location – Evidence should include a security sweep before facility use, access controls in the facility, badging, internal crowd control, and establishing law enforcement officer posts. Security breach procedures – Evidence should include evacuation or safety plans to enable people to shelter in place. **Insufficient Evidence** Some, but not all, required evidence is provided. **No Evidence** No documentation provided. **Contradictory Evidence** Multiple documents do not align.

Form Question (and Hint)	Reviewer Criteria
Security plans for primary RDS or LDS include security lead during public health emergency response, evacuation plans, exterior physical security of locations, interior physical security of location, and security breach plans • "Not applicable" only applies to CRI local planning jurisdictions that do not have the responsibility for establishing and maintaining an RDS or LDS. Required for CRI planning jurisdictions that do establish and maintain an RDS or LDS. • If security plans are created and maintained by law enforcement partners, a trusted agent can verbally affirm to the reviewer that the security lead during public health emergency response, evacuation plans, exterior security for location, interior security for location, and security breach procedures, or security command or management plan are clearly defined. Evidence or verification by a trusted agent must be provided for all underlined elements to meet criteria toward achieving an "established" planning status.	**Concur or Sufficient Evidence** Exterior security for location – Evidence should include specialized unit needs, canine explosive ordinance disposal, unit barriers, additional lighting, staging areas for people in vehicles, identification of entrances and exits, and external crowd control. Interior security for location – Evidence should include a security sweep before facility use, access controls in the facility, badging, internal crowd control, and establishing law enforcement officer posts. Security breach procedures – Evidence should include evacuation or safety plans to enable people to shelter in place. **Insufficient Evidence** Some, but not all, required evidence is provided. **No Evidence** No documentation provided. **Contradictory Evidence** Multiple documents do not align.
Transportation security plans include crossing jurisdictional lines, crossing governmental sovereignty, MCM arriving at RSS, MCM transported from RSS to RDS, LDS, or receiving site, such as a POD, and MCM transported from RDS or LDS to receiving site • "Not applicable" only applies to CRI local planning jurisdictions that do not have the responsibility of developing and executing a distribution transportation strategy. Evidence for transportation security should be provided (to include at least tracking of materiel) for crossing jurisdictional lines, MCM arriving at RSS, and MCM transported from RSS to RDS, LDS, or receiving site to meet criteria toward achieving an "established" planning status. MCM transported from RDS or LDS to receiving site is applicable to states with an RDS or LDS. Crossing governmental sovereignty is applicable only to states with tribal nations and is reviewed on a case-by-case basis.	**Concur or Sufficient Evidence** Evidence must include protocols for crossing jurisdictional lines, crossing governmental sovereignty, MCM arriving at RSS, MCM transported from RSS to RDS, LDS, or receiving site, such as a POD, and MCM transported from RDS or LDS to receiving site. Security contract with police or private security that includes all elements is acceptable evidence. If such a contract exists, but is not available for review, verification from a trusted agent is acceptable. **Insufficient Evidence** Some, but not all, required evidence is provided. **No Evidence** No transportation security plan is provided. **Contradictory Evidence** Transportation security procedures differ across planning documents. For example, SNS base plan and a security annex.

Form Question (and Hint)	Reviewer Criteria
Allocation and distribution elements include chain of custody, cold chain, delivery locations, delivery schedule, transportation method(s), transportation routes, receive from intermediary site, and process for allocating limited materiel • "Not applicable" only applies to CRI local planning jurisdictions that do not have allocation and distribution responsibilities. • With regard to transportation routes, knowledge of the whereabouts and security of medical materiel is always the responsibility of the state. Evidence should be provided for chain of custody, cold chain, delivery locations, delivery schedule, transportation methods, and transportation routes to meet criteria toward achieving an "established" planning status.	**Concur or Sufficient Evidence** Chain of custody – Evidence should include chain of custody process and forms. Cold chain – Evidence should describe the process necessary to monitor and maintain appropriate temperature at fixed locations and during transport, available freezer or refrigeration capabilities, or processes to acquire these assets. Documents should reference relevant elements from RSS site survey. List of delivery locations – Evidence should include locations such as RDS, LDS, open and closed PODs, and hospitals. Delivery schedule – Evidence should include allocation tables, routes, load plans, a delivery schedule, and a decision-making process to handle factors that could affect the delivery schedule, such as road closures and alternative routes. Transportation methods – Evidence should include a list of methods. Transportation routes – Evidence should include route planning or a process to address real-time conditions, and how the jurisdiction will maintain knowledge of the whereabouts and security of medical materiel at all times. Receive (confirmation) from intermediary site – Evidence should specify a process to receive acknowledgement from the RDS or LDS, such as e-mail or phone. Process for allocating limited materiel – Evidence should describe process for allocating and targeting critical workforce groups for vaccination in accordance with CDC guidance for a pandemic influenza scenario. **Insufficient Evidence** Some, but not all, required evidence is provided. **No Evidence** No plan is provided. **Contradictory Evidence** Procedures differ across planning documents.

Form Question (and Hint)	Reviewer Criteria
Recovery and demobilization elements include recovery of durable medical equipment and recovery of materiel • "Not applicable" only applies to CRI local planning jurisdictions that do not have the responsibility of recovery and demobilization. Evidence for both elements is required to meet criteria toward achieving an "established" planning status.	**Concur or Sufficient Evidence** Recovery of durable medical equipment and material – Evidence should identify responsible personnel, describe the process, and outline assets needed, such as vehicles, for recovery of durable medical equipment and MCM. Evidence also should include where durable medical equipment and MCMs will be taken or stored, such as back to RSS. **Insufficient Evidence** Recovery procedures for durable medical equipment or materiel are missing or are not thoroughly described. **No Evidence** Recovery procedures are not provided. **Contradictory Evidence** Recovery procedures differ across planning documents.

What impacts achieving "established" status for the distribution planning section overall?

To be eligible for "established" status, the jurisdiction's preparedness plan document(s) should be reviewed and signed every 2 years. Secondly, plans should identify a process for including or consulting with appropriate SMEs for a particular incident.

Standard operation procedures, at minimum, must include full activation procedures, notification procedures, partial activation procedures, and staff authorized to activate the EOC. In addition, the incident commander, finance or administration section chief, logistics section chief, operations section chief, planning section chief, and public information officer must be identified and clearly defined in the evidence to be eligible for the status. The same person can fill multiple positions, but each position description should be defined separately in the planning evidence.

Transportation agreements, at minimum, must describe primary transport, backup transport, operators, types of drivers or specially licensed operators, load capacity for vehicles, number of available vehicles, types of vehicles, vendor agreements with MOUs, procedures to maintain cold chain management, and the jurisdiction's response time for initial transportation requirements to be eligible for this status.

For RSS staff, the primary and backup distribution lead, primary logistics position, primary receiving site lead, primary security coordinator, and current DEA registrant (or individual[s] authorized to sign for MCMs) must be identified and clearly defined in the evidence to be eligible for the status.

Similarly, for RDS or LDS staff, the primary distribution lead, primary logistics position, primary receiving site lead, primary security coordinator, and current DEA registrant (or individual[s] authorized to sign for MCMs) must be identified and clearly defined in the evidence to be eligible for the status.

In addition, plans for requesting medical materiel must outline the assessment of local inventory and MCM caches, the decision process for acquiring medical materiel, identification of local pharmaceutical or medical-supply wholesalers, and the process for requesting medical countermeasures to be eligible for the status. Security plans for the primary RSS, at minimum, must clearly delineate a security lead during a public health emergency response, evacuation plans, exterior physical security of locations, interior physical security of location, and security breach plans to be eligible for the status. Additionally, transportation security plans must clearly explain the process for crossing jurisdictional lines; crossing governmental sovereignty (if applicable); MCM arriving at RSS; MCM transported from RSS to RDS, LDS, or POD; and MCM transported from RDS or LDS to POD (if applicable) to be eligible for the status.

Allocation and distribution plans must clearly define chain of custody, cold chain, delivery locations, delivery schedule, transportation method(s), transportation routes, and receive from intermediary site(s)(if applicable) to be eligible for the status. Allocation plans should also describe how limited resources, such as durable medical equipment during an incident, would be accessed, managed, and prioritized. Lastly, recovery and demobilization plans must clearly describe the recovery of durable medical equipment and materiel to be eligible for the status.

To be eligible for this status, jurisdictions must update and submit the ORR distribution planning form every 12 months.

Dispensing Planning

Completed By	Submission Timeline
States	Annual requirement
Directly funded localities	Annual requirement
U.S. territories and freely associated states	Annual requirement
CRI local planning jurisdictions	Annual requirement

Form Key Terms (refer to Appendix B): alert, all-hazard incidents, at-risk populations, Cities Readiness Initiative (CRI), command staff or incident management lead roles, community preparedness, critical infrastructure personnel, critical workforce group, dispensing modalities, displaced persons, economically disadvantaged, emergency management, Capability 4: Emergency Public Information and Warning, dispensing vaccination clinic, (DVC), event, functional needs, Hazard Vulnerability Analyses (HVA), incident, Inventory Management and Tracking System (IMATS), healthcare and community support services, homeland and national security, joint information center (JIC), jurisdictional risk assessment (JRA), materiel, Medical Reserve Corps (MRC), memorandum of agreement (MOA), memorandum of understanding (MOU), people with disabilities and others with access and functional needs, preparedness, public health emergency, Public Health Emergency Preparedness (PHEP) cooperative agreement, public information officer (PIO), rapid dispensing model (or non- medical model), request, resources, responder, scalability, Threat and Hazard

Why is this information collected?

The dispensing planning form provides insight about procedures for handling medical materiel management and dispensing. While the primary questions address those components, additional questions from other related capabilities inform situational awareness and include Capability 1: Community Preparedness; Capability 4: Emergency Public Information and Warning; Capability 14: Responder Safety and Health; and Capability 15: Volunteer Management. Questions from additional capabilities should be answered based on overall PHEP planning and, as applicable, to strengthen MCM plans.

How is the status for this section assessed?

Multiple criteria must be addressed to be considered eligible for "established" status within the planning form. Criteria to achieve "established" is detailed for each question and summarized at the end of each planning form. See also Appendix D: ORR Status Tips.

What do you need to know about this form?

Form Question (and Hint)	Reviewer Criteria
Date of most recently conducted JRA or equivalent Evidence that a risk assessment was conducted and is less than 5 years old should be provided to meet criteria toward achieving an "established" planning status.	**Concur or Sufficient Evidence** Any risk assessment that also includes a health component is acceptable. Evidence must include MCM or PHEP coordinator signature or acknowledgement. Evidence must be within a 5-year range and specific to that jurisdiction. In lieu of the PHEP director's signature, having their designee's or a higher-level authority's signature is acceptable. **Insufficient Evidence** JRA or equivalent does not include an MCM coordinator or PHEP director signature. The evidence is older than 5 years. The evidence did not include a health component, or the evidence is not specific to that jurisdiction. **No Evidence** No plan is provided, or no assessment was conducted. **Contradictory Evidence** The date on the JRA (or equivalent) is different from the date in the DCIPHER system.
Hazards identified in the assessment • Select identified risks from the most recent jurisdictional risk assessment or equivalent. A minimum number of hazards is not required toward achieving an "established" planning status; however, submitting the top five to 10 identified risks will inform the national picture of perceived risks across all jurisdictions.	**Concur or Sufficient Evidence** Acceptable documentation includes a plan that lists all hazards and applicable MCM hazards (at a minimum, influenza) completed within 5 years. MCM coordinator's or PHEP director's signature or acknowledgement also must be provided. If no plan or assessment is indicated, indicate concurrence by selecting "no evidence" as described below. **Insufficient Evidence** Some, but not all, required evidence is provided. **No Evidence** No plan is provided, or no assessment was conducted. **Contradictory Evidence** Multiple documents do not align.

Form Question (and Hint)	Reviewer Criteria
Select a vulnerable population partner • CDC recommends (but not requires) that stakeholders representing people with disabilities and others with access and functional needs be engaged during the JRA (or equivalent) process, or as a result of it, to ensure appropriate planning considerations are in place. • DFLs, TFAS, and CRI jurisdictions – Five broad populations potentially disproportionately impacted by an event include 1) persons with economic disadvantage, 2) persons with communication barriers because of language or literacy, 3) persons with medical issues or disability, 4) elderly persons, and 5) infants and children under age 18. CDC recommends (but does not require) that a stakeholder from each category be engaged during or as a result of the JRA. • Evidence that at least five (three for TFAS) partners were engaged should be provided to meet criteria toward achieving an "established" planning status.	**Concur or Sufficient Evidence** Acceptable evidence should include enough information to describe the relationship with the partner and the health department. For local jurisdictions, evidence of how the partner represents the population with access and functional needs, such as signed MOUs and MOAs (preferred). **Insufficient Evidence** Some, but not all, required evidence is provided. **No Evidence** No plan is provided. **Contradictory Evidence** Multiple documents do not align.
States **Did this vulnerable population partner participate or provide input into planning for emergency information and warning for vulnerable populations they represent?** This information is collected for program monitoring but does not impact planning status. Involvement of people with disabilities and others with access and functional needs is considered for the annual PHEP exercise requirement (see operations section).	**Concur or Sufficient Evidence** Evidence of engagement may include meeting notes or sign-in sheets. **Insufficient Evidence** Previously selected stakeholders are not included. No evidence of engagement in plans; instead, only a list of agencies. **No Evidence** No documentation provided. **Contradictory Evidence** Multiple documents do not align.

Form Question (and Hint)	Reviewer Criteria
DFLs, TFAS, and CRI jurisdictions **Estimate the number of people planned for with functional or access needs (including transportation) resulting from economic disadvantage, communication barriers because of language and literacy, medical issues or disability, and age (elderly persons and infants and children under age 18)** A number for each category must be provided. **Resources** • **ATSDR Social Vulnerability Index** – Go to https://svi.cdc.gov/ to estimate overall vulnerability by zip code. Once a zip code is input, information will be provided in color-coded quartiles. Hover over a particular color and click on the area to obtain the specific social vulnerability index and demographic information. • **HHS emPOWER Map 3.**0 – Go to https://empowermap.hhs.gov/ to find the number of electricity-dependent Medicare beneficiaries within your jurisdiction. Once a zip code is input, information about all Medicare and electricity-dependent Medicare residents will display. This information is collected for monitoring purposes. Reporting these numbers does not impact status.	**Concur or Sufficient Evidence** A number, source for the number, and evidence of the process for determining the number must be provided. **Insufficient Evidence** Some, but not all, required evidence is provided. **No Evidence** No plan is provided. **Contradictory Evidence** Multiple documents do not align.
Plans describe roles and responsibilities of public information staff and stakeholders • Public information and communication personnel regularly inform, educate, and communicate with the public during an incident. Evidence should be provided for PIO, backup PIO, and JIC personnel requirements to meet criteria toward achieving an "established" planning status.	**Concur or Sufficient Evidence** Job action sheet or other documents must outline requirements and duties; roles and responsibilities; and required qualifications or skillset. **Insufficient Evidence** Only the name and role are provided. Excludes responsibilities of the position or qualifications or skillset required to successfully perform the role. **No Evidence** No job action sheets or other documentation are provided. **Contradictory Evidence** Multiple job action sheets do not align.

Form Question (and Hint)	Reviewer Criteria
Required training plans for the PIO include FEMA course IS-250, *A New Approach to Emergency Communication and Information Distribution* or another comprehensive communication training must be specified in evidence as a required responsibility for the PIO to meet criteria toward achieving an "established" planning status. • If the FEMA course IS-250 or more comprehensive communication training such as Crisis and Emergency Risk Communication (CERC) training was provided to the PIO and additional staff, select IS-250. In the "evidence can be found" section, enter titles of the additional communication trainings along with page numbers, line numbers, and other pertinent information where evidence can be found.	**Concur or Sufficient Evidence** While IS-250 was retired, evidence should demonstrate the IS-250 training requirement or another comprehensive communication training in the PIO position description. Certificates of IS-250 or another comprehensive communication training also are acceptable. **Insufficient Evidence** Some, but not all, required evidence is provided. **No Evidence** No plan is provided. **Contradictory Evidence** Multiple documents do not align.
Plans include a process for dissemination of warning information through various channels Evidence that methods to issue alerts, warnings, and notifications and development of message templates based on planning or risk scenario identified by risk assessment should be provided to achieve "established" status. If evidence for either, but not both, is provided, status is "intermediate."	**Concur or Sufficient Evidence** Methods to issue alerts, warnings, and notifications and development of message templates based on planning risk scenarios must be clearly defined in evidence. PIO may provide a list of contacts and a press release form. Evidence can also be a jurisdiction-specific Community Outreach Information Network (COIN). **Insufficient Evidence** Evidence of some processes, but not all. **No Evidence** No documentation provided. **Contradictory Evidence** Multiple documents do not align.
Plans include process for real-time dissemination of information specific to vulnerable populations (select all that apply) • The process for dissemination of information to populations disproportionately impacted by planning risk scenarios must be clearly defined in evidence. • Language and literacy stakeholders should be engaged to ensure development and dissemination of culturally and linguistically appropriate messages. Evidence that real-time translation of language and literacy messages is necessary to meet criteria toward achieving an "established" planning status.	**Concur or Sufficient Evidence** Evidence should include translators, language lines, printing services, or mailing lists for specific groups. Evidence should not include prefabricated messages. **Insufficient Evidence** Some, but not all, required evidence is provided. **No Evidence** No plan is provided. **Contradictory Evidence** Multiple documents do not align.

Form Question (and Hint)	Reviewer Criteria
Process and plans in place for displaced persons (select all that apply) **Note.** If public health is not involved in tracking/managing evacuated persons with medical needs, enter text in the evidence box as "NA/<insert agency responsible>" e.g., NA/American Red Cross. **Resources** • 2018 Public Health Emergency Preparedness and Response Capabilities: National Standards for State, Local, Tribal, and Territorial Public Health; Capability 7: Mass Care, Functions 3 and 4.	**Concur or Sufficient Evidence** If tracking/managing evacuated persons with medical needs (e.g., those evacuated from a nursing home to a shelter) is a primary function of the public health system, evidence indicates how displaced persons are tracked and managed throughout the duration of the incident; evidence of the use of an established electronic database or other documented system is acceptable. If the public health system only provides support functions, plans should adequately describe how public health engages with the primary entity. **Insufficient Evidence** Some, but not all, required evidence is provided. **No Evidence** No plan is provided. **Contradictory Evidence** Multiple documents do not align.
Evidence of a public health responder and/or critical infrastructure personnel (CIP) plan for anthrax dispensing campaign (select all that apply) • States may not have the responsibility of dispensing MCMs to public health responders or run any open PODs at the state level (not including statewide responsibility for recipients with centralized governance structure). States should provide evidence of agreement with local jurisdiction to provide prophylaxis if the state does not provide it directly. This must be provided to meet criteria toward achieving an "established" planning status.	**Concur or Sufficient Evidence** Evidence should include a flow diagram or communication plan. Plans should specify the public health responders who will receive MCMs and how many will receive MCMs. If dispensing will occur at a POD, plans should describe agreement and POD staffing. The source and cache of MCMs also should be identified. Plans also should indicate if a jurisdiction is responsible for dispensing. **Insufficient Evidence** Some, but not all, required evidence is provided. **No Evidence** No plan is provided. **Contradictory Evidence** Multiple documents do not align.

Form Question (and Hint)	Reviewer Criteria
Process for critical workforce personnel to receive initial prophylaxis (select all that apply)	**Concur or Sufficient Evidence** Evidence should include process for allocating and targeting critical workforce groups for vaccination in accordance with CDC guidance for a pandemic influenza scenario. **Resource:** https://www.cdc.gov/flu/pandemic-resources/ **Insufficient Evidence** Some, but not all, required evidence is provided. **No Evidence** No plan is provided. **Contradictory Evidence** Multiple documents do not align.
DFLs, TFAS, and CRI jurisdictions **Evidence of a public health responder or critical infrastructure personnel (CIP) plan for anthrax dispensing campaign (select all that apply)** Plans must describe populations served and methods to obtain staff necessary to meet dispensing needs. Evidence is required to meet criteria toward achieving an "established" planning status.	**Concur or Sufficient Evidence** Evidence should include a flow diagram or communication plan. Plans should specify which public health responders will receive MCMs and how many will receive MCMs. If dispensing will occur at a POD, plans should describe who will staff the POD. The source and cache of MCMs also should be identified. Plans also should indicate if a jurisdiction is responsible for dispensing. Plans should support information represented on the JDS regarding the number of PODs and POD staff. **Insufficient Evidence** Lack of POD plans. Gaps in plans as related to staffing. **No Evidence** No documentation provided. **Contradictory Evidence** Multiple documents do not align.
Communication platform for notification of responders (select all that apply)	**Concur or Sufficient Evidence** Plans should include primary and backup forms of communication, cycle of maintenance and testing, cycle of updating rosters, evidence of updating rosters, and reminders for updates every 6 months. **Insufficient Evidence** Some, but not all, required evidence is provided. **No Evidence** No plan is provided. **Contradictory Evidence** Multiple documents do not align.

Form Question (and Hint)	Reviewer Criteria
Last date communication platform was updated or tested (whichever is more recent) As indicated in prior question, evidence that platform was updated or tested is required to meet criteria toward achieving an "established" planning status.	A date picker (pop-up calendar) will appear. For ham radio, satellite phone, or two-way VHF/UHF/700/800/900 MHz communications, select the most recent date a system test was completed. For all other platforms, select the most recent date distribution lists or contact information was updated.
DFLs, TFAS, and CRI jurisdictions **The process to request assistance from the state for MCM assets when a federal disaster is declared in the state is available** Evidence must be available to meet criteria toward achieving an "established" planning status.	**Concur or Sufficient Evidence** Signed plan or SOP should include the justification required for the request, specific method to gain the request, and who must authorize the process. Additional information about the status of the BioWatch Actionable Result (BAR), index case, or any information prompting request, assessment of need, and what is required to initiate the state request should be included. **Insufficient Evidence** Some, but not all, required evidence is provided. **No Evidence** No documentation provided. **Contradictory Evidence** Multiple documents do not align.
DFLs, TFAS, and CRI jurisdictions **The process to request assistance from the state for MCM assets in the absence of federal disaster declaration is available** Evidence must be available to meet criteria toward achieving an "established" planning status.	**Concur or Sufficient Evidence** Signed plan or SOP should include the justification required for the request, specific method to gain the request, and who must authorize the process. Additional information about the status of the BioWatch Actionable Result (BAR), index case, or any information prompting request, assessment of need, and what is required to initiate the state request should be included. Plans should highlight how the process differs when a federal disaster is declared. **Insufficient Evidence** Some, but not all, required evidence is provided. **No Evidence** No plan is provided. **Contradictory Evidence** Multiple documents do not align.

Form Question (and Hint)	Reviewer Criteria
DFLs, TFAS, and CRI jurisdictions **The process to request assistance from the state for MCM assets for an isolated, individual, or time-critical case is available** Evidence must be available to meet criteria toward achieving an "established" planning status.	**Concur or Sufficient Evidence** The process for requesting assistance for one or more individuals must be clearly defined in evidence. Signed plan or SOP should include the justification required for the request, specific method to gain the request, and who must authorize the process. Additional information about the status of the BAR, index case, or any information prompting request, assessment of need, and what is required to initiate the state request should be included. Plans also should include the process for expediting requests because of the time sensitivity of the isolated incident. **Insufficient Evidence** Some, but not all, required evidence is provided. **No Evidence** No plan is provided. **Contradictory Evidence** Multiple documents do not align.
DFLs, TFAS, and CRI jurisdictions **The process to request assistance from the state for MCM assets in coordination with tribal government(s) is available** • This needs to be in place to address how the federally recognized tribes will make requests. Requests may occur at the local, state, or federal level. Evidence must be available to meet criteria toward achieving an "established" planning status.	**Concur or Sufficient Evidence** Process should be clearly defined and understandable in evidence. **Insufficient Evidence** Some, but not all, required evidence is provided. **No Evidence** No plan is provided. **Contradictory Evidence** Multiple documents do not align.

Form Question (and Hint)	Reviewer Criteria
Plans for POD security address evacuation procedures, exterior security for location, interior security for location, scalability, security breach procedures, and security command or management plan Evidence for all six elements is required to meet criteria toward achieving an "established" planning status. DFLs, TFAS, and CRI jurisdictions • If security plans are created and maintained by law enforcement partners, a trusted agent can verbally affirm to the reviewer that the exterior security for location, interior security for location, security breach procedures, or security command or management plan are clearly defined. States • States are responsible for ensuring their CRI jurisdictions adequately address POD security elements and provide evidence of an oversight or a guidance role for POD security statewide. **NOTE:** Review of all local security plans through the ORR process provides partial evidence of this role. Evidence of oversight of non-CRI jurisdictions also should be provided.	**Concur or Sufficient Evidence** Exterior security for location – Evidence should include specialized unit needs, canine explosive ordinance disposal, unit barriers, additional lighting, staging areas for people in vehicles, identification of entrances and exits, and external crowd control. **Interior security for location** – Evidence should include a security sweep before facility use, access controls in the facility, internal crowd control, and establishing law enforcement officer posts. **Scalability** – Evidence should include how POD security is established based on threat levels, judgement of the law enforcement, and availability of the law enforcement officers. **Security breach procedures** – Evidence should include evacuation or safety plans to enable people to shelter in place. **Insufficient Evidence** Some, but not all, required evidence is provided (for the particular requirement). **No Evidence** No documentation provided. **Contradictory Evidence** Multiple documents do not align.

Form Question (and Hint)	Reviewer Criteria
States, DFLs, TFAS, and CRI jurisdictions **Process or protocols for PODs address adverse event reporting for dispensed drugs; Investigational New Drug (IND), Emergency Use Authorization (EUA), providing information on adverse events; record or log of drugs dispensed; reporting data to state or federal entities; and screening for the purpose of triaging visitors to the POD/DVC** Evidence for all five elements is required to meet criteria toward achieving an "established" planning status. States • States are responsible for ensuring that locals within the state address adverse event reporting for dispensed drugs. States should provide evidence of oversight or guidance on adverse event reporting even if the state does not have primary responsibility for open PODs. • **NOTE:** Review of all local adverse event reporting plans through the ORR process provides partial evidence of this role. Evidence of oversight of non-CRI jurisdictions also should be provided.	**Concur or Sufficient Evidence** Adverse event reporting for dispensed drugs – Evidence should include instructions on how reports are sent from local to state jurisdictions and from state to federal agencies and highlight the feedback cycle. Plans or evidence of established systems that facilitate timely recall or other countermeasures to reduce adverse events are acceptable. **Providing information on adverse events** – Evidence should include provision of health information upon entering or leaving the POD. Provision of a package insert (similar to the prescription information sheet from drug store) is acceptable. **Record or log of drugs dispensed** – Evidence should include a process for how to record the number and type of drug dispensed. **Reporting inventory specification data to state or federal entities** – Evidence should include Inventory Data Exchange (IDE) specification standards. **Screening for the purpose of triaging** – Evidence should include a clear process for screening and triaging visitors to the POD. **Insufficient Evidence** Some, but not all, required evidence is provided. **No Evidence** No plan is provided. **Contradictory Evidence** Multiple documents do not align.
Process to identify all public health responders (including any first responders and critical infrastructure staff if applicable) that will be used in an incident or event is available (select all that apply) • An incident, including an MCM incident with dispensing campaign, may have adverse effects on responders, including medical or mental health issues related to stress of the incident. The process to mitigate potential risks, including stress, mental health, or physical injury, for public health responders must be clearly defined in evidence.	**Concur or Sufficient Evidence** Evidence should include specific agency or partnership and numbers for responders. **Insufficient Evidence** Some, but not all, required evidence is provided. **No Evidence** No documentation provided. **Contradictory Evidence** Multiple documents do not align.

Form Question (and Hint)	Reviewer Criteria
Process to ensure that mission-critical responders receive initial prophylaxis during an MCM incident is available Evidence for this and the previous element (process to identify all public health responders that will be used in an incident or event) should be provided to meet criteria toward achieving an "established" planning status.	**Concur or Sufficient Evidence** Process for initial prophylaxis to mission-critical public health responders (for at least a 48-hour dispensing campaign) must be clearly defined in evidence and include who (by functional role) and in what priority prophylaxis will be provided. State recipients with no direct dispensing role should still have evidence about how state public health responders will receive prophylaxis. For example, local jurisdictions will provide prophylaxis to state-level responders. **Insufficient Evidence** Some, but not all, required evidence is provided. **No Evidence** No plan is provided. **Contradictory Evidence** Multiple documents do not align.
Procedures to notify volunteers* are available	**Concur or Sufficient Evidence** Evidence should include who will be notified, method of notification, triggers for notification, and where they will be required to assemble. Primary and backup process should be clearly defined in the evidence. **Insufficient Evidence** Some, but not all, required evidence is provided. **No Evidence** No plan is provided. **Contradictory Evidence** Multiple documents do not align.
Systems used to notify volunteers* required to complete a dispensing or distribution campaign (select all that apply) At least two systems (primary and backup) and updated testing of roster and systems every 6 months must be evident to meet criteria toward achieving an "established" planning status.	**Concur or Sufficient Evidence** Plans should include primary forms of communication, cycle of maintenance and testing, process and cycle for updating rosters, evidence of updating rosters, and reminders for updates every 6 months. **Insufficient Evidence** Some, but not all, required evidence is provided. **No Evidence** No documentation provided. **Contradictory Evidence** Multiple documents do not align.

Form Question (and Hint)	Reviewer Criteria
Last date notification system was updated or tested (whichever is more recent) As indicated in the prior question, evidence that platform was updated or tested is required to meet criteria toward achieving an "established" planning status. **If volunteers are not identified, enter the same information here as in the communications section.**	A date picker (pop-up calendar) will appear. For ham radio, satellite phone, or two-way VHF/UHF/700/800/900 MHz communications, select the most recent date a system test was completed. For all other platforms, select the most recent date distribution lists or contact information was updated.

*See Appendix B: Key Terms

What impacts achieving "established" status?

To be eligible for this status, the JRA or equivalent must be conducted at least every 5 years. CRI jurisdictions are encouraged to participate in a risk assessment and must provide documentation that demonstrates input into the risk assessment or equivalent process.

A minimum of five stakeholders representing people with disabilities and others with access and functional needs are required to be included for established status eligibility for all sites, including Puerto Rico; however, only three stakeholders are required for other U.S. territories and freely associated states.

A primary and backup PIO as well as Joint Information Center (JIC) personnel must be identified and clearly defined in the evidence to be eligible for the status. The PIO's required training plan must specify an equivalent to the retired FEMA IS-250 training course.

In addition, the process for dissemination of warning information through various channels must clearly describe methods to issue alerts, warnings, and notifications and the development of message templates based on planning risk scenarios to be eligible for this status.

The process for real-time translation of information specific to a response must address language and literacy barriers to be eligible for this status.

A primary and backup communication platform for the notification of the responders as well as volunteers required to complete a dispensing and distribution campaign must be included in the plans as well. Distribution lists for each platform must be updated every 6 months or less. A system test must be completed, at minimum, every 6 months for sites using ham radio, satellite phone, or two-way VHF/UHF/700/800/900 MHz communications.

Plans for POD security must address, at minimum, evacuation procedures, exterior security for location, interior security for location, scalability, security breach procedures, and a security command or management plan to be eligible for this status.

Lastly, POD protocols must describe screening for the purpose of triaging. Protocols also must provide information on adverse events and adverse event reporting. Protocols also must delineate how to record and log dispensed MCMs and report information to state or federal entities.

Additionally, the plans for DFLs, TFAS, and CRI planning jurisdictions must clearly outline their process to request assistance from the state or federal government (where applicable) for MCM assets for the following three scenarios to be eligible for this status: when a federal disaster is declared, in the absence of federal disaster declaration, and for an isolated, individual, or time-critical case.

To be eligible for this status, you must update and submit the dispensing planning form every 12 months.

OPERATIONAL FORMS

Facility Setup Drill

Completed By	Submission Timeline
Directly funded localities	Annual requirement
U.S. territories and freely associated states (at least one time in 5 years; exercise different PODs if completed more than once in 5 years)	5 year requirement
CRI local planning jurisdictions	Annual requirement

Form Key Terms (refer to Appendix B): chemical, biological, radiological, nuclear, and explosives (CBRNE), Cities Readiness Initiative (CRI), drill, facility setup, full notification, local distribution site (LDS), materiel, no notification (none), partial notification, preparedness, public health emergency, Public Health Emergency Preparedness (PHEP) cooperative agreement, rapid dispensing model (or nonmedical model), receipt, stage, store (RSS) facility, regional distribution site (RDS)

Why is this information collected?

The facility setup drill provides information on operational ability to standup a site with the necessary materiel, layout, and supplies for timely distribution and dispensing. The drill information should be completed for each facility setup.

What do you need to know about this form?

Form Question	Form Hint
Site(s) setup (select all that apply)	Select the type of facility that participated in the drill. You are strongly encouraged to exercise different types of sites each year. Different PODs also should be set up each year.
Emergency operations center (EOC) (if selected)	Select "Yes" to submit facility setup information for EOC.
Total number of EOCs	Include all EOCs in your jurisdiction. A similar question is repeated for all sites notified during the drill.
Number of EOCs set up	If more than one EOC is set up, indicate the number. Otherwise, input "1." A similar question is repeated for all sites notified during the drill.
EOC Type	Indicate the type of EOC staff notified during the drill.
Target time for setup (in minutes)	Input time for setup in minutes, such as "60." A similar question is repeated for all sites notified during the drill.
EOC setup start date and time	Enter date and time to begin auto-calculation of set up time. A similar question is repeated for all sites notified during the drill.
EOC setup end date and time	Enter date and time to begin auto-calculation of set up time. A similar question is repeated for all sites notified during the drill.

Form Question	Form Hint
EOC total setup time (in minutes)	Auto-calculated value for all sites, based on the following formula: (Setup end date and time) - (Setup start date and time)
RDS or LDS (if selected)	Select "Yes" to submit site activation information for RDS or LDS.
Name of RDS or LDS	Input name of facility.
Point of dispensing (POD) (if selected)	Select "Yes" to submit site activation information for POD.
Total number of planned primary PODs within jurisdiction	Include all planned primary PODs within jurisdiction. This number should match the number entered on the POD form.
Name of POD	POD name should match the information entered on the POD form.

What impacts achieving "established" status?

To be eligible for this status and meet the PHEP program requirement, jurisdictions must conduct and submit the facility setup drill annually by June 30.

Staff Notification and Assembly Drill

Completed By	Submission Timeline
States	Annual requirement
Directly funded localities	Annual requirement
U.S. territories and freely associated states (at least one time in 5 years; exercise different PODs if completed more than once in 5 years)	Annual requirement
CRI local planning jurisdictions	Annual requirement

Form Key Terms (refer to Appendix B): chemical, biological, radiological, nuclear, and explosives (CBRNE), Cities Readiness Initiative (CRI), command staff or incident management lead roles, core staff, drill, full notification, no notification (none), partial notification, preparedness, public health emergency, Public Health Emergency Preparedness (PHEP) cooperative agreement, rapid dispensing model (or nonmedical model), receipt, stage, and store (RSS) facility, regional distribution site (RDS) or local distribution site (LDS), responder, staff assembly, staff notification, volunteer

Why is this information collected?

The staff notification and assembly drill provides information on operational functions specific to staff notification and assembly procedures for various facilities, including EOCs, RSSs, RDSs, LDSs, and PODs. The drill measures the accuracy of staff rosters, timeliness of staff confirmations to the notification, and staff ability to report for duty within a designated timeframe. Communication methods and processes also are measured. DFLs and CRI planning jurisdictions must complete once annually for any of the facilities mentioned. TFAS must complete at least one time in five years.

What do you need to know about this form?

Form Question	Form Hint
Extent of advance notification (select 1)	Staff assembly must be no notice to meet the EOC staff notification and assembly requirement. Note the question is asking for extent of advance notification not activation.
Site(s) notified (select all that apply)	Select the type of facility that participated in the drill. You are strongly encouraged to exercise different types of sites each year. Different PODs also should be notified each year. At least one site type must be identified to complete the drill form for submission. Once the "site(s) notified" is selected, the information required to submit the drill form can be completed. Each type of site may be selected for each submission, and multiple sites of each type also may be reported. "EOC" must be selected to meet the EOC staff notification and assembly requirement.
Emergency operations center (EOC) (if selected)	Select "Yes" to submit staff assembly information for EOC staff assembly.
Total number of EOCs	Include all EOCs in your jurisdiction.

Form Question	Form Hint
Number of EOC sites included in staff notification	If staff from more than one EOC are notified, indicate the number, otherwise input "1."
EOC type	Indicate type of EOC staff notified during drill.
Current EOC incident management staff	Input number of staff, for example, "6." The following six ICS/IM lead roles,* at a minimum, must be activated and filled (to be staffed according to jurisdictional plans and procedures, e.g., 1 person may fill multiple roles in certain jurisdictions) to meet the EOC staff notification and assembly requirement: • Incident commander • Operations section chief • Planning section chief • Logistics section chief • Finance/administration section chief • Public information officer
Current EOC security staff	Input number of staff, for example, "6."
Current EOC health department staff	Input number of staff, for example, "6." Staff from any part of the health department needed to conduct EOC operations. Section may be left blank if EOC does not use health department staff.
Current EOC volunteer staff	Input number of staff, for example, "6." Staff from any volunteer organizations needed to conduct EOC operations. Section may be left blank if EOC does not use volunteer organizations.
Date and time first person notified	Enter date and time to begin auto-calculation of acknowledgement completion time. Question is repeated for all sites or staff types notified during the drill.
Date and time last person acknowledged notification	Enter date and time to end auto-calculation of acknowledgement completion time. Question is repeated for all sites or staff types notified during the drill.
Total number of staff who acknowledged notification	If staff responded outside of the specified event day or time, do not include them in the total number. Enter number for system to auto-calculate percent of staff who acknowledged notification. Question is repeated for all sites or staff types notified during the drill.
Incident management roles activated	Select all that apply for EOC.
Target time for assembly (in minutes)	Input time for assembly in minutes, for example, "60." Question is repeated for all sites or staff types notified during the drill.
Type of staff assembly	Indicate if staff assembly was virtual, physical, or no assembly occurred. Question is repeated for all sites or staff types notified during the drill.
Date and time last person assembled	Enter date and time to end auto-calculation of assembly completion time. Question is repeated for all sites or staff types notified during the drill.
Total number of staff who assembled	Input number of staff, for example, "6." Question is repeated for all sites or staff types notified during the drill.

Form Question	Form Hint
Total number of staff who assembled within target time	Input number of staff, for example, "6." Question is repeated for all sites or staff types notified during the drill.
Acknowledgement completion time	Auto-calculated value for all sites or staff types notified during the drill, based on the following formula: (Date and time last person acknowledged) - (Date and time first person notified)
Acknowledgement percentage	Auto-calculated value for all sites or staff types notified during the drill, based on the following formula: $\frac{\text{Total \# staff who acknowledged}}{\text{Total \# staff contacted}} \times 100$
Assembly completion time	Auto-calculated value for all sites or staff types notified during the drill, based on the following formula: (Date and time last staff member arrived at facility) - (Date and time first staff member notified) Assembly completion time must be less than 60 minutes to meet the EOC staff notification and assembly requirement.
Assembly percentage	Auto-calculated value for all sites or staff types notified during the drill, based on the following formula: $\frac{\text{Total \# staff assembled}}{\text{Total \# staff notified}} \times 100$
Regional distribution site or local distribution site (RDS or LDS)	Select "Yes" to submit staff assembly information for RDS or LDS staff assembly.
Total number of RDS or LDSs	Include all RDS or LDSs in your jurisdiction.
Number of RDS or LDSs included in staff notification	If staff from more than one RDS or LDS is notified, indicate number. Otherwise, input "1."
Name of RDS or LDS	Input name of RDS or LDS.
Current RDS, LDS management, or lead staff	Input number of staff, for example, "6."
Current RDS or LDS security staff	Input number of staff, for example, "6."
Current RDS or LDS staff (general health department, not management or lead)	Input number of staff, for example, "6." Staff from any part of the health department needed to conduct RDS or LDS operations. Section may be left blank if RDS or LDS does not use health department staff.
Current RDS or LDS volunteer staff	Input number of staff, for example, "6." Staff from any volunteer organizations needed to conduct RDS or LDS operations. Section may be left blank if RDS or LDS does not use volunteer organizations.
Point of dispensing (POD) (if selected)	Select "Yes" to submit staff assembly information for POD staff assembly.
Total number of planned primary PODs within jurisdiction	Include all planned primary PODs within jurisdiction. This number should match the number entered on the POD form.

Form Question	Form Hint
Number of POD sites included in staff notification	If staff from more than one POD is notified, indicate number. Otherwise, input "1."
Name of POD	POD name should match the information entered on the POD form.
POD staff notified for delivery of (select 1)	Indicate if notified POD staff dispenses oral antibiotics or administers vaccines.
Trigger or cause for MCMs to be dispensed	Select all causes for MCMs to be dispensed.
First shift core management or lead staff	Input number of staff, for example, "6." POD management lead staff includes manager, operations chief, logistics chief, and others. Staff identified and needed to activate and prepare for POD functions.
First shift additional management or lead staff	Input number of staff, for example, "6." Additional POD management lead staff may include tactical communications lead, IT leader, forms or data collection lead, staff care lead, and others. Staff that may support POD functions.
First shift core security staff	Input number of staff, for example, "6."
First shift additional security staff	Input number of staff, for example, "6."
First shift core medical health department staff	Input number of staff, for example, "6." Medical staff from any part of the health department needed to conduct clinical POD operations, such as dispensing lead. Section may be left blank if POD does not use health department staff.
First shift additional medical health department staff	Input number of staff, for example, "6." Medical staff from any part of the health department that may support clinical POD operations, such as extra medical personnel to explain adverse events. Section may be left blank if POD does not use health department staff.
First shift core nonmedical health department staff	Input number of staff, for example, "6." Staff from any part of the health department needed to conduct non-clinical POD operations, such as dispensing station staff. Section may be left blank if POD does not use health department staff.
First shift additional nonmedical health department staff	Input number of staff, for example, "6." Staff from any part of the health department that may support non-clinical POD operations, such as extra greeters and floaters. Section may be left blank if POD does not use health department staff.
First shift core medical volunteer staff	Input number of staff, for example, "6." Medical staff from any volunteer organizations needed to conduct clinical POD operations, such as dispensing lead. Section may be left blank if POD does not use volunteer organizations.
First shift additional medical volunteer staff	Input number of staff, for example, "6." Medical staff from any volunteer organization that may support clinical POD operations, such as extra medical personnel to explain adverse events. Section may be left blank if POD does not use volunteer organizations.

Form Question	Form Hint
First shift core nonmedical volunteer staff	Input number of staff, for example, "6." Staff from any volunteer organizations needed to conduct non-clinical POD operations, such as dispensing station staff. Section may be left blank if POD does not use volunteer organizations.
First shift additional nonmedical volunteer staff	Input number of staff, for example, "6." Staff from any volunteer organization that may support non-clinical POD operations, such as extra greeters and floaters. Section may be left blank if POD does not use volunteer organizations.

What impacts achieving "established" status?

To be eligible for this status and meet the PHEP program requirement, jurisdictions must conduct the staff notification and assembly drill by June 30. States, DFLs, and U.S. TFAS must meet EOC staff notification and assembly requirements. Credit is given when the drill (or incident) is no-notice, immediate assembly and requires six key EOC incident command staff assembled in less than 60 minutes. This requirement can also be met through applicable exercises or incidents using PHEP, functional, FSE or incident form or the distribution FSE or incident form.

Site Activation Drill

Completed By	Submission Timeline
Directly funded localities	Annual requirement
U.S. territories and freely associated states (at least one time in 5 years; exercise different PODs if completed more than once in 5 years)	5-year requirement
CRI local planning jurisdictions	

Form Key Terms (refer to Appendix B): chemical, biological, radiological, nuclear, and explosives (CBRNE), Cities Readiness Initiative (CRI), drill, full notification, no notification (none), partial notification, preparedness, public health emergency, Public Health Emergency Preparedness (PHEP) cooperative agreement, rapid dispensing model (or nonmedical model), receipt, stage, and store (RSS) facility, regional distribution site (RDS) or local distribution site (LDS), responder, site activation, site availability

Why is this information collected?

The site activation drill provides information on operational functions for procedures to open and activate various types of distribution and dispensing facilities. The drill measures the accuracy of site rosters, timeliness of site confirmations to the notification, and site function within a designated timeframe. Communication methods and processes also are measured. The drill information should be completed for each site notified.

What do you need to know about this form?

Form Question	Form Hint
Site(s) activated (select all that apply)	Select the type of facility that participated in the drill. You are strongly encouraged to exercise different types of sites each year. Different PODs should also be set up each year.
Emergency operations center (EOC) (if selected)	Select "Yes" to submit site activation information for EOCs.
Total number of EOCs	Include all EOCs in your jurisdiction. Similar question is repeated for all sites notified during the drill.
Number of EOC sites included in site activation	If more than one EOC is activated, indicate number. Otherwise, input "1." Similar question is repeated for all sites notified during the drill.
Date and time first EOC notified	Enter date and time to begin auto-calculation of acknowledgement completion time. Similar question is repeated for all sites notified during the drill.
Date and time last EOC acknowledged notification	Enter date and time to end auto-calculation of acknowledgement completion time. Similar question is repeated for all sites notified during the drill.
Acknowledgement completion time	Auto-calculated value for all sites notified, based on the following formula (Date and time last site acknowledged) - (Date and time first site notified)

Form Question	Form Hint
Acknowledgement percentage	Auto-calculated value for all sites notified, based on the following formula: Total # sites who acknowledged x 100 Total # sites notified
EOC type	Indicate type of EOC notified during drill.
Target time for availability (in minutes)	Input time for availability in minutes. For example, "60." Similar question is repeated for all sites notified during the drill.
Type of site availability	Indicate if site availability was virtual, physical, or only a call down occurred. Similar question is repeated for all sites notified during the drill.
Date and time EOC notified	Enter date and time to begin auto-calculation of availability completion time. Similar question is repeated for all sites notified during the drill.
Date and time EOC made available	Enter date and time to end auto-calculation of availability completion time. Similar question is repeated for all sites notified during the drill.
Availability completion time	Auto-calculated value for all sites notified, based on the following formula: (Date and time site made available) – (Date and time site notified)
Availability percentage	Auto-calculated value for all sites notified, based on the following formula: Total # sites made available x 100 Total # sites notified
Regional distribution site or local distribution site (RDS or LDS) (if selected)	Select "Yes" to submit site activation information for RDS or LDS.
Name of RDS or LDS	Input name of facility.
Point of dispensing (POD) **(if selected)**	Select "Yes" to submit site activation information for POD.
Total number of planned primary PODs within jurisdiction	Include all planned primary PODs within jurisdiction; this number should match the number entered on the POD form.
Name of POD	POD name should match the information entered on the POD form.

What impacts achieving "established" status?

To be eligible for this status and meet the PHEP program requirement, jurisdictions must conduct and submit the site activation drill annually by June 30.

Dispensing Throughput Drill

Completed By	Submission Timeline
Directly funded localities	5-year requirement (only if dispensing FSE was conducted for mass vaccination)
U.S. territories and freely associated states	5-year requirement (only if dispensing FSE was conducted for mass vaccination)
CRI local planning jurisdictions	5-year requirement (only if dispensing FSE was conducted for mass vaccination)

Form Key Terms (refer to Appendix B): advance notice, full notification, regimens per hour (RPH), partial notification

Why is this information collected?

The dispensing throughput drill tests dispensing procedures for pills and verifies estimates of regimens (or courses) and persons per hour in a given POD. Submission of this form is required only if the dispensing FSE was conducted using a mass vaccination model (not pills) or if dispensing throughput was not collected in the dispensing FSE.

What do you need to know about this form?

Form Question	Form Hint
Start date and time **End date and time**	A date picker (pop-up calendar) will appear for date and time fields. Select the appropriate information for the exercise or incident or event. For exercises, the start and end date might be the same. When using the date picker, the time will auto-populate as the time data is entered. Simply click the time to edit to the relevant start and end time for the exercise or incident or event.
Extent of advance notification	Select type of notification (full, partial, none) described in the exercise objectives.
Reporting throughput section	At minimum, one POD per CRI planning jurisdiction should exercise dispensing procedures. Throughput should be provided for each different size POD tested. Throughput should be entered from calculations outside of the DCIPHER system. External systems must be able to estimate the following: • Number of regimens dispensed to HoH • Traditional or assisted or express dispensing information • Total time for each individual to start and complete dispensing activities • Regimens per hour (required data entry) • Persons per hour (required data entry) • Average completion time (required data entry)
Total people or vehicles participating in POD throughput	A minimum of 50 people (or vehicles if a drive-through POD) must be submitted to calculate throughput.

What impacts achieving "established" status?

This form is only required once by June 30, 2022 if only one dispensing FSE is reported and was conducted as a mass-vaccination exercise or incident. If more than one dispensing FSE is reported and at least one of these FSEs measured pill throughput, then this form is not required (pill throughput will be captured via the Dispensing FSE or Incident form).

Tabletop Exercise (TTX)

Completed By	Submission Timeline
States	5 year requirement for each: fiscal/administrative, and continuity of operations for both emergency operations and lab (may be combined)
DFLs	5 year requirement for each: fiscal/administrative, and continuity of operations for both emergency operations and lab (may be combined)
TFAS (all)	5 year requirement for each: fiscal/administrative, and continuity of operations for both emergency operations and lab (may be combined)

Form Key Terms (refer to Appendix B): chemical, biological, radiological, nuclear, and explosives (CBRNE), event, full-scale exercise (FSE), functional needs, incident, preparedness, public health emergency, Public Health Emergency Preparedness (PHEP) cooperative agreement, rapid dispensing model (or nonmedical model), tabletop exercise (TTX)

Why is this information collected?

A TTX is a discussion-based exercise intended to generate discussion of various issues regarding a simulated emergency. The TTX form standardizes the information collected from a TTX. TTXs can increase participants' general awareness while validating plans and procedures. Participants also can assess the type of systems needed to prevent, protect against, mitigate negative effects, and recover from a defined incident. TTXs also can help identify strengths and areas for improvement in preparedness plans. Involving stakeholders who represent people with disabilities and others with access and functional needs in TTX (if relevant to the exercise) will satisfy the annual PHEP requirement to engage those partners.

What do you need to know about this form?

Form Question	Form Hint
Start date and time **End date and time**	A date picker (pop-up calendar) will appear for date and time fields. When using the date picker, the time will auto-populate as the time data is entered. Simply click the time to edit to the relevant start and end time for the exercise or incident or event.
Event type	If the exercise includes community reception centers for those potentially exposed to radioactive material, select CBRNE and type "Community Reception Center" as "Other."
Fiscal or other administrative processes and procedures included in exercise (select all that apply)	Completing an administrative and fiscal preparedness TTX is recommended, but not required. Grant allocation and hiring surge questions to inform exercise objectives are available in the Performs Resource Library (see 2017-2022 HPP-PHEP Supplemental Guidelines [CDC-RFA-1701-01]).
List jurisdictions that participated	Provide any regional, district, ward, parish, local federal partners that participated. You are not required to include them in the exercise.

Form Question	Form Hint
Pandemic processes and procedures included in exercise (select all that apply)	Suggested pandemic influenza topics include but are not limited to: Antimicrobials, antivirals, collaboration with clinical labs, communications of personal protection, contact tracing, crisis emergency risk communication, critical workforce registration/certification, critical workforce training, critical workforce vaccination, detection of novel Influenza A, epidemiologic investigations, epidemiology information sharing, hospital data sharing, Immunization Information Systems (IIS), isolation, laboratory specimen transport, laboratory surge, movement restrictions, pandemic vaccine, PPE, quarantine, school closures, SME roles and responsibility, social distancing, tracking for regulatory requirements, and ventilators. Resource: https://www.cdc.gov/flu/pandemic-resources/
Continuity of Operations (COOP) (select all that apply)	Suggested COOP topics include but are not limited to: Alternate/virtual worksites, essential Services – EOC, essential Services - LRN-B, essential Services - LRN-C, human capital management, scalable workforce (expansion/reduction)
Vulnerable population partner(s) that participated	Include stakeholders representing people who are likely to be disproportionately impacted by an incident or event. CDC recommends (but does not require) that these stakeholders be engaged during the TTX process to ensure appropriate planning considerations are in place.

What impacts achieving "established" status?

At least once during the project period (and at least every 5 years) table top exercises should be conducted exercising administrative preparedness, COOP for incident command, and COOP for laboratory services. If any of the 5-year requirements (administrative. preparedness, Incident command COOP, Laboratory Services COOP) are included in exercises or incidents, those would meet the 5-year requirement. Documented engagement with stakeholders representing people with disabilities and others with access and functional needs (either through a TTX, PHEP functional, or FSE or incident or a dispensing FSE form) will satisfy the annual PHEP requirement.

Distribution Full-scale Exercise (FSE) or Incident

Completed By	Submission Timeline
States	5-year requirement
Directly funded localities	5-year requirement

Form Key Terms (refer to Appendix B): chemical, biological, radiological, nuclear, and explosives (CBRNE), closed point of dispensing (closed POD or CPOD), command staff or incident management lead roles, core staff, demobilize, department operations center (DOC), emergency management agency (EMA), event, facility setup, full notification, incident, local distribution site (LDS), materiel, no notification (none), partial notification, preparedness, public health emergency, Public Health Emergency Preparedness (PHEP) cooperative agreement, rapid dispensing model (or nonmedical model), receipt, stage, store (RSS) facility, regional distribution site (RDS), request, responder, site activation, site availability, staff assembly, staff notification, volunteer

Why is this information collected?

The distribution FSE or Incident form provides information on operational functions specific to staff notification and assembly procedures for EOCs and RSS sites. Use this form to provide information about distribution functions for an anthrax-based exercise or incident. Jurisdictions focusing on operational readiness for emerging infectious diseases such as pandemic influenza may also use this form to submit information on a pandemic-related exercise or incident based on CDC's Pandemic Intervals Framework (PIF). Use this form if the exercise or incident occurs in the acceleration level, includes vaccination procedures, and focuses on Capabilities 8 and 9. If the exercise or incident occurs during an earlier pandemic interval (investigation, recognition, or initiation) submit information on the PHEP, Functional, Full-scale Exercise (FSE), or Incident form (see that form guidance for additional instructions).

What do you need to know about this form?

Form Question	Form Hint
Name of exercise, event, or incident	Information from previous incidents or FSEs less than 5 years old should be submitted until information can be updated with the current period of performance's incidents and FSEs. Current period of performance information should be submitted as it becomes available to provide up-to-date and accurate information about the status of the preparedness program. Data must be entered to submit the form.
Type	Select type of operation being reported: an FSE or actual incident or event. Information from previous incidents or FSEs less than 5 years old should be submitted until information can be updated with the current period of performance's incidents and FSEs. Current period of performance information should be submitted as it becomes available to provide up-to-date and accurate information about the status of the preparedness program. Data must be entered to submit the form.

Form Question	Form Hint
Start date and time **End date and time**	A date picker (pop-up calendar) will appear for date and time fields. Select the start and end date and time for the exercise or incident or event. For exercises, the start and end date might be the same. When using the date picker, the time will auto-populate as the time data is entered. Simply click the time to edit to the relevant start and end time for the exercise, incident, or event. Information from previous incidents or FSEs less than 5 years old should be submitted until information can be updated with the current period of performance's incidents and FSEs. Current period of performance information should be submitted as it becomes available to provide up-to-date and accurate information about the status of the preparedness program. Data must be entered to submit the form.
List jurisdictions that participated	Provide any regional, district, ward, parish, local federal partners that participated. You are not required to include them in the exercise.
Event type	Select the type of real-time incident or event or exercise. If the exercise includes community reception centers for those potentially exposed to radioactive material, select CBRNE and type "Community Reception Center" as "Other." Information from previous incidents or FSEs less than 5 years old should be submitted until information can be updated with the current period of performance's incidents and FSEs. Current period of performance information should be submitted as it becomes available to provide up-to-date and accurate information about the status of the preparedness program. Data must be entered to submit the form.
Site activation start date and time **Site activation end (when site is fully active) date and time**	EOC site activation may occur at the same time as the start of the activity or it can differ (depending on the scenario). Provide the date and time start even if the same as the date and time start of the activity.
Site activation: communication platforms used for notification	Select relevant communication platforms used or tested; this should align with planning documentation.
Number of EOC sites included in site activation	All EOC activations for all exercises and incidents or events, including virtual EOC activations, where public health was involved (regardless of type of EOC) should be reported.
Site activation: total number of sites that acknowledged notification	If site responded outside of the specified event day and time, do not include them in the total number.
Site activation: acknowledgement completion time	Auto-calculated value, based on the following formula: (Date and time last site acknowledged) - (Date and time first site notified)

Form Question	Form Hint
Site activation: acknowledgement percentage	Auto-calculated value, based on the following formula: Total # sites who acknowledged x 100 Total # sites notified
Site activation: availability completion time	Auto-calculated value, based on the following formula: (Date and time site made available) - (Date and time site notified)
EOC staff notification: start date and time **EOC staff notification: end date and time**	Staff notification may occur at the same time as the start of the activity or it can differ (depending on the scenario). Provide the date and time start even if the same as the date and time start of the activity. Must have occurred during the current budget period (July 1 – June 30) to meet the staff notification and assembly requirement.
EOC staff notification: extent of advance notification	Staff assembly must be no notice to satisfy the staff notification and assembly requirement. Note the question is asking for extent of advance notification not activation.
Incident management roles (or equivalent lead roles) activated	Incident commander, finance or administration section chief, logistics section chief, operations section chief, planning section chief, and public information officer should be activated to satisfy the staff notification and assembly requirement (one person may fill multiple roles).
Target time for assembly (in minutes)	Target time for assembly during an incident should be less than 60 minutes.
Name of RSS	RSS name should match the RSS site survey.
Staff notification and assembly: total number of staff who acknowledged notification	If staff responded outside of the specified event day or time, do not include them in the total number.
Staff notification and assembly: Type of staff assembly	To satisfy the EOC staff notification and assembly requirement, recipients must submit all EOC assembly information for incident management lead staff. Recipients may report physical or virtual assembly of EOC staff (or a combination of both).
Staff notification and assembly: Acknowledgement completion time	Auto-calculated value, based on the following formula: (Date and time last person acknowledged) - (Date and time first person notified)
Staff notification and assembly: acknowledgement percentage	Auto-calculated value, based on the following formula: Total # staff who acknowledged x 100 Total # staff contacted
Staff notification and assembly: assembly percentage	Auto-calculated value, based on the following formula: Total # staff assembled x 100 Total # staff notified

Form Question	Form Hint
Staff notification and assembly: assembly completion time (in minutes)	Auto-calculated value, based on the following formula: (Date and time last staff member arrived at facility) - (Date and time first staff member notified) EOC incident management lead staff assembly completion time must be 60 minutes or less to meet the EOC staff notification and assembly requirement.
RSS staff notification: number of security available	Provide the number of security staff available to participate. If this number cannot be provided given the security agreement, enter "000."
Number of sites receiving distributions from RSS	Provide the total number of sites that receive materiel directly from the RSS (RDS, LDS, others). If you have no intermediate sites within your state, enter "0."
Transportation assets section	Transportation assets need to be exercised or used in an incident at least once every 5 years to test capacity and availability.
Number of transportation assests mobilized to meet the incident need	Provide total number of vehicles used for distribution to PODs and intermediate distribution sites. Numbers should match information reported in the distribution planning form and should align with planning documentation.
Types of transportation assets mobilized to meet the incident need	Describe type of vehicles used for distribution to PODs and intermediate distribution sites. Types should match information reported in the distribution planning form and should align with planning documentation.
Backup transportation used	If backup transportation is used, briefly describe the inject used to exercise backup transport or the situation requiring use of backup transport during an incident.
Procedures to maintain cold chain management included	Cold chain management capability needs to be exercised or used in an incident at least once every 5 years to test capacity and availability.
Describe how cold chain management was exercised	Provide description of how cold chain management was tested, This should align with planning documentation.
Date and time of MCM asset request	Provide date and time when asset request was made. Complete subsequent sections to indicate any difference between estimate and actual time of asset arrival.
RSS estimate of warehouse processing time section: material processing start date and time	Processing includes MCM allocation, sorting, prioritizing, and picking. A date picker (pop-up calendar) will appear for date and time fields. Select the appropriate information for the exercise or incident or event. When using the date picker, the time will auto-populate as the time data is entered. Simply click the time to edit to the relevant start and end time for the exercise or incident or event. Start date and time should be the time assets arrive at the RSS and should match the actual date and time of arrival for federal shipment (in the "request for federal MCM assets" section).

Form Question	Form Hint
Material processing end date and time	A date picker (pop-up calendar) will appear for date and time fields. Select the appropriate information for the exercise or incident or event. When using the date picker, the time will auto-populate as the time data is entered. Simply click the time to edit to the relevant start and end time for the exercise or incident or event. End date and time should be when the first shipment leaves the RSS for distribution and match the date and time first MCM leaves RSS (in the "total time for distribution" section).
Date and time MCM (first round of MCM if more than one occur) arrives at the last identified receiving site	Provide date and time first MCM leaves RSS (prior question not included here) and this information to provide actual time for distribution of all MCM during exercise (or incident, if applicable).

What impacts achieving "established" status?

To be eligible for this status and meet the PHEP program requirement, jurisdictions must submit the distribution FSE or incident form, at minimum, once every 5 years.

Dispensing Full-scale Exercise (FSE) or Incident

Completed By	Submission Timeline
Directly funded localities	5-year requirement (The dispensing FSE can include annual facility setup and staff notification and assembly drill requirements the year the FSE is conducted; however, site activation must still be entered independently, in the site activation drill form.)
U.S. territories and freely associated states (TFAS must complete either a distribution or dispensing FE or FSE once every 5 years; the FE or FSE satisfies the annual drill requirement the year it is conducted and submitted.	
CRI local planning jurisdictions	5-year requirement (The dispensing FSE can include annual facility setup and staff notification and assembly drill requirements the year the FSE is conducted; however, site activation must still be entered independently, in the site activation drill form.)

Form Key Terms (refer to Appendix B): after-action report (AAR), chemical, biological, radiological, nuclear, and explosives (CBRNE), Cities Readiness Initiative (CRI), core staff, emergency management agency (EMA), event, facility setup, full notification, functional needs, head of household (HoH), incident, no notification (none), partial notification, preparedness, primary point of dispensing (POD), public health emergency, Public Health Emergency Preparedness (PHEP) cooperative agreement, rapid dispensing model (or nonmedical model), regimens per hour (RPH), request, responder, staff assembly, staff notification, subject matter expert (SME), throughput, volunteer

Why is this information collected?

The dispensing FSE or incident form provides information on operational functions specific to staff notification and assembly procedures for PODs. The exercise measures the accuracy of staff rosters, timeliness of staff confirmations to the notification, and staff ability to report for duty within a designated timeframe. The exercise also assesses the ability for a complete, timely POD setup with the necessary materiel, layout, and supplies for the general population as well as people with disabilities and others with access and functional needs. In addition, the exercise tests dispensing procedures and verifies estimates of regimens and persons per hour. Lastly, the exercise tests timeliness for developing and releasing public health messages to the public, including people with disabilities and others with access and functional needs.

What do you need to know about this form?

Form Question	Form Hint
Name of exercise, event, or incident	Information from previous incidents or FSEs less than 5 years old should be submitted until information can be updated with the current period of performance's incidents and FSEs. Current period of performance information should be submitted as it becomes available to provide up-to-date and accurate information about the status of the preparedness program. Data must be entered to submit the form.

Form Question	Form Hint
Type	Select whether you are reporting a FSE or actual incident or event. Information from previous incidents or FSEs less than 5 years old should be submitted until information can be updated with the current period of performance's incidents and FSEs. Current period of performance information should be submitted as it becomes available to provide up-to-date and accurate information about the status of the preparedness program. Data must be entered to submit the form.
Start date and time **End date and time**	A date picker (pop-up calendar) will appear for date and time fields. Select the appropriate information for the exercise or incident or event. For exercises, the start and end date might be the same. When using the date picker, the time will auto-populate as the time data is entered. Simply click the time to edit to the relevant start and end time for the exercise or incident or event. Information from previous incidents or FSEs less than 5 years old should be submitted until information can be updated with the current period of performance's incidents and FSEs. Current period of performance information should be submitted as it becomes available to provide up-to-date and accurate information about the status of the preparedness program. Data must be entered to submit the form.
Event type	If the exercise includes community reception centers for those potentially exposed to radioactive material, select CBRNE and type "Community Reception Center" as "Other." Information from previous incidents or FSEs less than 5 years old should be submitted until information can be updated with the current period of performance's incidents and FSEs. Current period of performance information should be submitted as it becomes available to provide up-to-date and accurate information about the status of the preparedness program. Data must be entered to submit the form.
Trigger or cause for MCM dispensed	Information from previous incidents or FSEs less than 5 years old should be submitted until information can be updated with the current period of performance's incidents and FSEs. Current period of performance information should be submitted as it becomes available to provide up-to-date and accurate information about the status of the preparedness program. Data must be entered to submit the form.
Staff received initial prophylaxis as part of exercise (or incident if applicable)	Will display only if previous question is answered "Yes". Select "Yes" if any public health responders used are given initial prophylaxis.

Form Question	Form Hint
EOC staff received initial prophylaxis as part of exercise (or incident, if applicable)	Select "Yes" if any type of EOC (public health EOC or DOC, EMA EOC, other EOC) staff is given initial prophylaxis. Information from previous incidents or FSEs less than 5 years old should be submitted until information can be updated with the current period of performance's incidents and FSEs. Current period of performance information should be submitted as it becomes available to provide up-to-date and accurate information about the status of the preparedness program. Data must be entered to submit the form.
POD staff received initial prophylaxis as part of exercise (or incident, if applicable)	Information from previous incidents or FSEs less than 5 years old should be submitted until information can be updated with the current period of performance's incidents and FSEs. Current period of performance information should be submitted as it becomes available to provide up-to-date and accurate information about the status of the preparedness program. Data must be entered to submit the form.
SMEs involved	If the activity is an exercise, select all SMEs that were included in the planning or participated in the exercise. If the activity is an incident or event, select all SMEs that were consulted or involved. The exercise forms, associated AAR forms, and supporting evidence should be reviewed to confirm reported information.
POD name	POD name should match the information entered on the descriptive POD form. Submit no more than five PODs per exercise or incident or event.
Date and time POD opened	Provide the date and time each POD opened.
Total number of planned primary PODs within jurisdiction	Provide number of PODs. This number should match the number entered on the POD planning sheets.
Staff notification is completed	Indicate whether POD staff are notified one POD at a time, for all PODs at one time, or if multiple PODs are activated at different times based on the scale of the FSE, incident, or event.
POD staff notification start date and time **POD staff notification end date and time**	Staff notification may occur at the same time as the start of the activity or it can differ (depending on the scenario). Provide the date and time start even if the same as the date and time start of the activity.
Extent of advance notification	Select type of notification (full, partial, none) described in the exercise objectives.
Communication platform(s) used for notification	Select relevant communication platforms used or tested. This should align with planning documentation.
Call notification process	Select type of notification (automated, manual, hybrid). This should align with planning documentation.
Automated system type	Select either concurrent or sequential. This should align with planning documentation.
Type of staff notified in addition to POD staff	Select the facility staff that also participated in the FSE, event, or incident.

Form Question	Form Hint
Staff notification and assembly staffing categories: management or lead staff, security staff, medical health department, nonmedical health department, general health department staff, medical volunteer, nonmedical volunteer staff	Complete if applicable to the POD staffing plans.
Current first shift POD staff or volunteers	Include number of staff participating in the activity. If multiple PODs are activated at different times based on the scale of the incident, provide numbers for each notification. If PODs are activated individually, provide numbers per POD. If a particular type of staff was not needed, leave blank. For security staff, if this number cannot be provided given the security contract, enter "000."
Total number of staff who acknowledged notification	If staff responded outside of the specified event date or time, do not include them in the total number.
Acknowledgement completion time	Auto-calculated value, based on the following formula: (Date and time last person acknowledged) - (Date and time first person notified)
Acknowledgement percentage	Auto-calculated value, based on the following formula: $\frac{\text{Total \# staff who acknowledged}}{\text{Total \# staff contacted}} \times 100$
Assembly completion time (in minutes)	Auto-calculated value, based on the following formula: (Date and time last staff member arrived at facility) - (Date and time first staff member notified)
Assembly percentage	Auto-calculated value, based on the following formula: $\frac{\text{Total \# staff physically assembled}}{\text{Total \# staff notified}} \times 100$
Messages about POD locations and hours of operation were disseminated during the incident or event	Select "Yes" if public health messages were disseminated during the incident or event and enter date and time that communication was sent. This question is asked for messages directed to both general and populations who have access and functional needs.
Vulnerable population stakeholders included in planning for the exercise (CRI, TFAS, or DFL)	In this section, information about stakeholders that support planning and communication to populations with access and functional needs is verified. Exercise and incident or event experiences should align with dispensing planning evidence.
POD setup section	Provide information for up to five PODs, including at least one for each different size POD exercised, such as one standard POD and one mega POD.
POD total setup time (in minutes)	Auto-calculated value, based on the following formula: (POD setup end date and time) - (POD setup start date and time)

Form Question	Form Hint
Reporting throughput section	At minimum, one POD per CRI should exercise dispensing procedures. Throughput should be provided for each different size POD tested. Throughput can be entered from calculations outside of the DCIPHER system or the DCIPHER system will calculate throughput if a minimum of 50 samples are entered. External systems must be able to estimate the following: Number of regimens dispensed to HoH Traditional or assisted or express dispensing information Total time for each individual to start and complete dispensing activities Regimens per hour (required data entry) Persons per hour (required data entry) Average completion time (required data entry)
Total people or vehicles participating in POD throughput	A minimum of 50 people (or vehicles if a drive-through POD) must be submitted to calculate throughput.

What impacts achieving "established" status?

To be eligible for this status and meet the PHEP program requirement, jurisdictions must submit the Dispensing FSE or Incident form, at minimum, once every 5 years.

Critical Workforce Group (CWG) Vaccination – Functional Exercise

Completed By	Submission Timeline
States	5-year requirement
Directly funded localities	5-year requirement
U.S. territories and freely associated states (TFAS must complete either a PHEP FE or FSE once every 5 years; the FE or FSE satisfies the annual drill requirement the year it is conducted and submitted.	

Form Key Terms (refer to Appendix B): Form key terms (refer to Appendix B): department operations center (DOC), dispensing/vaccination clinic, (DVC), emergency management agency (EMA), emergency operations center (EOC), full notification, Hospital Preparedness Program (HPP), no notification (none), partial notification, public health emergency, Public Health Emergency Preparedness (PHEP) cooperative agreement, rapid dispensing model (or nonmedical model), receipt, stage, store (RSS) facility, request, responder, site activation, site availability, staff assembly, staff notification, state operations center (SOC)

Why is this information collected?

The critical workforce group (CWG) vaccination functional exercise form provides information on operational functions related to allocating and targeting pandemic influenza vaccine for CWGs. This exercise assumes that in the event of a severe influenza pandemic (or similar public health emergency that limits vaccine supply), vaccine supply might be limited in the early phase. In the case of pandemic influenza, CDC developed guidance (https://www.cdc.gov/flu/pandemic-resources/) and tools to assist state and local partners in planning for rapid identification of critical workforce groups (CWGs). The form measures vaccination for prioritized CWGs and requires at least one CWG is included in the exercise. The exercise should be conducted in a closed DVC (Dispensing/Vaccination Clinic) to simulate real-world plans and ensure vaccine control.

Planners should work closely with immunization program counterparts to ensure best practices and procedures for vaccine protocols are adhered during the exercise. Particular attention to vaccine administration, storage, handling, and reporting is recommended. Additionally, collaboration with non-traditional prioritized CWGs (private sector, utilities, law enforcement, etc.) are encouraged. Finally, this FE exercises processes for reporting vaccine dose administration to the Immunization Information System (IIS). In a real incident, data on administered vaccine doses will inform practitioners, public health policy decisions, and ensure patient safety.

What do you need to know about this form?

Create this form by selecting "Functional Exercise – Critical Workforce Group (CWG) Vaccination." Locate the form in the "create form" section at the top of the current home page of the ORR.

Form Question	Form Hint
Start date and time **End date and time**	A date picker (pop-up calendar) will appear for date and time fields. Select the appropriate information for the exercise or incident or event. For exercises, the start and end date might be the same. When using the date picker, the time will auto-populate as the time data is entered. Simply click the time to edit to the relevant start and end time for the exercise or incident or event.
Participating Critical Workforce Groups (select all that apply)	Choose the relevant group from the drop-down choices, which are based on CDC's interim updated planning guidance on allocating and targeting pandemic influenza vaccine during an influenza pandemic ((https://www.cdc.gov/flu/pandemic-resources/).
Subject matter expertise involved	Select from the dropdown the first SME (role) included in the exercise and mark the circle to indicate whether the SME was a planning partner, exercise/incident participant, or both. Select done. Click the "add" icon to enter the next type of participant and repeat until all roles entered.
Method of notification of targeted critical workforce group	Select (or enter) all methods used to notify CWG about the exercise.
Communication platforms used for notification	Select relevant communication platforms used or tested; this should align with planning documentation.
Call notification process	Select type of notification (automated, manual, hybrid). This should align with planning documentation.
Automated system type	Select either concurrent or sequential. This should align with planning documentation.
Best practice evidence (for each POD/DVC)	Upload checklist used during the exercise. Credit is given regardless of how many yes/no are entered. Exercise is intended to identify strengths and weakness.
Start date and time **End date and time**	A date picker (pop-up calendar) will appear for date and time fields. Select the appropriate information for the exercise or incident or event. For exercises, the start and end date might be the same. When using the date picker, the time will auto-populate as the time data is entered. Simply click the time to edit to the relevant start and end time for the exercise or incident or event.
POD/DVC total set-up time (in minutes)	Auto-calculated value, based on the following formula: (POD/DVC setup end date and time) - (POD/DVC setup start date and time)

Form Question	Form Hint
Immunization Information Systems (IIS)	II IIS collect and consolidate vaccination data from providers in a geographic area. Reporting vaccinations to IIS is critical for tracking and measuring immunizations and guiding public health actions during outbreaks, especially for immunizations which require multiple doses at specific intervals (e.g., pandemic influenza planning assumes that two doses given 21 days apart may be required for all age groups). Each member of a jurisdiction's targeted critical workforce should have a demographic record in the IIS. In the pre-event planning stages, verify how many people in the target population have established demographic records in IIS. After this initial assessment, encourage missing persons in the target population to enroll in the IIS prior to the FE. During the FSE, practice checking IIS to verify each person arriving for vaccination is enrolled; this process will facilitate vaccination histories are reviewed in the IIS and test plans for IIS reporting for the target population.
Total number of targeted CWG enrolled in IIS prior to FE	Take time prior to the day of FE to enroll members of the targeted CWG into the IIS. Enrollment is defined as having a demographic record established in the IIS
Total number enrolled in IIS during FE	Some members will be enrolled on-site at the DVC
Number of vaccine doses reported to IIS the day of the FE	
Number of vaccine doses reported to IIS 2-7 days after the FE	For example, sometimes information is collected on paper and entered into IIS at a later date. This and the following item measure timeliness of reporting to IIS.
Vaccine history screening methods (select all that apply)	Select from the drop-down choices or add the method used to screen CWG vaccine history. Drop-down choices include: reviewed IIS, reviewed paper records, reviewed patient's personal documentation, and communication with other healthcare providers. During the FE staff is encouraged to use IIS but options can be simulated. Vaccine history is important factor during a pandemic since it likely will require two doses of vaccine separated by three weeks.
Verify membership in targeted CWG (select all that apply)	Confirm each person is a member of targeted CWG

What impacts achieving "established" status?

To be eligible for this status and meet the PHEP program requirement, jurisdictions must conduct and submit the critical workforce group vaccination functional exercise form, at minimum, once every 5 years.

PHEP, Functional, Full-scale Exercise (FSE) or Incident

Completed By	Submission Timeline
States	Annual requirement
Directly funded localities	
U.S. territories and freely associated states (TFAS must complete either a PHEP FE or FSE once every 5 years; the FE or FSE satisfies the annual drill requirement the year it is conducted and submitted.	

Form Key Terms (refer to Appendix B): department operations center (DOC), emergency management agency (EMA), emergency operations center (EOC), full notification, Hospital Preparedness Program (HPP), no notification (none), partial notification, public health emergency, Public Health Emergency Preparedness (PHEP) cooperative agreement, rapid dispensing model (or nonmedical model), receipt, stage, store (RSS) facility, request, responder, site activation, site availability, staff assembly, staff notification, state operations center (SOC)

Why is this information collected?

The PHEP functional, FSE or incident form provides operational information about EOCs, including staff notification and assembly procedures. Detail about staff roster accuracy, notification, and assembly are collected. Further, EOC procedures, including site activation and availability, are collected. Use this form to submit information from a functional exercise (except the critical workforce functional exercise for pandemic influenza) or FSE to meet the joint exercise requirement or the pandemic FSE requirement. In addition, use this form to submit information from an incident occurring during the first three pandemic intervals (investigation, recognition, or initiation) as outlined in CDC's Pandemic Intervals Framework (PIF). If activation during a pandemic incident (such as COVID-19) persists into the acceleration interval or longer, this form can also be used for submission of information. If an FSE is conducted primarily in the acceleration interval, submit information on the distribution or the dispensing FSE form (see guidance on those forms for additional detail).

Engagement with stakeholders representing people with disabilities and others with access and functional needs during an activation are collected to satisfy the PHEP program requirement to engage these partners if relevant to the exercise or incident or event. Information provided also might satisfy the joint planning exercise if HPP and state, regional, or federal emergency management are involved in the incident or event.

This form also should be used to submit information for a partial- or full-activation of the EOC during a non-MCM incident where public health is involved. The distribution FSE or incident form should be used to report MCM related EOC activations and staff notifications during incidents where public health is involved.

This form also should be used to submit the following: a) information for the PHEP exercise with vulnerable population partners requirement and b) the Joint HPP exercise requirement.

What do you need to know about this form?

Form Question	Form Hint
Name of exercise, event, or incident	Information from previous incidents or FSEs less than 5 years old should be submitted until information can be updated with the current period of performance's incidents and FSEs. Current period of performance information should be submitted as it becomes available to provide up-to-date and accurate information about the status of the preparedness program. Data must be entered to submit the form.
Type	This form can be used to report information about all non-MCM related EOC activations where public health was involved. Use this form to meet PHEP program reporting requirements for incident-based EOC activations, incident- or drill-based EOC staff notifications, and the PHEP exercise with vulnerable population partners. Incident, event, or drill should be chosen to satisfy the staff notification and assembly requirement. ONLY in the event that no incidents occur during the 12-month period: Select "Drill" as type. Selection of "drill" will allow the reporting of a no-notice, full or partial EOC staff notification and assembly to fulfill the annual staff assembly performance measure requirement (formerly 3.1). See Appendix D: 2018–2019 ORR Status Tips. Information from previous incidents or FSEs less than 5 years old should be submitted until information can be updated with the current period of performance's incidents and FSEs. Current period of performance information should be submitted as it becomes available to provide up-to-date and accurate information about the status of the preparedness program. Data must be entered to submit the form.

Form Question	Form Hint
Start date and time **End date and time**	A date picker (pop-up calendar) will appear for date and time fields. Select the appropriate information for the exercise or incident or event. For exercises, the start and end date might be the same. When using the date picker, the time will auto-populate as the time data is entered. Simply click the time to edit to the relevant start and end time for the exercise or incident or event. Information from previous incidents or FSEs less than 5 years old should be submitted until information can be updated with the current period of performance's incidents and FSEs. Current period of performance information should be submitted as it becomes available to provide up-to-date and accurate information about the status of the preparedness program. Data must be entered to submit the form. To meet the PHEP exercise with vulnerable population partners requirement, an exercise must have started and ended between the current budget period (July 1 - June 30). An incident/event must have started or ended between the current budget period (July 1 – June 30). To satisfy the staff notification and assembly requirement, a drill must have started and ended between the current budget period (July 1 - June 30). An incident/event must have started or ended between the current budget period (July 1 – June 30). To meet the Joint HPP exercise requirement, an exercise must have started and ended between July 1, 2017 and June 30, 2022. An incident/event must have started or ended between July 1, 2017 and June 30, 2022.
Event type	If the exercise includes community reception centers for those potentially exposed to radioactive material, select "CBRNE" and "CRC." If entering information for a drill, enter "Drill". Information from previous incidents or FSEs less than 5 years old should be submitted until information can be updated with the current period of performance's incidents and FSEs. Current period of performance information should be submitted as it becomes available to provide up-to-date and accurate information about the status of the preparedness program. Data must be entered to submit the form.
Fiscal or other administrative processes and procedures included in exercise (select all that apply)	Completing an administrative and fiscal preparedness exercise is recommended, but not required. Grant allocation and hiring surge questions to inform exercise objectives are available in the Performs Resource Library (see 2017–2022 HPP-PHEP Supplemental Guidelines (CDC-RFA-1701-01).

Form Question	Form Hint
Joint planning or exercise included the following community partners	Information from previous incidents or FSEs less than 5 years old should be submitted until information can be updated with the current period of performance's incidents and FSEs. Current period of performance information should be submitted as it becomes available to provide up-to-date and accurate information about the status of the preparedness program. Data must be entered to submit the form. To meet the Joint HPP exercise requirement, recipients must select Health Care Coalitions and at least one Emergency Management partner: •State Emergency Management Agencies/Organizations (EMA/O) •Public Health Emergency Management Agencies •Regional/Federal Emergency Management Agencies/ Organizations (EMA/O)
Vulnerable population stakeholders included in planning for the exercise	Those groups that will potentially be disproportionately impacted by an incident or event. At least one stakeholder representing people with access and functional needs be engaged while planning for or during an exercise or incident or event to meet the PHEP exercise with vulnerable population partners requirement.
EOC site activation drill information: communication platform(s) used for notification	Select relevant communication platforms used or tested. This should align with planning documentation.
EOC site activation drill information: Call notification process	Select type of notification (automated, manual, hybrid). This should align with planning documentation.
EOC general: total number of EOCs	Provide total number of EOCs in your jurisdiction (regardless of type of EOC). Examples include DOC, SOC, EMA EOC, and other EOC.
EOC general: number of EOC sites included in site activation	Provide total number of EOC activated for this exercise or incident or event, including virtual EOC activations, where public health was involved (regardless of type of EOC).
EOC general: total number of sites that acknowledged notification	If site responded outside of the specified event date or time, do not include it in the total number.
EOC general: acknowledgement completion time	Auto-calculated value, based on the following formula: (Date and time last site acknowledged) - (Date and time first site notified)
EOC general: acknowledgement percentage	Auto-calculated value, based on the following formula: Total # sites who acknowledged x 100 Total # sites notified
EOC general: availability percentage	Auto-calculated value, based on the following formula: Total # sites made available x 100 Total # sites notified

Form Question	Form Hint
Site activation EOC, per site: availability completion time	Auto-calculated value, based on the following formula: (Date and time site made available) - (Date and time site notified)
EOC staff notification drill information: extent of advance notification	Extent of advance notification should be "None" to satisfy staff notification and assembly requirements. Note the question is asking for extent of advance notification not activation.
EOC general: number of EOC sites included in staff notification	Provide total number of EOCs included in staff notification for this drill, exercise, or incident or event; (this includes virtual EOC assemblies).
EOC staff notification drill information: EOC type	Indicate type of EOC staff notified during drill.
EOC staff notification drill information: current EOC incident management lead staff	Provide the total number of EOC incident management staff notified for this exercise, drill, or incident or event.
EOC staff notification drill information: date and time first person notified	Enter date and time to begin auto-calculation of acknowledgement completion time.
EOC staff notification drill information: date and time last person acknowledged notification	Enter date and time to end auto-calculation of acknowledgement completion time.
EOC staff notification drill information: **total number of staff who acknowledged notification**	If staff responded outside of the specified event date or time, do not include them in the total number. Enter number for system to auto-calculate percent of staff who acknowledged notification.
EOC staff notification drill information: **incident management roles (or equivalent lead roles) activated (select all that apply)**	Incident commander, finance or administration section chief, logistics section chief, operations section chief, planning section chief, and public information officer all should be activated to satisfy the staff notification and assembly requirement (one person may fill multiple roles).
EOC staff notification drill information: target time for assembly (in minutes)	
EOC staff notification drill information: type of staff assembly	Staff assembly must be virtual, physical, or both to satisfy the staff notification and assembly requirement. Recipients must submit all of the following assembly information.
EOC staff notification drill information: date and time last person assembled	Enter date and time to end auto-calculation of assembly completion time.
EOC staff notification drill information: total number of staff who assembled	Input number of staff, for example, "6."
EOC staff notification drill information: total number of staff who assembled within target time	Input number of staff, for example, "6."
EOC staff notification drill information: acknowledgement completion time	Auto-calculated value, based on the following formula: (Date and time last person acknowledged) - (Date and time first person notified)
EOC staff notification drill information: acknowledgement percentage	Auto-calculated value, based on the following formula: Total # staff who acknowledged x 100 Total # staff contacted

Form Question	Form Hint
EOC staff notification drill information: assembly completion time	Auto-calculated value, based on the following formula: (Date and time last staff member arrived at facility) - (Date and time first staff member notified) EOC incident management lead staff assembly completion time must be 60 minutes or less to meet the EOC staff notification and assembly requirement.
EOC staff notification drill information: assembly percentage	Auto-calculated value, based on the following formula: Total # staff assembled x 100 Total # staff notified

What impacts achieving "established" status?

To receive credit toward “established” status and meet the annual PHEP exercise requirement, the exercise, incident, or event must include engagement with stakeholders representing people with disabilities and others with access and functional needs. This form also will meet the HPP-PHEP-EMA joint exercise requirement and must be submitted, at minimum, once every 5 years. This form must be used to report information about all non-MCM EOC activations, but it will not satisfy the MCM distribution exercise requirement.

After-action Report (AAR) and Improvement Plan (IP)

Completed By	Submission Timeline
This form is not currently required. Upload the actual AAR/IP document as evidence for incidents, FEs, and FSEs while completing those forms.	Not applicable

Training and Exercise Planning

Training and Exercise Planning Workshop (TEPW)

Completed By	Submission Timeline
States	Annual requirement
Directly funded localities	Annual requirement
U.S. territories and freely associated states	2-year requirement

Form Key Terms (refer to Appendix B): after-action report (AAR), preparedness, public health emergency, Public Health Emergency Preparedness (PHEP) cooperative agreement, PHEP capabilities

Multiyear Training and Exercise Plan (MYTEP)

Completed By	Submission Timeline
States	Annual requirement
Directly funded localities	Annual requirement
U.S. territories and freely associated states	Annual requirement
CRI local planning jurisdictions	Annual requirement

Form Key Terms (refer to Appendix B): Cities Readiness Initiative (CRI), Public Health Emergency Preparedness (PHEP) capabilities

Why is this information collected?

The training and exercise planning form standardizes the collection of areas for improvement identified in the TEPW and allows for monitoring of exercise program priorities used to develop the MYTEP. It also can inform technical assistance activities. The information collected outlines the plans to address specific threats and hazards, identified areas for improvement, and preparedness capabilities. The form does not replace the MYTEP document.

What do you need to know about this form?

Form Question	Form Hint
Methodology and tracking section	Provide information about how training and exercises are selected and monitored with respect to progression and improvement as indicated in HSEEP guidelines. Refer to https://preptoolkit.fema.gov/web/hseep-resources. Upload timeline or spreadsheet with planned exercises, if available.
Number of trainings planned in current budget period	Include all trainings, not just MCM-specific trainings.
Number of trainings planned in future budget periods	Include all trainings, not just MCM-specific trainings.

Changes in priorities from last year's MYTEP	Describe any significant changes from planned priorities. These should include shifts because of budgetary constraints, actual incidents, or other impediment. Information should support why improvement plans are altered and how continued improvement is supported.
Changes in exercise schedule from previous MYTEP	Briefly describe the reasons for any changes (both planned and unplanned) to the exercise schedule, including those because of priorities described in the previous question. There should be Updates to the MYTEP should be made each year even if priorities did not differ.

What impacts achieving "established" status?

To be eligible for this status and meet the PHEP program requirement, states and DFLs must conduct a TEPW annually by June 30. Territories and freely associated states must conduct a TEPW, at minimum, once every two years. To be eligible for this status and meet the PHEP program requirement, the MYTEP also must be updated annually by June 30 for states, DFLs, CRI local planning jurisdictions, and TFAS, and include at least one year of additional training and exercise planning. (A minimum of two years must be included to be eligible for "established," three or more to meet partial fulfillment of "advanced" status requirements).

Appendix A: Key Terms

A

Academic institutions: Refers to all academic facilities, including elementary schools, middle schools, junior high schools, high schools, colleges, universities, and community colleges.

Adequate: A system, process, procedure, or quantity that will achieve a defined response objective.

After-action report (AAR): Summarizes key exercise-related evaluation information, including the exercise overview and analysis of objectives and core capabilities. The AAR is usually developed in conjunction with an improvement plan (IP).

Alert: Time-sensitive tactical communication sent to parties potentially impacted by an incident to increase preparedness and response. Alerts can convey 1) urgent information for immediate action, 2) interim information with actions that may be required in the near future, or 3) information that requires minimal or no action by responders. CDC's Health Alert Network (HAN) is a primary method of sharing cleared information about urgent public health incidents with public information officers (PIOs); federal, state, territorial, and local public health practitioners; clinicians; and public health laboratories.

All-hazard incidents: Incidents, whether natural or manmade, that warrant action to protect life, property, environment, or public health safety.

Alternate dispensing methods: Alternate modes of dispensing include other methods used to reach individuals who do not use the open or public walk-through PODs. Alternate methods of dispensing may include drive-through or mobile dispensing sites; providing medications via businesses, nursing homes, and assisted living facilities; or door-to- door or direct deliveries to residences or deliveries to sheltered-in populations, such as incarcerated individuals or group homes.

Antemortem data: Information about a missing or deceased person used for identification. This includes demographic and physical descriptions, medical and dental records, and information regarding the person's last known whereabouts. Ante mortem information is gathered and compared to postmortem information when confirming a victim's identification.

At-risk populations: Population members who may have additional needs before, during, and after an incident in functional areas, including, but not limited to, maintaining independence, communication, transportation, supervision, and medical care. Individuals in need of additional response assistance may include those who have disabilities, who live in institutionalized settings, who are elderly, who are children, who are from diverse cultures, who have limited English proficiency, who are non-English speaking, or who are transportation disadvantaged (U.S. Department of Health and Human Services definition).

B

Backup (secondary) point of dispensing (POD): A pre-planned site that can be activated for POD medical countermeasures (MCMs) based on the incident response requirements.

BioWatch Actionable Result (BAR): One or more polymerase chain reaction (PCR)-verified positive result(s) from a BioWatch collector that meets the algorithm for one or more specific BioWatch agents. A BAR is one piece of information provided to federal, state, and local decision makers as they review findings from other collectors and additional relevant information to determine the cause of the BAR and whether a public health risk exists.

C

Category A, B, and C agents: Three categories of biological pathogens: Category A agents are high-priority organisms and toxins posing the greatest threat to public health. This category of agents causes the highest morbidity and mortality with a likelihood of subsequent public panic. Category B agents are fairly easy to disperse, but have lower morbidity and mortality than Category A agents. Category C agents are emerging infectious organisms that could become easily available in the future and used as a weapon.

- Category A agents include anthrax, botulism, plague, smallpox, Tularemia, viral hemorrhagic fevers, such as Ebola.
- Category B agents included food safety threats, for example, E. coli and Salmonella), Ricin toxin, staphylococcal enterotoxin B.
- Category C agents include hendra virus encephalitis, hantavirus pulmonary syndrome.

CBRNE: An acronym for a chemical, biological, radiological, nuclear, or explosives threat.

Centralized governance: A health governance structure where the state retains authority over local health units and most decisions related to the budget, issuing public health orders, and the selection of the local health official.

Center for Preparedness and Response (CPR): A center within the Centers for Disease Control and Prevention (CDC) that has primary oversight and responsibility for all programs that comprise CDC's public health preparedness and response portfolio.

Chain of custody: Tracking of possession of and responsibility for medical materiel during the distribution process.

Chief medical/science officer: Senior level infectious disease expert who advises the incident command staff through decision making throughout a response.

Cities Readiness Initiative (CRI): A CDC-funded program designed to enhance preparedness in the nation's largest population centers, where nearly 60% of the U.S. population resides, to respond successfully to large public health emergencies needing life-saving medications and medical supplies.

Closed point of dispensing (closed POD or CPOD): A point-of-dispensing site that serves a defined population and is not open to the general public.

Command staff or incident management (IM) lead roles: Refers to the command staff (incident commander, public information officer, safety officer, liaison officer) required to support the command function in an incident as well as general staff (operations section chief, planning section chief, logistics section chief, and finance or administration section chief), or their equivalent titles or roles, in a jurisdictional health department. The level of complexity and characteristics of an incident will direct the activation of certain IM lead roles. Not all lead roles will be activated for a given response. Moreover, in certain scenarios, individual staff members may cover more than one IM role at a time. Finally, an agency including additional personnel in key incident management lead roles, such as chief science officer or chief medical officer, is possible.

Common operating picture: A continuously updated overview of an incident compiled throughout the incident's life cycle. This overview includes data shared between integrated systems for communication, information management, and intelligence and information sharing. The common operating picture facilitates collaborative planning and assists achieving situational awareness across all engaged entities.

Community-based agencies: Refers to any organization or entity that is primarily based in the community, such as the American Red Cross and home health.

Community outreach information network (COIN): A grassroots network of people and trusted leaders who can help with emergency response planning and delivering information to at-risk populations during emergencies.

Community Preparedness (Public Health Emergency Preparedness and Response Capability 1): The ability of a community to prepare for, withstand, and recover from public health incidents in both the short and long terms.

Community Recovery (Public Health Preparedness and Response Capability 2): Community recovery is the ability of communities to identify critical assets, facilities, and other services within public health, emergency management, health care, human services, mental/behavioral health, and environmental health sectors that can guide and prioritize recovery operations.

Community support services: Community level support that includes, but is not limited to food and water, medication(s) as well as other social or mental health services for persons who are ill and isolated in their homes or are complying with recommendations for voluntary household quarantine during community pandemic outbreaks. Note: personnel supplying the community support services could be at increased risk of exposure to ill persons and, if infected could transmit illness, to vulnerable or high-risk populations.

Continuity of operations (COOP) plan: Describes the efforts an agency makes to ensure that its primary mission essential functions (PMEFs) can be continued throughout or resumed rapidly after a disruption of normal activities during a wide range of emergencies, including localized acts of nature or accidents and technological or man-made emergencies.

Core staff: Minimum staff required to activate a point of dispensing (POD) and provide just-in-time training to "additional" staff that may support POD functions.

Crisis standards of care (CSC): "Crisis standards of care" (CSC) are invoked when a situation requires a substantial change in health care operations and the level of care that can be delivered. Medical care delivered during disasters shifts beyond focusing on individuals to promoting the responsible planning and management of limited resources intended to result in the best possible health outcomes for the population as a whole. Note: Responsible planning and management of limited resources is essential during outbreak of a novel disease (influenza or emerging infectious disease).

Critical infrastructure: Assets, systems, and networks, whether physical or virtual, so vital to the United States that the incapacitation or destruction of such assets, systems, or networks would have a debilitating impact on security, national economic security, national public health or safety, or any combination of those matters.

Critical infrastructure personnel: Staff required to maintain critical infrastructure.

Critical workforce: Anyone whose occupation, skills, or license makes them essential to preserving the critical functions of a society or a given jurisdiction.

In a public health emergency, the specific skills, experience, certification or licensure status of the critical workforce can prevent severe bottlenecks in or the collapse of critical response functions or essential basic community services.

Critical workforce group: A select number of critical workforce personnel whose specific skills, experience, certification or licensure status are needed to prevent severe bottlenecks, or the collapse of critical functions or essential basic community services needed to respond to a public health emergency.

Crossdocking: A warehouse term for the transfer of goods from an inbound carrier, such as a truck or railroad car, to an outbound carrier without the goods or products being stored in the warehouse.

D

Drug Enforcement Administration (DEA) registrant: A practitioner—physician, dentist, veterinarian, scientific investigator, pharmacy, hospital, or other person—licensed, registered, or otherwise permitted, by the United States or the jurisdiction in which he or she practices or does research, to distribute, dispense, conduct research with respect to, administer, or use in teaching or chemical analysis, a controlled substance in the course of professional practice or research. All registrants are required by the Controlled Substance Act (CSA) to maintain complete and accurate inventories and records of all regulated transactions involving controlled substances and listed chemicals, as well as provide adequate security controls to prevent their diversion.

Decentralized governance: Refers to a health governance structure in which local health units are primarily governed by local authority (also known as home rule).

Delivery schedule: The estimated time to deliver medical materiel to final destination, including estimates for third-party involvement.

Demobilize: Release and return of resources that are no longer required for the support of an incident.

Department operations center (DOC): The public health emergency operation center (EOC) that gathers information and shares information with the state operation center (SOC). This is most likely the EOC for the agency that serves as the Emergency Support Function (ESF)-8 lead.

Deploy: The movement of assets, including personnel, to a specific area.

Designated official: Individuals in the health department who have the authority to take appropriate action on behalf of the agency, such as decide to activate incident management roles.

Devolution: The capability to transfer statutory authority and responsibility for essential functions from an organization's primary operating staff and facilities to other organization employees and facilities and to sustain that operational capability for an extended period.

Discussion-based exercises: Discussion-based exercises include seminars, workshops, tabletop exercises (TTXs), and games. These types of exercises can be used to familiarize participants with or develop new, plans, policies, agreements, and procedures. Discussion-based exercises focus on strategic, policy-oriented issues. Facilitators or presenters usually lead the discussion, keeping participants on track towards meeting exercise objectives.

Dispensing modalities: The strategies or methods—POD locations, drive-through pick-up locations, providing medications to private businesses—that a jurisdiction uses to provide the medical countermeasures.

Dispensing/administration sites: Locations where targeted populations can receive medical countermeasures, whether through the dispensing of pills or the administration of medicines and vaccines. Examples of dispensing/administration sites include open point of dispensing sites (PODs), closed point of dispensing sites (CPODs), vaccination clinics, pharmacies, and other sites in the community that meet requirements for dispensing/administration sites.

Dispensing/vaccination clinic (DVC): A site for high throughput dispensing or administration of medical countermeasures.

Displaced Persons: In the context of public health emergencies, displaced persons are people **evacuated with special medical needs** who have had to leave their homes or medical support facilities as a result of an incident or event.

Distribution assets: The resources, such as personnel, equipment, supplies, and technology, needed to transport materiel during a public health emergency or disaster.

Distribution planning: A systematic process for determining which goods, in

what quantity, at which location, and when are required in meeting anticipated demand.

Drill: A coordinated, supervised activity usually employed to validate a specific operation or function in a single agency or organization. Drills can used to provide training on new equipment; develop and validate new policies or procedures; or practice and maintain current skills.

Durable medical equipment: Equipment that can withstand repeated use, provides therapeutic benefits to a patient in need because of certain medical conditions or illnesses, and can be recovered after an emergency, such as ventilators.

E

Economically disadvantaged: Individuals who fall below the poverty level or would not have the financial means to get to a POD during a public health emergency requiring dispensing or administration of MCMs.

Emergency: An occurrence that may cause adverse physical, social, psychological, economic, or political effects that challenge a jurisdiction's ability to respond rapidly and effectively.

Emergency management: Federal, state, local, and nongovernmental organizations in the area of emergency management, homeland security, and first responders. Examples include the local emergency management agency; relevant tribal entities involved in emergency services or emergency management; the state emergency management agency; federal entities, such as Federal Emergency Management Agency (FEMA) and other components of the U.S. Department of Homeland Security; the Medical Reserve Corps (MRC); Citizen Corps groups; Community Emergency Response Teams (CERTs); and others. This sector also includes traditional first responder groups, including fire, police, and emergency medical services (EMS), as well as local public works agencies and nonprofit utility companies, such as city or county utilities, energy, water, and sanitation, and tribal utility authorities that may respond to an incident or provide services critical for an effective response.

Leaders from this sector may include emergency managers or their deputies; chiefs and assistant chiefs for divisions, such as special operations, hazardous materials and fire suppression; state police, city police, and county sheriffs involved in large planning events; special weapons and tactics supervisors; directors EMS supervisors; and senior public works administrators. Please note that, to the extent that this sector covers public safety, for example, police and sheriffs, it implies engagement to ensure incarcerated individuals are appropriately included in relevant public health preparedness efforts.

Emergency management agency (EMA): A jurisdictional agency that has the responsibility for an emergency management program (EMP). The agency typically has responsibility to ensure the overall preparation, implementation, and evaluation, of the program during a disaster.

Emergency Management Assistance Compact (EMAC): An all-hazards, all-disciplines mutual aid compact that serves as the cornerstone of the nation's mutual aid system. Through EMAC, a disaster-impacted state can request and receive assistance from other member states quickly and efficiently, resolving two key issues: liability and reimbursement.

Emergency operations center (EOC): The physical location at which the coordination of information and resources to support incident management (on-scene operations) activities normally takes place. An EOC may be a temporary facility or may be located in a more central or permanently established facility, perhaps at a higher level of organization within a jurisdiction. EOCs may be organized by major functional disciplines, such as fire, law enforcement, medical services, public health; by jurisdiction, such as federal, state, regional, tribal, city, county; or by some combination thereof.

Emergency Operations Coordination (Public Health Emergency Preparedness and Response Capability 3): The ability to coordinate

with emergency management and to direct and support an incident or event with public health or health care implications by establishing a standardized, scalable system of oversight, organization, and supervision that is consistent with jurisdictional standards and practices and the National Incident Management System (NIMS).

Emergency operations plan (EOP): The response plan that an entity, such as an organization, jurisdiction, or state, maintains that describes intended response to any emergency. It provides action guidance for management and emergency response personnel during the response phase.

Emergency Public Information and Warning (Public Health Emergency Preparedness and Response Capability 4): The ability to develop, coordinate, and disseminate information, alerts, warnings, and notification to the public and incident management responders.

Emergency Support Function #8 (ESF-8) – Public Health and Medical Services Annex: Provides the mechanism for coordinated federal assistance to supplement state, tribal, and local resources in response to

- Public health and medical care needs
- Veterinary or animal health issues in coordination with the U.S. Department of Agriculture (USDA)
- Potential or actual incidents of national significance
- A developing potential health and medical situation

Emergency Use Authorization (EUA): An EUA is a statutory (legal) authority of the FDA Commissioner to permit the emergency use of an unapproved medical product or unapproved use of an approved medical product to diagnose, treat, or prevent serious or life-threatening diseases or conditions for which no adequate, FDA-approved alternative is available. FDA's issuance of an EUA is predicated on the HHS Secretary's declaration of emergency based on threat determination.

Essential elements of information (EEI): Discrete types of reportable public health or health care-related, incident-specific knowledge communicated or received concerning a particular fact or circumstance, preferably reported in a standardized manner or format, which assists in generating situational awareness for decision-making purposes. EEI are often coordinated and agreed upon before an incident (and communicated to local partners) as part of information collection request templates and emergency response playbooks.

Event: A planned, non-emergency activity, such as concerts, conventions, parades, and sporting events.

F

Facility setup: Ability to quickly set up materiel and spatial layouts.

Fire suppression system: Uses a combination of dry chemicals or wet agents to suppress equipment fires.

Formal written agreements: A document between two or more parties that contains specific binding obligations or expectations that each involved party must attain. Examples of formal written agreements include the following:

- Contracts
- EOPs and annexes that describe roles and responsibilities of jurisdictional agencies
- Letters of agreement
- Memoranda of agreement (MOAs)
- Memoranda of understanding (MOUs)
- Mutual aid agreements (MAAs)
- Any other official document that describes the role of public health and carries with it an expectation that public health will undertake certain fatality management-related activities.

Full notification: Site and staff are told beforehand the time and place of the activity.

Full-scale exercises (FSEs): FSEs are typically the most complex and resource-intensive type of exercise. They involve multiple agencies, organizations, and jurisdictions and validate

many facets of preparedness. FSEs often include many players operating under cooperative systems, such as the Incident Command System (ICS) or Unified Command.

In an FSE, events are projected through an exercise scenario with event updates that drive activity at the operational level. FSEs are usually conducted in a real- time, stressful environment that is intended to mirror a real incident. Personnel and resources may be mobilized and deployed to the scene, where actions are performed as if a real incident had occurred. The FSE simulates reality by presenting complex and realistic problems that require critical thinking, rapid problem solving, and effective responses by trained personnel.

Functional exercises (FEs): FEs are designed to validate and evaluate capabilities, multiple functions or sub-functions, or interdependent groups of functions. FEs are typically focused on exercising plans, policies, procedures, and staff members involved in management, direction, command, and control functions. In FEs, events are projected through an exercise scenario with event updates that drive activity typically at the management level. An FE is conducted in a realistic, real-time environment; however, movement of personnel and equipment is usually simulated.

FE controllers typically use a Master Scenario Events List (MSEL) to ensure participant activity remains within predefined boundaries and ensure exercise objectives are accomplished. Simulators in a Simulation Cell (SimCell) can inject scenario elements to simulate real events.

Functional needs: Defined as communication, medical, independence, supervisory, and transportation needs of at-risk individuals.

G

Games: A game is a simulation of operations that often involves two or more teams, usually in a competitive environment, using rules, data, and procedures designed to depict an actual or hypothetical situation. Games explore the consequences of player decisions and actions. They are useful tools for validating plans and procedures or evaluating resource requirements.

H

Hazard vulnerability analysis (HVA): A process to identify hazards and associated risks to persons, property, and structures and to improve protection from natural and human-caused hazards.

Head of household (HoH): A dispensing modality where one person is permitted to pick up medications for other members of their household or other households, allowing jurisdictions to decrease the number of people who are anticipated to come in person to a POD location. Use of this method allows for rapid dispensing because one person can obtain MCMs for as many as the jurisdiction allows. For example, Mr. Doe picks up eight regimens of MCMs (one regimen for Joe and seven other regimens, one for his spouse, four for his children, and two for his parents).

Health alert network (HAN): A primary method of sharing cleared information about urgent public health incidents with PIOs; federal, state, territorial, and local public health practitioners; clinicians; and public health laboratories.

Hospital Preparedness Program (HPP) cooperative agreement: Administered by the HHS Office of the Assistant Secretary for Preparedness and Response (ASPR), the HPP cooperative agreement provides funding and guidance to assist the health care sector in preparing for, responding to, and recovering from adverse health effect of emergencies and disasters enabling the health care delivery system to save lives.

Homeland Security: Homeland Security is a concerted national effort to prevent and disrupt terrorist attacks, protect against man-made and natural hazards, and respond to and recover from incidents that do occur.

Homeland Security Exercise and Evaluation Program (HSEEP): HSEEP provides a set of guiding principles for

exercise programs as well as a common approach to exercise program management, design and development, conduct, evaluation, and improvement planning. Exercises are a key component of national preparedness—they provide elected and appointed officials and stakeholders from across the whole community with the opportunity to shape planning, assess and validate capabilities, and address areas for improvement.

Human impact: Refers to indicators, such as number of fatalities resulting from a particular hazard, injuries requiring EMS transport, outpatient injuries, or hospital emergency department visits because of injuries.

Hybrid point of dispensing (hybrid POD): Refers to a POD that can serve one or more functions i.e. combines medical and nonmedical models or begins as a closed POD that later opens as an open POD (pharmacy or clinic).

Hygiene: Behaviors that can improve cleanliness and lead to good health, such as frequent hand washing, face washing, and bathing with soap and water. http://www.cdc.gov/healthywater/hygiene/

I

Investigational New Drug (IND) or an Investigational Device Exemption (IDE) application: An IND is a regulatory mechanism by which Federal Drug Administration (FDA) permits access to/use of a medical product that has not received FDA-approval (i.e., "investigational" or unapproved product [experimental]) or allows a medical product to be used in a way that differs from its approved use. An IDE is a similar regulatory mechanism that covers devices that have not been cleared by FDA for the intended use.

Immediate: An expectation of performance with no delay. An expectation that, upon notification, pre-identified staff are to report for duty within the amount of time identified by the jurisdiction.

Improvement plan: A compilation of corrective actions and timelines that convert the AAR recommendations into specific, measurable steps that will result in improved preparedness. The complete IP is included in the final AAR and IP as a table that summarizes next steps. Participating organizations and agencies will use it to execute improvement planning.

Immunization Information Systems (IIS): Immunization information systems (IIS) are confidential, computerized, population-based systems that collect and consolidate vaccination data from vaccination providers that can be used in designing and sustaining effective immunization strategies.

Improvement planning: During improvement planning, the corrective actions identified during individual exercises are tracked to completion, ensuring that exercises yield tangible preparedness improvements. An effective corrective action program develops IPs that are dynamic documents, which are continually monitored and implemented as part of the larger system of improving preparedness.

Incident: An occurrence either human caused or by natural phenomena, that requires action to prevent or minimize loss of life or damage to property or natural resources.

Information Sharing (Public Health Emergency Preparedness and Response Capability 6): The ability to conduct multijurisdictional, multidisciplinary exchange of health-related information and situational awareness data, including public health alerts among federal, state, local, territorial, and tribal levels of government, and the private sector.

The ability to conduct multijurisdictional and multidisciplinary exchange of health-related information and situational awareness data among federal, state, local, tribal, and territorial levels of government and the private sector. This capability includes the routine sharing of information as well as issuing of public health alerts to all levels of government and the private sector in preparation for and in

response to events or incidents of public health significance.

Influenza: A highly contagious viral infection characterized by sudden onset of fever, severe aches and pains, and inflammation of the mucous membrane.

Influenza pandemic: A global outbreak of a new influenza A virus. Pandemics happen when new (novel) influenza A viruses emerge that are able to infect people easily and spread from person to person in an efficient and sustained way.

Interagency agreement (IAA): A written agreement entered into between two agencies that specifies the goods and services to be furnished or tasks to be accomplished by one agency (servicing agency) in support of the other (requesting agency). The length and contents of the agreement will depend on the complexity of the services, supplies or equipment to be provided and the conditions under which they are provided.

Intergovernmental agreement (IGA): An arrangement as to a course of action existing or occurring between two or more governments or levels of government.

Intermediary or intermediate distribution sites: Refers to any facility between the initial receiving site and the final delivery location where MCMs are dispensed to the public. These sites could include, but are not limited to, regional distribution sites (RDSs), local distribution sites (LDSs), or any other facility noted in the jurisdiction's planning documents.

Inventory Management and Tracking System (IMATS): A CDC IT platform developed with input from state and local jurisdictions that allows public health agencies to track MCM inventory down to the local level during an event, monitor reorder thresholds, and support warehouse operations, including receiving, staging, and storing inventory. IMATS also supports data exchange and allows state public health agencies to collect inventory totals from local jurisdictions, aggregate the data, and report to CDC. CDC also allows public health jurisdictions using inventory systems other than IMATS to electronically report data to CDC. IMATS supports synchronizing data from offline deployments.

Inventory management system: A database or software application developed to manage information regarding medical and nonmedical countermeasures.

J

Jurisdictions: Planning areas, such as directly funded localities, states, and U.S. territories and freely associated states.

Jurisdictional risk assessment (JRA): A process of assessing the potential loss or disruption of essential services, such as clean water or sanitation, or the interruption of health care services or public health agency infrastructure within a specified community.

K

Key community partners: An entity, group, agency, club, business, professional association, or individual service provider that public health deems critical, typically according to one or more of the following criteria:

- The entity is expected to provide health or human services—food, shelter or housing, social services, and mental or behavioral health services—to peoples with disabilities and others with access and functional needs in the context of a significant disaster or public health emergency.
- The entity is an essential vehicle for community outreach, information dissemination, or similar communications with at-risk and hard-to-reach populations as well as the public during response or recovery following an incident. Such key organizations may fit within one or more of the 11 community sectors, such as the media, community leaders, cultural and faith-based organizations, and

businesses.
- The entity is or would be an essential primary partner in a jurisdictional disaster or public health emergency response in terms of emergency operations, resource sharing, provision of goods or services, or surge capacity.
- The entity is represented in the incident management structure, for example, the EOC or other type of formal integration into an LHD's response to a public health emergency.
- Representation in the incident management structure, for example, the EOC, or other type of formal integration into an LHD's response to a public health emergency.

Key community partners are often characterized as

- Having a significant footprint or service area in a community, such as hospitals, television or radio stations, food banks, or the local emergency management agency.
- High-volume or throughput in terms of goods or services provided, such as high-volume food providers and distributers (businesses)]; low-income or publicly funded housing organizations; or shelters.
- Serving hard-to-reach, vulnerable, or at-risk populations, such as multi-service community or faith-based organizations.
- Historically significant institutions or key figures or icons within a community, often with significant influence within one or more cultural or affinity groups, such as community leaders and cultural and faith-based organizations.
- Providers of narrow or unique, but critical, services to the community, such as media outlets or hospitals.

L

Local partners: Local partners are entities or organizations that plan and respond together.

M

Materiel: The equipment, apparatus, or supplies necessary to successfully distribute or dispense MCMs during a public health emergency.

Medical countermeasures (MCMs): Life-saving medicines and medical supplies regulated by the U.S. Food and Drug Administration (FDA) used to diagnose, prevent, protect from, or treat conditions associated with CBRNE threats, emerging infectious diseases, or natural disasters. MCMs can include biologic products, such as vaccines, blood products, and antibodies; drugs, such as antimicrobial or antiviral drugs; devices, such as diagnostic tests to identify threat agents, and personal protective equipment (PPE), such as gloves, respirators (face masks), and ventilators.

Medical Countermeasure Dispensing and Administration (Public Health Emergency Preparedness and Response Capability 8): The ability to provide medical countermeasures to targeted population(s) to prevent, mitigate, or treat the adverse health effects of a public health incident. This capability focuses on dispensing and administering medical countermeasures, such as vaccines, antiviral drugs, antibiotics, and antitoxins.

Medical countermeasure incident: A public health emergency or event that requires rapid deployment of MCMs to mitigate morbidity and or mortality.

Medical Materiel Management and Distribution (Public Health Emergency Preparedness and Response Capability 9): The ability to acquire, manage, transport, and track medical materiel during a public health incident or event and the ability to recover and account for unused medical materiel, such as pharmaceuticals, vaccines, gloves, masks, ventilators, or medical equipment after an incident.

Medical model (clinical) POD: A type of dispensing model in which each person receives a personalized medical assessment and education prior to the dispensing or administration of MCMs. The medical model makes several assumptions for dispensing operations, including

- Each individual is unique;

therefore, MCMs are provided on a personalized medical evaluation , even if only of two MCM options are available
- Constraints may exist for the type of medical staff who can dispense
- No time constraints exist for conducting medical evaluations or providing MCMs
- All medical professionals have the necessary training and licensures to provide medical care based on current, best medical practices

Medical Reserve Corps (MRC): A national network of local groups of volunteers engaging local communities to strengthen public health, reduce vulnerability, build resilience, and improve preparedness, response, and recovery capabilities.

Mental and behavioral health: An overarching term to encompass behavioral, psychosocial, substance abuse, and psychological health.

Metropolitan statistical area (MSA): An area containing a large population nucleus and adjacent communities that have a high degree of integration with that nucleus. The Office of Management and Budget (OMB) establishes and maintains MSAs solely for statistical purposes. The classification provides a nationally consistent set of delineations for collecting, tabulating, and publishing federal statistics for geographic areas.

Military installations: Facilities (including leased) under the jurisdiction of the Department of Defense, including bases, camps, posts, stations, yards, centers, and ports.

Memorandum of agreement (MOA): A document describing in detail the specific responsibilities and actions that each of the parties must take to accomplish their common goals.

Memorandum of understanding (MOU): A document that describes a very broad concept of mutual understanding, goals, and plans shared by the parties.

Mutual aid agreement (MAA): An arrangement to provide assistance before, during, and after an emergency event facilitate the rapid mobilization of personnel, equipment, and supplies. The agreement can occur at multiple levels of government: between state or local agencies; between a state and localities in the state; between two or more states in a region; between states and tribes; or internationally between states and neighboring jurisdictions in Canada or Mexico. MAAs also can exist among a variety of organizational types, including governments, nonprofit organizations, and private businesses.

N

National Incident Management System (NIMS): A systematic, proactive approach to guide departments and agencies at all levels of government, nongovernmental organizations, and the private sector to work together seamlessly to manage incidents involving all threats and hazards—regardless of cause, size, location, or complexity—to reduce loss of life, property, and harm to the environment.

National security: Historically, national security was defined as comprehensive program of integrated policies and procedures for the departments, agencies, and functions of the United States government aimed at protecting the territory, population, infrastructure, institutions, values, and global interests of the nation." Over recent decades, our view of national security has broadened to include threats to individual citizens and to our way of life such as pandemics, as well as to the integrity and interests of the state.

No notification (none): Neither site nor staff are informed beforehand of the time nor place of the activity.

Nonpharmaceutical Interventions: The actions that people and communities can take to help slow the spread of illness or reduce the adverse impact of public health emergencies.

This term was also added

O

Outbreak: Sudden appearance of a disease in a specific geographic area (e.g. neighborhood or community) or population (e.g., adolescents).

Online Technical Resource and Assistance Center (On-TRAC): A CDC IT system that provides state and local public health departments with a secure, user-friendly platform for requesting public health preparedness and response technical assistance and accessing tools and resources.

Open point of dispensing (open POD): A dispensing site that serves the general public and does not have restrictions on who has access to the site. These PODs are open to everyone, including residents, visitors, commuters, or anyone else in the affected area during an incident.

Operations-based exercises: Operations-based exercises include drills, functional exercises (FEs), and full-scale exercises (FSEs). These exercises can be used to validate plans, policies, agreements, and procedures; clarify roles and responsibilities; and identify resource gaps. Operations-based exercises are characterized by actual reaction to an exercise scenario, such as initiating communications or mobilizing personnel and resources.

Operational plans: Describe roles and responsibilities, tasks, integration, and actions required of a jurisdiction or its departments and agencies during emergencies. Jurisdictions use plans to provide the goals, roles, and responsibilities that a jurisdiction's departments and agencies are assigned, and to focus on coordinating and integrating the activities of the many response and support organizations within a jurisdiction. They also consider private sector planning efforts as an integral part of community-based planning for ensuring efficient allocation of resources. Department and agency plans do the same thing for the internal elements of those organizations. Operational plans tend to focus more on the broader physical, spatial, and time-related dimensions of an operation; thus, they tend to be more complex and comprehensive, yet less defined, than tactical plans.

Operational readiness: The ability of a jurisdiction to execute their MCM distribution and dispensing plans during a public health response.

Order of succession: Provisions to delegate authority to a representative at the time of an incident when the legal authority is unable to conduct their duties.

P

Pandemic: An epidemic occurring over a very large geographic area.

Partial notification: Site or staff are informed beforehand that an activity will occur during a certain time, but do not know the exact time or location of the activity.

Personal protective behaviors: Personal behaviors to prevent the transmission of infection, such as coughing into your elbow, cover sneezing, hand washing, and keeping your hands away from your face.

Planning jurisdiction: Defined geographic area that develops a planning strategy. For example, several counties may form a regional planning jurisdiction.

Point of dispensing (POD): A facility where MCMs are dispensed or administered during a public health emergency requiring the use of MCMs.

Pre-identified staff: Personnel who are rostered and trained to fulfill specific roles in an incident. Contact information for public health staff with incident management roles should be maintained and updated frequently.

Pre-incident recovery planning (jurisdictional or community): Disaster recovery planning describes the establishment of processes and protocols prior to a disaster for coordinated post-disaster recovery planning and implementation through engagement between public health and key partners and sectors, including emergency management, health care providers, community leaders, media, businesses, service providers for at-risk populations,

and more. (Definition adapted from the National Disaster Recovery Framework.)

Preparedness: Actions that involve a combination of planning, resources, training, exercising, and organizing to build, sustain, and improve operational capabilities. Preparedness is the process of identifying the personnel, training, and equipment needed for a wide range of potential incidents and developing jurisdiction-specific plans for delivering capabilities.

Primary point of dispensing (primary POD): The facility designated and pre-planned as the priority to activate first to issue MCMs during a public health emergency.

Promising practices: Peer-validated techniques, procedures, and solutions that prove successful and are solidly grounded in actual experience in operation, training, and exercises.

Promulgated plan: A plan that is officially announced, published, or made known to the public.

Public health emergency: An occurrence or imminent threat of an illness or health condition caused by bioterrorism, epidemic or pandemic disease, or (a) novel and highly fatal infectious agent or biological toxin that poses a substantial risk of a significant number of human facilities or incidents or permanent or long-term disability.

Public Health Emergency Preparedness (PHEP) cooperative agreement: Since 2002, the PHEP cooperative agreement has provided a critical source of funding for 62 state, local, and territorial public health departments across the nation. This funding helps health departments build and strengthen their abilities to successfully respond to a range of public health threats, including infectious diseases, natural disasters, and biological, chemical, nuclear, and radiological threats. Preparedness activities funded by the PHEP cooperative agreement are specifically for the development of emergency-ready public health departments that are flexible and adaptable.

Public Health Emergency Preparedness and Response Capabilities composition: Each capability standard comprises capability functions, and each capability function contains specific capability tasks that are supported by multiple capability resource elements.

Capability Title and Definition—Description of the capability as it applies to state, local, tribal, and territorial public health agencies. Each definition includes a list of potential partners and stakeholders with which jurisdictions may consider working to achieve the capability

Capability Functions—Critical segments of the capability that must occur to achieve the capability definition

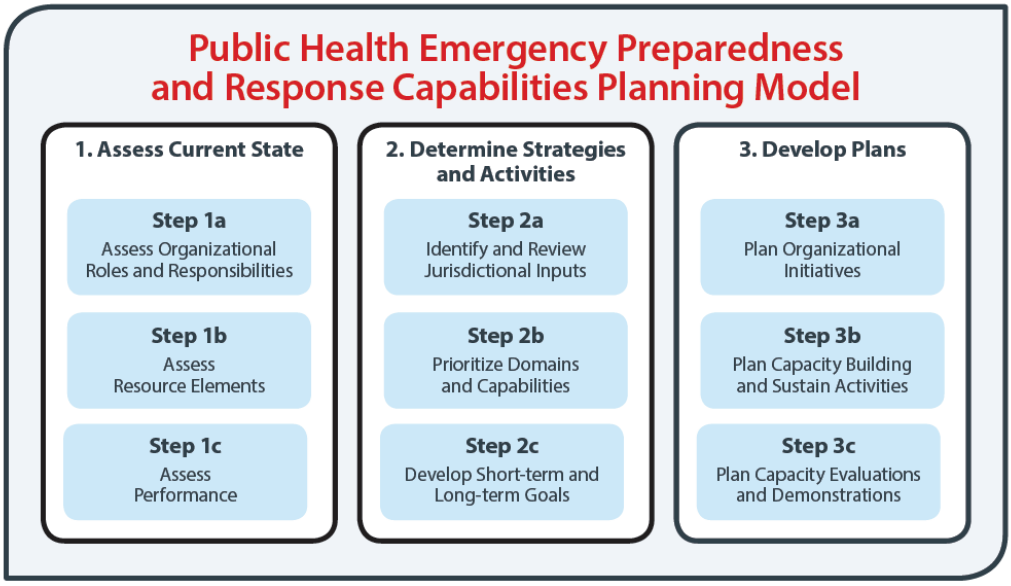
Capability Tasks—Action steps aligned to one or more capability functions. Capability tasks must be accomplished to complete a capability function

Capability Resource Elements—Resources a jurisdiction should have or have access to in order to successfully perform capability tasks associated with capability functions. Resource elements are listed sequentially to align with corresponding tasks in each function. While not necessarily listed first, "priority" resource elements are potentially the most critical for completing capability tasks based on jurisdictional risk assessments and other forms of community input. There are three categories of capability resource elements are Preparedness (P)—Components to consider within existing operational plans, standard operating procedures, guidelines, documents, or other types of written agreements, such as contracts or memoranda of understanding (MOUs)

Skills and Training (S/T)—General baseline descriptions, competencies, and skills that personnel and teams should possess in order to achieve a capability

Equipment and Technology (E/T)—Infrastructure a jurisdiction should have or have access to with sufficient quantities or levels of effectiveness to achieve the intent of any related capability task.

Public Health Emergency Preparedness and Response Capabilities planning model: The following Public Health Emergency Preparedness and Response Capabilities planning model updates the planning roadmap described in the 2011 Public Health Preparedness Capabilities: National Standards for State and Local Planning. It outlines a process that jurisdictional public health agencies can follow to identify public health emergency preparedness and response program development priorities. Consistent with the U.S. Department of Homeland Security (DHS) Preparedness Cycle, the following diagram illustrates a three-phase approach to identify priorities and implement jurisdictional emergency preparedness planning and response initiatives.



Public health system: Defined as executing the core functions of public health agencies at all levels of government.

Public information officer (PIO): The individual responsible for interfacing with the public, media, other agencies, and stakeholders to provide incident-related information and updates based on changes in the status of the incident or planned event.

Q

Quarantine: The separation and restriction of movement of people who were exposed to a contagious disease to see if they become sick.

Quarterly: Regular intervals every 3 months, four times a year.

R

Rapid-dispensing model (or nonmedical model): Refers to a modification of the medical model of dispensing that increases the dispensing throughput. Persons might receive a less comprehensive screening form; steps in the dispensing process might be combined or eliminated; head of household might be allowed to pick up MCM regimens for others; and trained nonmedical personnel may dispense MCMs under limited supervision from licensed medical professionals.

Receipt, stage, store (RSS) facility: Acts as the hub of the distribution system of the state or jurisdiction to which Strategic National Stockpile (SNS) assets are deployed.

Regimens per hour (RPH): The regimens (or courses) of MCMs issued within a certain period of time. For example, regimen per hour is the number of unit regimens (or courses) of medical countermeasure issued within 60 minutes. This is not to be confused with throughput, which focuses on the number of people served at the POD within a certain timeframe.

Regional distribution site (RDS) or local distribution site (LDS): A site or facility selected to receive MCMs from the RSS facility for further breakdown and distribution to determined dispensing sites, such as PODs.

Request: A request is a formal application to ask for a specific asset needed in the time of an emergency or incident.

Requested timeframe: Requested timeframe is a defined period of time for receiving requested EEI, such as operational period or set time to meet special request, for example, 1,500 hours.

Resources: Personnel and major assets available for assignment to incident operations.

Responsible entity or entities: A responsible entity or entities refers to an organization at the recipient or subrecipient level that is accountable for completing the specific activity or performance element associated with one or more PHEP performance measures.

- Recipient entities typically include the recipient's central office and, in some states, regional or district (state-operated) offices.
- Subrecipient entities usually refer to autonomous regional, district, or local health departments (LHDs). Occasionally this also may refer to local boards of health, coalitions, or other types of organizations.

Responder: Any individual responding to the public health task or mission, dependent on the jurisdiction.

Responder Safety and Health (Public Health Emergency Preparedness and Response Capability 14): Responder safety and health is the ability to protect public health and other emergency responders during pre-deployment, deployment, and post-deployment.

Response: Immediate actions to save lives, protect property and the environment, and meet basic human needs. Response also includes the execution of emergency plans and actions to support recovery.

S

Scalability: The ability to expand or decrease operations as dictated by the needs of the response.

Seminars: Seminars generally orient participants to or provide an overview of authorities, strategies, plans, policies, procedures, protocols, resources, concepts, and ideas. As a discussion-based exercise, seminars can be valuable for entities that are developing or making major changes to existing plans or procedures. Seminars can be similarly helpful when attempting to assess or gain awareness of the capabilities of interagency or inter-jurisdictional operations.

Site activation: The ability to contact and ensure that facilities are available for emergency response functions.

Site availability: The capacity for a facility to be ready to be turned over to the health department to begin their setup operations after receiving the notification for site activation.

Situational awareness: Capturing, analyzing, and interpreting data to inform decision making in a continuous and timely cycle. National health security calls for both routine and incident-related situational awareness. Situational awareness requires not only coordinated information collection to create a common operating picture (COP), but also the ability to process, interpret, and act upon this information. Action, in turn, involves making sense of available information to inform current decisions and making projections about likely future developments. Situational awareness helps identify resource gaps, with the goal of matching available and identifying additional resources to current needs. Ongoing situational awareness provides the foundation for successful detection and mitigation of emerging threats, better use of resources, and better outcomes for the population.

Social connections: Refers to personal (including family, friends, and neighbors) and professional (including service providers and community leaders) relationships among community residents.

Staff assembly: The ability of staff to report to their assigned stations in a timely manner. Staff assembly can occur at a physical location— a department or emergency operations center, virtually—through a web-based interface, such as WebEOC, or a combination of both.

Staff notification: The ability to contact and mobilize staff to perform emergency response functions.

Standard operating procedure (SOP): SOPs or operating manuals are complete reference documents that detail the procedures for performing a single function or a number of interdependent functions. Collectively, practitioners refer to both documents as SOPs. SOPs often describe processes that evolved institutionally over the years or document common practices so that institutional experience is not lost to the organization because of staff turnover. Sometimes they are task specific, for example, how to activate a siren system or issue an emergency alert system message.

State health official (SHO): An appointed senior official who plays a critical role in emergency preparedness and response, including making strategic and tactical decisions and communicating with key partners. Visit http://www.astho.org/Directory/ for a list of state and territorial health officials.

Strategic National Stockpile (SNS): The nation's supply of MCMs for use in a public health emergency severe enough to exhaust local resources.

Strategic plans: Describe jurisdiction needs to meet its emergency management or homeland security responsibilities over the long term. These plans are driven by policy from senior officials and establish planning priorities.

Subject matter expert (SME): An individual recognized as having expert knowledge about and specialized experience in a subject area.

T

Tabletop exercise (TTX): An exercise typically held in an informal setting intended to generate discussion of various issues regarding a simulated emergency. TTXs can be used to enhance general awareness, validate plans and procedures, rehearse concepts, or types of systems needed to guide the prevention of, protection from, mitigation of, response to, and recovery from a defined incident.

Technical assistance: Advice, assistance, or training pertaining to program development, implementation, maintenance, or evaluation provided by the funding agency.

Tertiary point of dispensing (POD): A site considered the third in place or order for activation to issue MCMs during a public health emergency.

Three tiers of planning: strategic, operational, and tactical: Strategic planning sets the context and expectations for operational planning, while operational planning provides the framework for tactical planning. All three tiers of planning occur at all levels of government.

Third-party logistics (3PL): A company that works with shippers to manage their logistics.

Threat and Hazard Identification and Risk Assessment (THIRA): A four-step, common risk assessment process that helps the whole community—individuals, business, faith-based organizations, nonprofit groups, schools, academia, and all levels of government—understand its risks and estimate capability requirements.

Threats: Three category types

- Natural threats, such as floods, tornadoes, earthquakes, hurricanes, and ice storms.
- Technical or man-made threats, such as radiological, chemical, biological, mechanical, and electrical.
- Intentional acts, such as terrorism, demonstrations, bomb threats, assaults, theft, and computer security.

Throughput: The number of people receiving MCMs at a point of dispensing (POD) during a certain period of time. For example, if 6,000 people visit a

POD over a 12-hour operational period, then the throughput is 6,000 persons/12 hours = 500 people/hour. This is not to be confused with the term "regimen," which is defined as the MCMs issued during a certain period of time.

Tiered approach: A systematic and flexible strategy to ensure the entire population is served through POD models that are implemented according to the individual needs of the jurisdiction or community.

Training and exercise planning workshop (TEPW): The TEPW establishes the strategy and structure for an exercise program. In addition, it sets the foundation for the planning, conduct, and evaluation of individual exercises. The purpose of the TEPW is to use the guidance provided by elected and appointed officials to identify and set exercise program priorities and develop a multiyear schedule of exercise events and supporting training activities to meet those priorities. This process ensures whole community exercise initiatives are coordinated, prevents duplication of effort, promotes the efficient use of resources, avoids overextending key agencies and personnel, and maximizes the efficacy of training and exercise appropriations. TEPWs are held on a periodic basis–annual or biennial–depending on the needs of the program and any grant or cooperative agreement requirements.

V

Vaccination: Introduction of a killed or weakened infectious organism to prevent the disease by injections, mouth, or aerosol.

Vaccine: A product that produces immunity therefore protecting the body from the disease. Vaccines are administered through needle injections, by mouth and by aerosol.

Vaccine information statements: Vaccine information statements (VISs) are information sheets produced by CDC that explain both the benefits and risks of the vaccine to vaccine recipients. Federal law requires that health care staff provide a VIS to a patient, parent, or legal representative before each dose of certain vaccines. VISs may be found at www.cdc.gov/vaccines/hcp/vis/index.html.

Vendor: An agency or organization that will complete the function or provide service.

Virtual assembly: The use of teleconference or Internet-based technology to convene two or more individuals in a real-time exchange of information, ideas, or thoughts, to facilitate efficient decision-making. This can include, but is not limited to, teleconferencing, Web-based meetings, and other types of online interactive systems and technologies in which voice or visual exchange of information is present. Virtual assembly does not include an active e-mail exchange with all parties or other types of time-delayed communications that do not allow for an immediate feedback or response discussion.

Virtual Initiatives Program: A TTX, usually regional, that focuses on enhancing CDC technical assistance and MCM capabilities. The program is led by CDC's Center for Preparedness and Response Division of Emergency Operations (CPR DEO).

Voice over Internet Protocol (VoIP): A technology that makes voice calls using a broadband Internet connection instead of a regular (or analog) phone line.

Volunteer: Individual or group who contributes time or skills to support the public health agency's response or is assigned responsibilities not defined in their primary job description that supports the public health agency's response, including public health, medical, and nonmedical personnel. Different jurisdictions may not recognize "volunteers" in a response. This definition is meant to provide broad interpretation of how "volunteers" are identified. In jurisdictions where volunteers are not defined or used because of legal or human resource restrictions, "responder" may be considered equivalent.

Volunteer Management (Public Health Emergency Preparedness and Response Capability 15): Volunteer management is the ability to coordinate with emergency management and partner agencies to identify, recruit, register, verify, train, and engage volunteers to support the jurisdictional public health agency's preparedness, response, and recovery activities during pre-deployment, deployment, and post deployment.

W

Workshops: Although similar to seminars, workshops differ in two important aspects: participant interaction is increased and the focus is placed on achieving or building a product. Effective workshops entail the broadest attendance by relevant stakeholders.

Products produced from a workshop can include new SOPs, EOPs, COOPs, or mutual aid agreements. To be effective, workshops should have clearly defined objectives, products, or goals, and should focus on a specific issue.

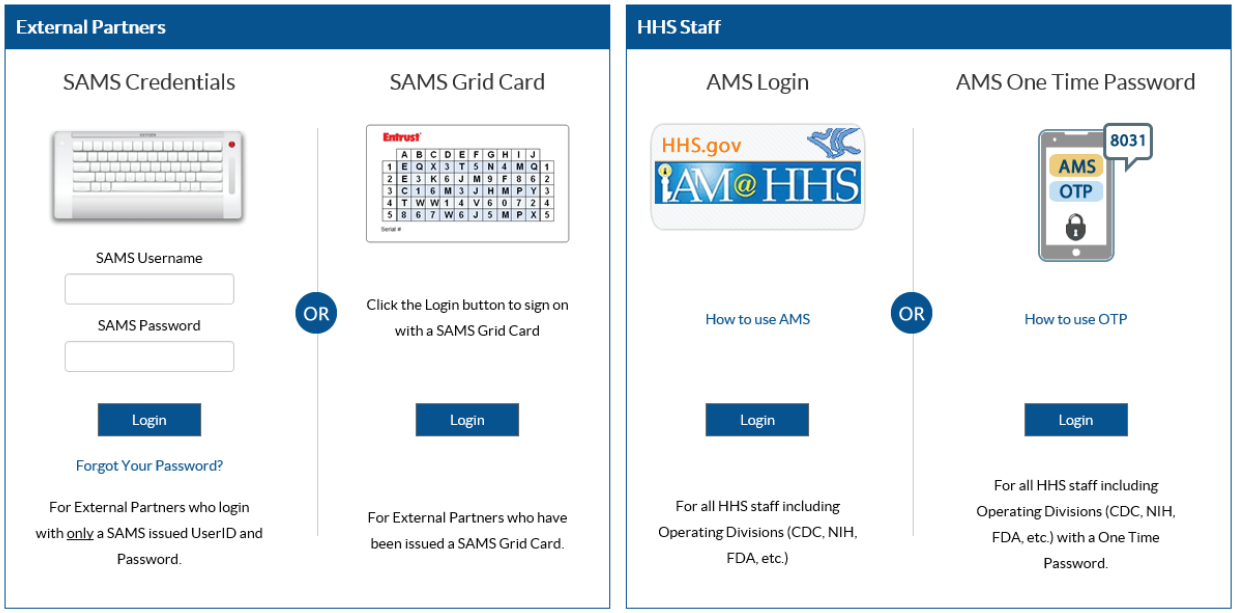
APPENDIX B:

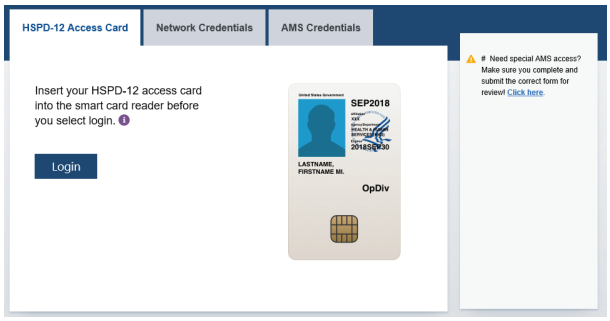
DCIPHER Frequently Asked Questions

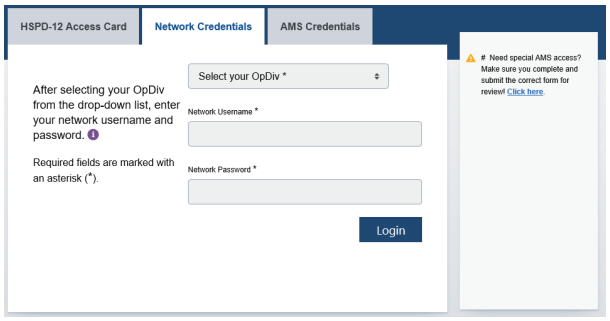
System Access

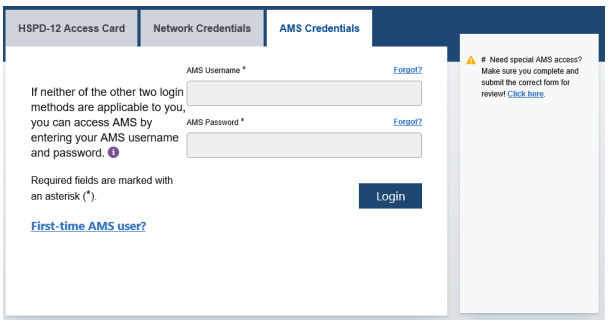
I am a CDC user. How do I log in?

Go to https://dcipher.cdc.gov. Choose the AMS Login option under the HHS Staff box heading (right side of screen). Select CDC/ASTDR OpDiv option from the drop-down menu and input your CDC user ID and password to access DCIPHER. Note that CDC employees must log in from within the CDC network, the VPN, or Citgo.









I am a jurisdiction or CRI user. How do I log in?

Go to https://dcipher.cdc.gov/. Input your SAMS username and password and click the "Login" button to access DCIPHER. For more information on SAMS please see the SAMS Access section.

When I log in, I do not see any "Activities" listed on the DCIPHER home page. Do I need to take additional action?

The first time you successfully log into DCIPHER, you will not see any activities listed for your account. This is because the DCIPHER system needs to match your account with the appropriate user permissions. If you log out and log back in to DCIPHER, the permissions updates will have taken place and you will be able to see a button labeled "ORR" on your screen. If you log out and log back in and still do not see any activity options, please contact dcipher-orr@cdc.gov.

SAMS Access

What is SAMS?

Secure Access Management Services (SAMS) is an external authentication system that allows public health partners to interact with CDC applications online behind a secure firewall.

How do I get my invitation to register with SAMS?

Invitations are created and sent by CDC's program administrator, which is the DCIPHER administrator. You will receive an invitation e-mail from sams-no-reply@cdc.gov with the subject "U.S. Centers for Disease Control: SAMS Partner Portal – Invitation to Register". The invitation will contain instructions on how to begin the SAMS registration process.

How do I get my SAMS user ID and password?

Your SAMS username will always be your full e-mail address. During the SAMS registration process, you will be assigned a temporary password that you will be required to change during the creation of your SAMS profile.

How long will it be until I can access the DCIPHER MCM ORR platform using SAMS?

The entire SAMS process—from registration to completion of processing—can take up to 1 month, so the DCIPHER team recommends starting this process as soon as you receive the invitation e-mail.

I have an existing SAMS account. Do I need to take any additional action?

Contact your MCM specialist to inform them of your existing account and the associated contact information. You will not have to go through the SAMS identity proofing process again; however, you still need to be given access to the MCM ORR platform through SAMS.

What if I have forgotten my SAMS user ID or password?

Click on the "Forgot SAMS Password?" link when you reach the SAMS login page. Then follow the prompts to reset your password or contact the SAMS help desk at (877) 681-2901 or e-mail them at samshelp@cdc.gov.

I have additional questions about SAMS. Where can I find more information?

For more information about the SAMS process, please reference the SAMS Frequently Asked Questions website, which can be found at https://auth.cdc.gov/sams/samsfaq.html.

Data Input

How do I edit the information in a form?

To edit a form, first select the form by clicking on the form name. Once highlighted, click "Edit" at the bottom of the form list (to input information or update responses). NOTE: You may only edit a form when it is in the "Open" review stage.

What does the fraction at the top of a form's navigation panel represent? What are the numbers next to each sub-section when I'm editing a form?

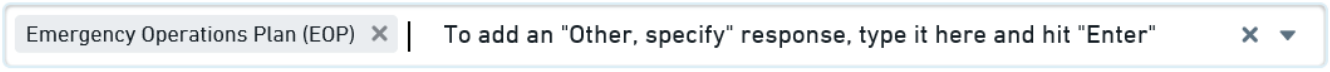
The fraction at the top of the navigation panel represents the number of questions you have completed out of the total number of questions in the form. The denominator may change over the course of your time editing the form, as questions can be revealed or hidden due to input-triggered conditional display. The fractions next to each subsection represent the number of questions complete within that particular section out of the total number of questions in that section.

What do we do if a question is unclear?

You can leave a comment for your reviewer on the question and they can provide additional information. Comments can be left for a reviewer in the review page of a form. If you are editing a form, you can access the review page by saving the form. If you want to access the review page of a form directly from the home page, select the form and click "Review" at the bottom of the form list.

How do I provide an "other" response for a question?

For questions in which the response is chosen by using a dropdown menu, users may create their own response choice if one of the preset options does not suffice. A new option can be added by typing the additional response(s) into the answer field and pressing "Enter" to create the option. NOTE: Some questions will force you to use a preset response. In this case, if you attempt to type in a custom response, the dropdown will say "No results found" and you will be unable to proceed with the custom text.



NOTE: Some questions will force you to use a preset response. In this case, if you attempt to type in a custom response, the dropdown will say "No results found" and you will be unable to proceed with the custom text.

How do I upload an offline version of RSS site survey or POD planning form?

To upload the offline version of either of these forms, select the form name on your home page and then click "Upload." A small pop-up window will appear to prompt you to select the document from your local device and upload it. **NOTE:** If you try to upload anything other than the DCIPHER-provided offline form template, the data will not be loaded into the online system. Direct data entry into the online system is highly encouraged. However, for sites with connectivity issues, the official CDC-distributed PDF forms will be the only offline format supported for direct data upload.

How do I update a response from an offline form?

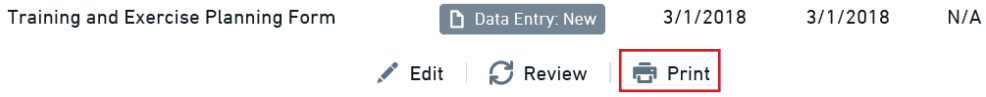
After uploading an offline form into the ORR platform, the data is saved into the online form as if you had input the data online. You will be able to update these responses from within the online platform. You may resubmit an offline form to update your responses; however, the data within the offline form will overwrite any existing data stored in the online system for that particular form.

How do I input data into the online version of the RSS Site Survey or POD Planning Form?

Select the form name on your home page and then click "Edit". A small pop-up will appear, click "Add" to enter data for many PODs as needed.

How do I print a form?

Select the form name on your home page and then click "Print".



How do I provide evidence for a question?

Each form has an associated page in which you can upload supporting documents or other files pertinent to your ORR review. This page, named "Supporting Documents", can be accessed from the review page of a form.

How do I indicate the document or page numbers of evidence for a question?

The document or page number for evidence related to a question can be added in edit mode.

Does the "History" page show comments from everyone in our local group?

The "History" page contains any saved edits to the form made by anyone with access to the form, which is anyone in the local group or the reviewer. Edits to the form include initial responses to a question, any response updates, and comments left on any particular response. All items in the "History" page are tagged with the date of the update, the user making the update, and the update made.

How do I know if a question is required?

The platform is set up to hide any question(s) your jurisdiction is not required to address. Therefore, if a question is displayed within a form, you should provide a response. While you are not forced to respond to every question to save the form, the platform will prevent you from submitting until you have addressed all required fields. A message will appear at the top of the review page to indicate which required fields were left blank.

How do I remove an additional vulnerable population, RSS site, or similar list item that I have accidently added?

After creating the sub-form, click the "Done" button in the lower right hand corner of the sub-form. An "X" button is located on the right hand side of the list item that can be clicked to remove extraneous sub-form data. NOTE: Clicking the "X" button next to a particular subform will delete it, regardless of the content.

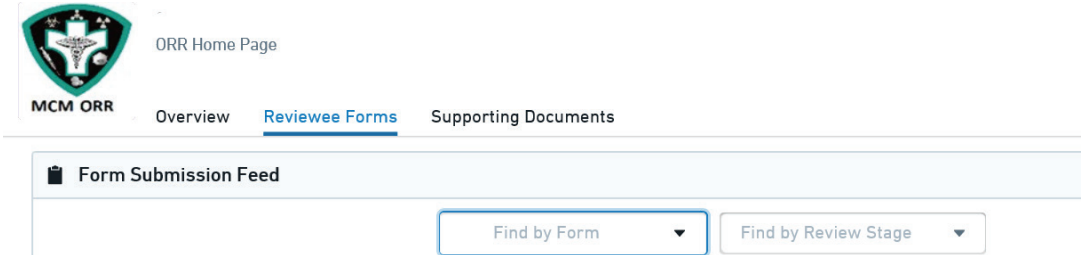
Data Review

How does submission work?

Forms will be submitted, reviewed, and acknowledged on a form-by-form basis. An ORR review is considered final when all required forms are marked acknowledged.

As a reviewer, how can I search for specific jurisdiction?

The Awardee Forms tab (accessible from the home page) allows a reviewer to view, search, and assess review stage for all the forms assigned to a given jurisdiction.



Is an option available for bulk approvals or approval status change?

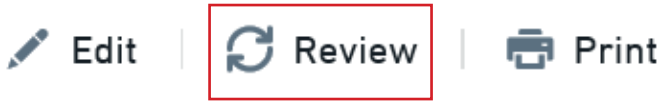
Most forms do allow an overall form approval versus approval of individual questions. Those forms that require individual question approvals are Distribution Planning and Dispensing Planning. For these two forms, reviewers must assess each item individually.

When does form approval indicate?

Approval indicates that the reviewer agrees with information provided and that the information provided is sufficient.

What if I want to just view, not edit, an acknowledged form?

Select the form of interest and click the "Review" button at the bottom of the form list to view all responses.



Will both CDC and assigned regional MCM specialists have the ability to view the same jurisdictions and make comments?

Yes, all appropriate parties will be able to review form data and provide comments. While only an official ORR reviewer can approve or disagree with particular responses submitted by their assigned jurisdiction(s), all users associated with a particular jurisdiction can leave comments on a response. CDC administrators will have the ability to view all jurisdictions' forms, and MCM specialists will be able to view all forms for those jurisdictions that they review. All comments, regardless of who wrote them, will be viewable by clicking on the speech bubble icon next to a particular response in the review page.

Are CRI jurisdictions going to have to submit their own self-assessment? If so, does that show up for the state to review?

Yes, states will have reviewer permissions for the CRI jurisdictions that fall under their jurisdiction. The review process of CRI jurisdictions by states will be the same as the review process of recipients by CDC.

A form was returned to a recipient with feedback from their ORR reviewer and they have resubmitted it. How do you know what was changed since the most recent submission?

The history tab, accessible from the "Review" page of a form, shows all changes made to a form. Each change is listed with the date and time that the update was made, as well as the name of the individual who made the change.

General Questions

Clicking MCM-ORR icon does not take me "home." Is something wrong?

The icon is currently not hyperlinked. You can go back to the main ORR screen by clicking the "Home" button in the upper, left-hand corner of your screen.

Is an option available to remove comments?

Comments cannot be deleted or edited once they have been saved.

Technical Assistance

What browsers can I use to access the platform?

You may access the platform using Internet Explorer (version 11), Google Chrome, Mozilla Firefox, or Microsoft Edge. While the platform is accessible by all of the aforementioned browsers, DCIPHER recommends using Google Chrome or Microsoft Edge for optimal system performance.

What software should I use to input data into offline forms?

For any PDF files that will be uploaded into the system, DCIPHER recommends using Adobe Acrobat Reader. For any workbook or spreadsheet files that will be uploaded into the system, DCIPHER recommends using Microsoft Excel.

I have logged into the platform but I only see a white screen. Is something wrong?

- Here are some steps you should take before reaching out to dcipher-orr@cdc.gov for assistance:
- Ensure you are using one of the accepted web browsers (listed above).
- If you are accessing the platform using Internet Explorer version 11, check to see if your browser is running in Compatibility Mode. You can do this by clicking the settings icon in the top, right hand corner of your browser and clicking "Compatibility View settings". Ensure that the option "Display intranet sites in Compatibility View" is unchecked. If the option is checked, uncheck it and refresh your browser.
- If neither of the options above resolves your problem, contact the DCIPHER team for further assistance.

APPENDIX C: ORR Status Tips

Status determination is hard coded into the online system and is calculated from the self-assessment responses and reviewer input. A preliminary status will display for each section (descriptive, planning, and operational) as forms are submitted.

Descriptive and Demographic Status

Data from four forms inform the calculation of demographic status. Criteria are primarily based on the date of form submission. (Details are provided in the table below.)

Form	Jurisdictions	Contribute Toward "Early" Status	Contribute Toward "Intermediate" Status	Contribute Toward "Established" Status
Critical contact sheet	State, DFL, TFAS	Submission more than 1 year	Submission more than 6 months and 1 year or less	Submission 6 months or less
Jurisdictional data sheet	State, DFL, TFAS, CRI jurisdictions	Submission more than 2 years	Submission more than 1 year and 2 years or less	Submission 1 year or less
RSS site survey	State, DFL	Submission more than 2 years OR Less than 2 RSS sites OR No site validation ever conducted	Submission more than 1 year and 2 years or less for any valid RSS sites OR RSS site visit and certification more than 3 years	Submission with at least two valid RSS site survey entries 1 year or less AND RSS site visit and certification 3 years or less for each RSS site
RSS site survey	TFAS	Submission more than 2 years OR No RSS site OR No site validation ever conducted	Submission more than 1 year and 2 years or less for any valid RSS sites OR RSS site visit and certification more than 3 years	Submission of at least one valid RSS site survey entry 1 year or less AND RSS site visit and certification 3 years or less for each RSS site
POD planning	DFL, TFAS, CRI	Submission more than 2 years OR Current primary POD value does not match value entered in JDS (local JDS section, open POD numbers)	Submission more than 1 year and 2 years or less OR Current primary POD value does not match value entered in JDS (local JDS section, open POD numbers)	Submission 1 year or less AND Current primary POD values match values entered in JDS (local JDS section, open POD numbers)
Descriptive Status	All	All four forms meet criteria in "early" status column	Combination of status columns are met by any of the four forms	All four forms meet criteria in "established" status column

Planning Status

Two forms (dispensing planning and distribution planning) cover attributes for achieving "established" status for an MCM mission across several capabilities. Variable detail is provided in the table below. Preliminary status populates from submitted self-assessed information. Adjudicated status populates when the reviewer finalizes and acknowledges the form.

Dispensing Planning Form

Question	Jurisdiction	Contribute Toward "Early" Status	Contribute Toward "Intermediate" Status	Contribute Toward "Established" Status
JRA or equivalent	All	Last update more than 5 years	Essential criteria, no partial credit	Last update 5 years or less from date of review
Vulnerable populations	States, DFL, CRI	0 identified	1–4 identified	5 or more identified
Vulnerable populations	TFAS	0 identified	1–2 identified	3 or more identified
Roles and responsibilities for public information staff	All	Anything less than minimum criteria	Essential criteria, no partial credit	Must have minimum evidence for public information officer (PIO), backup PIO, and joint information center (JIC) personnel; additional responses inform program performance
Required training plans for the PIO	All	No training requirements identified	Essential criteria, no partial credit	FEMA IS-50 selected
Plans include a process for dissemination of warning information through various channels	All	Blank or None identified	Minimum evidence of either methods to issue alerts, warnings, and notifications or development of message templates based on planning or risk scenarios identified by risk assessment. Additional responses inform program performance (excluding "None identified").	Must have minimum evidence of methods to issue alerts, warnings, and notifications and development of message templates based on planning or risk scenarios identified by risk assessment. Additional responses inform program performance (excluding "None identified").
Plans include process for real-time translation of information specific to vulnerable populations	All	Anything less than minimum criteria	Essential criteria, no partial credit	Must have minimum evidence for language and literacy translation
Evidence of a public health responder or critical infrastructure personnel (CIP) plan for anthrax dispensing campaign (select all that apply)	All	No evidence	Essential criteria, no partial credit	Sufficient evidence documented
Communication platforms for notification of responders	All	Insufficient or no evidence	Sufficient evidence for only one	Sufficient evidence for at least two

Question	Jurisdiction	Contribute Toward "Early" Status	Contribute Toward "Intermediate" Status	Contribute Toward "Established" Status
Last date communication platform was updated or tested (whichever is more recent)	All	More than one since last test or roster update year	Last test or roster update more than 6 months, but less than 1 year	6 months or less since last test or roster update
The process to request assistance from the state for MCM assets when a federal disaster is declared in the state is available	DFL, TFAS, CRI	Insufficient or no evidence	Evidence for one or two questions in this section	Evidence for three or more questions in this section. Credit for tribal response, only if applicable to jurisdiction
The process to request assistance from the state for MCM assets in the absence of federal disaster declaration is available	DFL, TFAS, CRI	Insufficient or no evidence	Essential criteria, no partial credit	Sufficient evidence documented
The process to request assistance from the state for MCM assets for an isolated, individual, or time-critical case is available	DFL, TFAS, CRI	Insufficient or no evidence	Essential criteria, no partial credit	Sufficient evidence documented
The process to request assistance from the state for MCM Assets in coordination with tribal government(s) is available	DFL, TFAS, CRI	Insufficient or no evidence	Essential criteria, no partial credit	Sufficient evidence documented
Plans for POD security address 1. Evacuation procedures 2. Exterior security 3. Interior security 4. Scalability 5. Security breach procedures 6. Security management plan	All	Insufficient or no evidence	Sufficient evidence for one to five attributes	Sufficient evidence for all six attributes

Question	Jurisdiction	Contribute Toward "Early" Status	Contribute Toward "Intermediate" Status	Contribute Toward "Established" Status
Process or protocols for PODs address: 1. Adverse event reporting for dispensed drugs 2. Providing information on adverse events 3. Recording/logging of drugs dispensed 4. Reporting data to state/federal entities 5. Screening for the purpose of triaging	All	Insufficient or no evidence	Sufficient evidence for one to four attributes	Sufficient evidence for all five attributes
Process to identify all public health responders (including any first responders and critical infrastructure staff, if applicable) that will be used in an incident or event is available	All	Insufficient or no evidence	Sufficient evidence for process to identify first responders or critical infrastructure staff	Sufficient evidence for process to identify first responders and critical infrastructure staff
Process to ensure that mission-critical responders receive initial prophylaxis during an MCM incident is available	All	Insufficient or no evidence	Essential criteria, no partial credit	Sufficient evidence documented
Systems used to notify volunteers required to complete a dispensing or distribution campaign	All	Insufficient or no evidence	Sufficient evidence for only one attribute	Sufficient evidence for at least two attributes
Last date of notification system was updated or tested (whichever is more recent)	All	1 year or more since last system or roster update	Last system or roster updated more than 6 months, but less than 1 year	6 months or less since last system or roster update
Planning status	All	All planning criteria in "early status" column for both the Dispensing Planning Form and Distribution Planning Form (next page)	Combination of status across all criteria for both the Dispensing Planning Form and Distribution Planning Form (next page)	All criteria in "established" status column for both the Dispensing Planning Form and Distribution Planning Form (next page)

Distribution Planning Form

Question	Jurisdiction	Contribute Toward "Early" Status	Contribute Toward "Intermediate" Status	Contribute Toward "Established" Status
Date of most recent preparedness plans review or update	All	4 years or more since last update	2 to 4 years since last update	2 years or less since last update
Plans include strategies to coordinate with subject matter experts to inform incident management decision making	All	Insufficient or no evidence	Essential criteria, no partial credit	Sufficient evidence in plans and at least one SME involved in writing plans
Standard operating procedures include 1. Full activation procedures 2. Notification procedures 3. Partial activation procedures 4. Staff (by functional role) authorized to activate EOC	All	Insufficient or no evidence	Sufficient evidence for one to three attributes	Sufficient evidence for all four attributes
Identified incident command staff roles identified in plans 1. Incident commander 2. Finance or admin section chief 3. Public information officer 4. Logistics section chief 5. Operations section chief 6. Planning section chief 7. Liaison officer 8. Safety officer	All	Insufficient or no evidence for any of the following: • Incident commander • Finance or admin section chief • Public information officer • Logistics section chief • Operations section chief • Planning section chief	Essential criteria, no partial credit	Sufficient evidence for all of the following: • Incident commander • Finance or admin section chief • Public information officer • Logistics section chief • Operations section chief • Planning section chief

Question	Jurisdiction	Contribute Toward "Early" Status	Contribute Toward "Intermediate" Status	Contribute Toward "Established" Status
Transportation agreements include 1. Primary transport 2. Backup transport 3. # of operators available 4. Types of drivers or specially licensed operators 5. Vehicles – load capacity 6. Vehicles – number available 7. Vehicle type 8. Vendor agreements with MOUs 9. Procedures to maintain cold chain management 10. Jurisdiction's response time for initial transportation requirements	All	Insufficient or no evidence of primary transport and less than 10 attributes	Sufficient evidence for primary transport and less than 10 attributes	Sufficient evidence for all 10 attributes
RSS staff roles identified in plans 1. Distribution lead, primary 2. Backup 3. Logistics, primary 4. Backup 5. Receiving site lead, primary 6. Backup 7. Security coordinator, primary 8. Backup 9. Current DEA registrant	States DFLs TFAS	Insufficient or no evidence for any of the essential roles • Distribution lead, primary • Distribution lead, back-up • Logistics, primary • Receiving site lead, primary • Security coordinator, primary • Current DEA registrant	Essential criteria, no partial credit	Sufficient evidence for all 6 essential roles • Distribution lead, primary • Distribution lead, back-up • Logistics, primary • Receiving site lead, primary • Security coordinator, primary • Current DEA registrant

Question	Jurisdiction	Contribute Toward "Early" Status	Contribute Toward "Intermediate" Status	Contribute Toward "Established" Status
RDS or LDS staff roles identified in plans 1. Distribution lead, primary 2. Backup 3. Logistics, primary 4. Backup 5. Receiving site lead, primary 6. Backup 7. Security coordinator, primary 8. Backup 9. Current DEA registrant	All applicable	Insufficient or no evidence for any of the essential roles • Distribution lead, primary • Logistics, primary • Receiving site lead, primary • Security coordinator, primary • Current DEA registrant	Essential criteria, no partial credit	Sufficient evidence for all five essential roles • Distribution lead, primary • Logistics, primary • Receiving site lead, primary • Security coordinator, primary • Current DEA registrant • CRI Note. If not applicable, this section will not be factored into status
Plans include the following elements for requesting materiel: 1. Assessment of local inventory or MCM caches 2. Decision process, such as trigger indicators or thresholds 3. Identification of pharmaceutical or medical wholesalers 4. Process for requesting MCMs	All	Insufficient or no evidence	Sufficient evidence for one to three attributes	Sufficient evidence for all four attributes
Security plans for primary RSS include 1. Security lead during public health emergency response 2. Evacuation plans 3. Exterior physical security of locations 4. Interior physical security of location 5. Security breach plans	States DFLs TFAS	Insufficient or no evidence for any of the five attributes	Essential criteria, no partial credit	Sufficient evidence for all five attributes

Question	Jurisdiction	Contribute Toward "Early" Status	Contribute Toward "Intermediate" Status	Contribute Toward "Established" Status
Security plans for primary RDS or LDS include 1. Security lead during public health emergency response 2. Evacuation plans 3. Exterior physical security of locations 4. Interior physical security of location 5. Security breach plans	All applicable	Insufficient or no evidence for any of the five attributes	Essential criteria, no partial credit	Sufficient evidence for all five attributes CRI Note. If not applicable, this section will not be factored into status
Transportation security plans include 1. Crossing jurisdictional lines 2. Crossing government sovereignty, such as tribal, if applicable 3. MCM arriving at RSS 4. MCM transported from RSS to RDS, LDS, or receiving site 5. MCM transported from RDS or LDS to receiving site	States DFLs TFAS CRIs, if applicable	Insufficient or no evidence for any of the following attributes: • Crossing jurisdictional lines • MCM arriving at RSS • MCM transported from RSS to RDS or LDS or receiving site • MCM transported from RDS or LDS to receiving site • Crossing government sovereignty (only if applicable)	Essential criteria, no partial credit	Sufficient evidence for the following attributes: • Crossing jurisdictional lines • MCM arriving at RSS • MCM transported from RSS to RDS or LDS/ Receiving site • MCM transported from RDS or LDS to receiving site • Crossing government sovereignty (only if applicable) CRI Note. If not applicable, this section will not be factored into status
Allocation and distribution elements include 1. Chain of custody 2. Cold chain management 3. Delivery locations 4. Delivery schedule 5. Transportation method(s) 6. Transportation routes 7. Receive from intermediary site if applicable 8. Process for allocating limited material	States DFLs TFAS CRIs, if applicable	Insufficient or no evidence	Sufficient evidence for one to six of the following attributes: 1. Chain of custody 2. Cold chain management 3. Delivery locations 4. Delivery schedule 5. Transportation method(s) 6. Transportation routes	Sufficient evidence for all six of the following attributes: 1. Chain of custody 2. Cold chain management 3. Delivery locations 4. Delivery schedule 5. Transportation method(s) 6. Transportation routes CRI Note. If not applicable, this section will not be factored into status

Question	Jurisdiction	Contribute Toward "Early" Status	Contribute Toward "Intermediate" Status	Contribute Toward "Established" Status
Recovery and demobilization elements include 1. Recovery of durable medical equipment 2. Recovery of materiel	States DFLs TFAS CRIs, if applicable	Insufficient or no evidence	Sufficient evidence for one of the required attributes	Sufficient evidence for both attributes CRI Note. If not applicable, this section will not be factored into status
Planning Status	All	All planning criteria in "early status" column for both the Dispensing Planning Form and Distribution Planning Form (next page)	Combination of status across all criteria for both the Dispensing Planning Form and Distribution Planning Form	All criteria in "established" status column for both the Dispensing Planning Form and Distribution Planning Form

Operational status

Operational status is based on criteria in the Notice of Funding Opportunity. To achieve "established" operational status, a jurisdiction must meet outlined requirements on time (any exceptions for additional criteria to achieve "established" status is noted in the far right hand column of the table below).

Form	Submission Cycle*	State	DFL	TFAS	CRI	Status
Facility set-up drill	Once a year, no later than June 30		Yes	Every 2 years by June 30	Yes	
Staff notification and assembly drill	Once a year, no later than June 30	Yes (formerly PM 3. 1)	Yes	Yes	Yes	
Site activation drill	Once a year, no later than June 30		Yes	Yes	Yes	
Successful IMATS or Information Data Exchange (IDE) • Information is populated directly from Strategic National Stockpile (SNS) reports; no data entry required	Once a year, no later than June 30	Yes	Yes	Yes**		
Training and exercise planning form • Documents training and exercise plan workshop (TEPW) information	Once a year, no later than June 30	Yes	Yes	Every 2 years by June 30		
Training and exercise planning form • Documents multiyear training and exercise plan (MYTEP)	Once a year, no later than June 30	Yes	Yes	Yes	Yes	
• PHEP, functional, or full-scale exercise (FSE) or incident to document PHEP exercise with vulnerable populations	Once a year, no later than June 30	Yes	Yes	At least once every 5 years		Must demonstrate vulnerable populations are engaged during either an incident or exercise (functional or full-scale) to achieve established status
PHEP, functional, or FSE or incident • To document emergency operations center (EOC) staff notification and assembly (formerly PM 3.1)	At least once annually, no later than June 30	Yes	Yes	Puerto Rico only		

Form	Submission Cycle*	State	DFL	TFAS	CRI	Status
PHEP, functional, or FSE or incident • For all EOC activations for incidents	Each activation having a public health component	Yes	Yes	Yes		
PHEP, functional, or FSE or incident • To document joint Hospital Preparedness Program (HPP) or PHEP functional or full-scale exercise	At least once every 5 years	Yes	Yes	Puerto Rico only		Statewide-joint exercise must meet HPP and PHEP requirements to achieve "established" status. Requirements include involvement of HPP or HCCs and emergency management agencies or organizations
Dispensing full-scale exercise (FSE) or incident	At least once every 5 years	***	Yes	Functional exercise (FE) or FSE for dispensing or distribution	Yes	
Distribution FSE or incident	At least once every 5 years	Yes	Yes	FE or FSE for dispensing or distribution		
After-action report (AAR) and improvement plan (IP); documents should be uploaded; form submission is optional	Submit with each incident, FE and FSE	Yes	Yes	Yes	Yes	
Dispensing throughput drill • Only used to document if mass vaccination was conducted in lieu of pill dispensing	Required at least once every 5 years only if throughput not calculated during dispensing FSE		Yes	Yes	Yes	
Tabletop exercise (TTX) • Documents any TTX including incident command COOP, laboratory services COOP, (CRC) and fiscal- or administrative-focused exercises	At least once every 5 years for each					

***NOTE**: Operational forms above must be submitted or updated as indicated. Status is measured by submission requirements and deadlines. Missing operational criteria contributes toward early status, late submissions or missed targets toward intermediate status. Established operational status reflects all requirements were met and received on time.

****NOTE**: To document compliance, American Samoa, Commonwealth of Northern Mariana Islands, Federated States of Micronesia, Guam, Republic of Palau, Republic of the Marshall Islands, and U.S. Virgin Islands may continue to submit an Excel spreadsheet (if IMATS or IDE is unavailable) to respond to CDC inventory request. Puerto Rico must submit through IMATS or another IDE.

*****NOTE**: Required for states with dispensing responsibilities.

2019-2020 PANDEMIC INFLUENZA TIPS

The table describes where changes to the ORR were made to accommodate pandemic influenza measures. Review the relevant guidance sections above for specific detail on how to complete each form.

Form	Section Header	Added Variables
Critical contact sheet		1. Influenza Coordinator 2. Immunization Coordinator 3. Laboratorian 4. Epidemiologist
Dispensing Planning	Mass Care (retired header) New Header: Coordinate public health, health care and mental/ behavioral health services	Process and plans in place for displaced persons (select all that apply)
Dispensing Planning	Identify and Initiate MCM Dispensing	Process for critical workforce personnel to receive initial prophylaxis (select all that apply)
Dispensing Planning	Activate Dispensing Modalities: Plans for POD security address (retired header)	Activate Dispensing Modalities - Plans for POD/Dispensing Vaccination Clinics (DVCs) security address
Dispensing Planning	Activate Dispensing Modalities: Process or protocols for dispensing PODs address (retired header) New Header: Activate Dispensing Modalities: Process or protocols for dispensing PODs and DVCs address	1. Investigational New Drug (IND) 2. Emergency Use Authorization (EUA) 3. Screening for the purpose of triaging visitors to the POD/DVC
Distribution Planning	Activate Public Health Emergency Operations - Identified Incident Command Staff	1. Chief Medical Officer 2. Chief Science Officer 3. Epidemiologist 4. Infectious Disease/Influenza SME
Distribution Planning	Distribute Medical Materiel – Allocation and distribution elements include	Process for allocating limited materiel
Tabletop Exercise (TTX)		1. Pandemic processes and procedures included in exercise (select all that apply) 2. Continuity of Operations (COOP) (select all that apply)
Functional Exercise	New Form: Functional Exercise: Critical Workforce Group (CWG) Vaccination	Review guidance above for detail on how to complete the form

Notes