North Carolina Public Health Preparedness and Response

Since its creation in 2002, the North Carolina Public Health Preparedness and Response Branch (PHP&R) has diligently worked to increase response to health crises and provide support to local health departments. PHP&R responds to incidents of cases such as West Nile Virus, H1N1 influenza pandemic, bacterial contamination of food, hurricanes, terrorism, and other crises.

The goal of Public Health Preparedness is to enhance the capability and readiness of public health care systems, communities, and individuals to identify, prevent, protect against, respond to, and recover from public health emergencies.

North Carolina Public Health Preparedness and Response Branch is divided into four regions across the state. Rockingham County lies within the Central Region. Each region consists of a multitude of state employees of various sectors that collaborate to support the goals of PHP&R (NCDHHS, 2012[a]).

In order for response efforts to be truly effective, coordination of efforts must happen at every level of authority. There are three major documents that guide officials when managing the smallest of incidents to the largest of catastrophes. These documents are:

National Response Framework (NRF) – In recent years our nation has faced an unprecedented series of disasters and emergencies. The NRF was created to meet the needs of those threats. The NRF establishes a comprehensive, national, all-hazards approach to domestic incident response. It defines the key principles, roles, and structures that organize the way senior elected and appointed leaders (federal departments or agency heads, governors, mayors, and city or county officials) respond as a Nation (USDHS, 2008).

National Incident Management System (NIMS) – NIMS works hand-in-hand with the National Response Framework. NIMS provides a systematic, proactive approach to guide departments and agencies at all levels of governmental, nongovernmental, and private sectors to work uniformly to prevent, protect against, respond to, recover from, and reduce the effects of incidents, regardless of cause, size, location, or complexity, in order to decrease the loss of life and property, and harm to the environment. NIMS provides the foundation needed to ensure that officials can work together when communities and the nation need help the most (USDHS, 2012).

Emergency Operations Plan (EOP) – The local EOP focuses on the measures that are essential for protecting the public, including warnings, emergency public information, evacuations, and shelters. An EOP assigns responsibility to organizations and individuals for carrying out, during emergencies, specific actions that exceed the capability or routine responsibility of any one agency. The EOP will show how all actions will be coordinated and will describe how people and property will be protected in emergencies. It will also identify personnel, equipment, facilities, supplies, and available resources for use during emergencies (USDHS, 1996).

Rockingham County Local Emergency Planning Committee

Rockingham County Local Emergency Planning Committee (RCLEPC) is in charge of helping Rockingham County in emergency situations. RCLEPC is a federally mandated committee with membership from business and industry; emergency response groups such as fire, medical, and law enforcement; community groups; media; hospitals; environmental interest groups; the community college; and the general public. Its mission is to effectively plan for emergencies involving hazardous materials. The RCLEPC meets quarterly, and the public is invited to attend.

The Rockingham County Local Emergency Planning Committee is tasked with the following responsibilities:

- SARA Title III Environmental Compliance (also known as Emergency Planning and Community Right-to-Know Act (EPCRA)) – requires states to promote outreach for developing local emergency preparedness programs to respond to chemical releases; receive reports from the regulated community; and organize, analyze, and disseminate the resulting information on hazardous chemicals to local governments and the public.
- HAZMAT Training and Exercises
- Site-Specific Chemical Planning Program
- Coordination of Chemical Information to Emergency Responders

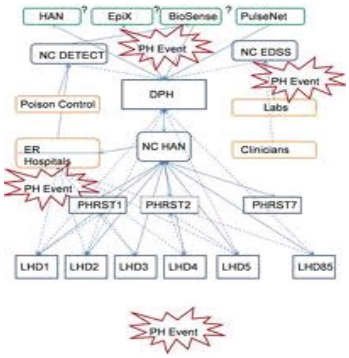
The primary responsibility of the RCLEPC is to receive information about hazardous substances from industry and to use this information to develop comprehensive site emergency plans to handle emergencies. They are also responsible for establishing procedures and programs which make it easy for citizens to understand and have access to the information that industry submits.

RCLEPC can assist in obtaining chemical related information from industry in Rockingham County. Federal law requires Local Emergency Planning Committees to establish procedures for receiving and processing requests from the public for information. The Rockingham County Emergency Management Office has been

designated as the official agency to serve as coordinator of this information (RCG, 2011).

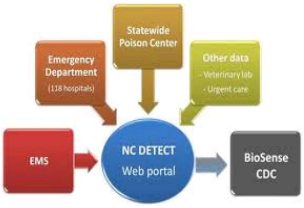
Rapid response is a key component to how well agencies that serve the RCLEPC can do their jobs. There are three systems that are utilized in North Carolina that make sharing information regarding emergency situations extremely effective and efficient. Those systems include:

North Carolina Health Alert Network (NC HAN)



NC HAN is a part of the national alert network funded by the Centers for Disease Control and Prevention (CDC). NC HAN serves as a notification system that alerts staff members in key organizations about events that may pose a risk to community health. NC HAN will issue an alert that is sent to members via email, pager, phone, and/or fax. An alert will state the priority level (high, medium, or low) and will give details, including the nature of the event and the affected areas (UNC, 2011).

North Carolina Disease Event Tracking and Epidemiology Collection Tool (NC DETECT)



NC DETECT is a statewide surveillance system created by the NC Division of Public Health in 2004. This system addresses the need for early event detections and timely responses. Users of this system are able to monitor a variety of important public health issues in a secure and appropriate fashion, including incidents such as influenza, injury and violence, and post hurricane health issues. NC DETECT is designed to uncover suspicious patterns of illness in both human and animal populations and is a key tool in early detection of infectious disease (NCDHHS, 2012[b]).

North Carolina Electronic Disease Surveillance System (NC EDSS)

NC EDSS is the epitome of how the exchange and reporting of emergency situations can be done in a timely manner using this web-based surveillance and reporting system. NC EDSS is a component of a CDC initiative and involves local health departments; HIV/STD regional offices; the Department of Environment, Health, and Natural Resources; and the Division of Public Health. NC EDSS allows users to have ready access to emergency data, analyze morbidity patterns across diseases, and manage statewide outbreaks (NCCDM, 2009).

Federal law also requires all Local Emergency Planning Committees to complete an Emergency Response Plan within two years after the date of the enactment of the

Community Right-to-Know Act of 1986. The LEPC is required to review the plan at least annually. A comprehensive plan was developed for Rockingham County and is available for public inspection at the Rockingham County Emergency Management Office.

Visit the website at http://www.em.rockinghames.org/ to learn more about how you can prepare for emergency situations in your home.

Department of Public Health Preparedness Since 2008

2009 H1N1 Influenza

One example of how Public Health Preparedness responds to health crises was the 2009 H1N1 influenza virus. In the spring of 2009, a new (novel) H1N1 influenza virus strain affecting humans was identified by the Centers for Disease Control and Prevention (CDC) in Atlanta. On April 26, 2009, the US Department of Health and Human Services declared a national public health emergency involving H1N1 influenza. With this declaration the CDC took a major step against the rapidly spreading H1N1 influenza virus by deploying its Strategic National Stockpile (SNS) assets of antiviral drugs to state health departments to be distributed to local health departments and hospitals. This deployment tested state and local health departments' individual SNS plans (under development since 2005) and their capability for receiving and distributing SNS assets.

Rockingham County experienced its first case of H1N1 in May 2009. By June 2009, the World Health Organization (WHO) raised the pandemic alert level, indicating a global H1N1 pandemic due to the widespread infection in North America, Australia, the United Kingdom, Argentina, Chile, Spain, and Japan. On October 24, 2009, President Obama declared the H1N1 influenza pandemic a national emergency.

Although most strains of influenza, including H1N1, affect everyone, they affect special populations more severely, such as adults older than 60, the very young, those with weak immune systems, and pregnant women. The virus was spread from person to person worldwide through coughing, sneezing, and touching people infected with influenza. Symptoms include fever, cough, sore throat, runny nose, headache, chills, fatigue, respiratory symptoms, and even severe illness or death as a result of illness associated with the virus (CDC, 2010).

When Rockingham County began experiencing its first cases of H1N1 influenza, it recognized the importance of the health department and community partners, such as the school system, hospitals, long-term and assisted care facilities, private physicians, the media, and other agencies working together to respond quickly to prevent further spread of the H1N1 influenza virus within the county.

As the H1N1 influenza vaccine became available from the NC Division of Public Health, the Rockingham County Department of Public Health worked together with community partners to get the vaccine out to the most vulnerable populations first. In order to best allocate the initially limited supplies of vaccine, the US Advisory Committee on Immunization Practices (ACIP) made vaccine recommendations to the CDC and designated certain target groups to receive the initial doses of the vaccine. As more vaccine became available, it was distributed to the public in tiers until anyone who wanted the vaccine could get it. The Rockingham County Department of Public Health distributed 4,335 doses of vaccine to community health care providers and held numerous flu clinics to vaccinate as much of the county population as possible. According to the CDC, about 127 million doses of vaccine were shipped to vaccine providers in the United States during the 2009 - 2010 H1N1 influenza pandemic.

Due to the pandemic situation changing so rapidly, there were daily communications between federal, state, and local agencies to address changes in recommendations and provide new information as it became available. The Rockingham County Department of Public Health worked closely with state and local agencies, and community partners in an ongoing public information campaign to educate the public on the H1N1 virus, preventing its spread, use of antivirals, and vaccine availability.

The World Health Organization issued a final report on the 2009 influenza pandemic, indicating more than 17,000 deaths worldwide. In the United States, the number of patients infected was estimated at 59 million, with 265,000 hospitalizations and 12,000 deaths. The US Office of Public Health Emergency declared that the 2009 H1N1 Influenza pandemic ended on June 23, 2010. On August 10, 2010, the World Health Organization declared an end to the 2009 H1N1 pandemic globally.

Table 12.1 outlines the locations and numbers of H1N1 vaccines that were distributed to the community from 2009 - 2010 by the Rockingham County Department of Public Health. In all, over 1500 vaccines were given out.

CDC
CENTERS FOR DISEASE™
CONTROL AND PREVENTION

World Health Organization

Table 12.1 Rockingham County Department of Public Health H1N1 Vaccines Disbursement, 2012

Vaccination Clinic Site	H1N1 Injection	H1N1 Intranasal Mist	Total H1N1 Vaccines
Bayberry Retirement Home	18	---	18
Caregivers of Rockingham County	2	---	2
Community Baptist Church	---	38	38
Covington Wesleyan	30	1	31
Dr. Burleson	13	---	13
Dr. Kinney	1	---	1
Eden Drug	25	---	25
Eden YMCA	18	---	18
Growing Oaks Church	26	1	27
Holmes Middle School	154	10	164
Holy Infant Catholic Church, Reidsville	29	3	32
Hospice of Rockingham County	14	---	14
Meals on Wheels (Homebound Clients)	2	---	2
North Pointe	15	---	15
Reidsville Middle School	163	4	167
Reidsville Outreach Center	28	---	28
Reidsville YMCA	15	---	15
Rockingham Community College	97	73	170
Rockingham County Department of Public Health	103	4	107

Vaccination Clinic Site	H1N1 Injection	H1N1 Intranasal Mist	Total H1N1 Vaccines
Rockingham County Head Start	---	191	191
Rockingham County Student Health Centers	---	69	69
The Lord's Pantry, Eden	63	1	64
The New Reidsville Housing Authority	6	---	6
Trinity Wesleyan Church	77	26	103
Turner's Home Care	8	---	8
Weils-McLean	23	5	28
Western Rockingham Middle School	189	29	218
Total	1,119	455	1,574

Source: RCDPH, 2012

Defining Special Needs or At-Risk Populations

Community preparedness and response are essential for surviving and having a good outcome when a disaster or public health threat occurs. It is one of the most difficult and challenging areas of planning for local response planners. Federal, state, and local emergency management have identified that individuals and their families have the primary responsibility for being prepared for surviving disasters, and guidelines are available for all types of emergency events. However, responsibility extends to the caregivers for special needs populations or those at risk for health problems during emergency situations. Local government and community support agencies, such as the American Red Cross, provide as much assistance as their capacities allow during disasters or emergencies.

Special needs populations are defined within all emergency services professions according to the mission of that particular service agency. Public Health has identified persons with health risks as special needs populations, such as pregnant women, infants, children, the elderly, persons with disabilities, and those with language barriers. Identifying a group of individuals as a "special needs population" depends on the task to

be accomplished. Not all individuals have special needs in all types of emergencies and for all emergency activities.

The Rockingham County Department of Public Health, through group or individual meetings and regional or local exercises, has collaborated with state and community partners such as the Local Emergency Planning Committee (LEPC), American Red Cross (ARC), Department of Social Services (DSS), and Emergency Management (EM) to define special needs populations within the county and establish what resources are available to meet the needs of those populations. The Department of Social Services is designated as the lead agency for identifying special needs or vulnerable populations in Rockingham County. The Program Manager for Adult, Prevention, and Human Services at DSS maintains a listing of all licensed facilities and works with Emergency Management to help those vulnerable groups develop required plans for potential emergencies, such as evacuation and sheltering. The listing is updated quarterly and sent to the Rockingham County Emergency Services Director for GIS map layering on the county 911 system. The map layering assists emergency response agencies in locating at-risk populations during emergency events. The list consists of the following groups: nursing homes, adult mental health facilities, substance abuse halfway houses, adult care homes, family care homes, Hospice, child and adolescent care group homes, psychosocial rehabilitation/adult development vocational program, adult day/health care facilities, and childcare facilities (Appendix G).

Individuals with special needs who may need assistance during a disaster can register through the Rockingham County Emergency Management website. Registration is voluntary, and the special needs form is web-based; the individual or a family member can complete it. A copy automatically goes to the Emergency Services Director and to the Program Manager for Adult, Prevention, and Human Services at DSS. The service is free, and the individual may opt out at any time.

The Health Department serves on the LEPC Shelter Committee and works closely with DSS, American Red Cross, and Emergency Management to help identify populations that would need sheltering at special-needs shelters and to develop emergency operation plans to meet the needs of both the general population and special needs groups.

Public health preparedness' definition of a special-needs population is based on the mission—to provide and communicate public health information during an emergency, provide rapid mass prophylaxis to the county population during a bioterrorism or infectious disease event, and to contain or stop the spread of disease. The list of

special-needs populations may not match the lists of other segments of health department or community partners because the objectives in the crisis are different.

The public health preparedness goal is to define special needs or at-risk groups as they relate to three major public health target capabilities and priorities during emergency events:

- **Emergency Communications**- identify populations that would be unable to receive general public health emergency messages through mass communication channels during the initial phase of a public health emergency.
- **Mass Prophylaxis and Vaccination**- identify what populations would be difficult to provide medical prophylaxis or vaccination during a bioterrorism or infectious disease event.
- **Community Containment**- identify at-risk populations among whom it may be difficult to control the spread of disease.

Emergency Communications

During the time of a disaster or emergency, things will be chaotic, and communication efforts will be an "All Hazards" approach aimed at achieving the greatest good for the greatest number while still having enough resources to reach those few who cannot help themselves. Communications will be directed to help individuals and communities to help themselves and each other.

During emergency events the public health Public Information Officer (PIO) is responsible for a portion of public information messages related to general physical well-being and health risks which will be shared with other agencies at all jurisdictional levels. Early in the crisis, public information will be coordinated with jurisdictional partners to ensure consistency of information from response authorities in order to prevent further illness, injury, or death; restore or maintain calm; and engender confidence in the operational response. Public health resources for public information activities during a crisis will be limited and must be prioritized, especially early in the crisis.

The Rockingham County Department of Public Health collaborates regularly with community partners such as the Local Emergency Planning Committee (LEPC), Rockingham County Emergency Management Services, Rockingham County Department of Social Services (DSS), other counties, and the State Office of Public Health Preparedness and Response to identify at-risk populations and develop corresponding plans to respond to potential public health events. At-risk populations are addressed in the *All Hazards Plan*, *Strategic National Stockpile Plan, Mass Vaccination Plan, Pandemic Influenza Response Plan,* and the *Quarantine and Isolation Plan.*

For public health public information purposes, a special population is any group who cannot be reached effectively by general public health messages delivered through mass communication channels during the initial phase of a public safety emergency. Persons who fall within the following categories may not have the ability to receive and act on beneficial health/risk information that is released.

- cognitive impairment (if a proxy/guardian is not present to receive the message);
- language barriers severe enough that the message could be incorrectly acted on (if a proxy/guardian is not present to receive the message);
- physical impairments (if compensating technology or human resources are not available);
- strong challenges to important cultural beliefs relevant to the event;
- environmental barriers (e.g., homeless, no TV or phone); and
- pre-existing group psychological, social, or political/ legal contexts (e.g., strong mistrust of the organization sending the message or fear of retribution if the receiver acts on the information) that could interfere with honest and respectful information exchange during emergency events.

Belonging to any of the groups listed above is not, in itself, a qualifier as a special needs population. If basic emergency health messages can be communicated and received, members of these groups would be considered part of the general population.

Early in a crisis, communication resources will be limited, and the potential for mixed messages confusing the public will be great. The overwhelming evidence-based communication research is that, in an emergency, persons tend to have more in common regarding their information needs than not. Therefore, simple and consistent messages will be best unless strong evidence supports the fact that the messages will not be effectively received by an identifiable group that may effectively receive them in some other form.

The Health Department utilizes e-mail listserves and a rapid fax system to send out health alerts and advisories to the first responder agencies, media, and the medical community. The county has a *Code Red* (reverse 911-type system) in place to disseminate emergency information out to the general public based on a targeted geographical area or to the entire county as needed. Anyone can register through the Rockingham County Emergency Management website. Registration is voluntary and is free. Messages may be received by phone, fax, text, or e-mail.

Mass Prophylaxis and Vaccination

Mass prophylaxis and vaccination have the capability to protect the health of the population through administration of critical interventions (e.g., antibiotics, vaccinations, antivirals) to prevent against the development of disease among those who are exposed or potentially exposed to public health threats. This capability includes the provision of appropriate follow-up and monitoring of adverse events.

Any of the previously mentioned groups could be identified as populations for whom it would be difficult to provide medical prophylaxis or vaccinations during a bioterrorism or infectious disease event. In addition to this group, the *County Strategic National Stockpile Plan* identifies the following groups as at-risk populations: pregnant women, infants, children, the elderly, persons with co-morbidities, persons with renal impairment, and those with drug allergies to SNS asset medications. A set of instructions, policies, and standing orders is established to determine appropriate prophylaxis for these populations.

Community Containment

North Carolina General Statutes (130A-14 and 130A-480) give the state or local health director authority to issue isolation/quarantine orders or to activate social distancing measures such as school dismissal or limiting public gatherings to decrease opportunities for close contact in an effort to reduce the spread of infection or disease. The statutes also allow access to federal and state surveillance programs which track symptoms that characterize certain diseases.

The Health Department functions under established disease investigation protocols and standing orders, and has trained communicable disease and environmental health staff on call 24 hours a day, 7 days a week. These designated staff members have access to surveillance data that allows them to provide early disease surveillance and investigation, and to issue control measures.

Since the 2009 H1N1 pandemic there has been an increased collaborative effort in Rockingham County with representatives from the Health Department, LEPC, DSS, volunteer agencies, hospitals, the school system, private physicians, emergency medical providers, mental health providers, long-term care facilities, home health agencies, and pharmacists. These groups have been working to develop strategies and update plans and databases to provide infection control measures in all settings to limit the spread of disease.

In any disease outbreak decision makers must consider the scope of their legal authority, social and economic impact, anticipated effectiveness, and current epidemiology of the disease event prior to implementing control measures. During a disease outbreak or exposure, any population within the county could be identified as at-risk, and it may be difficult to control the spread of disease among these groups. *The Pandemic Influenza Response Plan* identifies the previously mentioned groups as at-risk/vulnerable populations, but disease effects on the following groups could result in devastating outcomes: pregnant women, infants, children, the elderly, and persons with co-morbidities. Regardless of the group affected, early event/disease identification, rapid deployment of control measures, and increasing community preparedness and response are essential for survival and a good outcome when a disaster or public health threat occurs.

Local Emergency Preparation

Rockingham County government has the responsibility to ensure public health and safety for the residents of Rockingham County. Emergency Management is the designated lead agency for identifying and planning a response network for all potential hazards or threats. Identifying and planning for potential events require collaboration from many agencies and community partners. This collaboratin is accomplished through group and sub-committee meetings of the Local Emergency Planning Committee (LEPC).

In February 2012, the county held a Tornado Tabletop Exercise designed to establish a learning environment for participating agencies and groups to exercise their plans and procedures for responding to a tornado-related incident affecting multiple jurisdictions and locations within Rockingham County. The exercise was held in the Rockingham County Emergency Operations Center (EOC) and was conducted in a no-fault learning environment wherein systems and processes, not individuals, were evaluated. Exercise simulation was realistic and plausible, and contained sufficient detail for players to respond to the information in the same manner as if it had been a real event. The purpose of the exercise was to measure capabilities of on-site management, communications, public safety and security, and EOC Management.

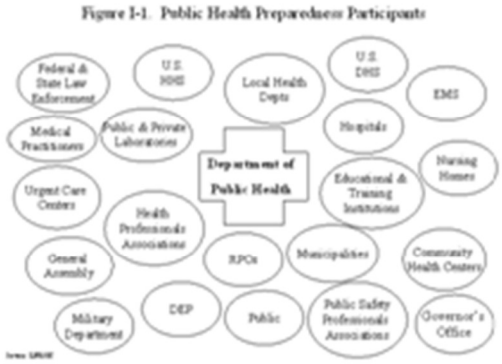
The following were objectives of the exercise:

- Determine strengths and weaknesses in the current plan governing on-scene command and control, the EOC, and coordination and integration of various response resources.
- Review plans for area perimeter control, staging, and the Incident Command Post (ICP), Central Receiving and Distribution Point/Points of Distribution (CRDP/PODS), and shelter security.
- Assess the adequacy of local plans for use of media resources and ways in which communication will be managed during emergency events.
- Discuss ICS and how to maintain and prevent failures in the system as an event becomes a multi-jurisdiction incident.
- Discuss how information flows among agencies.
- Discuss plans for back-up communication system(s) if the primary communication is inoperable.

Approximately 95 participants attended the exercise, consisting of individuals from state and federal emergency management agencies, local police and fire departments, rescue squads, and many other county government departments.

The exercise was evaluated as an overall success. Since the exercise, Emergency Management is developing a training plan for county responders and is offering more ICS training classes to help strengthen the response process.

Moving Forward: Strategy for Improving State and Local Preparedness in 2011-2012



Public health has made much progress in preparedness since 2001. Despite the progress made, state and local health departments continue to face multiple challenges, including an ever-changing list of public health threats and declining federal funds for preparedness.

These challenges create concern over the ability to sustain the real and measurable advances made in public health preparedness since September 11, 2001. In the future, state and local planners must work together to make difficult choices about how to prioritize and ensure that funding dollars are directed to priority areas.

State and local health departments are first responders for public health emergencies, and the Centers for Disease Control (CDC) remains committed to strengthening their preparedness. The CDC has identified the actions listed below for improving state and local preparedness:

- Maintain preparedness gains and resolve gaps
- Build on the successes and lessons learned from the response to the 2009 H1N1 influenza pandemic
- Ensure continuous funding to build and maintain a skilled state and local public health workforce
- Expand performance measurement to assess and monitor preparedness activities and to drive program improvement and accountability (CDC, 2012[a])

Development of National Standards for State and Local Planning

Each year, the Centers for Disease Control and Prevention (CDC) Office of Public Health Preparedness and Response (PHP&R) receive approximately $1.3 billion from Congress to build and strengthen national preparedness for public health emergencies caused by natural, accidental, or intentional events. Congress appropriates the majority of this funding for two programs, the Public Health Emergency Preparedness (PHEP) cooperative agreement and the Strategic National Stockpile (SNS). CDC Office of PHP&R allocates the remainder of the funding to preparedness programs across the CDC. Congress also provides emergency supplemental funding to address preparedness needs related to specific health threats, such as pandemic influenza.

It is through the Public Health Emergency Preparedness (PHEP) cooperative agreement that the CDC provides funding to state and local public health departments for building and strengthening abilities to respond to public health incidents. In response to the challenges that public health is facing and for the new five-year PHEP cooperative agreement that took effect in August 2011, the CDC implemented the *Public Health Preparedness Capabilities: National Standards for State and Local Planning* to assist state and local planners in identifying gaps, determining priorities, and for developing plans for building and sustaining capabilities. The capabilities will be addressed in three phases:

- Phase 1: Assess current state of capabilities and plans
- Phase 2: Determine goals
- Phase 3: Develop plans

Aligning Capabilities with National Programs

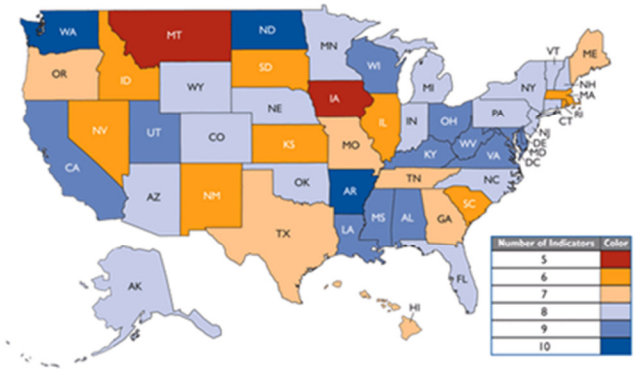
The CDC developed the *Public Health Preparedness Capabilities* document to align with both Department of Homeland Security target capabilities and Department of Health and Human Services 10 Essential Public Health Services that focus on public health capabilities critical to preparedness.

In developing the document, the CDC reviewed key legislative and executive directives to identify state and local public health preparedness priorities, including the following:

- Pandemic and All-Hazards Preparedness Act (PAHPA)
- Homeland Security Presidential Directives 5, 8, and 21
- National Health Security Strategy (NHSS) 21 Capabilities

The CDC's public health preparedness capability standards are designed to accelerate planning, provide guidance and recommendations, and ultimately assure safer, more resilient, and better prepared communities. The standards demonstrate capabilities within the following domains:

- Biosurveillance
- Community Resilience
- Countermeasures and Mitigation
- Incident Management
- Information Management
- Surge Management



Disasters, and Bioterrorism Report – 10 Indicators for Public Health Emergency Preparedness

The following 15 public health preparedness capabilities are the basis for state and local public health preparedness:

1. Community Preparedness
2. Community Recovery
3. Emergency Operations Coordination
4. Emergency Public Information and Warning
5. Fatality Management
6. Information Sharing
7. Mass Care
8. Medical Countermeasure Dispensing
9. Medical Material Management and Distribution
10. Medical Surge
11. Non-Pharmaceutical Interventions
12. Public Health Laboratory Testing
13. Public Health Surveillance and Epidemiological Investigation
14. Responder Safety and Health
15. Volunteer Management (CDC, 2011)

Accountability

The CDC has developed and continues to design standardized annual performance measures that are indicators of preparedness and response capabilities and supports program improvement through targeted technical assistance and training. All recipients of funding from the CDC's Public Health Emergency Preparedness (PHEP) cooperative agreement must submit data on annual performance measures to the CDC. The CDC is committed to publicly reporting on these performance measures and progress in other PHEP-funded activities that improve the nation's ability to prepare for and respond to public health emergencies. Preparedness reports demonstrate results, drive program improvements, and increase accountability for federal investments.

Guidance and Technical Assistance

In addition to funding, the CDC provides annual guidance, technical assistance, and training to assist state and local health departments with their strategic planning to strengthen their public health preparedness capabilities. Technical assistance includes CDC public health expertise, standards for developing priority preparedness capabilities, and expertise for conducting exercises and meeting performance goals.
The CDC is currently developing a series of training guides to assist state and local health departments in achieving the 15 public health preparedness capabilities (CDC, 2012[b]).

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