Mitchell E. Daniels, Jr.
Governor

Judith A. Monroe, M.D.
State Health Commissioner

Indiana State Department of Health

An Equal Opportunity Employer

September 6, 2006

Ms. Angela Webb
Grants Management Specialist – Regions 5, 6, 7, 8, 9
Acquisition & Assistance Branch VI
Procurement and Grants Office
Centers for Disease Control and Prevention (CDC)
2920 Brandywine Road
Atlanta, GA 30341-4146

Re: Cooperative Agreement U90/CCU517024-07, Public Health Preparedness and Response for Bioterrorism cooperative agreement, ending 08/30/2007, Supplemental Pandemic Influenza Funding.

Dear Ms. Webb:

Attached you will find a copy of the Indiana State Department of Health's application for Phase 2 Pandemic Influenza, Public Health Preparedness supplemental funds, previously awarded in the amount of $4,601,761. Our Letter of Intent to request these funds was submitted back on 07/15/06 with our original application for continued funding under the Public Health Preparedness for Bioterrorism cooperative agreement. We are aware that the original application was due by 08/31/06; however, due to a Public Health Emergency response that was occurring in Indiana at that time, we were granted a submission extension per our Project Officer, Mr. John Scott, and by Ms. Susan True (Director, Program Services Branch, DSLR, CDC) on 08/29/06. A copy of the email extension approval is on record at ISDH and can be forwarded to the Procurement and Grants Office upon request. As required by the supplemental funding guidance, all application contents have been uploaded electronically into the CDC's Secure Data Network Management Information System (MIS) as file attachments.

The following is a complete list of the application appendices:

- Work Plan Template (CDC Attachment D)
- Budget Template (CDC Attachment C)
- Phase 1 Pandemic Influenza Mid-Year Progress Report
- APPENDIX A – SF 424
- APPENDIX B – SF 424 A
- APPENDIX C – Signed PHS 5161, Certifications & Assurances
- APPENDIX D – Local Health Consensus Spreadsheet

- APPENDIX E – Pandemic Influenza Executive Summary State Pandemic Flu Plan
- APPENDIX F – CDC PRIORITY 1: State Pandemic Influenza Self-Assessment
- APPENDIX G – CDC PRIORITY 1: State Pandemic Influenza Gap Analysis
- APPENDIX H – CDC PRIORITY 1: Local Health Department Gap Analysis Reports – A single county within each of the Indiana Homeland Security Districts is being included within the application as representative of consistent gaps identified for all other counties within the Local Health Jurisdiction. Upon receipt of completed Gap Analysis project from our vendor (see Work Plan Action Item #21) copies of all other gap analysis will be provided.

  - APPENDIX H:1 – Indiana Homeland Security District 1 – Newton County
  - APPENDIX H:2 – Indiana Homeland Security District 2 – Marshall County
  - APPENDIX H:3 – Indiana Homeland Security District 3 – Noble County
  - APPENDIX H:4 – Indiana Homeland Security District 4 – Fountain/Warren LHD
  - APPENDIX H:5 – Indiana Homeland Security District 5 – Hamilton County
  - APPENDIX H:6 – Indiana Homeland Security District 6 – Tipton County
  - APPENDIX H:7 – Indiana Homeland Security District 7 – Vigo County
  - APPENDIX H:8 – Indiana Homeland Security District 8 – Bartholomew County
  - APPENDIX H:9 – Indiana Homeland Security District 9 – Ripley County
  - APPENDIX H:10 – Indiana Homeland Security District 10 – Warrick County

- APPENDIX I – CDC PRIORITY 1: Attachment 4c Self Assessment Local TOTALS

- APPENDIX J – CDC PRIORITY 2: 2006/2007 Master Exercise Plan & Schedule

- APPENDIX K – CDC PRIORITY 3: Summary Timeline for planned steps to develop the Anti-Viral Drug Distribution plan

- APPENDIX L – Detailed Budget for University of Illinois Contract for Laboratory Professional Training

- APPENDIX M - Detailed Indiana University Bioethics Contract Proposal

Please note that unless notified to do so, a hard copy original is not being submitted of this application, but will remain on file in our Finance Division as official record. In addition, an electronic of this entire application is being submitted via email to both the CDC Procurement and Grants Office as well as to Indiana's Project Officer, Mr. John Scott.

If you have any questions or concerns regarding this supplemental application, please contact Mr. Michael Hurst at (317) 234-3545 or Ms. Carolyn M. Dawson, at (317) 233-7396. Fiscal management questions should be directed to Mr. Kenneth Mayfield, at (317) 233-7328.

Sincerely,

Michael A. Hurst
Executive Director
Public Health Preparedness &
Emergency Response

Linda L. Brown
Director
Finance Division

MH/cd

Grant Application Work Plan Instructions

1) The Work Plan templates are contained in 25 tabs. Each tab allows you to add up to 5 activities/action items. For example, Tab 1 is labeled Action Items 1-5, Tab 2 is labeled Action Items 6-10, Tab 3 is labeled Action Items 11-15, and so on. Once on a tab, scroll to the right to view additional blank templates. Each Action Item and Tab is independent; selections made for one Action Item do not affect other selections. You are not required to include all Action Items that fall under a certain CDC Goal or Target Capability under one tab.

2) The Work plan template allows you to add up to 125 Action Items/Activities based on the gaps identified. However, this does not imply that you need to add that many Action Items/Activities.

3) Selection of CDC Goals, Target Capabilities, Performance Measures and corresponding Critical Tasks are made from drop down menus. The choices available under the Target Capability drop down are scoped based on the Goal selected. Similarly, the choices available under the Performance Measure and Critical Task are scoped to the Target Capability selected.

4) First select a CDC Goal. The Target Capabilities drop down menu will refresh itself to display only those Capabilities that correspond to the selected Goal.

5) Similarly, once you select at Target Capability, the drop down menu for the Performance Measures and the Critical Tasks will refresh to display the corresponding information.

6) Once you make the appropriate selections for the Goals, Target Capabilities, Performance Measures and Critical Tasks, enter information for your Action Item. This includes describing the Action Item by providing information in the 'What', 'Who', 'When', 'Where' and 'How' sections.

7) If you are defining an Action Item under Target Capability 1A; Critical Task 1 or Target Capability 6A; Critical Task 1 a reference to the specific sub categories addressed can be included in the 'Action Items' text box.

8) Next, define the success factors for your action plan by describing the Output, the Output Performance Measures and the Output Target. Note that you do not have to provide information for Outcomes, Outcome Performance Measures and Outcome Targets as part of this application.

9) Guidance regarding reporting for your mid year and end of year progress will be forthcoming.

10) If you have questions regarding this template or regarding the work plan model, please contact Prachi Mehta at pnm9@cdc.gov or 404-639-7078.

Prioritized Target Capabilities/Critical Tasks for Pandemic Influenza Preparedness

Target Capability 10	Critical Task 68	CDC Guidance Page #	Description of Critical Task or Priority	Phase 1 or Previous Period Activity 21	Phase 2 - Year 1 Activity 26	Phase 2 - Year 2 Activity 17	Phase 2 - Year 3 Activity 4
TC 1A: Planning	CT 1	26	Develop, exercise and improve operational plans for pandemic influenza at the state and local level.	x	x	x	x
	CT 2	27	Formalize agreements that address communication, mutual aid, and other cross-jurisdictional needs with neighboring domestic and/or international jurisdictions sharing an international border with Canada or Mexico (e.g., city-state-tribal collaboration arrangements or city-state-province/state collaboration arrangements)	x	x	x	x
	CT 3	27	**Assess and map local community; identify and build social networks; and develop community outreach information networks, pre-event, to** a) define, locate and reach special, at-risk and vulnerable populations and b) maximize capacity to effectively disseminate public information during a pandemic.			x	x
	CT 4	27	Clarify and communicate to all stakeholders the process for requesting, coordinating, and approving requests for resources to state and federal agencies		x	x	x
	CT 5	27	Ensure that legal authorities for executing the operational plan, especially those relevant to case identification, isolation, quarantine, movement restriction, healthcare services, emergency care, and mutual aid, are transparent to all stakeholders	x	x	x	x
	CT 6	27	Develop and document schemes to activate non-pharmacological interventions, including home isolation of patients and quarantine of household contacts, social distancing measures such as closure of schools and workplaces, reduced public transport, cancellation of mass gatherings and public education on hygiene measures such as hand and respiratory hygiene. The scheme should clearly outline how and when decisions are made to implement the interventions.			x	x
	CT 7	27	Identify and communicate to all stakeholders the authority responsible for declaring a public health emergency at the state, local and tribal levels and for officially activating the pandemic influenza response plan	x	x	x	x
	CT 8	27	Identify State, local and tribal law enforcement personnel who will maintain public order and help implement control measures		x	x	x
	CT 9	27	**Exercise operational plan in cooperation with animal health sectors (including but not limited to industry, veterinary diagnostic laboratories, state departments of agriculture), to prevent, detect and respond to reports of disease in animals as a early warning of threat to human health including:** a) education of and risk communication to the poultry owning public, poultry farmers and vendors, especially small operations b) a plan for surveillance in birds c) disease reporting and data sharing d) triggers for action to contain disease within the animal sector e) triggers to perform heightened surveillance to detect human illness			x	x

	CT 10	27	Train to and exercise the operational elements of the jurisdictional plan including plan activation, incident command, integration with partner agencies; integration with and assistance to hospitals and healthcare systems particularly regarding surge capacity, assisting persons with special needs, coordination with schools			x	x
	CT 11	28	Conduct at least one exercise per year jointly with HHS and DHS funded pandemic influenza responders through exercises, drills, tabletop exercises, etc.	x	x	x	x
	CT 12	28	Assign responsibilities and resources to complete, update and execute the plan. Assure that the plan includes timelines and Outcomes to be achieved as well as back-up systems for each part of the plan	x	x	x	x
TC 3A: Epi. Surveillance & Investigation	CT 1	28	Recruit and maintain a group of healthcare providers that report influenza-like illness (ILI) regularly, year-round, to the influenza sentinel provider surveillance network	x	x	x	x
	CT 2	28	Develop the ability to rapidly provide healthcare providers, clinics, and hospitals with updated information on case definitions and sample collection requests and protocols		x	x	x
	CT 3	28	Establish a system for healthcare providers to contact public health authorities about suspect cases or outbreaks	x	x	x	x
	CT 4	28	Develop an electronic system for rapid reporting of deaths and contributing causes of death (i.e. pneumonia and influenza-related) occurring in the state		x	x	x
	CT 5	28	Improve capacity for rapid identification of unusual influenza strains by working with federal partners to enhance laboratory-based monitoring of seasonal influenza subtypes		x	x	x
	CT 6	28	Ensure that tribal entities such as local Service Units, tribal health facilities and Area IHS review mechanism for influenza case reporting and identify local surveillance coordinators, thereby assuring linkage of local surveillance activities with federal, state and local systems				x
	CT 7	28	Inventory and maintain tribal and IHS supplies of influenza rapid diagnostic tests				x
	CT 8	28	Coordinate protocols for influenza testing with tribal entities and establish means of transportation for respiratory specimens to State public health laboratories when necessary				x
	CT 9	28	Develop protocols to enhance surveillance activities for early detection of influenza-like illness (ILI) among patients and health care workers at Tribal/IHS facilities.				x
TC 3B: Public Health Laboratory Testing	CT 1	29	Maintain the ability to test for influenza viruses year-round	x	x	x	x
	CT 2	29	Perform Polymerase Chain Reaction (PCR) testing for rapid detection and subtyping of influenza viruses	x	x	x	x
	CT 3	29	Electronically exchange specimen-level data among clinical laboratories, the state public health lab, and CDC	x	x	x	x
	CT 4	29	Institute surveillance for influenza-like illness (ILI) among laboratory personnel working with novel influenza viruses			x	x
	CT 5	29	Develop and exercise an operational plan to augment the capacity of public health and clinical laboratories to meet the needs of the jurisdiction during an influenza pandemic		x	x	x

	CT 6	29	Assess all public health and clinical laboratory influenza diagnostic testing proficiency and adherence to biosafety containment and biomonitoring protocols at least annually			x	x
	CT 7	29	**Test the knowledge and competency of frontline clinicians and laboratory personnel with regard to:** a) Protocols for safe specimen collection and testing b) How and to whom a potential case of novel influenza should be reported c) Mechanism for submitting specimens to referral laboratories		x	x	x
	CT 8	29	Determine how hospitals and health care systems will use systems and communications tools to report information to public health and response partners with an emphasis on regional hospital coordination			x	x
TC 4A: Communications	CT 1	29	Support exchange of essential information before and during an influenza pandemic. Coordinate procurement and placement of technology communication systems that, based on a gap analysis of requirements versus existing capabilities, are compliant with PHIN Preparedness Functional Area ***Partner Communication and Alerting.***	x	x	x	x
	CT 2	29-30	Have or have access to interoperable information systems that support the initial identification and that provide situational awareness of possible pandemic influenza outbreak in compliance with PHIN Preparedness Functional Area ***Early Event Detection.***		x	x	x
	CT 3	30	Have or have access to interoperable information systems to capture and manage data associated with the investigation and containment of an outbreak (e.g., pandemic influenza) or public health emergency in compliance with PHIN Preparedness Functional Area ***Outbreak Management.***		x	x	x
	CT 4	30	Have or have access to interoperable information systems for electronic exchange of laboratory related information with public health partners (e.g. to support laboratory surveillance and electronic reporting in a pandemic) in compliance with PHIN Preparedness Functional Area ***Connecting Laboratory Systems.***		x	x	x
	CT 5	30	Have or have access to interoperable information systems that comply with PHIN Preparedness Functional Area ***Countermeasure and Response Administration*** to allocate, manage and track measures taken to contain or provide protection against an actual or possible outbreak or event.		x	x	x
	CT 6	30	Have or have access to interoperable information systems that span PHIN functional areas by adhering to standards and specifications for public health system and data architecture requirements (e.g., secure message exchange, terminology standards and public health directory) in compliance with PHIN Preparedness Functional Area ***Cross Functional Components.***		x	x	x
	CT 7	30	Develop plans to address gaps in achieving PHIN certification.	x	x	x	x
TC 5A: Epi. Surveillance & Investigation	CT 1	31	Conduct year-round surveillance for seasonal influenza (e.g. virologic, outpatient visits, hospitalization, and mortality) preferably through the use of electronic reporting	x	x	x	x
	CT 2	31	Assure capacity to implement enhanced surveillance once a pandemic is detected, to ensure recognition of the first cases of pandemic virus infection in time to initiate appropriate containment protocols	x	x	x	x

	CT 3	31	Link animal and human health surveillance systems and routinely share information			x	x
	CT 4	31	**Develop systems to obtain and track numbers and rates of these Outcomes daily during an influenza pandemic on:** a) the numbers of newly hospitalized persons with influenza or pneumonia b) the numbers of newly isolated and quarantined persons, and c) hospitals with pandemic influenza cases d) the number of pneumonia or influenza-associated deaths		x	x	x
TC 6A: Medical Surge	**CT 1**	**31-32**	**Before March 31, 2007, coordinate with the HRSA Bioterrorism coordinator to detail the gaps identified in the HRSA NBHPP program Pandemic Influenza Scenario and a plan for how funds from this Supplement would be used to augment funding provided by the HRSA NBHPP program**		x	x	x
	CT 1a	31-32	In concert with public health partners, ensure that healthcare entities (primary care, community health centers, rural health programs, and hospitals) are a key component in the exercising of state, local and tribal plans that address…		x	x	x
	CT 1b	32	Exercise communication systems, plans and procedures to ensure that hospitals, health care systems and public health inform the community about the operating status of hospitals and the triggers for sending a person to the hospital		x	x	x
	CT 1c	32	Exercise vaccination and prophylaxis plans to cover healthcare staff and patients		x	x	x
	CT 1d	32	Exercise triage and admission plans that would serve to minimize stress on the hospital system and maintain control of the situation		x	x	x
	CT 1e	32	Hospitals and health care systems in conjunction with public health partners identify the location, set-up, staffing and operation of alternate care sites during a pandemic.		x	x	x
	CT 1f	32	Identify how public health, hospitals and healthcare systems will establish systems for healthcare facility level infection control while allowing necessary personnel access to the facility		x	x	x
TC 6B: Isolation and Quarantine	CT 1	32-33	Develop and exercise an operational plan for community mitigation of pandemic influenza using non-pharmacological, including home isolation of patients and quarantine of household contacts, social distancing measures such as closure of schools and workplaces, reduced public transport, and cancellation of mass gatherings, and public education on hygiene measures such as hand and respiratory hygiene.		x	x	x
	CT 2	33	Conduct multiple municipal or regional tabletop exercises regarding the decision-processes associated with school closure and the use of other non-pharmacologic interventions.	x	x	x	x
	CT 3	33	Develop and exercise a plan to communicate to healthcare providers about infection control guidelines and for communication about containment measures at the State, local and tribal level	x	x	x	x
	CT 4	33	Exercise and improve the ability to implement infection control guidelines and public health measures at the State, local and tribal levels		x	x	x

	CT 5	33	**Disseminate information from public health sources on:** a) routine infection control (e.g., hand hygiene, cough/sneeze etiquette) b) pandemic influenza fundamentals (e.g., signs and symptoms of influenza, modes of transmission) c) personal and family protection and response strategies (e.g., guidance for the at-home care of ill students and family members)		x	x	x
	CT 6	33	**Develop and exercise an operational plan for isolation and quarantine that delineates the following:** a) the criteria for isolation and quarantine b) the procedures and legal authorities for implementing and enforcing these containment measures, and c) the methods that will be used to support, service, and monitor those affected by these containment measures in healthcare facilities, other residential facilities, homes, community facilities, and other settings		x	x	x
	CT 7	33	Develop and exercise an operational plan to implement various levels of movement restrictions within, to, and from the jurisdiction			x	x
	CT 8	33	Inform citizens in advance what community mitigation measures may be used in the jurisdiction (e.g. tabletop exercises)			x	x
	CT 9	33	Develop and exercise an operational plan for implementing social distancing measures in a jurisdiction that addresses school and workplace closures and cancellation of public gatherings			x	x
	CT 10	33	Implementation in sub-populations where non-pharmacological interventions may pose particular challenges			x	x
	CT 11	33	Providing support and services to help counteract the secondary impact of such measures			x	x
	CT 12	33	Monitoring compliance with non-pharmacological interventions including tracking persons in quarantine			x	x
TC6C: Mass Prophylaxis	CT 1	34	Describe the receipt, distribution, storage, security, monitoring and administration of pandemic influenza vaccines including plans for limited vaccine availability and prioritization of population groups. Take into account potential for administration of vaccines subject to Investigational New Drug (IND) or Emergency Use Authorization (EUA)		x	x	x
	CT 2	34	Collaborate in mass prophylaxis planning and exercising with community-wide partners, bordering jurisdictions, IHS and tribal nations	x	x	x	x
	CT 3	34	Maintain PHIN compliant information systems for tracking vaccine distribution and administration		x	x	x
TC6D: Emergency Public Information and Warning	CT 1	34	**Exercise communication plans with an emphasis on:** a) coordination with response partners and tribal nations b) rapid provision of public health risk information and recommendations c) addressing stigmatization, rumors and misperceptions in real time d) surge capacity for public information, media operations and spokespersons e) procedures to secure resources to activate the public information and media operation during a public health emergency around the clock if needed for a minimum of 10 days			x	x
	CT 2	34	Prepare supporting materials for public health issues that are unique to an influenza pandemic such as issues of isolation, social distancing, and public health law	x	x	x	x

	CT 3	34	Establish a contact list of additional spokespersons and persons outside the state health department who can be available as subject matter experts on pandemic health issues to respond as surge capacity to meet demands for speakers or interviewees from the media, civic organizations and others			x	x
	CT 4	35	Identify additional and nontraditional vehicles of information dissemination to the public, partners and stakeholders			x	x
TC6F: Community Preparedness and Participation	CT 1a	35	**Develop and exercise a continuity of operations plan for essential department services that includes:** a) contingency planning for increasing public health workforce in response to absenteeism among health department staff and stakeholder groups that have key responsibilities under a community's response plan	x	x	x	x
	CT 1b	35	**Develop and exercise a continuity of operations plan for essential department services that includes:** b) ensuring availability of psychosocial support services (including educational and training materials) for employees who participate in or provide support for the response to public health emergencies such as influenza pandemics	x	x	x	x

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Priority/ Critical Task	CDC Guidance Page	Description of Critical Task or Priority	Worksheet Name	Action #
Priority 1	**10 & 13**	**State and Local Pandemic Influenza Preparedness Assessments/Completion of Phase 1 Critical Tasks**	TC1A,CT1,A21-25	21
	State & Local Phase 1 Gaps to be Addressed under Year 1 of Phase 2			
		(LOCAL GAP) Goal 1 Prevent, TC 1A, CT 10 - Train to and exercise the operational elements of the jurisdictional plan including plan activation, incident command, integration with partner agencies; integration with and assistance to hospitals and healthcare systems particularly regarding surge capacity, assisting persons with special needs, coordination with schools	Phase 1 Misc Gaps, A61-65	61
		(LOCAL GAP) Goal 1 Prevent, TC 1A, CT 10 - Train to and exercise the operational elements of the jurisdictional plan including plan activation, incident command, integration with partner agencies; integration with and assistance to hospitals and healthcare systems particularly regarding surge capacity, assisting persons with special needs, coordination with schools	Phase 1 Misc Gaps, A61-65	62
		(LOCAL GAP) Goal 6 Control, TC 6A - An operational plan for provision of mortuary services during a pandemic has been developed and tested.	Phase 1 Misc Gaps, A61-65	63
		(STATE GAP) TC 3A:CT 4 - Develop an electronic system for rapid reporting of deaths and contributing causes of death (i.e. pneumonia and influenza-related) occurring in the state;	Phase 1 Misc Gaps, A61-65	64
		TBD	Phase 1 Misc Gaps, A61-65	65
		(STATE GAP) TC 3B:CT 6 - Assess all public health and clinical laboratory influenza diagnostic testing proficiency and adherence to biosafety containment and biomonitoring protocols at least annually	TC3B (Phase 1 Gap), A6-10	6
		(STATE GAP) TC 3B:CT 7 - Test the knowledge and competency of frontline clinicians and laboratory personnel with regard to: a) Protocols for safe specimen collection and testing b) How and to whom a potential case of novel influenza should be reported c) Mechanism for submitting specimens to referral laboratories	TC3B (Phase 1 Gap), A6-10	7

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Priority/ Critical Task	CDC Guidance Page	Description of Critical Task or Priority	Worksheet Name	Action #
		(STATE GAP) TC 3B:CT 1 - Maintain the ability to test for influenza viruses year-round	TC3B (Phase 1 Gap), A6-10	8
		(STATE GAP) TC 3B:CT 2 - Perform Polymerase Chain Reaction (PCR) testing for rapid detection and subtyping of influenza viruses	TC3B (Phase 1 Gap), A6-10	9
		(STATE GAP) TC 3B:CT 3 - 3. Electronically exchange specimen-level data among clinical laboratories, the state public health lab, and CDC	TC3B (Phase 1 Gap), A6-10	10
Priority 2	**10-11**	**Pandemic Influenza Exercise Program - Included Under Separate Cover**		
Priority 3	11-12	**Summary Timeline for planned steps to develop the Anti-Viral Drug Distribution plan - Included Under Separate Cover**		
		Antiviral Drug Distribution Plan Development WorkPlan	P3-TC6C,CT1 & TC6C,CT2-3	26
Priority 4	12-13	Statewide Comprehensive Pandemic Influenza Preparedness Plan	TC1A,CT1,A1-5	2
Priority 5	**Table 2 - Crosswalk**	**Communications - See Goal 4/Target Capability 4A**	**SEE BELOW**	**SEE BELOW**
TC1A:CT1	**26**	**Develop, exercise and improve operational plans for pandemic influenza at the state and local level.**	**TC1A,CT1,A1-5**	**1**
		" " "	TC1A,CT1,A1-5	3
		" " "	TC1A,CT1,A1-5	4
		" " "	TC1A,CT1,A1-5	5
		" " "	TC1A,CT1,A21-25	22
		" " "	TC1A,CT1,A21-25	23
		" " "	TC1A,CT1,A21-25	24
		" " "	TC1A,CT1,A21-25	25
TC1A:CT2	27	Formalize agreements that address communication, mutual aid, and other cross-jurisdictional needs with neighboring domestic and/or international jurisdictions sharing an international border with Canada or Mexico (e.g., city-state-tribal collaboration arrangements or city-state-province/state collaboration arrangements)	TC1A,CT2&4,A46-50	46
TC1A:CT4	27	Clarify and communicate to all stakeholders the process for requesting, coordinating, and approving requests for resources to state and federal agencies	TC1A,CT2&4,A46-50	47

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Priority/ Critical Task	CDC Guidance Page	Description of Critical Task or Priority	Worksheet Name	Action #
		TBD	TC1A,CT2&4,A46-50	48
		TBD	TC1A,CT2&4,A46-50	49
		TBD	TC1A,CT2&4,A46-50	50
TC4A:CT1	**29-30**	**Support exchange of essential information before and during an influenza pandemic. Coordinate procurement and placement of technology communication systems that, based on a gap analysis of requirements versus existing capabilities, are compliant with PHIN Preparedness Functional Area Partner Communication and Alerting.**	**TC4A,CT1-3,A106-110**	**106-108**
TC4A:CT2	29-30	Have or have access to interoperable information systems that support the initial identification and that provide situational awareness of possible pandemic influenza outbreak in compliance with PHIN Preparedness Functional Area Early Event Detection.	TC4A,CT1-3,A106-110	109
TC4A:CT3	29-30	Have or have access to interoperable information systems to capture and manage data associated with the investigation and containment of an outbreak (e.g., pandemic influenza) or public health emergency in compliance with PHIN Preparedness Functional Area Outbreak Management.	TC4A,CT1-3,A106-110	110
		Have or have access to interoperable information systems to capture and manage data associated with the investigation and containment of an outbreak (e.g., pandemic influenza) or public health emergency in compliance with PHIN Preparedness Functional Area Outbreak Management.	TC4A,CT3-5,A101-105	101
TC4A:CT4	29-30	Have or have access to interoperable information systems for electronic exchange of laboratory related information with public health partners (e.g. to support laboratory surveillance and electronic reporting in a pandemic) in compliance with PHIN Preparedness Functional Area Connecting Laboratory Systems.	TC4A,CT3-5,A101-105	102 & 103

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Priority/ Critical Task	CDC Guidance Page	Description of Critical Task or Priority	Worksheet Name	Action #
TC4A:CT5	29-30	Have or have access to interoperable information systems that comply with PHIN Preparedness Functional Area Countermeasure and Response Administration to allocate, manage and track measures taken to contain or provide protection against an actual or possible outbreak or event.	TC4A,CT3-5,A101-105	104
		TBD	TC4A,CT3-5,A101-105	105
TC4A:CT6	29-30	Have or have access to interoperable information systems that span PHIN functional areas by adhering to standards and specifications for public health system and data architecture requirements (e.g., secure message exchange, terminology standards and public health directory) in compliance with PHIN Preparedness Functional Area Cross Functional Components.	TC4A,CT6-7,A81-85	81
TC4A:CT7	29-30	Develop plans to address gaps in achieving PHIN certification.	TC4A,CT6-7,A81-85	82-85
TC6A:CT1	**31-32**	**Before March 31, 2007, coordinate with the HRSA Bioterrorism coordinator to detail the gaps identified in the HRSA NBHPP program Pandemic Influenza Scenario and a plan for how funds from this Supplement would be used to augment funding provided by the HRSA NBHPP program**	**N/A**	**N/A**
TC6A:CT1a	31-32	In concert with public health partners, ensure that healthcare entities (primary care, community health centers, rural health programs, and hospitals) are a key component in the exercising of state, local and tribal plans that address...	TC6A,CT1a-c, A11-15	11-13
TC6A:CT1b	32	Exercise communication systems, plans and procedures to ensure that hospitals, health care systems and public health inform the community about the operating status of hospitals and the triggers for sending a person to the hospital	TC6A,CT1a-c, A11-15	14
TC6A:CT1c	32	Exercise vaccination and prophylaxis plans to cover healthcare staff and patients	TC6A,CT1a-c, A11-15	15
TC6A:CT1e	32	Hospitals and health care systems in conjunction with public health partners identify the location, set-up, staffing and operation of alternate care sites during a pandemic.	TC6A,CT1d-f, A36-40	36

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Priority/ Critical Task	CDC Guidance Page	Description of Critical Task or Priority	Worksheet Name	Action #
TC6A:CT1f	32	Identify how public health, hospitals and healthcare systems will establish systems for healthcare facility level infection control while allowing necessary personnel access to the facility	TC6A,CT1d-f, A36-40	37
TC6B:CT1	32-33	Develop and exercise an operational plan for community mitigation of pandemic influenza using non-pharmacological, including home isolation of patients and quarantine of household contacts, social distancing measures such as closure of schools and workplaces, reduced public transport, and cancellation of mass gatherings, and public education on hygiene measures such as hand and respiratory hygiene.	TC6B,CT1&4&6&9, A16-20	16
TC6B:CT4	33	Exercise and improve the ability to implement infection control guidelines and public health measures at the State, local and tribal levels	TC6B,CT1&4&6&9, A16-20	17
TC6B:CT6	33	Develop and exercise an operational plan for isolation and quarantine that delineates the following: a) the criteria for isolation and quarantine b) the procedures and legal authorities for implementing and enforcing these containment measures, and c) the methods that will be used to support, service, and monitor those affected by these containment measures in healthcare facilities, other residential facilities, homes, community facilities, and other settings	TC6B,CT1&4&6&9, A16-20	18
TC6B:CT9	33	Develop and exercise an operational plan for implementing social distancing measures in a jurisdiction that addresses school and workplace closures and cancellation of public gatherings	TC6B,CT1&4&6&9, A16-20	19
		TBD	TC6B,CT1&4&6&9, A16-20	20
TC6C:CT1	34	Describe the receipt, distribution, storage, security, monitoring and administration of pandemic influenza vaccines including plans for limited vaccine availability and prioritization of population groups. Take into account potential for administration of vaccines subject to Investigational New Drug (IND) or Emergency Use Authorization (EUA)	P3-TC6C,CT1 & TC6C,CT2-3	30

TABLE OF CONTENTS & GUIDANCE CROSS REFERENCE

Priority/ Critical Task	CDC Guidance Page	Description of Critical Task or Priority	Worksheet Name	Action #
TC6C:CT2	34	Collaborate in mass prophylaxis planning and exercising with community-wide partners, bordering jurisdictions, IHS and tribal nations	P3-TC6C,CT1 & TC6C,CT2-3	27
TC6C:CT2	34	Collaborate in mass prophylaxis planning and exercising with community-wide partners, bordering jurisdictions, IHS and tribal nations	P3-TC6C,CT1 & TC6C,CT2-3	28
TC6C:CT3	34	Maintain PHIN compliant information systems for tracking vaccine distribution and administration	P3-TC6C,CT1 & TC6C,CT2-3	29

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Priority/ Critical Task	**Action Item**		**Worksheet Name**	**Action #**	**Status as of 08/28/06**
Priority 1	ACTION LINKED TO PRIORITY 1, PHASE 1 CT3:: Analyze and Review Finalized Gap Analysis Project being completed by Contractor, which ISDH is scheduled to receive the day prior to submission of the Phase 2 application		TC1A,CT1,A21-25	21	1 of 1
	State & Local Phase 1 Gaps to be Addressed under Year 1 of Phase 2				
LOCAL GAP	ACTION LINKED TO PRIORITY 1: TC1A:CT10:: Build local capacity to enhance community/public education programs to address Phase 1 primary gaps identifed in local self-assessments.	LG	Phase 1 Misc Gaps, A61-65	61	1 of 1
LOCAL GAP	ACTION LINKED TO PRIORITY 1: TC1A:CT10:: Develop structured Volunteer Management program to assist Local Health Departments throughout the state to recruit, train, credential, and maintain volunteers, in an effort to address Phase 1 primary gaps identified in local self-assessments.	LG	Phase 1 Misc Gaps, A61-65	62	1 of 1
LOCAL GAP	ACTION LINKED TO PRIORITY 1 (LOCAL GAP): TC6A:: Assist local funeral directors, coroners and other preparedness partners in the development and exercising of mass fatalities plans in an effort to address Phase 1 gaps identified in local self-assessments.	LG	Phase 1 Misc Gaps, A61-65	63	0 of 1
STATE GAP	ACTION LINKED TO PRIORITY 1: TC3A:CT4:: The ISDH proposes to acquire a Web-based Electronic Death Certificate (WebEDC) that includes all the functionality necessary to capture, report and store data pertaining to the death event by funeral directors, physicians, medical examiners, coroners and initial contact personnel involved in the registration process.	SG	Phase 1 Misc Gaps, A61-65	64	1 of 1
TBD	0		Phase 1 Misc Gaps, A61-65	65	0

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Priority/ Critical Task	**Action Item**		**Worksheet Name**	**Action #**	**Status as of 08/28/06**
STATE GAP	(PHASE 1 GAP): 3B:CT6:: Select/adapt/develop an online competency-based training for public health & clinical lab staff as an enhancement to the current face-to-face training, which serves as an annual review for staff. This training course will include Modules on: Influenza Diagnostic Testing (virus isolation, flu kits, Do Kits pick up H5N1?), Biosafety Containment (biosafety cabinet, safety reminders, & spills), Bio-monitoring Protocols (incident reporting, fever watch), & a Course Exam	SG	TC3B (Phase 1 Gap), A6-10	6	1 of 1
STATE GAP	(PHASE 1GAP): 3B:CT7:: Select/adapt/develop online competency-based training for public health & clinical lab staff as an enhancement to current face-to-face trainings & which serves as annual review for staff. The course will include Modules on: Sample Collection (swab, body source), Working inside a Biosafety Cabinet, Reportable Diseases, Specimen Collection for Referral Labs (collection, paperwork submission), & Shipping and Packaging of Category A & B Biological Substances, & a Course Exam	SG	TC3B (Phase 1 Gap), A6-10	7	1 of 1
STATE GAP	(PHASE 1GAP): 3B:CT1:: Develop and enhance the laboratory's capability to rapidly detect and subtype influenza viruses.	SG	TC3B (Phase 1 Gap), A6-10	8	1 of 1
STATE GAP	(PHASE 1GAP): 3B:CT2:: Develop and enhance the laboratory's capability to rapidly detect and subtype influenza viruses.	SG	TC3B (Phase 1 Gap), A6-10	9	1 of 1
STATE GAP	(PHASE 1GAP): 3B:CT3:: We are currently implementing the STARLIMS system to support the ISDH labs. STARLIMS is a critical component of our PHIN Certification plan. We need to add a Web developer to the team to provide additional functionality to support both Panflu programs and PHIN Certification.	SG	TC3B (Phase 1 Gap), A6-10	10	1 of 1
Priority 2	**Pandemic Influenza Exercise Program - Included Under Separate Cover**			**COMPLETE**	**COMPLETE**
Priority 3	ACTION LINKED TO PRIORITY 3: 6C:CT1:: To provide anti-virals to the state population, as determined in the state plan, as quickly as possible.		P3-TC6C,CT1 & TC6C,CT2-3	26	1 of 1

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Priority/ Critical Task	**Action Item**		**Worksheet Name**	**Action #**	**Status as of 08/28/06**
Priority 4	ACTION LINKED TO PRIORITY 1 & 4: 1A:CT1:: Revise & Update the State Department of Health Pandemic Influenza Preparedness Plan as needed based on exercises, lessons learned, after action reports, as well as additional Federal and State guidance.		TC1A,CT1,A1-5	2	1 of 1
Priority 5	**Communications - See Goal 4/Target Capability 4A**		**SEE BELOW**	**SEE BELOW**	**SEE BELOW**
TC1A:CT1	ACTION LINKED TO 1A:CT1a:: The Indiana Pandemic Plan must be compliant with the National Incident Management System (NIMS) which includes the Incident Command System (ICS).		TC1A,CT1,A1-5	1	1 of 1
TC1A:CT1	ACTION LINKED TO 1A:CT1:: Review, Revise & Update Local Health Department Pandemic Influenza operational plans as needed pending lessons learned from Exercise AARs as well as additional state and federal guidance		TC1A,CT1,A1-5	3	1 of 1
TC1A:CT1	ACTION LINKED TO 1A:CT1:: The Indiana State Department of Health will collaborate with the Indiana University Center for Bioethics to develop a Community Advisory Group to provide technical assistance and guidance on ethical and policy issue in order to exercise and improve operational plans for pandemic influenza at the state and local level.		TC1A,CT1,A1-5	4	1 of 1
TC1A:CT1	ACTION LINKED TO 1A:CT1:: The Indiana State Department of Health will collaborate with the Indiana University Center for Bioethics to develop and exercise an ethical framework for decision making in order to improve operational plans for pandemic influenza on the state and local level.		TC1A,CT1,A1-5	5	1 of 1
TC1A:CT1	ACTION LINKED TO 1A:CT1:: Complete, Exercise & Revise Statewide Comprehensive Pandemic Influenza operational plan as needed pending lessons learned from exercise after action reports, or additional federal guidance		TC1A,CT1,A21-25	22	1 of 1

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Priority/ Critical Task	**Action Item**	**Worksheet Name**	**Action #**	**Status as of 08/28/06**
TC1A:CT1	ACTION LINKED TO 1A:CT1:: The Indiana State Department of Health with collaborate with the Indiana University Center for Bioethics to develop a guidance document on ethical decision making and policy issues for local health departments and hospitals and conduct district training sessions on its use in order to improve operational plans for pandemic influenza at the district and local level.	TC1A,CT1,A21-25	23	1 of 1
TC1A:CT1	ACTION LINKED TO 1A:CT1:: The Indiana State Department of Health with collaborate with the Indiana University Center for Bioethics to develop and facilitate 10 district exercises on ethical decision making and policy issues in order to improve operational plans for pandemic influenza at the district and local level.	TC1A,CT1,A21-25	24	1 of 1
TC1A:CT1	ACTION LINKED TO 1A:CT1:: The Indiana State Department of Health with collaborate with the Indiana University Center for Bioethics to facilitate 10 district exercises on ethical decision making and policy issues in order to re-test and improve operational plans for pandemic influenza at the district and local level.	TC1A,CT1,A21-25	25	1 of 1
TC1A:CT2	ACTION LINKED TO 1A:CT2:: Attend Cross-border conferences and meetings	TC1A,CT2&4,A46-50	46	1 of 1
TC1A:CT4	ACTION LINKED TO 1A:CT4:: Develop & Disseminate a procedure for requesting resources from the state and federal agencies.	TC1A,CT2&4,A46-50	47	1 of 1
TC4A:CT1	ACTION LINKED TO PRIORITY 5: 4A:CT1:: Develop Webinar capabilities to provide training and communication in the event of an incident.	TC4A,CT1-3,A106-110	106	**1 of 1**
TC4A:CT1	ACTION LINKED TO PRIORITY 5: 4A:CT1:: As part of our Disaster Recovery (DR) site we have eastablished a recovery area. This recovery area serves as a backup operations center. We need to upgrade our connectivity.	TC4A,CT1-3,A106-110	107	**1 of 1**
TC4A:CT1	ACTION LINKED TO PRIORITY 5: 4A:CT1:: We need to replace our current system for surveys with a canned application.	TC4A,CT1-3,A106-110	108	**1 of 1**

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Priority/ Critical Task	**Action Item**		**Worksheet Name**	**Action #**	**Status as of 08/28/06**
TC4A:CT2	ACTION LINKED TO 4A:CT2:: We currently have some EED capabilities with an internally developed system called PHESS. It does not contain all the capabilities that we need to become PHION compliant. We made the system to implement a NEDSS system. NEDSS is currently work-in-progress and we need to accelerate the implementation of it. Part of the implementation of NEDSS includes insuring it is PHIN compliant.		TC4A,CT1-3,A106-110	109	1 of 1
TC4A:CT3	ACTION LINKED TO 4A:CT3:: Make the Outbreak Management System (OMS) PHIN compliant.		TC4A,CT1-3,A106-110	110	1 of 1
TC4A:CT3	ACTION LINKED TO 4A:CT3:: We are establishing a credentialing system to support our Outbreak Management System and other POD activities. We have eleven component systems that we will use to capture data and need PCs to drive the credentialing system..		TC4A,CT3-5,A101-105	101	1 of 1
TC4A:CT4	ACTION LINKED TO 4A:CT4:: Have a developer make changes to the ISDH Web page to support the labs new STARLIMS system.		TC4A,CT3-5,A101-105	102	1 of 1
TC4A:CT4	ACTION LINKED TO 4A:CT4:: We are currently implementing the STARLIMS system to support the ISDH labs. STARLIMS is a critical component of our PHIN Certification plan. We need to add a Web developer to the team to provide additional functionality to support both pan flu programs and PHIN Certification.		TC4A,CT3-5,A101-105	103	1 of 1
TC4A:CT5	ACTION LINKED TO 4A:CT5:: We need to track medication given at a Point of Dispensing (POD). In addition to needing the information for ISDH purposes, this is part of our Countermasure Resonse Administration (CRA) PHIN Certification plan.		TC4A,CT3-5,A101-105	104	1 of 1
TC4A:CT6	ACTION LINKED TO 4A:CT6:: Provide a person to oversee PHIN MS development and implementation activities.		TC4A,CT6-7,A81-85	81	1 of 1
TC4A:CT7	ACTION LINKED TO 4A:CT7:: Add a project manager to coordinate PHIN certification activities between the six functional areas.		TC4A,CT6-7,A81-85	82	1 of 1

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Priority/ Critical Task	**Action Item**	**Worksheet Name**	**Action #**	**Status as of 08/28/06**
TC4A:CT7	ACTION LINKED TO 4A:CT7:: As part of PHIN Certification we need to be able to pass data between systems in the six functional certification areas. We need a developer to establish an interface approach and provide access to the data to the various systems.	TC4A,CT6-7,A81-85	83	1 of 1
TC4A:CT7	ACTION LINKED TO 4A:CT7:: We need to purchase seven copies of Visual Studio and Source Safe to support increased development staff.	TC4A,CT6-7,A81-85	84	1 of 1
TC4A:CT7	ACTION LINKED TO 4A:CT7:: Upgrade technical support / development equipment used for PHIN Certification and related applications..	TC4A,CT6-7,A81-85	85	1 of 1
TC6A:CT1	**SEE BELOW**	**N/A**	**N/A**	**SEE BELOW**
TC6A:CT1a	ACTION LINKED TO 6A:CT1a,i.,ii.,iii., & v.:: In concert with public health partners, ensure that healthcare entities are a key component in the exerising of state/local plans that address: Maintenance of essential hospital support functions; Severe shortages of health care workers; Adequate personnel & staffing needs based on CDC's FluSurge software; Ensuring real-time situational awareness of patient visits, hospital bed & intensive care needs, medical supply needs & medical staffing needs.	TC6A,CT1a-c, A11-15	11	1 of 1
TC6A:CT1a	ACTION LINKED TO 6A:CT1a,iv.:: We need to improve the capabilities of hospitals and Local Health Departmetns in using the ESAR-VHP volunteer program.	TC6A,CT1a-c, A11-15	12	1 of 1
TC6A:CT1a	ACTION LINKED TO 6A:CT1a,vi.:: In concert with public health partners, ensure that healthcare entities are a key component in the exercising of state and local plans that address the purchase and storage of beds, equipment, supplies, and pharmaceuticals needed to treat influenza patients.	TC6A,CT1a-c, A11-15	13	1 of 1
TC6A:CT1b	ACTION LINKED TO 6A:CT1b:: Exercise communication systems, plans and procedures to ensure that hospitals, health care systems and public health care systems and public health inform the community about the operating status of hospitals and the triggers for sending a person to the hospital.	TC6A,CT1a-c, A11-15	14	1 of 1

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Priority/ Critical Task	Action Item		Worksheet Name	Action #	Status as of 08/28/06
TC6A:CT1c	ACTION LINKED TO 6A:CT1c:: Exercise vaccination and prophylaxis plans to cover healthcare staff and patients.		TC6A,CT1a-c, A11-15	15	1 of 1
TC6A:CT1e	ACTION LINKED TO 6A:CT1e & LOCAL GAP:: Identify the location, set-up, staffing and operation of alternate care sites during a pandemic.	LG	TC6A,CT1d-f, A36-40	36	1 of 1
TC6A:CT1f	ACTION LINKED TO 6A:CT1f:: f) Identify how public health, hospitals and healthcare systems will establish systems for healthcare facility level infection control while allowing necessary personnel access to the facility.		TC6A,CT1d-f, A36-40	37	1 of 1
TC6B:CT1	ACTION LINKED TO PRIORITY 2:i., 6B:CT1:: Utilize the Community Containment Plan and Statewide Pandemic Influenza Exercise to exercise operational plans for community mitigation of pandemic influenza using non-pharmacological interventions.		TC6B,CT1&4&6&9, A16-20	16	1 of 1
TC6B:CT4	ACTION LINKED TO CT 4: Conduct Indiana Health Alert Network exercise to improve the ability to implement infection control guidelines and public health measures.		TC6B,CT1&4&6&9, A16-20	17	1 of 1
TC6B:CT6	ACTION LINKED TO 6B:CT6:: Utilize the Hoosier Guardian Statewide Exercise to test operational plans for isolation and quarantine.		TC6B,CT1&4&6&9, A16-20	18	1 of 1
TC6B:CT9	ACTION LINKED TO 6B:CT9:: Utilize the Community Containment Plan and the Statewide Pandemic Influenza Exercise to exercise operational plans for implementing social distancing measures in a jurisdiction that addresses school and workplace closures and cancellation of public gatherings		TC6B,CT1&4&6&9, A16-20	19	1 of 1
TC6C:CT1	In conjunction with the CDC SNS RSS SOP vaccines will be received, stored, staged and distributed in a similar manor to the 12 Hour Push Package.		P3-TC6C,CT1 & TC6C,CT2-3	30	1 of 1
TC6C:CT2	ACTION LINKED TO PRIORITY 2:iii., 6C:CT2:: Exercise mass vaccination capabilites, including PODs, in three urban and two rural Local Health Departments (LHDs) in conjunction with seasonal influenza vaccination clinics.		P3-TC6C,CT1 & TC6C,CT2-3	27	1 of 1

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Priority/ Critical Task	**Action Item**		**Worksheet Name**	**Action #**	**Status as of 08/28/06**
TC6C:CT2	ACTION LINKED TO 6C:CT2:: Develop an online Pan Flu Simulation Exercise which functions as a drill, in accordance with HSEEP standards to be used within the Indiana Learning/Content Management System (ILCMS)		P3-TC6C,CT1 & TC6C,CT2-3	28	**1 of 1**
TC6C:CT3	ACTION LINKED TO 6C:CT3:: We have an application that provides vaccine management information. However, it is not PHIN complaint and does not meet all of our needs. As a part of our CRA certification efforts we determined the gaps we have in vaccine management. We are requesting a contractor to determine the best approach for achieving PHIN Certification and then implement that approach.		P3-TC6C,CT1 & TC6C,CT2-3	29	1 of 1
TC6C:CT2	ACTION LINKED TO PRIORITY 2:iii., 6C:CT2:: Exercise mass vaccination capabilites, including PODs, in three urban and two rural Local Health Departments (LHDs) in conjunction with seasonal influenza vaccination clinics.		P3-TC6C,CT1 & TC6C,CT2-3	27	1 of 1
TC6C:CT2	ACTION LINKED TO 6C:CT2:: Develop an online Pan Flu Simulation Exercise which functions as a drill, in accordance with HSEEP standards to be used within the Indiana Learning/Content Management System (ILCMS)		P3-TC6C,CT1 & TC6C,CT2-3	28	1 of 1
TC6C:CT3	ACTION LINKED TO 6C:CT3:: We have an application that provides vaccine management information. However, it is not PHIN complaint and does not meet all of our needs. As a part of our CRA certification efforts we determined the gaps we have in vaccine management. We are requesting a contractor to determine the best approach for achieving PHIN Certification and then implement that approach.		P3-TC6C,CT1 & TC6C,CT2-3	29	1 of 1

Action Item 61	Work Plan Template for Pandemic Flu Guidance Grantees should fill out a separate template for each Action Item
Grantee Input	
	Goal:
Pull Down Menu	**Pandemic Influenza Preparedness Goal 1: PREVENT**
	Increase the use and development of clinical, non-pharmaceutical, and risk communications interventions known to minimize the spread of influenza.
	Target Capability:
Pull Down Menu	**1A Target Capability: Planning**
	(links to HHS State and Local Pandemic Influenza Planning Checklist, Community Preparedness, Leadership and Networking)
	Associated CDC Performance Measure:
Pull Down Menu	#N/A
	Critical Task:
Pull Down Menu	Train to and exercise the operational elements of the jurisdictional .
	Action Item: The program efforts conducted to achieve the critical tasks that result in the creation of a product or service.
Fill In Box	ACTION LINKED TO PRIORITY 1: TC1A:CT10:: Build local capacity to enhance community/public education programs to address Phase 1 prima
	Description
Fill In Box	What: PURPOSE OF THE ACTION ITEM: Provide mechanism to build local capacity for Public Education programs on Pandemic Influenza preparedness and response by identifying and assigning at least one state level staff member to develop, coordinate, and monitor a Pan Flu "Train-the-Trainer" Program to increase the number of local educators available to provide pan flu education programs to schools, businesses, faith-based organizations; community organizations, preparedness partners, etc. Increasing demand for local public education programs requires a pool of trained community educators to efficiently and effectively meet this need. Partner organizations and programs will be identified; public education tool kits and other materials will be identified and/or developed; a "Train-the-Trainer" curriculum will be developed and implemented, and the utilization of the trained community educators will be tracked and evaluated.
Fill In Box	Who: TARGET AUDIENCE: Local, district, and regional preparedness personnel throughout the state; local faith-based organizations; community-based organizations; professional and business associations; civic organizations; parent-teacher associations; cooperative extension offices; volunteer organizations; health care organizations; and others to be determined as appropriate.
Fill In Box	STAKEHOLDERS CRITICAL TO SUCCESS: Local health departments across the state with coordination assistance from preparedness partners such as state Homeland Security personnel; local Emergency Management Agencies; local health care providers; regional educational programs such as MAPHTC and UIC; and organizations identified as potential target audiences.
Fill In Box	WHO IS RESPONSIBLE FOR OUTPUTS: State and local health departments, and targeted partner organizations across the state.
Fill In Box	When: TIME PERIOD OF PROJECT: 08/31/06 - 08/30/07
Fill In Box	Where: VENUE: Public and community education programs will be offered in schools, churches, community centers, health care facilities, and businesses as appropriate.
Fill In Box	LOCATION: Communities in all 92 Indiana counties
Fill In Box	Why: WHAT EVIDENCE DO YOU HAVE TO SUPPORT THE PROPOSED INTERVENTION/COURSE OF ACTION/OUTCOME FOR THIS ACTION ITEM?: Gap Analysis of LHD Self-Assesments revealed a significant need for additional assistance to provide local-level public education programs It is more effective and cost-efficient to expand local capacity to assist the LHDs meet the increasing demand for education programs than to utilize a small pool of available state level staff to travel statewide to present in local communities
Fill In Box	WHAT IS THE CAPACITY OF THE RECIPIENT TO DEAL WITH THIS PROBLEM/OPPORTUNITY?: Collaboration between state and local public health departments and the identified partner organizations, in conjunction with preparedness stakeholders will ensure adequate capacity for executing public education programs.

Fill In Box		WHY DOES THIS ACTION ITEM DESERVE THE RECIPIENTS ATTENTION NOW?: This is an identified gap that needs immediate attention to have a successful pandemic influenza operation.
Fill In Box		SUMMARY: This is a crucial part of the pre-event planning and execution and its success or failure will greatly effect the ability to execute successfully our pandemic influenza plan.
	Success Factors for Action Item	
Fill In Box	Outputs	WHAT DOES THIS PRODUCE?: Increased numbers of trained local educators to provide community education programs.
Fill In Box	Output Performance Measure	MEASURE OF QUANTITY/QUALITY: To have participation by partner organizations; to have an effective "Train-the-Trainer Program in place; and to have structured local public health edcuation programs in place by 8/30/07.
Fill In Box	Output Target	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM WILL ACCOMPLISH A PERFORMANCE MEASURE: For 90% of the local Health Departments to have a public education program by 8/30/07.
Fill In Box	Immediate Outcome*	DESCRIBE THE INTENDED RESULT:
Fill In Box	Immediate Outcome Performance Measure*	IMMEDIATE OUTCOME EFFECTIVENESS:
Fill In Box	Outcome Target*	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM MUST ACCOMPLISH A PERFORMANCE MEASURE:
	Progress Report- To be Reported Mid Year and End of Year	
Fill In Box	Progress Report-Outputs	PROVIDE QUANTIFIABLE EXTENT THAT OUTPUTS HAVE BEEN ACHIEVED:
Fill In Box	Progress Report-Barriers	BRIEFLY EXPLAIN BARRIERS/PROBLEMS FACED IN ACHIEVING THE TARGET OUTPUT:

Note: *Grantees only need to report on Outputs, Output Performance Measures and Output Targets. They are not required to report Immediate Outcomes, Outcome Performance Measures and Outcome Targets.

Action Item 62	Work Plan Template for Pandemic Flu Guidance Grantees should fill out a separate template for each Action Item
Grantee Input	
	Goal:
Pull Down Menu	**Pandemic Influenza Preparedness Goal 1: PREVENT**
	Increase the use and development of clinical, non-pharmaceutical, and risk communications interventions known to minimize the spread of influenza.
	Target Capability:
Pull Down Menu	**1A Target Capability: Planning**
	(links to HHS State and Local Pandemic Influenza Planning Checklist, Community Preparedness, Leadership and Networking)
	Associated CDC Performance Measure:
Pull Down Menu	Adequacy of State and local plans to receive and dispense medical countermeasures as demonstrated through assessment by the Strategic National Stockpile/Cities Readiness Initiative (CRI)
	Critical Task:
Pull Down Menu	Train to and exercise the operational elements of the jurisdictional .
	Action Item: The program efforts conducted to achieve the critical tasks that result in the creation of a product or service.
Fill In Box	ACTION LINKED TO PRIORITY 1: TC1A:CT10:: Develop structured Volunteer Management program to assist Local Health Departments through
	Description
Fill In Box	What: PURPOSE OF THE ACTION ITEM: Provide financial assistance to the LHDs in the form of mini-grants for the development and testing of pilot/demonstration projects for volunteer management. Upon completion of the demonstration period, successful strategies will be identified as best practice models and replicated as appropriate in other jurisdictions. This will ensure the availability of an adequate number of trained volunteers to support Point of Distribution (POD) site, as well as alternate treatment center, activities at the local level.
Fill In Box	Who: TARGET AUDIENCE: Local level preparedness personnel throughout the state of Indiana.
Fill In Box	STAKEHOLDERS CRITICAL TO SUCCESS: Selected local preparedness personnel, in coordination with identified partner organizations.
Fill In Box	WHO IS RESPONSIBLE FOR OUTPUTS: State and local preparedness personnel
Fill In Box	When: TIME PERIOD OF PROJECT: 08/31/06 - 08/30/07
Fill In Box	Where: VENUE: 5-10 selected Local Public Health jurisdictions throughout Indiana (pending submission of acceptable min-grant proposal to develop and test a pilot or demonstration project and the availability of funds to be awarded for this purpose.
Fill In Box	LOCATION: Selected local public health jurisdictions across the state.
Fill In Box	Why: WHAT EVIDENCE DO YOU HAVE TO SUPPORT THE PROPOSED INTERVENTION/COURSE OF ACTION/OUTCOME FOR THIS ACTION ITEM?: Gap Analysis of Local Health Department Self-Assessments revealed significant need for additional resources and assistance to develop adequate rosters of qualified and trained volunteers.
Fill In Box	WHAT IS THE CAPACITY OF THE RECIPIENT TO DEAL WITH THIS PROBLEM/OPPORTUNITY?: Local preparedness personnal have been developing pools of potential volunteers and providing limited training for the past 1-2 years. The identification of successful volunteer management strategies will enhance recruitment, credentialing, trainiing, and retention of volunteers.

Fill In Box		WHY DOES THIS ACTION ITEM DESERVE THE RECIPIENTS ATTENTION NOW?: The issue has been identified in our local gap analysis and in AARs from exercises we have completed. Virtually every public health jurisdiction has expressed concerns about the availability and preparedness of adequate numbers of volunteers and the effects o successful mass prophylaxis efforts without a strong volunteer management program.
Fill In Box		SUMMARY: This is a critical piece to the development of the Local Health Departments ability to execute their pandemic influenza plans.
	Success Factors for Action Item	
Fill In Box	Outputs	WHAT DOES THIS PRODUCE?: A selection of demonstrated volunteer management strategies or programs.
Fill In Box	Output Performance Measure	MEASURE OF QUANTITY/QUALITY: A selection of programs for volunteer management suitable for replication by 8/30/07.
Fill In Box	Output Target	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM WILL ACCOMPLISH A PERFORMANCE MEASURE: 90% of the local health departments will have a volunteer management plan by 8/30/07.
Fill In Box	Immediate Outcome*	DESCRIBE THE INTENDED RESULT:
Fill In Box	Immediate Outcome Performance Measure*	IMMEDIATE OUTCOME EFFECTIVENESS:
Fill In Box	Outcome Target*	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM MUST ACCOMPLISH A PERFORMANCE MEASURE:
	Progress Report- To be Reported Mid Year and End of Year	
Fill In Box	Progress Report-Outputs	PROVIDE QUANTIFIABLE EXTENT THAT OUTPUTS HAVE BEEN ACHIEVED:
Fill In Box	Progress Report-Barriers	BRIEFLY EXPLAIN BARRIERS/PROBLEMS FACED IN ACHIEVING THE TARGET OUTPUT:

Note: *Grantees only need to report on Outputs, Output Performance Measures and Output Targets. They are not required to report Immediate Outcomes, Outcome Performance Measures and Outcome Targets.

Action Item 63	Work Plan Template for Pandemic Flu Guidance Grantees should fill out a separate template for each Action Item
Grantee Input	
	Goal:
Pull Down Menu	**Pandemic Influenza Preparedness Goal 6: CONTROL**
	Decrease the time needed to implement rapid outbreak response actions and provide other countermeasures, including personnel, risk communications, and health interventions and guidance to those at risk of pandemic influenza
	Target Capability:
Pull Down Menu	**6A Target Capability: Medical Surge**
	(link to HHS State and Local Pandemic Influenza Planning Checklist, Healthcare and Public Health Partners)
	Associated CDC Performance Measure:
Pull Down Menu	#N/A
	Critical Task:
Pull Down Menu	
	Action Item: The program efforts conducted to achieve the critical tasks that result in the creation of a product or service.
Fill In Box	ACTION LINKED TO PRIORITY 1 (LOCAL GAP): TC6A:: Assist local funeral directors, coroners and other preparedness partners in the developr
	Description
Fill In Box	What: PURPOSE OF THE ACTION ITEM: An overall lack of mass fatalities planning at the local level was identified as a significant gap in the self-assessments. While the LHDs do not have the lead responsibility for developing such plans, LHD staff is expected to coordinate and assist local preparedness partners, as approriate, in the development of the plans, and to participate in joint exercises to test components of the plans. ISDH will coordinate with preparedness partners at the state level to provide technical assistance and other guidance to the local preparedness partners.
Fill In Box	Who: TARGET AUDIENCE: Local preparedness partners
Fill In Box	STAKEHOLDERS CRITICAL TO SUCCESS: ISDH, the IN Department of Homeland Security, and other state level agencies and programs as appropriate; local EMAs, public health departments, funeral directors, coroners, hospitals and other preparedness stakeholders.
Fill In Box	WHO IS RESPONSIBLE FOR OUTPUTS: Local EMAs will be responsible for ensuring that coordinated mass fatalities plans are developed and exercised within their jurisdictions. State and local health department staff will ensure that guidance and assistance on public health aspects of the mass fatalities plans is provided as appropriate.
Fill In Box	When: TIME PERIOD OF PROJECT: 8/31/06 - 8/30/07
Fill In Box	Where: VENUE: Local funeral homes, mortuaries, hospitals, and other locations as appropriate.
Fill In Box	LOCATION: Statewide in local jurisdictions.
Fill In Box	Why: WHAT EVIDENCE DO YOU HAVE TO SUPPORT THE PROPOSED INTERVENTION/COURSE OF ACTION/OUTCOME FOR THIS ACTION ITEM?:
Fill In Box	WHAT IS THE CAPACITY OF THE RECIPIENT TO DEAL WITH THIS PROBLEM/OPPORTUNITY?: Local funeral directors and coroners are becoming increasingly aware of the need for coordinated planning to accommodate large numbers of fatalities, and have begun to consider strategies to meet anticipated needs. Many are beginning to participate in local or district preparedness meetings and have begun to educate members of their disciplines on the need for coordinated planning.

Fill In Box		WHY DOES THIS ACTION ITEM DESERVE THE RECIPIENTS ATTENTION NOW?: Very little has been done at this point to ensure participation of appropriate stakeholders in coordinated planning activities.
Fill In Box		SUMMARY: The provision of guidance and technical assistance by state level public health and emergency response partners to the local jurisdictions will result in the coordinated development of mass fatalities plans, and opportunties to exercise and refinet those plans.
	Success Factors for Action Item	
Fill In Box	Outputs	WHAT DOES THIS PRODUCE?: Coordinated Mass Fatalities Plans for local jurisdictions.
Fill In Box	Output Performance Measure	MEASURE OF QUANTITY/QUALITY: Number of jurisdictions statewide with developed and exercised mass fatalities plans.
Fill In Box	Output Target	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM WILL ACCOMPLISH A PERFORMANCE MEASURE: 90 local jurisdictions will have mass fatalities plans.
Fill In Box	Immediate Outcome*	DESCRIBE THE INTENDED RESULT:
Fill In Box	Immediate Outcome Performance Measure*	IMMEDIATE OUTCOME EFFECTIVENESS:
Fill In Box	Outcome Target*	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM MUST ACCOMPLISH A PERFORMANCE MEASURE:
	Progress Report- To be Reported Mid Year and End of Year	
Fill In Box	Progress Report-Outputs	PROVIDE QUANTIFIABLE EXTENT THAT OUTPUTS HAVE BEEN ACHIEVED:
Fill In Box	Progress Report-Barriers	BRIEFLY EXPLAIN BARRIERS/PROBLEMS FACED IN ACHIEVING THE TARGET OUTPUT:

Note: *Grantees only need to report on Outputs, Output Performance Measures and Output Targets. They are not required to report Immediate Outcomes, Outcome Performance Measures and Outcome Targets.

Action Item 64	Work Plan Template for Pandemic Flu Guidance Grantees should fill out a separate template for each Action Item
Grantee Input	
	Goal:
Pull Down Menu	**Pandemic Influenza Preparedness Goal 3: DETECT AND REPORT**
	Decrease the time needed to detect and report an influenza outbreak with pandemic potential.
	Target Capability:
Pull Down Menu	**3A Target Capability: Epidemiological Surveillance and Investigation**
	(links to HHS State and Local Pandemic Influenza Planning Checklist, Surveillance)
	Associated CDC Performance Measure:
Pull Down Menu	
	Critical Task:
Pull Down Menu	Develop an electronic system for rapid reporting of deaths and contributing causes of death (i.e. pneumonia and influenza-related)
	Action Item: The program efforts conducted to achieve the critical tasks that result in the creation of a product or service.
Fill In Box	ACTION LINKED TO PRIORITY 1: TC3A:CT4:: The ISDH proposes to acquire a Web-based Electronic Death Certificate (WebEDC) that includes
	Description
Fill In Box	What: PURPOSE OF THE ACTION ITEM: The proposed computer application includes the ability for the funeral director, coroner, medical examiner, hospitals, nursing homes and/or physician to enter death registration information directly into the system when connected via a secure Web connection. This will facilitate timely reporting of deaths for epidemiologic and program purposes.
Fill In Box	Who: TARGET AUDIENCE: The electronic death reporting system will facilitate death reporting by funeral directors, coroners, medical examiners, hospitals, physicians, nursing facilities, and others who report deaths.
Fill In Box	STAKEHOLDERS CRITICAL TO SUCCESS: Funeral directors, coroners, medical examiners, hospitals, nursing homes and/or physicians, local health departments, and others who report death data to the Indiana State Department of Health
Fill In Box	WHO IS RESPONSIBLE FOR OUTPUTS: The Indiana State Department of Health Vital Records Division for implementation of the system and receipt and maintenance of death records and the ISDH Epidemiology Resource Center for analysis of data.
Fill In Box	When: TIME PERIOD OF PROJECT: 10/2006 to 09/2007
Fill In Box	Where: VENUE: Deaths are reported by funeral directors, coroners, medical examiners, hospitals, nursing homes, physicians, and local health departments. The local health departments submit death data to the Indiana State Department of Health.
Fill In Box	LOCATION: Death data are reported in the local public health jurisdiction where the death occurred. There are 94 local health jurisdictions in Indiana. Local health departments submit death data to the Indiana State Department of Health
Fill In Box	Why: WHAT EVIDENCE DO YOU HAVE TO SUPPORT THE PROPOSED INTERVENTION/COURSE OF ACTION/OUTCOME FOR THIS ACTION ITEM?: Electronic reporting of birth data in Indiana has reduced the time between the event and the recording of data about the event and reduced errors in the data. This principle will apply to death data reporting. Other states have implemented electronic death reportings systems and seen reduced time between the occurrence and reporting of death data to support epidemiologic analysis.
Fill In Box	WHAT IS THE CAPACITY OF THE RECIPIENT TO DEAL WITH THIS PROBLEM/OPPORTUNITY?: he ISDH Vital Records Division has worked with local health departments and ISDH epidemiologists to assess the need for electronic death reporting. The ISDH Vital Records staff along with the vendor identified for the project have sufficient capacity to implement the electronic death reporting system.

Fill In Box		WHY DOES THIS ACTION ITEM DESERVE THE RECIPIENTS ATTENTION NOW?: The need to reduce the time between the occurrence of a death and the availability of the data to support epidemiologic purposes has been identified as a gap. The current paper-based system is slow and subject to more data errors than an electronic system that facilitates data reporting and accuracy.
Fill In Box		SUMMARY: This investment will support the timely recording of deaths including causes during an emergency response situation whether intentional or naturally occurring. Timely reporting of deaths and causes is an important step in assessing the nature of the event and impact measured in lives lost by location.
	Success Factors for Action Item	
Fill In Box	Outputs	WHAT DOES THIS PRODUCE?: This project will result in an integrated, statewide, electronic system for the timely accurate reporting of death data.
Fill In Box	Output Performance Measure	MEASURE OF QUANTITY/QUALITY: The electronic death reporting system, when fully implemented, will enable local health departments and the Indiana State Department of Health to receive and analyze death data as soon as the first reporter enters data into the system rather than waiting for a paper copy of the death data. The system will also reduce data errors by providing drop-down menus of code options.
Fill In Box	Output Target	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM WILL ACCOMPLISH A PERFORMANCE MEASURE: The target is to reduce the number of days between a death occurring and the data being available for analysis from over 60 days to within five days of the event occurring during normal operations and immediately during emergency situations.
Fill In Box	Immediate Outcome*	DESCRIBE THE INTENDED RESULT:
Fill In Box	Immediate Outcome Performance Measure*	IMMEDIATE OUTCOME EFFECTIVENESS:
Fill In Box	Outcome Target*	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM MUST ACCOMPLISH A PERFORMANCE MEASURE:
	Progress Report- To be Reported Mid Year and End of Year	
Fill In Box	Progress Report-Outputs	PROVIDE QUANTIFIABLE EXTENT THAT OUTPUTS HAVE BEEN ACHIEVED:
Fill In Box	Progress Report-Barriers	BRIEFLY EXPLAIN BARRIERS/PROBLEMS FACED IN ACHIEVING THE TARGET OUTPUT:

Note: *Grantees only need to report on Outputs, Output Performance Measures and Output Targets. They are not required to report Immediate Outcomes, Outcome Performance Measures and Outcome Targets.

Action Item 1	Work Plan Template for Pandemic Flu Guidance Grantees should fill out a separate template for each Action Item
Grantee Input	
	Goal:
Pull Down Menu	**Pandemic Influenza Preparedness Goal 1: PREVENT**
	Increase the use and development of clinical, non-pharmaceutical, and risk communications interventions known to minimize the spread of influenza.
	Target Capability:
Pull Down Menu	**1A Target Capability: Planning**
	(links to HHS State and Local Pandemic Influenza Planning Checklist, Community Preparedness, Leadership and Networking)
	Associated CDC Performance Measure:
Pull Down Menu	
	Critical Task:
Pull Down Menu	Develop, exercise and improve operational plans for pandemic influenza at the state and local level.
	Action Item: The program efforts conducted to achieve the critical tasks that result in the creation of a product or service.
Fill In Box	ACTION LINKED TO 1A:CT1a:: The Indiana Pandemic Plan must be compliant with the National Incident Management System (NIMS) which inc
	Description
	What
Fill In Box	PURPOSE OF THE ACTION ITEM: The public health ICS should be understood by all potential persons called to respond or assist in a pandemic. Familiarity and understanding of the functions of the ICS will be critical in a response. Those called to respond will, at a minimum have completed the NIMS IS 100 and 700 course.
	Who
Fill In Box	TARGET AUDIENCE: The ICS requirements will affect State, Local, and volunteer persons called upon to respond. The primary and secondary staff have been identified for core funtional roles delinated in the ICS for Public Health. This action item is complete and is located in an appendix B of the Indiana Pandemic Influenza Plan.
Fill In Box	STAKEHOLDERS CRITICAL TO SUCCESS: The stakeholders who are critical to the succes of the project and are in the best position to contribute to the solution are the Indiana State Department of Health and the Indiana Department of Homeland Security
Fill In Box	WHO IS RESPONSIBLE FOR OUTPUTS: The Public Health Preparedness Emergency Response Divison is the responsible for the outputs.
	When
Fill In Box	TIME PERIOD OF PROJECT: 08/31/2006 to 08/30/2007
	Where
Fill In Box	VENUE: The IS 700 and 100 courses are available online in several locations. The locations in which one could access the required courses are available through the online resources of the Indiana Learning Content Mannagment System available through the Indiana State Department of Health and the FEMA website.
Fill In Box	LOCATION: Statewide
	Why
Fill In Box	WHAT EVIDENCE DO YOU HAVE TO SUPPORT THE PROPOSED INTERVENTION/COURSE OF ACTION/OUTCOME FOR THIS ACTION ITEM?: An influenza pandemic may require the activation of the National Response Plan. The Dept. of Homeland Security, in collaboration with the other response partners have deveolped the National Incident Management System pursuant to the requirements of the HSPD # 5. It requires that the Incident Management System is used to mimimize the confusion of decision making and authority
Fill In Box	WHAT IS THE CAPACITY OF THE RECIPIENT TO DEAL WITH THIS PROBLEM/OPPORTUNITY?:

Fill In Box		WHY DOES THIS ACTION ITEM DESERVE THE RECIPIENTS ATTENTION NOW?:
Fill In Box		SUMMARY: An influenza pandmic may require the activation of the National Response Plan. The public health ICS shall be understood by all of those whom are asked to respond. At a minimum, those asked to respond shall have completed the IS 700 and the IS 100 course offered by FEMA. Those asked to respond shall provide documentation that the courses have successfully been completed. Using the ICS will assist in limiting the confusion of decison making and authority.
	Success Factors for Action Item	
Fill In Box	Outputs	WHAT DOES THIS PRODUCE?:
Fill In Box	Output Performance Measure	MEASURE OF QUANTITY/QUALITY:
Fill In Box	Output Target	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM WILL ACCOMPLISH A PERFORMANCE MEASURE:
Fill In Box	Immediate Outcome*	DESCRIBE THE INTENDED RESULT:
Fill In Box	Immediate Outcome Performance Measure*	IMMEDIATE OUTCOME EFFECTIVENESS:
Fill In Box	Outcome Target*	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM MUST ACCOMPLISH A PERFORMANCE MEASURE:
	Progress Report- To be Reported Mid Year and End of Year	
Fill In Box	Progress Report-Outputs	PROVIDE QUANTIFIABLE EXTENT THAT OUTPUTS HAVE BEEN ACHIEVED:
Fill In Box	Progress Report-Barriers	BRIEFLY EXPLAIN BARRIERS/PROBLEMS FACED IN ACHIEVING THE TARGET OUTPUT:

Note: *Grantees only need to report on Outputs, Output Performance Measures and Output Targets. They are not required to report Immediate Outcomes, Outcome Performance Measures and Outcome Targets.

Action Item 2	Work Plan Template for Pandemic Flu Guidance Grantees should fill out a separate template for each Action Item
Grantee Input	
	Goal:
Pull Down Menu	**Pandemic Influenza Preparedness Goal 1: PREVENT**
	Increase the use and development of clinical, non-pharmaceutical, and risk communications interventions known to minimize the spread of influenza.
	Target Capability:
Pull Down Menu	**1A Target Capability: Planning**
	(links to HHS State and Local Pandemic Influenza Planning Checklist, Community Preparedness, Leadership and Networking)
	Associated CDC Performance Measure:
Pull Down Menu	Public health agency has primary and secondary staff identified for core functional roles delineated in the Incident Command System (ICS) for public health
	Critical Task:
Pull Down Menu	Develop, exercise and improve operational plans for pandemic influenza at the state and local level.
	Action Item: The program efforts conducted to achieve the critical tasks that result in the creation of a product or service.
Fill In Box	ACTION LINKED TO PRIORITY 1 & 4: 1A:CT1:: Revise & Update the State Department of Health Pandemic Influenza Preparedness Plan as nee
	Description
Fill In Box	What: PURPOSE OF THE ACTION ITEM: The ISDH will review & update the Health portion of the State plan to ensure that it is compliant with NIMS (including ICS); That it delineates responsibilities on the State & Local level for addressing/responding in the event of a pandemic to issues such as movement restrictions, school closures, isolation & quarantine, identification of healthcare services & alternative care sites; That it links specifically to the WHO Pandemic Influenza phases; That it clearly defines the State role in providing guidance & assistance to the local level, integrating plans across jurisdictional boundaries; That it identifies psychosocial support services to responders & communities that will be affected by the pandemic; That it includes continuity of operations for public health, & provides guidance to hospitals & health care systems on how to implement similar procedures; And that it addresses unique characteristics necessary to assist vulnerable/special needs populations.
Fill In Box	Who: TARGET AUDIENCE: State & Local Preparedness Personnel
Fill In Box	STAKEHOLDERS CRITICAL TO SUCCESS: ISDH Staff as assigned
Fill In Box	WHO IS RESPONSIBLE FOR OUTPUTS: Indiana State Department of Health Public Health Preparedness Division
Fill In Box	When: TIME PERIOD OF PROJECT: 08/31/06 - 08/30/07
Fill In Box	Where: VENUE: Statewide
Fill In Box	LOCATION: Statewide
Fill In Box	Why: WHAT EVIDENCE DO YOU HAVE TO SUPPORT THE PROPOSED INTERVENTION/COURSE OF ACTION/OUTCOME FOR THIS ACTION ITEM?: These are requirements outlined in our Pandemic Influenza Preparedness program guidance.
Fill In Box	WHAT IS THE CAPACITY OF THE RECIPIENT TO DEAL WITH THIS PROBLEM/OPPORTUNITY?: This process began 2 years ago, and has been incrementally changed to meet necessary capacity and corrective actions based on AARs on exercises and through collaboration with other business partners.

Fill In Box		WHY DOES THIS ACTION ITEM DESERVE THE RECIPIENTS ATTENTION NOW?: Mandatory Time-Frame Compliance
Fill In Box		SUMMARY: Operational plan improvements yield an enhanced ability to respond flexibly to a pandemic as well as standard Public Health emergencies
	Success Factors for Action Item	
Fill In Box	Outputs	WHAT DOES THIS PRODUCE?: An updated and improved State Health Pandemic Influenza operational plan
Fill In Box	Output Performance Measure	MEASURE OF QUANTITY/QUALITY: Plan will be reviewed and revised by 08/30/07
Fill In Box	Output Target	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM WILL ACCOMPLISH A PERFORMANCE MEASURE: 100% Complete
Fill In Box	Immediate Outcome*	DESCRIBE THE INTENDED RESULT:
Fill In Box	Immediate Outcome Performance Measure*	IMMEDIATE OUTCOME EFFECTIVENESS:
Fill In Box	Outcome Target*	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM MUST ACCOMPLISH A PERFORMANCE MEASURE:
	Progress Report- To be Reported Mid Year and End of Year	
Fill In Box	Progress Report-Outputs	PROVIDE QUANTIFIABLE EXTENT THAT OUTPUTS HAVE BEEN ACHIEVED:
Fill In Box	Progress Report-Barriers	BRIEFLY EXPLAIN BARRIERS/PROBLEMS FACED IN ACHIEVING THE TARGET OUTPUT:

Note: *Grantees only need to report on Outputs, Output Performance Measures and Output Targets. They are not required to report Immediate Outcomes, Outcome Performance Measures and Outcome Targets.

Action Item 3	Work Plan Template for Pandemic Flu Guidance Grantees should fill out a separate template for each Action Item
Grantee Input	
	Goal:
Pull Down Menu	**Pandemic Influenza Preparedness Goal 1: PREVENT**
	Increase the use and development of clinical, non-pharmaceutical, and risk communications interventions known to minimize the spread of influenza.
	Target Capability:
Pull Down Menu	**1A Target Capability: Planning**
	(links to HHS State and Local Pandemic Influenza Planning Checklist, Community Preparedness, Leadership and Networking)
	Associated CDC Performance Measure:
Pull Down Menu	Public health agency has primary and secondary staff identified for core functional roles delineated in the Incident Command System (ICS) for public health
	Critical Task:
Pull Down Menu	Develop, exercise and improve operational plans for pandemic influenza at the state and local level.
	Action Item: The program efforts conducted to achieve the critical tasks that result in the creation of a product or service.
Fill In Box	ACTION LINKED TO 1A:CT1:: Review, Revise & Update Local Health Department Pandemic Influenza operational plans as needed pending less
	Description
Fill In Box	What: PURPOSE OF THE ACTION ITEM: Continual Improvement of plans enhances coordinated preparedness and Emergency response activities.
Fill In Box	Who: TARGET AUDIENCE: Local level preparedness personnel throughout the state of Indiana
Fill In Box	STAKEHOLDERS CRITICAL TO SUCCESS: Local Emergency Management, Hospitals, Community Health Centers, Rural Health Centers, Community Mental Health Centers, Law Enforcement, Funeral Directors/Coroners, Local Government, Schools, FBOs, CBOs, Local Health Departments, and Community Businesses
Fill In Box	WHO IS RESPONSIBLE FOR OUTPUTS: Local Emergency Management Agencies in collaboration with the Local Health Department and other identified Local Level responders as assigned
Fill In Box	When: TIME PERIOD OF PROJECT: 08/31/06 - 08/30/07
Fill In Box	Where: VENUE: 92 Counties throughout the State of Indiana
Fill In Box	LOCATION: Statewide
Fill In Box	Why: WHAT EVIDENCE DO YOU HAVE TO SUPPORT THE PROPOSED INTERVENTION/COURSE OF ACTION/OUTCOME FOR THIS ACTION ITEM?: Exercising plan components will yield improved information on operational plans, procedures, and protocols.
Fill In Box	WHAT IS THE CAPACITY OF THE RECIPIENT TO DEAL WITH THIS PROBLEM/OPPORTUNITY?: In collaboration with all units of local government and guidance provided from the State level down, local units should be capable of exercising and re-writing operational plans as necessary

Fill In Box		WHY DOES THIS ACTION ITEM DESERVE THE RECIPIENTS ATTENTION NOW?: In order to ensure continuity of activities happening at the state and local level, resulting from the shift of activities to include pandemic preparedness
Fill In Box		SUMMARY: It is crucial that local plans be developed and exercised in order to prepare for Pandemic Influenza especially since they will be the level most affected and responsible for community response.
	Success Factors for Action Item	
Fill In Box	Outputs	WHAT DOES THIS PRODUCE?: Updated, improved Local Pandemic Influenza preparedness plans that have been exercised accordingly
Fill In Box	Output Performance Measure	MEASURE OF QUANTITY/QUALITY: 90% of all Local Pandemic Flu plans will be exercised and revised accordingly by 08/30/07
Fill In Box	Output Target	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM WILL ACCOMPLISH A PERFORMANCE MEASURE: All Local operational plans will be revised annually
Fill In Box	Immediate Outcome*	DESCRIBE THE INTENDED RESULT:
Fill In Box	Immediate Outcome Performance Measure*	IMMEDIATE OUTCOME EFFECTIVENESS:
Fill In Box	Outcome Target*	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM MUST ACCOMPLISH A PERFORMANCE MEASURE:
	Progress Report- To be Reported Mid Year and End of Year	
Fill In Box	Progress Report-Outputs	PROVIDE QUANTIFIABLE EXTENT THAT OUTPUTS HAVE BEEN ACHIEVED:
Fill In Box	Progress Report-Barriers	BRIEFLY EXPLAIN BARRIERS/PROBLEMS FACED IN ACHIEVING THE TARGET OUTPUT:

Note: *Grantees only need to report on Outputs, Output Performance Measures and Output Targets. They are not required to report Immediate Outcomes, Outcome Performance Measures and Outcome Targets.

Action Item 4	Work Plan Template for Pandemic Flu Guidance Grantees should fill out a separate template for each Action Item
Grantee Input	
	Goal:
Pull Down Menu	**Pandemic Influenza Preparedness Goal 1: PREVENT**
	Increase the use and development of clinical, non-pharmaceutical, and risk communications interventions known to minimize the spread of influenza.
	Target Capability:
Pull Down Menu	**1A Target Capability: Planning**
	(links to HHS State and Local Pandemic Influenza Planning Checklist, Community Preparedness, Leadership and Networking)
	Associated CDC Performance Measure:
Pull Down Menu	
	Critical Task:
Pull Down Menu	Develop, exercise and improve operational plans for pandemic influenza at the state and local level.
	Action Item: The program efforts conducted to achieve the critical tasks that result in the creation of a product or service.
Fill In Box	ACTION LINKED TO 1A:CT1:: The Indiana State Department of Health will collaborate with the Indiana University Center for Bioethics to develop
	Description
Fill In Box	What: PURPOSE OF THE ACTION ITEM: The Indiana State Department of Health will collaborate with the Indiana University Center for Bioethics to develop a Community Advisory Group (CAG) that will bring together the expertise and support of professional disciplines and citizens throughout Indiana. The Communicy Advisory Group will provide technical assistance, guidance, and recommendations on ethical and policy issues in order to exercise and improve state and local operational plans.
Fill In Box	Who: TARGET AUDIENCE: Indiana State Department of Health, local health departments, hospitals and health clinics, and others as selected.
Fill In Box	STAKEHOLDERS CRITICAL TO SUCCESS: Indiana State Department of Health, Indiana University Center for Bioethics, local health departments and hospital representatives, various medical and professional disciplines and organization, and community representatives.
Fill In Box	WHO IS RESPONSIBLE FOR OUTPUTS: Indiana State Department of Health and the Indiana University Center for Bioethics.
Fill In Box	When: TIME PERIOD OF PROJECT: 08/31/06 - 08/30/07
Fill In Box	Where: VENUE: Indiana State Department of Health and the Indiana University Center for Bioethics in Indianapolis Indiana to expand to include the 10 Indiana preparedness districts.
Fill In Box	LOCATION: Statewide
Fill In Box	Why: WHAT EVIDENCE DO YOU HAVE TO SUPPORT THE PROPOSED INTERVENTION/COURSE OF ACTION/OUTCOME FOR THIS ACTION ITEM?: During a pandemic critical ethical and policy decisions will be by health officials and other leaders. The World Health Organiation, the National Governors Association, and the National Academies Institute of Medicine explicitly recommend an examination of critical ethical issues and the use of an ethical framework for decision making.
Fill In Box	WHAT IS THE CAPACITY OF THE RECIPIENT TO DEAL WITH THIS PROBLEM/OPPORTUNITY?: Indiana University Center for Bioethics in collaboration with the Indiana State Department of Healht has the unique capabilities to develop and facilitate the Community Advisory Group and formulate guidnace on ethical and policy issues.

Fill In Box		WHY DOES THIS ACTION ITEM DESERVE THE RECIPIENTS ATTENTION NOW?: There have been explicit request for assistance from local health, hospital, and other partners for guidance from the Indiana State Department of Health on ethical and policy issues as it relates to operational plans for pandemic influenza.
Fill In Box		SUMMARY: The Indiana State Department of Health in collaboration with the Indiana University Center for Bioethics will develop a Community Advisory Group to provide techinal assistance, guidance, and recommendations for the exercising and improvement of state and local operational pandemic influenza plans.
	Success Factors for Action Item	
Fill In Box	Outputs	WHAT DOES THIS PRODUCE?: A Community Advisory Group for pandemic influenza and technical assistance on ethical and policy issues in pandemic influenza planning.
Fill In Box	Output Performance Measure	MEASURE OF QUANTITY/QUALITY: # of technical assistance documents that emerge as a result of the Community Advisory Group.
Fill In Box	Output Target	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM WILL ACCOMPLISH A PERFORMANCE MEASURE: 5 technical assistance documents on emerge as a result of the Community Advisory Group.
Fill In Box	Immediate Outcome*	DESCRIBE THE INTENDED RESULT:
Fill In Box	Immediate Outcome Performance Measure*	IMMEDIATE OUTCOME EFFECTIVENESS:
Fill In Box	Outcome Target*	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM MUST ACCOMPLISH A PERFORMANCE MEASURE:
	Progress Report- To be Reported Mid Year and End of Year	
Fill In Box	Progress Report-Outputs	PROVIDE QUANTIFIABLE EXTENT THAT OUTPUTS HAVE BEEN ACHIEVED:
Fill In Box	Progress Report-Barriers	BRIEFLY EXPLAIN BARRIERS/PROBLEMS FACED IN ACHIEVING THE TARGET OUTPUT:

Note: *Grantees only need to report on Outputs, Output Performance Measures and Output Targets. They are not required to report Immediate Outcomes, Outcome Performance Measures and Outcome Targets.

Action Item 5	Work Plan Template for Pandemic Flu Guidance Grantees should fill out a separate template for each Action Item
Grantee Input	
	Goal:
Pull Down Menu	**Pandemic Influenza Preparedness Goal 1: PREVENT**
	Increase the use and development of clinical, non-pharmaceutical, and risk communications interventions known to minimize the spread of influenza.
	Target Capability:
Pull Down Menu	**1A Target Capability: Planning**
	(links to HHS State and Local Pandemic Influenza Planning Checklist, Community Preparedness, Leadership and Networking)
	Associated CDC Performance Measure:
Pull Down Menu	
	Critical Task:
Pull Down Menu	Develop, exercise and improve operational plans for pandemic influenza at the state and local level.
	Action Item: The program efforts conducted to achieve the critical tasks that result in the creation of a product or service.
Fill In Box	ACTION LINKED TO 1A:CT1:: The Indiana State Department of Health will collaborate with the Indiana University Center for Bioethics to develop
	Description
	What
Fill In Box	PURPOSE OF THE ACTION ITEM: To collaborate with the Indiana University Center for Bioethics to develop and exercise an ethical framework for decision making, which is focused on ethical and policy issues and designed to improve operational plans for pandemic influenza at the state level.
	Who
Fill In Box	TARGET AUDIENCE: Indiana State Department of Health and others as selected.
Fill In Box	STAKEHOLDERS CRITICAL TO SUCCESS: Indiana University Center for Bioethics and the Indiana State Department of Health.
Fill In Box	WHO IS RESPONSIBLE FOR OUTPUTS: Indiana University Center for Bioethics and Indiana State Department of Health.
	When
Fill In Box	TIME PERIOD OF PROJECT: 08/31/06 - 08/31/07
	Where
Fill In Box	VENUE: Indiana State Department of Health and the Indiana University Center for Bioethics in Indianapolis Indiana.
Fill In Box	LOCATION: Indianapolis
	Why
Fill In Box	WHAT EVIDENCE DO YOU HAVE TO SUPPORT THE PROPOSED INTERVENTION/COURSE OF ACTION/OUTCOME FOR THIS ACTION ITEM?: During a pandemic critical ethical and policy decisions will be by health officials and other leaders. The World Health Organiation, the National Governors Association, and the National Academies Institute of Medicine explicitly recommend an examination of critical ethical issues and the use of an ethical framework for decision making.
Fill In Box	WHAT IS THE CAPACITY OF THE RECIPIENT TO DEAL WITH THIS PROBLEM/OPPORTUNITY?: Indiana University Center for Bioethics in collaboration with the Indiana State Department of Healht has the unique capabilities to develop and exercise and ethical framework for decision making on ethical and policy issues.

Fill In Box		WHY DOES THIS ACTION ITEM DESERVE THE RECIPIENTS ATTENTION NOW?: There have been explicit request for assistance from local health, hospital, and other partners for guidance from the Indiana State Department of Health on ethical and policy issues as it relates to operational plans for pandemic influenza.
Fill In Box		SUMMARY: The Indiana State Department of Health in collaboration with the Indiana University Center for Bioethics will develop and exercise an ethical framework for decision making focused on ethical and policy issues in order to improve operational plans for pandemic influenza.
	Success Factors for Action Item	
Fill In Box	Outputs	WHAT DOES THIS PRODUCE?: An ethical framework for decision making and an exercise that includes and after action report with a recommended improvement plan.
Fill In Box	Output Performance Measure	MEASURE OF QUANTITY/QUALITY: # of recommendations to improve state operational plans for pandemic influenza.
Fill In Box	Output Target	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM WILL ACCOMPLISH A PERFORMANCE MEASURE: 2 recommendations to improve state operational plan for pandemic influenza.
Fill In Box	Immediate Outcome*	DESCRIBE THE INTENDED RESULT:
Fill In Box	Immediate Outcome Performance Measure*	IMMEDIATE OUTCOME EFFECTIVENESS:
Fill In Box	Outcome Target*	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM MUST ACCOMPLISH A PERFORMANCE MEASURE:
	Progress Report- To be Reported Mid Year and End of Year	
Fill In Box	Progress Report- Outputs	PROVIDE QUANTIFIABLE EXTENT THAT OUTPUTS HAVE BEEN ACHIEVED:
Fill In Box	Progress Report- Barriers	BRIEFLY EXPLAIN BARRIERS/PROBLEMS FACED IN ACHIEVING THE TARGET OUTPUT:

Note: *Grantees only need to report on Outputs, Output Performance Measures and Output Targets. They are not required to report Immediate Outcomes, Outcome Performance Measures and Outcome Targets.

Action Item 21	Work Plan Template for Pandemic Flu Guidance Grantees should fill out a separate template for each Action Item
Grantee Input	
	Goal:
Pull Down Menu	**Pandemic Influenza Preparedness Goal 1: PREVENT**
	Increase the use and development of clinical, non-pharmaceutical, and risk communications interventions known to minimize the spread of influenza.
	Target Capability:
Pull Down Menu	**1A Target Capability: Planning**
	(links to HHS State and Local Pandemic Influenza Planning Checklist, Community Preparedness, Leadership and Networking)
	Associated CDC Performance Measure:
Pull Down Menu	
	Critical Task:
Pull Down Menu	
	Action Item: The program efforts conducted to achieve the critical tasks that result in the creation of a product or service.
Fill In Box	ACTION LINKED TO PRIORITY 1, PHASE 1 CT3:: Analyze and Review Finalized Gap Analysis Project being completed by Contractor, which ISD
	Description
Fill In Box	What: PURPOSE OF THE ACTION ITEM: This will allow ISDH to complete a formal review of and prioritize identified Local Gaps
Fill In Box	Who: TARGET AUDIENCE: Indiana State Department of Health; Centers For Disease Control & Prevention, Division of State & Local Readiness
Fill In Box	STAKEHOLDERS CRITICAL TO SUCCESS: Indiana State Department of Health, Public Health Preparedness & Emergency Response Division; Purdue Homeland Security Institute, Local Health Departments
Fill In Box	WHO IS RESPONSIBLE FOR OUTPUTS: Indiana State Department of Health, Public Health Preparedness & Emergency Response Division
Fill In Box	When: TIME PERIOD OF PROJECT: 04/2006 - 09/30/2006
Fill In Box	Where: VENUE: Sate & Local Health Departments
Fill In Box	LOCATION: Statewide
Fill In Box	Why: WHAT EVIDENCE DO YOU HAVE TO SUPPORT THE PROPOSED INTERVENTION/COURSE OF ACTION/OUTCOME FOR THIS ACTION ITEM?: This is a required element of both the Phase 1 & Phase 2 Pandemic Influenza preparedness plan.

Fill In Box		WHAT IS THE CAPACITY OF THE RECIPIENT TO DEAL WITH THIS PROBLEM/OPPORTUNITY?: ISDH is fully capable of completing this review, to evaluate, and implement Gaps discovered within the Local Health Departments throughout the State
Fill In Box		WHY DOES THIS ACTION ITEM DESERVE THE RECIPIENTS ATTENTION NOW?: This is completion of a Critical Task identified under the Pandemic Influenza Phase 1 program.
Fill In Box		SUMMARY: Given the limited timeframe (1 day between receipt of 94 completed Local Gap Analysis to the time required to review/submit them to CDC) for analysis of local preparedness gaps, additional time is needed to complete Phase 1, Critical Task 3. A sub-set of Local Gap Analysis, 1 from each of IN's 10 Districts, indicative of similar gaps identified within that district, has been initially reviewed in order to determine Local Level Gaps that we want to work on filling during Phase 2.
	Success Factors for Action Item	
Fill In Box	Outputs	WHAT DOES THIS PRODUCE?: Local Gap Analysis documentation for 94 Local Health Departments throughout Indiana, and revised methods necessary to fill Local Level Pandemic Influenza preparedness gaps.
Fill In Box	Output Performance Measure	MEASURE OF QUANTITY/QUALITY: 94 Completed Gap Analysis based on the Phase 1 Local Self-Assessments and meetings/discussions with the individual Local Health Departments
Fill In Box	Output Target	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM WILL ACCOMPLISH A PERFORMANCE MEASURE: 94 Reports
Fill In Box	Immediate Outcome*	DESCRIBE THE INTENDED RESULT:
Fill In Box	Immediate Outcome Performance Measure*	IMMEDIATE OUTCOME EFFECTIVENESS:
Fill In Box	Outcome Target*	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM MUST ACCOMPLISH A PERFORMANCE MEASURE:
	Progress Report- To be Reported Mid Year and End of Year	
Fill In Box	Progress Report-Outputs	PROVIDE QUANTIFIABLE EXTENT THAT OUTPUTS HAVE BEEN ACHIEVED:
Fill In Box	Progress Report-Barriers	BRIEFLY EXPLAIN BARRIERS/PROBLEMS FACED IN ACHIEVING THE TARGET OUTPUT:

Note: *Grantees only need to report on Outputs, Output Performance Measures and Output Targets. They are not required to report Immediate Outcomes, Outcome Performance Measures and Outcome Targets.

Action Item 22	Work Plan Template for Pandemic Flu Guidance Grantees should fill out a separate template for each Action Item
Grantee Input	
	Goal:
Pull Down Menu	**Pandemic Influenza Preparedness Goal 1: PREVENT**
	Increase the use and development of clinical, non-pharmaceutical, and risk communications interventions known to minimize the spread of influenza.
	Target Capability:
Pull Down Menu	**1A Target Capability: Planning**
	(links to HHS State and Local Pandemic Influenza Planning Checklist, Community Preparedness, Leadership and Networking)
	Associated CDC Performance Measure:
Pull Down Menu	#N/A
	Critical Task:
Pull Down Menu	Develop, exercise and improve operational plans for pandemic influenza at the state and local level.
	Action Item: The program efforts conducted to achieve the critical tasks that result in the creation of a product or service.
Fill In Box	ACTION LINKED TO 1A:CT1:: Complete, Exercise & Revise Statewide Comprehensive Pandemic Influenza operational plan as needed pending
	Description
Fill In Box	What: PURPOSE OF THE ACTION ITEM: Continued improvement of operational plans creates additional flexibility and enhances coordination of preparedness and emergency response activities across all state/local agencies and first responders.
Fill In Box	Who: TARGET AUDIENCE: State and Local Public Health and Emergency Response operational personnel
Fill In Box	STAKEHOLDERS CRITICAL TO SUCCESS: Indiana State Department of Health, Public Health Preparedness & Emergency Response Division; Indiana State Department of Homeland Security, Indiana Department of Natural Resources, Indiana Board of Animal Health
Fill In Box	WHO IS RESPONSIBLE FOR OUTPUTS: Indiana Department of Homeland Security
Fill In Box	When: TIME PERIOD OF PROJECT: 08/31/06-08/30/07
Fill In Box	Where: VENUE: Statewide
Fill In Box	LOCATION: Statewide
Fill In Box	Why: WHAT EVIDENCE DO YOU HAVE TO SUPPORT THE PROPOSED INTERVENTION/COURSE OF ACTION/OUTCOME FOR THIS ACTION ITEM?: Preparedness and Exercise of components within the comprehensive plan will yield improved information included in plans, procedures, and protocols for incident management.

Fill In Box		WHAT IS THE CAPACITY OF THE RECIPIENT TO DEAL WITH THIS PROBLEM/OPPORTUNITY?: State and Local Public Health Departments have a vast amount of experience in preparing, conducting exercises and retraining, and rewriting plan based on the outcome of those exercises.
Fill In Box		WHY DOES THIS ACTION ITEM DESERVE THE RECIPIENTS ATTENTION NOW?: This is a National and International priority that has become the central focal point for preparedness planning over the past 9 months.
Fill In Box		SUMMARY: This action item will be an ongoing project as we continue to develop, exercise, and implement corrective actions to prepare, prevent, and control pandemic preparedness responses.
	Success Factors for Action Item	
Fill In Box	Outputs	WHAT DOES THIS PRODUCE?: Annually revised, updated, and improved State pandemic preparedness comprehensive plan that has been exercised as appropriate
Fill In Box	Output Performance Measure	MEASURE OF QUANTITY/QUALITY: Completed plan by 11/30/06, which is exercised and revised if necessary by 08/30/07.
Fill In Box	Output Target	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM WILL ACCOMPLISH A PERFORMANCE MEASURE: Annually revised state comprehensive, operational plan.
Fill In Box	Immediate Outcome*	DESCRIBE THE INTENDED RESULT:
Fill In Box	Immediate Outcome Performance Measure*	IMMEDIATE OUTCOME EFFECTIVENESS:
Fill In Box	Outcome Target*	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM MUST ACCOMPLISH A PERFORMANCE MEASURE:
	Progress Report- To be Reported Mid Year and End of Year	
Fill In Box	Progress Report-Outputs	PROVIDE QUANTIFIABLE EXTENT THAT OUTPUTS HAVE BEEN ACHIEVED:
Fill In Box	Progress Report-Barriers	BRIEFLY EXPLAIN BARRIERS/PROBLEMS FACED IN ACHIEVING THE TARGET OUTPUT:

Note: *Grantees only need to report on Outputs, Output Performance Measures and Output Targets. They are not required to report Immediate Outcomes, Outcome Performance Measures and Outcome Targets.

Action Item 23	Work Plan Template for Pandemic Flu Guidance Grantees should fill out a separate template for each Action Item
Grantee Input	
	Goal:
Pull Down Menu	**Pandemic Influenza Preparedness Goal 1: PREVENT**
	Increase the use and development of clinical, non-pharmaceutical, and risk communications interventions known to minimize the spread of influenza.
	Target Capability:
Pull Down Menu	**1A Target Capability: Planning**
	(links to HHS State and Local Pandemic Influenza Planning Checklist, Community Preparedness, Leadership and Networking)
	Associated CDC Performance Measure:
Pull Down Menu	#N/A
	Critical Task:
Pull Down Menu	
	Action Item: The program efforts conducted to achieve the critical tasks that result in the creation of a product or service.
Fill In Box	ACTION LINKED TO 1A:CT1:: The Indiana State Department of Health with collaborate with the Indiana University Center for Bioethics to develop
	Description
	What
Fill In Box	PURPOSE OF THE ACTION ITEM: To collaborate with the Indiana University Center for Bioethics to develop and train local health departments and hospitals on an ethical framework for pandemic influenza, which is focused on ethical and policy issues and designed to improve operational plans for pandemic influenza at the district and local level.
	Who
Fill In Box	TARGET AUDIENCE: Local health departments, hospitals, and others as selected.
Fill In Box	STAKEHOLDERS CRITICAL TO SUCCESS: Indiana University Center for Bioethics, Indiana State Department of Health, local health departments, and hosptials.
Fill In Box	WHO IS RESPONSIBLE FOR OUTPUTS: Indiana State Department of Health and the Indiana University Center for Bioethics.
	When
Fill In Box	TIME PERIOD OF PROJECT: 08/31/06 - 08/30/07
	Where
Fill In Box	VENUE: Indiana University Center for Bioethics and in 5 districts throughout Indiana.
Fill In Box	LOCATION: Statewide
	Why
Fill In Box	WHAT EVIDENCE DO YOU HAVE TO SUPPORT THE PROPOSED INTERVENTION/COURSE OF ACTION/OUTCOME FOR THIS ACTION ITEM?: During a pandemic critical ethical and policy decisions will be by health officials and other leaders. The World Health Organiation, the National Governors Association, and the National Academies Institute of Medicine explicitly recommend an examination of critical ethical issues and the use of an ethical framework for decision making.

Fill In Box		WHAT IS THE CAPACITY OF THE RECIPIENT TO DEAL WITH THIS PROBLEM/OPPORTUNITY?: Indiana University Center for Bioethics in collaboration with the Indiana State Department of Healht has the unique capabilities to develop and exercise and ethical framework for decision making on ethical and policy issues.
Fill In Box		WHY DOES THIS ACTION ITEM DESERVE THE RECIPIENTS ATTENTION NOW?: There have been explicit request for assistance from local health, hospital, and other partners for guidance from the Indiana State Department of Health on ethical and policy issues as it relates to operational plans for pandemic influenza.
Fill In Box		SUMMARY: The Indiana State Department of Health in collaboration with the Indiana University Center for Bioethics will develop and train local health departments and hospitals on an ethical framework for decision making, which is focused on ethical and policy issues and designed to improve operational plans for pandemic influenza at the district and local level.
	Success Factors for Action Item	
Fill In Box	Outputs	WHAT DOES THIS PRODUCE?: A guidance document, training sessions and improved operational plans.
Fill In Box	Output Performance Measure	MEASURE OF QUANTITY/QUALITY: # of training sessions completed.
Fill In Box	Output Target	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM WILL ACCOMPLISH A PERFORMANCE MEASURE: Completion of 4 training session.
Fill In Box	Immediate Outcome*	DESCRIBE THE INTENDED RESULT:
Fill In Box	Immediate Outcome Performance Measure*	IMMEDIATE OUTCOME EFFECTIVENESS:
Fill In Box	Outcome Target*	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM MUST ACCOMPLISH A PERFORMANCE MEASURE:
	Progress Report- To be Reported Mid Year and End of Year	
Fill In Box	Progress Report- Outputs	PROVIDE QUANTIFIABLE EXTENT THAT OUTPUTS HAVE BEEN ACHIEVED:
Fill In Box	Progress Report- Barriers	BRIEFLY EXPLAIN BARRIERS/PROBLEMS FACED IN ACHIEVING THE TARGET OUTPUT:

Note: *Grantees only need to report on Outputs, Output Performance Measures and Output Targets. They are not required to report Immediate Outcomes, Outcome Performance Measures and Outcome Targets.

Action Item 24	Work Plan Template for Pandemic Flu Guidance Grantees should fill out a separate template for each Action Item
Grantee Input	
	Goal:
Pull Down Menu	**Pandemic Influenza Preparedness Goal 1: PREVENT**
	Increase the use and development of clinical, non-pharmaceutical, and risk communications interventions known to minimize the spread of influenza.
	Target Capability:
Pull Down Menu	**1A Target Capability: Planning**
	(links to HHS State and Local Pandemic Influenza Planning Checklist, Community Preparedness, Leadership and Networking)
	Associated CDC Performance Measure:
Pull Down Menu	#N/A
	Critical Task:
Pull Down Menu	
	Action Item: The program efforts conducted to achieve the critical tasks that result in the creation of a product or service.
Fill In Box	ACTION LINKED TO 1A:CT1:: The Indiana State Department of Health with collaborate with the Indiana University Center for Bioethics to develop
	Description
	What
Fill In Box	PURPOSE OF THE ACTION ITEM: To collaborate with the Indiana University Center for Bioethics to develop and facilitate 10 district exercises on ethical and policy issues in order to improve operational plans for pandemic influenza.
	Who
Fill In Box	TARGET AUDIENCE: District health jurisdictions, local health departments, hospitals, and others as selected.
Fill In Box	STAKEHOLDERS CRITICAL TO SUCCESS: Indiana University Center for Bioethics, Indiana State Department of Health, local health departments, hosptials, and others as necessary.
Fill In Box	WHO IS RESPONSIBLE FOR OUTPUTS: Indiana State Department of Health and the Indiana University Center for Bioethics.
	When
Fill In Box	TIME PERIOD OF PROJECT: 08/31/07 -08/30/08
	Where
Fill In Box	VENUE: Indiana University Center for Bioethics and in 10 districts throughout Indiana.
Fill In Box	LOCATION: Statewide
	Why
Fill In Box	WHAT EVIDENCE DO YOU HAVE TO SUPPORT THE PROPOSED INTERVENTION/COURSE OF ACTION/OUTCOME FOR THIS ACTION ITEM?: During a pandemic critical ethical and policy decisions will be by health officials and other leaders. The World Health Organiation, the National Governors Association, and the National Academies Institute of Medicine explicitly recommend an examination of critical ethical issues and the use and exercising of an ethical framework for decision making.

Fill In Box		WHAT IS THE CAPACITY OF THE RECIPIENT TO DEAL WITH THIS PROBLEM/OPPORTUNITY?: Indiana University Center for Bioethics in collaboration with the Indiana State Department of Healht has the unique capabilities to develop and exercise and ethical framework for decision making on ethical and policy issues.
Fill In Box		WHY DOES THIS ACTION ITEM DESERVE THE RECIPIENTS ATTENTION NOW?: There have been explicit request for assistance from local health, hospital, and other partners for guidance from the Indiana State Department of Health on ethical and policy issues as it relates to operational plans for pandemic influenza.
Fill In Box		SUMMARY: The Indiana State Department of Health in collaboration with the Indiana University Center for Bioethics will develop and facilitate 10 district exercises on ethical and policy issues in order to improve operational plans for pandemic influenza at the district and local level.
	Success Factors for Action Item	
Fill In Box	Outputs	WHAT DOES THIS PRODUCE?: 10 district exercises and improved operational plans for pandemic influenza.
Fill In Box	Output Performance Measure	MEASURE OF QUANTITY/QUALITY: # of district exercises completed.
Fill In Box	Output Target	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM WILL ACCOMPLISH A PERFORMANCE MEASURE: 8 district exercises are completed.
Fill In Box	Immediate Outcome*	DESCRIBE THE INTENDED RESULT:
Fill In Box	Immediate Outcome Performance Measure*	IMMEDIATE OUTCOME EFFECTIVENESS:
Fill In Box	Outcome Target*	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM MUST ACCOMPLISH A PERFORMANCE MEASURE:
	Progress Report- To be Reported Mid Year and End of Year	
Fill In Box	Progress Report-Outputs	PROVIDE QUANTIFIABLE EXTENT THAT OUTPUTS HAVE BEEN ACHIEVED:
Fill In Box	Progress Report-Barriers	BRIEFLY EXPLAIN BARRIERS/PROBLEMS FACED IN ACHIEVING THE TARGET OUTPUT:

Note: *Grantees only need to report on Outputs, Output Performance Measures and Output Targets. They are not required to report Immediate Outcomes, Outcome Performance Measures and Outcome Targets.

Action Item 25	Work Plan Template for Pandemic Flu Guidance Grantees should fill out a separate template for each Action Item
Grantee Input	
	Goal:
Pull Down Menu	**Pandemic Influenza Preparedness Goal 1: PREVENT**
	Increase the use and development of clinical, non-pharmaceutical, and risk communications interventions known to minimize the spread of influenza.
	Target Capability:
Pull Down Menu	**1A Target Capability: Planning**
	(links to HHS State and Local Pandemic Influenza Planning Checklist, Community Preparedness, Leadership and Networking)
	Associated CDC Performance Measure:
Pull Down Menu	#N/A
	Critical Task:
Pull Down Menu	Develop, exercise and improve operational plans for pandemic influenza at the state and local level.
	Action Item: The program efforts conducted to achieve the critical tasks that result in the creation of a product or service.
Fill In Box	ACTION LINKED TO 1A:CT1:: The Indiana State Department of Health with collaborate with the Indiana University Center for Bioethics to facilitat
	Description
Fill In Box	What: PURPOSE OF THE ACTION ITEM: To collaborate with the Indiana University Center for Bioethics to facilitate 10 district exercises on ethical and policy issues in order to re-test and improve operational plans for pandemic influenza.
Fill In Box	Who: TARGET AUDIENCE: District health jurisdictions, local health departments, hospitals, and others as selected.
Fill In Box	STAKEHOLDERS CRITICAL TO SUCCESS: Indiana University Center for Bioethics, Indiana State Department of Health, local health departments, hosptials, and others as necessary.
Fill In Box	WHO IS RESPONSIBLE FOR OUTPUTS: Indiana State Department of Health and the Indiana University Center for Bioethics.
Fill In Box	When: TIME PERIOD OF PROJECT: 08/31/08 - 08/30/09
Fill In Box	Where: VENUE: Indiana University Center for Bioethics and in 10 districts throughout Indiana.
Fill In Box	LOCATION: Statewide
Fill In Box	Why: WHAT EVIDENCE DO YOU HAVE TO SUPPORT THE PROPOSED INTERVENTION/COURSE OF ACTION/OUTCOME FOR THIS ACTION ITEM?: During a pandemic critical ethical and policy decisions will be by health officials and other leaders. The World Health Organiation, the National Governors Association, and the National Academies Institute of Medicine explicitly recommend an examination of critical ethical issues and the use and exercising of an ethical framework for decision making.

Fill In Box		WHAT IS THE CAPACITY OF THE RECIPIENT TO DEAL WITH THIS PROBLEM/OPPORTUNITY?: Indiana University Center for Bioethics in collaboration with the Indiana State Department of Healht has the unique capabilities to develop and exercise and ethical framework for decision making on ethical and policy issues.
Fill In Box		WHY DOES THIS ACTION ITEM DESERVE THE RECIPIENTS ATTENTION NOW?: There have been explicit request for assistance from local health, hospital, and other partners for guidance from the Indiana State Department of Health on ethical and policy issues as it relates to operational plans for pandemic influenza.
Fill In Box		SUMMARY: The Indiana State Department of Health in collaboration with the Indiana University Center for Bioethics will facilitate10 district exercises on ethical and policy issues in order to re-test and improve operational plans for pandemic influenza at the district and local level.
	Success Factors for Action Item	
Fill In Box	Outputs	WHAT DOES THIS PRODUCE?: 10 district exercises and improved operational plans for pandemic influenza.
Fill In Box	Output Performance Measure	MEASURE OF QUANTITY/QUALITY: # of district exercises completed.
Fill In Box	Output Target	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM WILL ACCOMPLISH A PERFORMANCE MEASURE: 8 district exercises are completed.
Fill In Box	Immediate Outcome*	DESCRIBE THE INTENDED RESULT:
Fill In Box	Immediate Outcome Performance Measure*	IMMEDIATE OUTCOME EFFECTIVENESS:
Fill In Box	Outcome Target*	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM MUST ACCOMPLISH A PERFORMANCE MEASURE:
	Progress Report- To be Reported Mid Year and End of Year	
Fill In Box	Progress Report-Outputs	PROVIDE QUANTIFIABLE EXTENT THAT OUTPUTS HAVE BEEN ACHIEVED:
Fill In Box	Progress Report-Barriers	BRIEFLY EXPLAIN BARRIERS/PROBLEMS FACED IN ACHIEVING THE TARGET OUTPUT:

Note: *Grantees only need to report on Outputs, Output Performance Measures and Output Targets. They are not required to report Immediate Outcomes, Outcome Performance Measures and Outcome Targets.

Action Item 6	Work Plan Template for Pandemic Flu Guidance
Grantee Input	
	Goal:
Pull Down Menu	**Pandemic Influenza Preparedness Goal 3: DETECT AND REPORT**
	Decrease the time needed to detect and report an influenza outbreak with pandemic potential.
	Target Capability:
Pull Down Menu	**3B Target Capability: Public Health Laboratory Testing**
	(links to HHS State and Local Pandemic Influenza Planning Checklist, Public Health and Clinical Laboratories)
	Associated CDC Performance Measure:
Pull Down Menu	
	Critical Task:
Pull Down Menu	Assess all public health and clinical laboratory influenza diagnostic testing proficiency and adherence to biosafety containment and
	Action Item: The program efforts conducted to achieve the critical tasks that result in the creation of a product or service.
Fill In Box	(PHASE 1 GAP): 3B:CT6:: Select/adapt/develop an online competency-based training for public health & clinical lab staff as an enhancement to th
	Description
Fill In Box	What: PURPOSE OF THE ACTION ITEM: To maintain quality techniques and standards for ensuring accuracy and safety with specimen collection and submission, diagnostic testing, adherence to biosafety containment, and biomonitoring protocols.
Fill In Box	Who: TARGET AUDIENCE: Frontline clinicians and laboratory personnel will be targeted.
Fill In Box	STAKEHOLDERS CRITICAL TO SUCCESS: Indiana's Indiana State Department of Health labs, designated public health and clinical lab personnel, Indiana Mid America Public Health Training Center instructional designer, and LMS Coordinator, and the University of Illinois at Chicago-Center for the Advancement of Distance Education, Acute Care Divison-Clinical Laboratory Improvment Act (CLIA) Supervisor
Fill In Box	WHO IS RESPONSIBLE FOR OUTPUTS: Indiana State Department of Health Emergency Preparedness and Response (ISDH-EPR) Lab Director, Acute Care Division-Clinical Laboratory Improvement Act (CLIA) Supervisor, Learning Content Management System (LCMS) Coordinator, and contractual instructional designer through the University of Illinois at Chicago- Center for the Advancement of Distance Education (UIC-CADE)
Fill In Box	When: TIME PERIOD OF PROJECT: 08/31/2006 through 08/30/2007
Fill In Box	Where: VENUE: Available statewide through Indiana's online Learning/Content Management System (IN LCMS)
Fill In Box	LOCATION: Available statewide
Fill In Box	Why: WHAT EVIDENCE DO YOU HAVE TO SUPPORT THE PROPOSED INTERVENTION/COURSE OF ACTION/OUTCOME FOR THIS ACTION ITEM?: Face-to-face trainings have been previously conducted. However, there are currently no online courses within the Indiana LCMS that are specific to the training needs identified by the Emergency Preparedness and Response Lab Director.
Fill In Box	WHAT IS THE CAPACITY OF THE RECIPIENT TO DEAL WITH THIS PROBLEM/OPPORTUNITY?: The ISDH Lab staff have the knowledge about training needs,federal lab regulations & specific content for course development. The LCMS Coor. has public health educ./methods/training expertise including ISDH's LCMS technical expertise. UIC-CADE developed, owns & manages the overall LCMS, & its staff has the online instructional technology/design expertise for course development.

Fill In Box		WHY DOES THIS ACTION ITEM DESERVE THE RECIPIENTS ATTENTION NOW?: To increase the venue for review, training and testing the competency of frontline clinicians and laboratory personnel. To increase the individual clinician 's opportunity for material review on an as needed basis. Online trainings will also increase the likelihood that more clinicians will have access to critical information sooner and more consistently.
Fill In Box		SUMMARY: This action will help to decrease time needed to detect & report an influenza outbreak with pandemic potential through assessing all public health and clinical laboratory personnel. Specifically, an online course will be created that increases the capability of maintaining quality diagnostic testing, biosafety containment, and biomonitoring protocols.
	Success Factors for Action Item	
Fill In Box	Outputs	WHAT DOES THIS PRODUCE?: An online course will be available through the IN LCMS for use by frontline clinicians and laboratory personnel to educate the individual on influenza biosafety and biomonitoring protocols. Specifically, content will include influenza diagnostic testing, biosafety containment, and biomonitoring protocols.
Fill In Box	Output Performance Measure	MEASURE OF QUANTITY/QUALITY: Determine the percentage of facilities whose staff completed the online training course. Use an exam to evaluate if the individuals are retaining the information or determine if more training is necessary.
Fill In Box	Output Target	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM WILL ACCOMPLISH A PERFORMANCE MEASURE: Increase the knowledge related to the potential opportunities for influenza exposure in the laboratory.
Fill In Box	Immediate Outcome*	DESCRIBE THE INTENDED RESULT:
Fill In Box	Immediate Outcome Performance Measure*	IMMEDIATE OUTCOME EFFECTIVENESS:
Fill In Box	Outcome Target*	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM MUST ACCOMPLISH A PERFORMANCE MEASURE:
	Progress Report- To be Reported Mid Year and End of Year	
Fill In Box	Progress Report-Outputs	PROVIDE QUANTIFIABLE EXTENT THAT OUTPUTS HAVE BEEN ACHIEVED:
Fill In Box	Progress Report-Barriers	BRIEFLY EXPLAIN BARRIERS/PROBLEMS FACED IN ACHIEVING THE TARGET OUTPUT:

Note: *Grantees only need to report on Outputs, Output Performance Measures and Output Targets. They are not required to report Immediate Outcomes, Outcome Performance Measures and Outcome Targets.

Action Item 7	Work Plan Template for Pandemic Flu Guidance Grantees should fill out a separate template for each Action Item
Grantee Input	
	Goal:
Pull Down Menu	**Pandemic Influenza Preparedness Goal 3: DETECT AND REPORT**
	Decrease the time needed to detect and report an influenza outbreak with pandemic potential.
	Target Capability:
Pull Down Menu	**3B Target Capability: Public Health Laboratory Testing**
	(links to HHS State and Local Pandemic Influenza Planning Checklist, Public Health and Clinical Laboratories)
	Associated CDC Performance Measure:
Pull Down Menu	
	Critical Task:
Pull Down Menu	Test the knowledge and competency of frontline clinicians and laboratory personnel
	Action Item: The program efforts conducted to achieve the critical tasks that result in the creation of a product or service.
Fill In Box	(PHASE 1GAP): 3B:CT7:: Select/adapt/develop online competency-based training for public health & clinical lab staff as an enhancement to curre
	Description
Fill In Box	What: PURPOSE OF THE ACTION ITEM: To maintain quality techniques and standards for ensuring accuracy and safety with specimen collection and submission, diagnostic testing, adherence to biosafety containment, and biomonitoring protocols.
Fill In Box	Who: TARGET AUDIENCE: Frontline clinicians and laboratory personnel will be targeted.
Fill In Box	STAKEHOLDERS CRITICAL TO SUCCESS: Indiana's Indiana State Department of Health labs, designated public health and clinical lab personnel, Indiana Mid America Public Health Training Center instructional designer, and LMS Coordinator, and the University of Illinois at Chicago-Center for the Advancement of Distance Education, Acute Care Division-Clinical Laboratory Improvment Act (CLIA) Supervisor
Fill In Box	WHO IS RESPONSIBLE FOR OUTPUTS: Indiana State Department of Health Emergency Preparedness and Response (ISDH-EPR) Lab Director, Acute Care Divison-Clinical Laboratory Improvement Act (CLIA) Supervisor, Learning Content Management System (LCMS) Coordinator, and contractual instructional designer through the University of Illinois at Chicago- Center for the Advancement of Distance Education (UIC-CADE)
Fill In Box	When: TIME PERIOD OF PROJECT: 08/31/2006 through 08/30/2007
Fill In Box	Where: VENUE: Available statewide through Indiana's online Learning/Content Management System (IN LCMS)
Fill In Box	LOCATION: Available statewide
Fill In Box	Why: WHAT EVIDENCE DO YOU HAVE TO SUPPORT THE PROPOSED INTERVENTION/COURSE OF ACTION/OUTCOME FOR THIS ACTION ITEM?: Face-to-face trainings have been previously conducted. However, there are currently no online courses within the Indiana LCMS that are specific to the training needs identified by the Emergency Preparedness and Response Lab Director.
Fill In Box	WHAT IS THE CAPACITY OF THE RECIPIENT TO DEAL WITH THIS PROBLEM/OPPORTUNITY?: The ISDH Lab staff have the knowledge about training needs,federal lab regulations & specific content for course development. The LCMS Coor. has public health educ./methods/training expertise including ISDH's LCMS technical expertise. UIC-CADE developed, owns & manages the overall LCMS, & its staff has the online instructional technology/design expertise for course development.

Fill In Box		WHY DOES THIS ACTION ITEM DESERVE THE RECIPIENTS ATTENTION NOW?: To increase the venue for review, training and testing the competency of frontline clinicians and laboratory personnel. To increase the individual clinician 's opportunity for material review on an as needed basis. Online trainings will also increase the likelihood that more clinicians will have access to critical information sooner and more consistently.
Fill In Box		SUMMARY:This action will help to decrease time needed to detect & report an influenza outbreak with pandemic potential through testing the knowledge & accuracy of frontline clinicians & laboratory personnel. Specifically, an online course will be created that increases the capability of maintaining quality techniques & standards to ensure accuracy & safety with specimen collection & submission, diagnostic testing, adherence to biosafety containment, and biomonitoring protocols.
	Success Factors for Action Item	
Fill In Box	Outputs	WHAT DOES THIS PRODUCE?: An online course will be available through the IN LCMS for use by frontline clinicians and laboratory personnel to educate the individual on sample collection, reporting and shipping to referral laboratories.
Fill In Box	Output Performance Measure	MEASURE OF QUANTITY/QUALITY: Determine the percentage of facilities whose staff completed the online training course. Use an exam to evaluate if the individuals are retaining the information or determine if more training is necessary.
Fill In Box	Output Target	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM WILL ACCOMPLISH A PERFORMANCE MEASURE:
Fill In Box	Immediate Outcome*	DESCRIBE THE INTENDED RESULT:
Fill In Box	Immediate Outcome Performance Measure*	IMMEDIATE OUTCOME EFFECTIVENESS:
Fill In Box	Outcome Target*	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM MUST ACCOMPLISH A PERFORMANCE MEASURE:
	Progress Report- To be Reported Mid Year and End of Year	
Fill In Box	Progress Report-Outputs	PROVIDE QUANTIFIABLE EXTENT THAT OUTPUTS HAVE BEEN ACHIEVED:
Fill In Box	Progress Report-Barriers	BRIEFLY EXPLAIN BARRIERS/PROBLEMS FACED IN ACHIEVING THE TARGET OUTPUT:

Note: *Grantees only need to report on Outputs, Output Performance Measures and Output Targets. They are not required to report Immediate Outcomes, Outcome Performance Measures and Outcome Targets.

Action Item 8	Work Plan Template for Pandemic Flu Guidance Grantees should fill out a separate template for each Action Item
Grantee Input	
	Goal:
Pull Down Menu	**Pandemic Influenza Preparedness Goal 3: DETECT AND REPORT**
	Decrease the time needed to detect and report an influenza outbreak with pandemic potential.
	Target Capability:
Pull Down Menu	**3B Target Capability: Public Health Laboratory Testing**
	(links to HHS State and Local Pandemic Influenza Planning Checklist, Public Health and Clinical Laboratories)
	Associated CDC Performance Measure:
Pull Down Menu	Time from presumptive identification to confirmatory identification of select agents by Laboratory Response Network (LRN) reference lab
	Critical Task:
Pull Down Menu	Maintain the ability to test for influenza viruses year-round.
	Action Item: The program efforts conducted to achieve the critical tasks that result in the creation of a product or service.
Fill In Box	(PHASE 1GAP): 3B:CT1:: Develop and enhance the laboratory's capability to rapidly detect and subtype influenza viruses.
	Description
Fill In Box	What: PURPOSE OF THE ACTION ITEM: To maintain quality and enhance our ability for rapid and accurate detection of influenza and the subsequent subtyping of influenza isolates, the ISDH Laboratory must maintain capacity for the testing of large numbers of samples and must be able to utilize current technology.
Fill In Box	Who: TARGET AUDIENCE: Submitters of clinical specimens for influenza testing
Fill In Box	STAKEHOLDERS CRITICAL TO SUCCESS: State Health Department, Local Health Departments, Clinicians
Fill In Box	WHO IS RESPONSIBLE FOR OUTPUTS: ISDH Laboratory Director
Fill In Box	When: TIME PERIOD OF PROJECT: 08/31/2006 to 08/30/2007
Fill In Box	Where: VENUE: Statewide availability
Fill In Box	LOCATION: Statewide
Fill In Box	Why: WHAT EVIDENCE DO YOU HAVE TO SUPPORT THE PROPOSED INTERVENTION/COURSE OF ACTION/OUTCOME FOR THIS ACTION ITEM?: The ISDH Laboratory follows protocols developed by the CDC, WHO, etc. and must be able to perform those procedures on any sample submitted for influenza in an accurate, rapid manner.
Fill In Box	WHAT IS THE CAPACITY OF THE RECIPIENT TO DEAL WITH THIS PROBLEM/OPPORTUNITY?: The ISDH Laboratory can perform influenza testing, but capacity needs to be enhanced.

Fill In Box		WHY DOES THIS ACTION ITEM DESERVE THE RECIPIENTS ATTENTION NOW?: To ensure that the ISDH laboratory is better prepared to meet the needs of the State for pandemic influenza testing and subtyping with the necessary equipment and methodology in place before a pandemic occurs.
Fill In Box		SUMMARY: To ensure that the State is better prepared to detect the presence of influenza and has laboratory capacity for a large number of samples.
	Success Factors for Action Item	
Fill In Box	Outputs	WHAT DOES THIS PRODUCE?: Laboratory influenza test results
Fill In Box	Output Performance Measure	MEASURE OF QUANTITY/QUALITY: Accurate influenza test results that meet quality assurance standards.
Fill In Box	Output Target	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM WILL ACCOMPLISH A PERFORMANCE MEASURE: Equipment and methodology is in place.
Fill In Box	Immediate Outcome*	DESCRIBE THE INTENDED RESULT:
Fill In Box	Immediate Outcome Performance Measure*	IMMEDIATE OUTCOME EFFECTIVENESS:
Fill In Box	Outcome Target*	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM MUST ACCOMPLISH A PERFORMANCE MEASURE:
	Progress Report- To be Reported Mid Year and End of Year	
Fill In Box	Progress Report-Outputs	PROVIDE QUANTIFIABLE EXTENT THAT OUTPUTS HAVE BEEN ACHIEVED:
Fill In Box	Progress Report-Barriers	BRIEFLY EXPLAIN BARRIERS/PROBLEMS FACED IN ACHIEVING THE TARGET OUTPUT:

Note: *Grantees only need to report on Outputs, Output Performance Measures and Output Targets. They are not required to report Immediate Outcomes, Outcome Performance Measures and Outcome Targets.

Action Item 9	Work Plan Template for Pandemic Flu Guidance Grantees should fill out a separate template for each Action Item
Grantee Input	
	Goal:
Pull Down Menu	**Pandemic Influenza Preparedness Goal 3: DETECT AND REPORT**
	Decrease the time needed to detect and report an influenza outbreak with pandemic potential.
	Target Capability:
Pull Down Menu	**3B Target Capability: Public Health Laboratory Testing**
	(links to HHS State and Local Pandemic Influenza Planning Checklist, Public Health and Clinical Laboratories)
	Associated CDC Performance Measure:
Pull Down Menu	Time from presumptive identification to confirmatory identification of select agents by Laboratory Response Network (LRN) reference lab
	Critical Task:
Pull Down Menu	Perform Polymerase Chain Reaction (PCR) testing for rapid detection and subtyping of influenza viruses.
	Action Item: The program efforts conducted to achieve the critical tasks that result in the creation of a product or service.
Fill In Box	(PHASE 1GAP): 3B:CT2:: Develop and enhance the laboratory's capability to rapidly detect and subtype influenza viruses.
	Description
Fill In Box	What: PURPOSE OF THE ACTION ITEM: To maintain quality and enhance our ability for rapid and accurate detection of influenza and the subsequent subtyping of influenza isolates, the ISDH Laboratory must maintain capacity for the testing of large numbers of samples and must be able to utilize current technology.
Fill In Box	Who: TARGET AUDIENCE: Submitters of clinical specimens for influenza testing
Fill In Box	STAKEHOLDERS CRITICAL TO SUCCESS: State Health Department, Local Health Departments, Clinicians
Fill In Box	WHO IS RESPONSIBLE FOR OUTPUTS: ISDH Laboratory Director
Fill In Box	When: TIME PERIOD OF PROJECT: 08/31/2006 to 08/30/2007
Fill In Box	Where: VENUE: Statewide availability
Fill In Box	LOCATION: Statewide
Fill In Box	Why: WHAT EVIDENCE DO YOU HAVE TO SUPPORT THE PROPOSED INTERVENTION/COURSE OF ACTION/OUTCOME FOR THIS ACTION ITEM?: The ISDH Laboratory follows protocols developed by the CDC, WHO, etc. and must be able to perform those procedures on any sample submitted for influenza in an accurate, rapid manner.
Fill In Box	WHAT IS THE CAPACITY OF THE RECIPIENT TO DEAL WITH THIS PROBLEM/OPPORTUNITY?: The ISDH Laboratory can perform influenza testing, but capacity needs to be enhanced.

Fill In Box		WHY DOES THIS ACTION ITEM DESERVE THE RECIPIENTS ATTENTION NOW?: To ensure that the ISDH laboratory is better prepared to meet the needs of the State for pandemic influenza testing and subtyping with the necessary equipment and methodology in place before a pandemic occurs.
Fill In Box		SUMMARY: To ensure that the State is better prepared to detect the presence of influenza and has laboratory capacity for a large number of samples.
	Success Factors for Action Item	
Fill In Box	Outputs	WHAT DOES THIS PRODUCE?: Laboratory influenza test results
Fill In Box	Output Performance Measure	MEASURE OF QUANTITY/QUALITY: Accurate influenza test results that meet quality assurance standards.
Fill In Box	Output Target	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM WILL ACCOMPLISH A PERFORMANCE MEASURE: Equipment and methodology is in place.
Fill In Box	Immediate Outcome*	DESCRIBE THE INTENDED RESULT:
Fill In Box	Immediate Outcome Performance Measure*	IMMEDIATE OUTCOME EFFECTIVENESS:
Fill In Box	Outcome Target*	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM MUST ACCOMPLISH A PERFORMANCE MEASURE:
	Progress Report- To be Reported Mid Year and End of Year	
Fill In Box	Progress Report-Outputs	PROVIDE QUANTIFIABLE EXTENT THAT OUTPUTS HAVE BEEN ACHIEVED:
Fill In Box	Progress Report-Barriers	BRIEFLY EXPLAIN BARRIERS/PROBLEMS FACED IN ACHIEVING THE TARGET OUTPUT:

Note: *Grantees only need to report on Outputs, Output Performance Measures and Output Targets. They are not required to report Immediate Outcomes, Outcome Performance Measures and Outcome Targets.

Action Item 10	Work Plan Template for Pandemic Flu Guidance Grantees should fill out a separate template for each Action Item
Grantee Input	
	Goal:
Pull Down Menu	**Pandemic Influenza Preparedness Goal 3: DETECT AND REPORT**
	Decrease the time needed to detect and report an influenza outbreak with pandemic potential.
	Target Capability:
Pull Down Menu	**3B Target Capability: Public Health Laboratory Testing**
	(links to HHS State and Local Pandemic Influenza Planning Checklist, Public Health and Clinical Laboratories)
	Associated CDC Performance Measure:
Pull Down Menu	Time from presumptive identification to confirmatory identification of select agents by Laboratory Response Network (LRN) reference lab
	Critical Task:
Pull Down Menu	Electronically exchange specimen-level data among clinical laboratories, the state public health lab, and CDC
	Action Item: The program efforts conducted to achieve the critical tasks that result in the creation of a product or service.
Fill In Box	(PHASE 1GAP): 3B:CT3:: We are currently implementing the STARLIMS system to support the ISDH labs. STARLIMS is a critical component of c
	Description
	What
Fill In Box	PURPOSE OF THE ACTION ITEM: There are a number of Web based applications we need to develop to support the STARLIMS implementation. These includes establishing a flexible, comprehensive database that addresses the workflow and communication needs of a public health laboratory. We will also provide additional functionality such as central accessioning and remote Web based pan flu pre-accessioning.
	Who
Fill In Box	TARGET AUDIENCE: End users of lab information.
Fill In Box	STAKEHOLDERS CRITICAL TO SUCCESS: The primary stakeholder are the lab managers that support lab processes.
Fill In Box	WHO IS RESPONSIBLE FOR OUTPUTS: We will develop applications that provide access to the data. The lab technicians are responsible for providing the data.
	When
Fill In Box	TIME PERIOD OF PROJECT: 08/31/06 - 08/30/07
	Where
Fill In Box	VENUE: The data is collected at the ISDH labs.
Fill In Box	LOCATION: The data is collected at the ISDH labs.
	Why
Fill In Box	WHAT EVIDENCE DO YOU HAVE TO SUPPORT THE PROPOSED INTERVENTION/COURSE OF ACTION/OUTCOME FOR THIS ACTION ITEM?: We have evaluated the STARLIMS application and identified the work that needs to be done to both achieve PHIN Certification and support ISDH pan flu programs.
Fill In Box	WHAT IS THE CAPACITY OF THE RECIPIENT TO DEAL WITH THIS PROBLEM/OPPORTUNITY?: We do not forsee any technical capacity limitations in providing access to the data through the Web site.

Fill In Box		WHY DOES THIS ACTION ITEM DESERVE THE RECIPIENTS ATTENTION NOW?: This will simplify access to the information and reduce the staff demands to provide some of the information. In addition, this is work that we need to complete to meet PHIN Certification requirments.
Fill In Box		SUMMARY: We are in the process of iplementing a STARLIMS system to support the stat lab. As part of this, we need to establish a a database and develop some additional applications. These are neded to both support pan flu and PHIN Certification requirements.
	Success Factors for Action Item	
Fill In Box	Outputs	WHAT DOES THIS PRODUCE?: This will produce additional access to lab data.
Fill In Box	Output Performance Measure	MEASURE OF QUANTITY/QUALITY: The measure will be in presenting the information in a timely fashion.
Fill In Box	Output Target	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM WILL ACCOMPLISH A PERFORMANCE MEASURE: Our direction is to provide the information in "real time" as soon as is available.
Fill In Box	Immediate Outcome*	DESCRIBE THE INTENDED RESULT:
Fill In Box	Immediate Outcome Performance Measure*	IMMEDIATE OUTCOME EFFECTIVENESS:
Fill In Box	Outcome Target*	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM MUST ACCOMPLISH A PERFORMANCE MEASURE:
	Progress Report- To be Reported Mid Year and End of Year	
Fill In Box	Progress Report- Outputs	PROVIDE QUANTIFIABLE EXTENT THAT OUTPUTS HAVE BEEN ACHIEVED:
Fill In Box	Progress Report- Barriers	BRIEFLY EXPLAIN BARRIERS/PROBLEMS FACED IN ACHIEVING THE TARGET OUTPUT:

Note: *Grantees only need to report on Outputs, Output Performance Measures and Output Targets. They are not required to report Immediate Outcomes, Outcome Performance Measures and Outcome Targets.

Action Item 106	Work Plan Template for Pandemic Flu Guidance Grantees should fill out a separate template for each Action Item
Grantee Input	
	Goal:
Pull Down Menu	**Pandemic Influenza Preparedness Goal 4: DETECT AND REPORT**
	Improve the timeliness and accuracy of communications regarding the threat posed by an influenza outbreak with pandemic.
	Target Capability:
Pull Down Menu	**4A Target Capability: Communications**
	(links to HHS State and Local Pandemic Influenza Planning Checklist, Public Health Communications.)
	Associated CDC Performance Measure:
Pull Down Menu	For each PHIN Functional Area, the percent of critical functional requirements that have been achieved based on either the Functional Self Assessment Tool or the PHIN certification process.
	Critical Task:
Pull Down Menu	Support exchange of essential information before and during an influenza pandemic.
	Action Item: The program efforts conducted to achieve the critical tasks that result in the creation of a product or service.
Fill In Box	ACTION LINKED TO PRIORITY 5: 4A:CT1:: Develop Webinar capabilities to provide training and communication in the event of an incident.
	Description
Fill In Box	What: PURPOSE OF THE ACTION ITEM: We have a need to provide ongoing training to our local Health Departments and hospitals. This is critical to the expansion of our volunteer (ESAR-VHP) and communication (IHAN) programs. We also want to include Webinar capabilities at our Disaster Recovery Site and Recovery Area to supplement current communication procedures.
Fill In Box	Who: TARGET AUDIENCE: Local Health Departmetns and Hospitals.
Fill In Box	STAKEHOLDERS CRITICAL TO SUCCESS: The key stakeholders at the ISDH are the coordinators of the LMS (Learning Management System), ESAR-VHP Coordinator and the IHAN Coordinator.
Fill In Box	WHO IS RESPONSIBLE FOR OUTPUTS: The ISDH IT manager is responsible for the succesful implementation. The ESAR-VHP Coordinator and IHAN Coordinator are responsible for using the software.
Fill In Box	When: TIME PERIOD OF PROJECT: 08/31/06 - 08/30/07
Fill In Box	Where: VENUE: The Webcasts will originate from the ISDH or the Disaster Recovery Site.
Fill In Box	LOCATION: The Webcasts will originate from the ISDH or the Disaster Recovery Site.
Fill In Box	Why: WHAT EVIDENCE DO YOU HAVE TO SUPPORT THE PROPOSED INTERVENTION/COURSE OF ACTION/OUTCOME FOR THIS ACTION ITEM?: We currently have major costs and problems associated with providing statewide training. We also have problems with coordinating activities associated with the implementation of major changes. Webinars provide an inexpensive solution.
Fill In Box	WHAT IS THE CAPACITY OF THE RECIPIENT TO DEAL WITH THIS PROBLEM/OPPORTUNITY?: We are targeting at being able to support 100 people in a session. The complexity of the situation will dictate the size of our audience.

Fill In Box		WHY DOES THIS ACTION ITEM DESERVE THE RECIPIENTS ATTENTION NOW?: We are in the process of developing a number of new / enhanced applications (CRA, ESAR-VHP, IHAN, etc.) that will directly impact the field.
Fill In Box		SUMMARY: We need to develop a low cost method to provide ongoing training and communicate key information directly to our field. Webinars provide this capability. We are also incorporating Webinars into our Disaster Recovery site to provide a redundant communication alternative.
	Success Factors for Action Item	
Fill In Box	Outputs	WHAT DOES THIS PRODUCE?: A sucessful software implementation and creating an effective environment for training.
Fill In Box	Output Performance Measure	MEASURE OF QUANTITY/QUALITY: The quality will be reflected in the number of people that want to use the system.
Fill In Box	Output Target	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM WILL ACCOMPLISH A PERFORMANCE MEASURE: Our initial goal is to support EASR-VHP, IHAN and CRA. However, we have expectations that it will be used for a number of other purposes.
Fill In Box	Immediate Outcome*	DESCRIBE THE INTENDED RESULT:
Fill In Box	Immediate Outcome Performance Measure*	IMMEDIATE OUTCOME EFFECTIVENESS:
Fill In Box	Outcome Target*	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM MUST ACCOMPLISH A PERFORMANCE MEASURE:
	Progress Report- To be Reported Mid Year and End of Year	
Fill In Box	Progress Report-Outputs	PROVIDE QUANTIFIABLE EXTENT THAT OUTPUTS HAVE BEEN ACHIEVED:
Fill In Box	Progress Report-Barriers	BRIEFLY EXPLAIN BARRIERS/PROBLEMS FACED IN ACHIEVING THE TARGET OUTPUT:

Note: *Grantees only need to report on Outputs, Output Performance Measures and Output Targets. They are not required to report Immediate Outcomes, Outcome Performance Measures and Outcome Targets.

Action Item 107	Work Plan Template for Pandemic Flu Guidance Grantees should fill out a separate template for each Action Item
Grantee Input	
	Goal:
Pull Down Menu	**Pandemic Influenza Preparedness Goal 4: DETECT AND REPORT**
	Improve the timeliness and accuracy of communications regarding the threat posed by an influenza outbreak with pandemic.
	Target Capability:
Pull Down Menu	**4A Target Capability: Communications**
	(links to HHS State and Local Pandemic Influenza Planning Checklist, Public Health Communications.)
	Associated CDC Performance Measure:
Pull Down Menu	For each PHIN Functional Area, the percent of critical functional requirements that have been achieved based on either the Functional Self Assessment Tool or the PHIN certification process.
	Critical Task:
Pull Down Menu	Support exchange of essential information before and during an influenza pandemic.
	Action Item: The program efforts conducted to achieve the critical tasks that result in the creation of a product or service.
Fill In Box	ACTION LINKED TO PRIORITY 5: 4A:CT1:: As part of our Disaster Recovery (DR) site we have eastablished a recovery area. This recovery are
	Description
Fill In Box	What: PURPOSE OF THE ACTION ITEM: We have a number of fixed PCs in our recovery area that are imaged and ready to run. We need to add a switch that will allow field staff and others to plug in their laptop when they arrive. This allows for a mobile workforce that already has laptops and does not require us to have additional PCs in the recovery area.
Fill In Box	Who: TARGET AUDIENCE: ISDH and agency partners that need to use our recovery area.
Fill In Box	STAKEHOLDERS CRITICAL TO SUCCESS: The ISDH Incident commander.
Fill In Box	WHO IS RESPONSIBLE FOR OUTPUTS: The ISDH and agency partners will receive the benefit of the switch.
Fill In Box	When: TIME PERIOD OF PROJECT: 08/31/06 - 10/1/2006.
Fill In Box	Where: VENUE: The installation will be at our DR site recovery area.
Fill In Box	LOCATION: The installation will be at our DR site recovery area.
Fill In Box	Why: WHAT EVIDENCE DO YOU HAVE TO SUPPORT THE PROPOSED INTERVENTION/COURSE OF ACTION/OUTCOME FOR THIS ACTION ITEM?: We have a need to be able to provide system access to ISDH staff and other agencies that arrive at our DR site. The individuals that need the service may change and adding a switch allows us to provide access without purchasing additional PCs.
Fill In Box	WHAT IS THE CAPACITY OF THE RECIPIENT TO DEAL WITH THIS PROBLEM/OPPORTUNITY?: The capacity of the router is 12 ports. It will allow 12 additional individuals to access the system.

Fill In Box		WHY DOES THIS ACTION ITEM DESERVE THE RECIPIENTS ATTENTION NOW?: Without this switch we will either noeed to purchase additional PCs or restrict system access at the DR site.
Fill In Box		SUMMARY: We are limited at the recovery area at our DR site to the number of individuals that can have system access. Rather than add additional PCs, we are recommending purchasing a switch that allows individuals with laptops to plug in directly to the system.
	Success Factors for Action Item	
Fill In Box	Outputs	WHAT DOES THIS PRODUCE?: The output is the installation of the switch.
Fill In Box	Output Performance Measure	MEASURE OF QUANTITY/QUALITY: We will test network access to insure the switch operates correctly.
Fill In Box	Output Target	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM WILL ACCOMPLISH A PERFORMANCE MEASURE: It must work for all twelve ports.
Fill In Box	Immediate Outcome*	DESCRIBE THE INTENDED RESULT:
Fill In Box	Immediate Outcome Performance Measure*	IMMEDIATE OUTCOME EFFECTIVENESS:
Fill In Box	Outcome Target*	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM MUST ACCOMPLISH A PERFORMANCE MEASURE:
	Progress Report- To be Reported Mid Year and End of Year	
Fill In Box	Progress Report-Outputs	PROVIDE QUANTIFIABLE EXTENT THAT OUTPUTS HAVE BEEN ACHIEVED:
Fill In Box	Progress Report-Barriers	BRIEFLY EXPLAIN BARRIERS/PROBLEMS FACED IN ACHIEVING THE TARGET OUTPUT:

Note: *Grantees only need to report on Outputs, Output Performance Measures and Output Targets. They are not required to report Immediate Outcomes, Outcome Performance Measures and Outcome Targets.

Action Item 108	Work Plan Template for Pandemic Flu Guidance Grantees should fill out a separate template for each Action Item
Grantee Input	
	Goal:
Pull Down Menu	**Pandemic Influenza Preparedness Goal 4: DETECT AND REPORT**
	Improve the timeliness and accuracy of communications regarding the threat posed by an influenza outbreak with pandemic.
	Target Capability:
Pull Down Menu	**4A Target Capability: Communications**
	(links to HHS State and Local Pandemic Influenza Planning Checklist, Public Health Communications.)
	Associated CDC Performance Measure:
Pull Down Menu	For each PHIN Functional Area, the percent of critical functional requirements that have been achieved based on either the Functional Self Assessment Tool or the PHIN certification process.
	Critical Task:
Pull Down Menu	Support exchange of essential information before and during an influenza pandemic.
	Action Item: The program efforts conducted to achieve the critical tasks that result in the creation of a product or service.
Fill In Box	ACTION LINKED TO PRIORITY 5: 4A:CT1:: We need to replace our current system for surveys with a canned application.
	Description
Fill In Box	What: PURPOSE OF THE ACTION ITEM: We currently have a "home grown" survey system that is limited in what we can do with it. We are constantly modifying it and cannot capture all the information that we need. We need a Web-based survey application that we can integrate into our Health net portal.
Fill In Box	Who: TARGET AUDIENCE: Local Health Department / Local Public Health Coordinators and hospitals.
Fill In Box	STAKEHOLDERS CRITICAL TO SUCCESS: The key stakeholders are the grant administrators that initiate most of our surveys.
Fill In Box	WHO IS RESPONSIBLE FOR OUTPUTS: The IT manager is responsible for packaging the survey results. The grant administrators and others analyze the results.
Fill In Box	When: TIME PERIOD OF PROJECT: 4/1/2007 - 6/1/2007
Fill In Box	Where: VENUE: The surveys originate at the ISDH.
Fill In Box	LOCATION: most surveys are completed at health departments and hospitals.
Fill In Box	Why: WHAT EVIDENCE DO YOU HAVE TO SUPPORT THE PROPOSED INTERVENTION/COURSE OF ACTION/OUTCOME FOR THIS ACTION ITEM?: We currently cannot provide all the functionality that is requested. It also takes us too long to prepare the survey.
Fill In Box	WHAT IS THE CAPACITY OF THE RECIPIENT TO DEAL WITH THIS PROBLEM/OPPORTUNITY?: The proposed survey system will reduce the time required to submit, respond and analyze the data.

Fill In Box		WHY DOES THIS ACTION ITEM DESERVE THE RECIPIENTS ATTENTION NOW?: The restrictions we currently have on delivering surveys will be removed.
Fill In Box		SUMMARY: We have an ongoing problem with handling surveys. It takes too long to produce the survey and there are restrictions on what we can deliver. We are looking at software that will provided additional features, simplify creating surveys and will integrate into our existing applications.
	Success Factors for Action Item	
Fill In Box	Outputs	WHAT DOES THIS PRODUCE?: The software will produce a tailored survey oriented toward a specific audience. It will collect the survey data and integrate the data into existing applications.
Fill In Box	Output Performance Measure	MEASURE OF QUANTITY/QUALITY: The primary measure will be the time it takes to submit a survey.
Fill In Box	Output Target	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM WILL ACCOMPLISH A PERFORMANCE MEASURE: We expect that we can deliver a survey within one week and 98% of the survey requirements will be from the base software package.
Fill In Box	Immediate Outcome*	DESCRIBE THE INTENDED RESULT:
Fill In Box	Immediate Outcome Performance Measure*	IMMEDIATE OUTCOME EFFECTIVENESS:
Fill In Box	Outcome Target*	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM MUST ACCOMPLISH A PERFORMANCE MEASURE:
	Progress Report- To be Reported Mid Year and End of Year	
Fill In Box	Progress Report- Outputs	PROVIDE QUANTIFIABLE EXTENT THAT OUTPUTS HAVE BEEN ACHIEVED:
Fill In Box	Progress Report- Barriers	BRIEFLY EXPLAIN BARRIERS/PROBLEMS FACED IN ACHIEVING THE TARGET OUTPUT:

Note: *Grantees only need to report on Outputs, Output Performance Measures and Output Targets. They are not required to report Immediate Outcomes, Outcome Performance Measures and Outcome Targets.

Action Item 109	Work Plan Template for Pandemic Flu Guidance Grantees should fill out a separate template for each Action Item
Grantee Input	
	Goal:
Pull Down Menu	**Pandemic Influenza Preparedness Goal 4: DETECT AND REPORT**
	Improve the timeliness and accuracy of communications regarding the threat posed by an influenza outbreak with pandemic.
	Target Capability:
Pull Down Menu	**4A Target Capability: Communications**
	(links to HHS State and Local Pandemic Influenza Planning Checklist, Public Health Communications.)
	Associated CDC Performance Measure:
Pull Down Menu	For each PHIN Functional Area, the percent of critical functional requirements that have been achieved based on either the Functional Self Assessment Tool or the PHIN certification process.
	Critical Task:
Pull Down Menu	Have or have access to interoperable information systems that support the initial identification and that provide situational awareness of
	Action Item: The program efforts conducted to achieve the critical tasks that result in the creation of a product or service.
Fill In Box	ACTION LINKED TO 4A:CT2:: We currently have some EED capabilities with an internally developed system called PHESS. It does not contain a
	Description
Fill In Box	What: PURPOSE OF THE ACTION ITEM: We have received the NEDSS system that Pennsylvania developed and are in the process of implementing it in Indiana. This is a key requirement for us to achieve PHIN certification in Early Event Detection (EED). Our current plan is to not even start certification efforts until the next grant year. By accelerating the implementation of NEDSS, we will accelerate our certification efforts and start them in the current grant year. We are looking at accelerating both the development / implementation activities and the preparation of documentation and training materials.
Fill In Box	Who: TARGET AUDIENCE: The State Epidemiologists will benefit most from the implementation of an EED application.
Fill In Box	STAKEHOLDERS CRITICAL TO SUCCESS: The lead EED IT support technician and thee State Epidemiology Manager is responsible for Early Event Detection.
Fill In Box	WHO IS RESPONSIBLE FOR OUTPUTS: The State Epidemiologists that monitor NEDSS are responsible for system outputs.
Fill In Box	When: TIME PERIOD OF PROJECT: 08/31/06 - 08/30/07
Fill In Box	Where: VENUE: NEDSS will monitor statewide activity.
Fill In Box	LOCATION: NEDSS will monitor hospitals and labs statewide.
Fill In Box	Why: WHAT EVIDENCE DO YOU HAVE TO SUPPORT THE PROPOSED INTERVENTION/COURSE OF ACTION/OUTCOME FOR THIS ACTION ITEM?: We completed a review of all the requirements for implementing NEDSS in our environment and are in the process of modifying the application. By adding development and training resources, we will be able to accelerate our implementation and focus on PHIN Certification earlier.
Fill In Box	WHAT IS THE CAPACITY OF THE RECIPIENT TO DEAL WITH THIS PROBLEM/OPPORTUNITY?: This will simplify many of the current procedures that the epidemiologist performs and the only capacity limitations will be on how quickly we can provide support / helpdesk facilities.

Fill In Box		WHY DOES THIS ACTION ITEM DESERVE THE RECIPIENTS ATTENTION NOW?: The current PHESS system provides some EED support but it does not offer the complete system thqt NEDSS provides. We need NEDSS both to provide additional EED capabilities and provide a basic application required for PHIN Certification. We need NEDSS both to provide additional EED capabilities and provide a basic application required for PHIN Certification.
Fill In Box		SUMMARY: We currently have a PHESS system that provides EED capabilities; however , we need to provide additional capabilities to meet our EED needs. The implementation of NEDSS will accomplish this and also provide a basis for PHIN Certification.
	Success Factors for Action Item	
Fill In Box	Outputs	WHAT DOES THIS PRODUCE?: The outputs are the reports and tools that provide early notice of a pending event.
Fill In Box	Output Performance Measure	MEASURE OF QUANTITY/QUALITY: The measure will be whether all events are detected.
Fill In Box	Output Target	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM WILL ACCOMPLISH A PERFORMANCE MEASURE: Our target is 100% of all major events will be detected though NEDSS and PHESS.
Fill In Box	Immediate Outcome*	DESCRIBE THE INTENDED RESULT:
Fill In Box	Immediate Outcome Performance Measure*	IMMEDIATE OUTCOME EFFECTIVENESS:
Fill In Box	Outcome Target*	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM MUST ACCOMPLISH A PERFORMANCE MEASURE:
	Progress Report- To be Reported Mid Year and End of Year	
Fill In Box	Progress Report-Outputs	PROVIDE QUANTIFIABLE EXTENT THAT OUTPUTS HAVE BEEN ACHIEVED:
Fill In Box	Progress Report-Barriers	BRIEFLY EXPLAIN BARRIERS/PROBLEMS FACED IN ACHIEVING THE TARGET OUTPUT:

Note: *Grantees only need to report on Outputs, Output Performance Measures and Output Targets. They are not required to report Immediate Outcomes, Outcome Performance Measures and Outcome Targets.

Action Item 110	Work Plan Template for Pandemic Flu Guidance Grantees should fill out a separate template for each Action Item
Grantee Input	
	Goal:
Pull Down Menu	**Pandemic Influenza Preparedness Goal 4: DETECT AND REPORT**
	Improve the timeliness and accuracy of communications regarding the threat posed by an influenza outbreak with pandemic.
	Target Capability:
Pull Down Menu	**4A Target Capability: Communications**
	(links to HHS State and Local Pandemic Influenza Planning Checklist, Public Health Communications.)
	Associated CDC Performance Measure:
Pull Down Menu	For each PHIN Functional Area, the percent of critical functional requirements that have been achieved based on either the Functional Self Assessment Tool or the PHIN certification process.
	Critical Task:
Pull Down Menu	Have or have access to interoperable information systems to capture and manage data associated with the investigation and containment
	Action Item: The program efforts conducted to achieve the critical tasks that result in the creation of a product or service.
Fill In Box	ACTION LINKED TO 4A:CT3:: Make the Outbreak Management System (OMS) PHIN compliant.
	Description
Fill In Box	What: PURPOSE OF THE ACTION ITEM: We currently have an internally developed OMS system that is not PHIN compliant and does not deliver all the functionality that we need. We need start by evaluating the current CDC OMS system. We need to determine if we want to convert to the CDC system or enhance our system to make it PHIN compatible.
Fill In Box	Who: TARGET AUDIENCE: The individuals that use the system are the State Epidemiologists.
Fill In Box	STAKEHOLDERS CRITICAL TO SUCCESS: OMS developer who is responsible for the IT support and the OMS manager who is responsible for the epidemiologists that monitor the OMS.
Fill In Box	WHO IS RESPONSIBLE FOR OUTPUTS: The State Epidemiologists that monitor the OMS are responsible for system outputs.
Fill In Box	When: TIME PERIOD OF PROJECT: 08/31/06 - 08/30/07
Fill In Box	Where: VENUE: OMS monitoring is statewide.
Fill In Box	LOCATION: Monitoring is done at all locations statewide.
Fill In Box	Why: WHAT EVIDENCE DO YOU HAVE TO SUPPORT THE PROPOSED INTERVENTION/COURSE OF ACTION/OUTCOME FOR THIS ACTION ITEM?: We have completed a review of all the PHIN certification requirements. With existing resources we would be able to only do minimal work in the next year. This allows us to accelerate our certification plan.
Fill In Box	WHAT IS THE CAPACITY OF THE RECIPIENT TO DEAL WITH THIS PROBLEM/OPPORTUNITY?: We feel that one person will be able to do the analysis and handle the implementation.

Fill In Box		WHY DOES THIS ACTION ITEM DESERVE THE RECIPIENTS ATTENTION NOW?: On the basis of our review of the PHIN requirements, we have identified a number of gaps in our current processes. This will accelerate our ability to close them.
Fill In Box		SUMMARY: Our PHIN Certification goal for the 2005 - 2006 CDC grant year was evaluate the six functional certification areas and develop a plan for achieving certification. As part of that plan we identified gaps with our OMS. We do not have resources available to address the gaps now; this request is to fund accelerating our schedule and achieve certification in the coming year.
	Success Factors for Action Item	
Fill In Box	Outputs	WHAT DOES THIS PRODUCE?: The OMS system provides the tools we need to manage a major outbreak. It interfaces with early event detection systems and countermeasure response systems.
Fill In Box	Output Performance Measure	MEASURE OF QUANTITY/QUALITY: Our goal is that OMS will be PHIN compliant and should manage 1all major outbreaks.
Fill In Box	Output Target	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM WILL ACCOMPLISH A PERFORMANCE MEASURE: The measurable statistic will be if 100% of mandatory PHIN Certification requirements are met.
Fill In Box	Immediate Outcome*	DESCRIBE THE INTENDED RESULT:
Fill In Box	Immediate Outcome Performance Measure*	IMMEDIATE OUTCOME EFFECTIVENESS:
Fill In Box	Outcome Target*	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM MUST ACCOMPLISH A PERFORMANCE MEASURE:
	Progress Report- To be Reported Mid Year and End of Year	
Fill In Box	Progress Report- Outputs	PROVIDE QUANTIFIABLE EXTENT THAT OUTPUTS HAVE BEEN ACHIEVED:
Fill In Box	Progress Report- Barriers	BRIEFLY EXPLAIN BARRIERS/PROBLEMS FACED IN ACHIEVING THE TARGET OUTPUT:

Note: *Grantees only need to report on Outputs, Output Performance Measures and Output Targets. They are not required to report Immediate Outcomes, Outcome Performance Measures and Outcome Targets.

Action Item 101	Work Plan Template for Pandemic Flu Guidance Grantees should fill out a separate template for each Action Item
Grantee Input	
	Goal:
Pull Down Menu	**Pandemic Influenza Preparedness Goal 4: DETECT AND REPORT**
	Improve the timeliness and accuracy of communications regarding the threat posed by an influenza outbreak with pandemic.
	Target Capability:
Pull Down Menu	**4A Target Capability: Communications**
	(links to HHS State and Local Pandemic Influenza Planning Checklist, Public Health Communications.)
	Associated CDC Performance Measure:
Pull Down Menu	For each PHIN Functional Area, the percent of critical functional requirements that have been achieved based on either the Functional Self Assessment Tool or the PHIN certification process.
	Critical Task:
Pull Down Menu	Have or have access to interoperable information systems to capture and manage data associated with the investigation and containment
	Action Item: The program efforts conducted to achieve the critical tasks that result in the creation of a product or service.
Fill In Box	ACTION LINKED TO 4A:CT3:: We are establishing a credentialing system to support our Outbreak Management System and other POD activities
	Description
Fill In Box	What: PURPOSE OF THE ACTION ITEM: We need PCs to serve as the repository for the collection / verification / transmission of data.
Fill In Box	Who: TARGET AUDIENCE: Data collection staff at a centralized / incident location.
Fill In Box	STAKEHOLDERS CRITICAL TO SUCCESS: OMS management.
Fill In Box	WHO IS RESPONSIBLE FOR OUTPUTS: The data collection / verification staff.
Fill In Box	When: TIME PERIOD OF PROJECT: 08/31/2006 - 12/1/2006
Fill In Box	Where: VENUE: The data will be collected at a site in the district. The site will be dependent upon the location of the incident.
Fill In Box	LOCATION: The location will be a back office, probably at an LHD or POD.
Fill In Box	Why: WHAT EVIDENCE DO YOU HAVE TO SUPPORT THE PROPOSED INTERVENTION/COURSE OF ACTION/OUTCOME FOR THIS ACTION ITEM?: We have a working prototype and need the PCs to implement the system. The prototype provided both capacity information and procedure guidelines.
Fill In Box	WHAT IS THE CAPACITY OF THE RECIPIENT TO DEAL WITH THIS PROBLEM/OPPORTUNITY? We have configured the laptops with sufficient capacity to support the system requirements.

Fill In Box		WHY DOES THIS ACTION ITEM DESERVE THE RECIPIENTS ATTENTION NOW?: Through the working prototype we have an understanding of the system requirements and need the laptops to complete our implementation.
Fill In Box		SUMMARY: We have developed a prototype of a credentialing system and established how we want to use it. To support the implementation we will need eleven PCs for capturing / verifying / transmitting data.
	Success Factors for Action Item	
Fill In Box	Outputs	WHAT DOES THIS PRODUCE?: The laptops will run our credentialing system.
Fill In Box	Output Performance Measure	MEASURE OF QUANTITY/QUALITY: The measurement will be whether the laptops have sufficient capacity to support credentialing.
Fill In Box	Output Target	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM WILL ACCOMPLISH A PERFORMANCE MEASURE: Our goal is to support real time data capture / verification with no wait time.
Fill In Box	Immediate Outcome*	DESCRIBE THE INTENDED RESULT:
Fill In Box	Immediate Outcome Performance Measure*	IMMEDIATE OUTCOME EFFECTIVENESS:
Fill In Box	Outcome Target*	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM MUST ACCOMPLISH A PERFORMANCE MEASURE:
	Progress Report- To be Reported Mid Year and End of Year	
Fill In Box	Progress Report- Outputs	PROVIDE QUANTIFIABLE EXTENT THAT OUTPUTS HAVE BEEN ACHIEVED:
Fill In Box	Progress Report- Barriers	BRIEFLY EXPLAIN BARRIERS/PROBLEMS FACED IN ACHIEVING THE TARGET OUTPUT:

Note: *Grantees only need to report on Outputs, Output Performance Measures and Output Targets. They are not required to report Immediate Outcomes, Outcome Performance Measures and Outcome Targets.

Action Item 102	Work Plan Template for Pandemic Flu Guidance Grantees should fill out a separate template for each Action Item
Grantee Input	
	Goal:
Pull Down Menu	**Pandemic Influenza Preparedness Goal 4: DETECT AND REPORT**
	Improve the timeliness and accuracy of communications regarding the threat posed by an influenza outbreak with pandemic.
	Target Capability:
Pull Down Menu	**4A Target Capability: Communications**
	(links to HHS State and Local Pandemic Influenza Planning Checklist, Public Health Communications.)
	Associated CDC Performance Measure:
Pull Down Menu	For each PHIN Functional Area, the percent of critical functional requirements that have been achieved based on either the Functional Self Assessment Tool or the PHIN certification process.
	Critical Task:
Pull Down Menu	Have or have access to interoperable information systems for electronic exchange of laboratory related information with public health
	Action Item: The program efforts conducted to achieve the critical tasks that result in the creation of a product or service.
Fill In Box	ACTION LINKED TO 4A:CT4:: Have a developer make changes to the ISDH Web page to support the labs new STARLIMS system.
	Description
Fill In Box	What: PURPOSE OF THE ACTION ITEM: We are installing the STARLIMS system in the state lab. This is required to improve lab operations and meet the requirements needed for PHIN Certification. To support STARLIMS we need to change the ISDH Web page to provide additional information. This includes a variety of information including instructions on handling samples and shipping instructions.
Fill In Box	Who: TARGET AUDIENCE: The target audience will be people that need to use the lab's services.
Fill In Box	STAKEHOLDERS CRITICAL TO SUCCESS: The key stakeholders will be the lab operations staff that will receive the benefit of improved preparation / sending of samples.
Fill In Box	WHO IS RESPONSIBLE FOR OUTPUTS: This request is to provide additional information and the state lab director is ultimately responsible for what is displayed.
Fill In Box	When: TIME PERIOD OF PROJECT: 08/31/06 - 012/31/06
Fill In Box	Where: VENUE: The information will be displayed on the ISDH Web site.
Fill In Box	LOCATION: The information will be displayed on the ISDH Web site.
Fill In Box	Why: WHAT EVIDENCE DO YOU HAVE TO SUPPORT THE PROPOSED INTERVENTION/COURSE OF ACTION/OUTCOME FOR THIS ACTION ITEM?: Our evaluation of the STARLIMS system and review of PHIN Certification requirements identified that we need to make this information available.
Fill In Box	WHAT IS THE CAPACITY OF THE RECIPIENT TO DEAL WITH THIS PROBLEM/OPPORTUNITY?: We do not foresee any technical capacity limitations in providing access to the data through the Web site.

Fill In Box		WHY DOES THIS ACTION ITEM DESERVE THE RECIPIENTS ATTENTION NOW?: This will provide a easy source for information that individuals using the lab services need.
Fill In Box		SUMMARY: As part of our STARLIMS implementation, we need to modify the ISDH Web page to provide additional information relating to the labs. This is needed to both facilitate lab operations and meet PHIN Certification requirements.
	Success Factors for Action Item	
Fill In Box	Outputs	WHAT DOES THIS PRODUCE?: This will produce access to additional lab realted information on the ISDH Web page.
Fill In Box	Output Performance Measure	MEASURE OF QUANTITY/QUALITY: This will help lab operations in that there will be readily available information to support users of lab services.
Fill In Box	Output Target	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM WILL ACCOMPLISH A PERFORMANCE MEASURE: This should reduce mistakes in delivering samples to the state lab.
Fill In Box	Immediate Outcome*	DESCRIBE THE INTENDED RESULT:
Fill In Box	Immediate Outcome Performance Measure*	IMMEDIATE OUTCOME EFFECTIVENESS:
Fill In Box	Outcome Target*	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM MUST ACCOMPLISH A PERFORMANCE MEASURE:
	Progress Report- To be Reported Mid Year and End of Year	
Fill In Box	Progress Report-Outputs	PROVIDE QUANTIFIABLE EXTENT THAT OUTPUTS HAVE BEEN ACHIEVED:
Fill In Box	Progress Report-Barriers	BRIEFLY EXPLAIN BARRIERS/PROBLEMS FACED IN ACHIEVING THE TARGET OUTPUT:

Note: *Grantees only need to report on Outputs, Output Performance Measures and Output Targets. They are not required to report Immediate Outcomes, Outcome Performance Measures and Outcome Targets.

Action Item 103	Work Plan Template for Pandemic Flu Guidance Grantees should fill out a separate template for each Action Item
Grantee Input	
	Goal:
Pull Down Menu	**Pandemic Influenza Preparedness Goal 4: DETECT AND REPORT**
	Improve the timeliness and accuracy of communications regarding the threat posed by an influenza outbreak with pandemic.
	Target Capability:
Pull Down Menu	**4A Target Capability: Communications**
	(links to HHS State and Local Pandemic Influenza Planning Checklist, Public Health Communications.)
	Associated CDC Performance Measure:
Pull Down Menu	For each PHIN Functional Area, the percent of critical functional requirements that have been achieved based on either the Functional Self Assessment Tool or the PHIN certification process.
	Critical Task:
Pull Down Menu	Have or have access to interoperable information systems that comply with PHIN Preparedness Functional Area Countermeasure and
	Action Item: The program efforts conducted to achieve the critical tasks that result in the creation of a product or service.
Fill In Box	ACTION LINKED TO 4A:CT4:: We are currently implementing the STARLIMS system to support the ISDH labs. STARLIMS is a critical componen
	Description
Fill In Box	What: PURPOSE OF THE ACTION ITEM: There are a number of Web based applications we need to develop to support the STARLIMS implementation. These include establishing a flexible, comprehensive database that addresses the workflow and communication needs of a public health laboratory. We will also provide additional functionality such as central accessioning and remote Web based pan flu pre-accessioning.
Fill In Box	Who: TARGET AUDIENCE: End users of lab information.
Fill In Box	STAKEHOLDERS CRITICAL TO SUCCESS: The primary stakeholder are the lab managers that support lab processes..
Fill In Box	WHO IS RESPONSIBLE FOR OUTPUTS: We will develop applications that provide access to the data. The lab technicians are responsible for providing the data.
Fill In Box	When: TIME PERIOD OF PROJECT: 08/31/06 - 08/30/07
Fill In Box	Where: VENUE: The data is collected at the ISDH labs.
Fill In Box	LOCATION: The data is collected at the ISDH labs.
Fill In Box	Why: WHAT EVIDENCE DO YOU HAVE TO SUPPORT THE PROPOSED INTERVENTION/COURSE OF ACTION/OUTCOME FOR THIS ACTION ITEM?: We have evaluated the STARLIMS application and identified the work that needs to be done to both achieve PHIN Certification and support ISDH pan flu programs.
Fill In Box	WHAT IS THE CAPACITY OF THE RECIPIENT TO DEAL WITH THIS PROBLEM/OPPORTUNITY?: We do not foresee any technical capacity limitations in providing access to the data.

Fill In Box		WHY DOES THIS ACTION ITEM DESERVE THE RECIPIENTS ATTENTION NOW?: This will simplify access to the information and reduce the staff demands to provide some of the information. In addition, this is work that we need to complete to meet PHIN Certification requirements.
Fill In Box		SUMMARY: We are in the process of implementing a STARLIMS system to support the stat lab. As part of this, we need to establish a a database and develop some additional applications. These are neded to both support pan flu and PHIN Certification requirements.
	Success Factors for Action Item	
Fill In Box	Outputs	WHAT DOES THIS PRODUCE?: This will produce additional access to lab data.
Fill In Box	Output Performance Measure	MEASURE OF QUANTITY/QUALITY: The measure will be in presenting the information in a timely fashion.
Fill In Box	Output Target	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM WILL ACCOMPLISH A PERFORMANCE MEASURE: Our direction is to provide the information in "real time" as soon as is available.
Fill In Box	Immediate Outcome*	DESCRIBE THE INTENDED RESULT:
Fill In Box	Immediate Outcome Performance Measure*	IMMEDIATE OUTCOME EFFECTIVENESS:
Fill In Box	Outcome Target*	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM MUST ACCOMPLISH A PERFORMANCE MEASURE:
	Progress Report- To be Reported Mid Year and End of Year	
Fill In Box	Progress Report-Outputs	PROVIDE QUANTIFIABLE EXTENT THAT OUTPUTS HAVE BEEN ACHIEVED:
Fill In Box	Progress Report-Barriers	BRIEFLY EXPLAIN BARRIERS/PROBLEMS FACED IN ACHIEVING THE TARGET OUTPUT:

Note: *Grantees only need to report on Outputs, Output Performance Measures and Output Targets. They are not required to report Immediate Outcomes, Outcome Performance Measures and Outcome Targets.

Action Item 104	Work Plan Template for Pandemic Flu Guidance Grantees should fill out a separate template for each Action Item
Grantee Input	
	Goal:
Pull Down Menu	**Pandemic Influenza Preparedness Goal 4: DETECT AND REPORT**
	Improve the timeliness and accuracy of communications regarding the threat posed by an influenza outbreak with pandemic.
	Target Capability:
Pull Down Menu	**4A Target Capability: Communications**
	(links to HHS State and Local Pandemic Influenza Planning Checklist, Public Health Communications.)
	Associated CDC Performance Measure:
Pull Down Menu	For each PHIN Functional Area, the percent of critical functional requirements that have been achieved based on either the Functional Self Assessment Tool or the PHIN certification process.
	Critical Task:
Pull Down Menu	Have or have access to interoperable information systems that comply with PHIN Preparedness Functional Area Countermeasure and
	Action Item: The program efforts conducted to achieve the critical tasks that result in the creation of a product or service.
Fill In Box	ACTION LINKED TO 4A:CT5:: We need to track medication given at a Point of Dispensing (POD). In addition to needing the information for ISDH
	Description
Fill In Box	What: PURPOSE OF THE ACTION ITEM: We have completed a preliminary study to establish the scope of our CRA effort. We are focusing on two areas. First, we will develop a paper form and use scanners to capture the medication dispensed. This will be a "backoffice" function that utilizes ICR / OCR technology to create data files which will be consolidated centrally. Second we will upgrade our existing STC software to make it PHIN compliant.
Fill In Box	Who: TARGET AUDIENCE: We will be capturing information from the Local Health Department's Point of Dispensing.
Fill In Box	STAKEHOLDERS CRITICAL TO SUCCESS: The LPHC at the Local Health Deaprtments are critical stakeholders. We will get them involved in both the design and the implementation. The ISDH Countermeasure Response Administration (CRA) project monitor is the other key stakeholder. We have formed a Steering Committe to oversee the develoment and implementation of the CRA system.
Fill In Box	WHO IS RESPONSIBLE FOR OUTPUTS: The ISDH will set up a back office function which will be responsible for capturing the data.
Fill In Box	When: TIME PERIOD OF PROJECT: 08/31/06 - 08/30/07
Fill In Box	Where: VENUE: The medication will be dispensed at the location of the POD and the forms completed there. They will be sent to a back office for scanning and data capture.
Fill In Box	LOCATION: There will be at least one POD in each county in Indiana. Many countes will have multiple sites.
Fill In Box	Why: WHAT EVIDENCE DO YOU HAVE TO SUPPORT THE PROPOSED INTERVENTION/COURSE OF ACTION/OUTCOME FOR THIS ACTION ITEM?: We evaluated the need in this area as part of putting together our five year PHIN Certification plan.
Fill In Box	WHAT IS THE CAPACITY OF THE RECIPIENT TO DEAL WITH THIS PROBLEM/OPPORTUNITY?: We are targetting our PODs to be able to support 600 people per hour. Our goal is to capture the information in a back office environment within 3 days.

Fill In Box		WHY DOES THIS ACTION ITEM DESERVE THE RECIPIENTS ATTENTION NOW?: Not only do we need to be capturing the data, it is a requirement for PHIN Certification.
Fill In Box		SUMMARY: We currently do not have a consistent method for capturing data on medication that is dispensed. We have finisheed a study and identiofied an approach for us. This request supports software, development activities and equipment.
	Success Factors for Action Item	
Fill In Box	Outputs	WHAT DOES THIS PRODUCE?: This produces electronic data on medication that is dispensed.
Fill In Box	Output Performance Measure	MEASURE OF QUANTITY/QUALITY: Our goal is to capture all the sheets of dispensed medication. We would like to get 100% of the data but we need to evaluate the actual rate of clean data captured.
Fill In Box	Output Target	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM WILL ACCOMPLISH A PERFORMANCE MEASURE: The measurable statistic will be if 100% of mandatory PHIN Certification requirements are met.
Fill In Box	Immediate Outcome*	DESCRIBE THE INTENDED RESULT:
Fill In Box	Immediate Outcome Performance Measure*	IMMEDIATE OUTCOME EFFECTIVENESS:
Fill In Box	Outcome Target*	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM MUST ACCOMPLISH A PERFORMANCE MEASURE:
	Progress Report- To be Reported Mid Year and End of Year	
Fill In Box	Progress Report-Outputs	PROVIDE QUANTIFIABLE EXTENT THAT OUTPUTS HAVE BEEN ACHIEVED:
Fill In Box	Progress Report-Barriers	BRIEFLY EXPLAIN BARRIERS/PROBLEMS FACED IN ACHIEVING THE TARGET OUTPUT:

Note: *Grantees only need to report on Outputs, Output Performance Measures and Output Targets. They are not required to report Immediate Outcomes, Outcome Performance Measures and Outcome Targets.

Action Item 81	Work Plan Template for Pandemic Flu Guidance Grantees should fill out a separate template for each Action Item
Grantee Input	
	Goal:
Pull Down Menu	**Pandemic Influenza Preparedness Goal 4: DETECT AND REPORT**
	Improve the timeliness and accuracy of communications regarding the threat posed by an influenza outbreak with pandemic.
	Target Capability:
Pull Down Menu	**4A Target Capability: Communications**
	(links to HHS State and Local Pandemic Influenza Planning Checklist, Public Health Communications.)
	Associated CDC Performance Measure:
Pull Down Menu	For each PHIN Functional Area, the percent of critical functional requirements that have been achieved based on either the Functional Self Assessment Tool or the PHIN certification process.
	Critical Task:
Pull Down Menu	Have or have access to interoperable information systems that span PHIN functional areas by adhering to standards and specifications
	Action Item: The program efforts conducted to achieve the critical tasks that result in the creation of a product or service.
Fill In Box	ACTION LINKED TO 4A:CT6:: Provide a person to oversee PHIN MS development and implementation activities.
	Description
Fill In Box	What: PURPOSE OF THE ACTION ITEM: One of the key items in the Cross Functional Component (CFC) part of PHIN Certification is PHIN MS messaging protocols. This is a technical process that wraps a communications protocol around an exiting message. It requires a number of setup procedures for establishing communications with every communications partner. We need someone to manage the PHIN MS tables and oversee the implementation of PHIN MS with all our partners.
Fill In Box	Who: TARGET AUDIENCE: All users that require PHIN MS messaging services.
Fill In Box	STAKEHOLDERS CRITICAL TO SUCCESS: The individuals responsible for the six PHIN certification areas are the primary stakeholders.
Fill In Box	WHO IS RESPONSIBLE FOR OUTPUTS: This request is to have a person oversee PHIN MS communications. This person is responsible for the transmissions which are the output of PHIN MS.
Fill In Box	When: TIME PERIOD OF PROJECT: 08/31/2006 - 08/30/2007
Fill In Box	Where: VENUE: The PHIN MS tables / transmissions will occur at the ISDH and the sender / receiver location.
Fill In Box	LOCATION: The PHIN MS tables / transmissions will occur at the ISDH and the sender / receiver location.
Fill In Box	Why: WHAT EVIDENCE DO YOU HAVE TO SUPPORT THE PROPOSED INTERVENTION/COURSE OF ACTION/OUTCOME FOR THIS ACTION ITEM?: This is a requirement of PHIN MS and all six PHIN Certification areas will need to use PHIN MS.
Fill In Box	WHAT IS THE CAPACITY OF THE RECIPIENT TO DEAL WITH THIS PROBLEM/OPPORTUNITY?: We have established a working model for PHIN MS and project no problems with production capacities to support it.

Fill In Box		WHY DOES THIS ACTION ITEM DESERVE THE RECIPIENTS ATTENTION NOW?: This is a PHIN Certification requirement that all six functional areas will need to use PHIN MS. To be effective it needs to be managed centrally.
Fill In Box		SUMMARY: PHIN MS is a key part of the Cross Function Component of PHIN Certification and every other PHIN Certification component needs to use. We have established a working model and determined that we need a person to manage the PHIN MS tables and oversee the implementation in all areas.
	Success Factors for Action Item	
Fill In Box	Outputs	WHAT DOES THIS PRODUCE?: PHIN MS provides a transport mechanism to securely transmit information between different partners.
Fill In Box	Output Performance Measure	MEASURE OF QUANTITY/QUALITY: Our measure is successful PHIN MS transmissions.
Fill In Box	Output Target	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM WILL ACCOMPLISH A PERFORMANCE MEASURE: Once established our target is 100% of all PHIN MS transmissions will be successful.
Fill In Box	Immediate Outcome*	DESCRIBE THE INTENDED RESULT:
Fill In Box	Immediate Outcome Performance Measure*	IMMEDIATE OUTCOME EFFECTIVENESS:
Fill In Box	Outcome Target*	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM MUST ACCOMPLISH A PERFORMANCE MEASURE:
	Progress Report- To be Reported Mid Year and End of Year	
Fill In Box	Progress Report-Outputs	PROVIDE QUANTIFIABLE EXTENT THAT OUTPUTS HAVE BEEN ACHIEVED:
Fill In Box	Progress Report-Barriers	BRIEFLY EXPLAIN BARRIERS/PROBLEMS FACED IN ACHIEVING THE TARGET OUTPUT:

Note: *Grantees only need to report on Outputs, Output Performance Measures and Output Targets. They are not required to report Immediate Outcomes, Outcome Performance Measures and Outcome Targets.

Action Item 82	Work Plan Template for Pandemic Flu Guidance Grantees should fill out a separate template for each Action Item
Grantee Input	
	Goal:
Pull Down Menu	**Pandemic Influenza Preparedness Goal 4: DETECT AND REPORT**
	Improve the timeliness and accuracy of communications regarding the threat posed by an influenza outbreak with pandemic.
	Target Capability:
Pull Down Menu	**4A Target Capability: Communications**
	(links to HHS State and Local Pandemic Influenza Planning Checklist, Public Health Communications.)
	Associated CDC Performance Measure:
Pull Down Menu	For each PHIN Functional Area, the percent of critical functional requirements that have been achieved based on either the Functional Self Assessment Tool or the PHIN certification process.
	Critical Task:
Pull Down Menu	Develop plans to address gaps in achieving PHIN certification.
	Action Item: The program efforts conducted to achieve the critical tasks that result in the creation of a product or service.
Fill In Box	ACTION LINKED TO 4A:CT7:: Add a project manager to coordinate PHIN certification activities between the six functional areas.
	Description
Fill In Box	What: PURPOSE OF THE ACTION ITEM: We completed a five year PHIN Certification Plan. As part of that plan we identified a need to have a dedicated PHIN Coordinator to support the six functional areas. As part of an accelerated certification program, this person will insure we are moving ahead in all six functional areas and address any issues that cannot be resolved within the functional area.
Fill In Box	Who: TARGET AUDIENCE: This person will work with the project leads in the six PHIN Certification areas.
Fill In Box	STAKEHOLDERS CRITICAL TO SUCCESS: The key stakeholders are the PHIN Certification Coordinator and the six functional area leaders.
Fill In Box	WHO IS RESPONSIBLE FOR OUTPUTS: This person is responsible for overseeing the progress in each of the six functional areas.
Fill In Box	When: TIME PERIOD OF PROJECT: 8/31/2006 - 8/30/2007
Fill In Box	Where: VENUE: All work will be done at the ISDH.
Fill In Box	LOCATION: All work will be done at the ISDH.
Fill In Box	Why: WHAT EVIDENCE DO YOU HAVE TO SUPPORT THE PROPOSED INTERVENTION/COURSE OF ACTION/OUTCOME FOR THIS ACTION ITEM?: When the ISDH completed their PHIN Certification plan, the need for a Project Manager to oversee and coordinate the six certification areas was established.
Fill In Box	WHAT IS THE CAPACITY OF THE RECIPIENT TO DEAL WITH THIS PROBLEM/OPPORTUNITY?: This person is will have sufficient time to manage the certification process.

Fill In Box		WHY DOES THIS ACTION ITEM DESERVE THE RECIPIENTS ATTENTION NOW?: The need for this level of project management was established as part of our PHIN Certification plan.
Fill In Box		SUMMARY: As part of our plan for PHIN Certification we established the need for a project manager to coordinate and oversee the certification process in the six functional areas. The scope of certification is large enough that we need to have this level of management.
	Success Factors for Action Item	
Fill In Box	Outputs	WHAT DOES THIS PRODUCE?: The project manager will monitor progress and provide status reports concerning our progress.
Fill In Box	Output Performance Measure	MEASURE OF QUANTITY/QUALITY: The end result will be PHIN Certification in each area.
Fill In Box	Output Target	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM WILL ACCOMPLISH A PERFORMANCE MEASURE: Each area will meet 100% of all critical requirements.
Fill In Box	Immediate Outcome*	DESCRIBE THE INTENDED RESULT:
Fill In Box	Immediate Outcome Performance Measure*	IMMEDIATE OUTCOME EFFECTIVENESS:
Fill In Box	Outcome Target*	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM MUST ACCOMPLISH A PERFORMANCE MEASURE:
	Progress Report- To be Reported Mid Year and End of Year	
Fill In Box	Progress Report-Outputs	PROVIDE QUANTIFIABLE EXTENT THAT OUTPUTS HAVE BEEN ACHIEVED:
Fill In Box	Progress Report-Barriers	BRIEFLY EXPLAIN BARRIERS/PROBLEMS FACED IN ACHIEVING THE TARGET OUTPUT:

Note: *Grantees only need to report on Outputs, Output Performance Measures and Output Targets. They are not required to report Immediate Outcomes, Outcome Performance Measures and Outcome Targets.

Action Item 83	Work Plan Template for Pandemic Flu Guidance Grantees should fill out a separate template for each Action Item
Grantee Input	
	Goal:
Pull Down Menu	**Pandemic Influenza Preparedness Goal 4: DETECT AND REPORT**
	Improve the timeliness and accuracy of communications regarding the threat posed by an influenza outbreak with pandemic.
	Target Capability:
Pull Down Menu	**4A Target Capability: Communications**
	(links to HHS State and Local Pandemic Influenza Planning Checklist, Public Health Communications.)
	Associated CDC Performance Measure:
Pull Down Menu	For each PHIN Functional Area, the percent of critical functional requirements that have been achieved based on either the Functional Self Assessment Tool or the PHIN certification process.
	Critical Task:
Pull Down Menu	Develop plans to address gaps in achieving PHIN certification.
	Action Item: The program efforts conducted to achieve the critical tasks that result in the creation of a product or service.
Fill In Box	ACTION LINKED TO 4A:CT7:: As part of PHIN Certification we need to be able to pass data between systems in the six functional certification are
	Description
Fill In Box	What: PURPOSE OF THE ACTION ITEM: There are major requirements to pass data between the applications running in the six functional PHIN Certification areas. Rather than develop them individually we need to design a global approach for providing access to the data and then implement it in each of the six areas.
Fill In Box	Who: TARGET AUDIENCE: Project leads in each of the six PHIN Certification areas.
Fill In Box	STAKEHOLDERS CRITICAL TO SUCCESS: Project leads in each of the six PHIN Certification areas.
Fill In Box	WHO IS RESPONSIBLE FOR OUTPUTS: This person will be responsible for insure each system receives the data it needs.
Fill In Box	When: TIME PERIOD OF PROJECT: 12/1/2006 - 8/30/2007
Fill In Box	Where: VENUE: All work will be done at the ISDH.
Fill In Box	LOCATION: All work will be done at the ISDH.
Fill In Box	Why: WHAT EVIDENCE DO YOU HAVE TO SUPPORT THE PROPOSED INTERVENTION/COURSE OF ACTION/OUTCOME FOR THIS ACTION ITEM?: As part of our review of all the PHIN Certification requirements, we identified a number of points in which we need to share data. Rather than have each area develop individual interfaces, we need to establish a global method for sharing data.
Fill In Box	WHAT IS THE CAPACITY OF THE RECIPIENT TO DEAL WITH THIS PROBLEM/OPPORTUNITY?: We have sufficient technical resources to support sharing the data.

Fill In Box		WHY DOES THIS ACTION ITEM DESERVE THE RECIPIENTS ATTENTION NOW?:It needs to be done before we start developing individual interfaces.
Fill In Box		SUMMARY: As part of our PHIN Certification plan, we identified a number of points at which we need to share data. Rather than develop them individually we need to design a global approach to support all application data needs. This person will develop this approach and insure all systems have access to the data.
	Success Factors for Action Item	
Fill In Box	Outputs	WHAT DOES THIS PRODUCE?: Data that can be shared between applications.
Fill In Box	Output Performance Measure	MEASURE OF QUANTITY/QUALITY: The measure will be whether all systems have ascess to the data that they need.
Fill In Box	Output Target	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM WILL ACCOMPLISH A PERFORMANCE MEASURE: The measure will be whether all systems have ascess to the data that they need.
Fill In Box	Immediate Outcome*	DESCRIBE THE INTENDED RESULT:
Fill In Box	Immediate Outcome Performance Measure*	IMMEDIATE OUTCOME EFFECTIVENESS:
Fill In Box	Outcome Target*	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM MUST ACCOMPLISH A PERFORMANCE MEASURE:
	Progress Report- To be Reported Mid Year and End of Year	
Fill In Box	Progress Report- Outputs	PROVIDE QUANTIFIABLE EXTENT THAT OUTPUTS HAVE BEEN ACHIEVED:
Fill In Box	Progress Report- Barriers	BRIEFLY EXPLAIN BARRIERS/PROBLEMS FACED IN ACHIEVING THE TARGET OUTPUT:

Note: *Grantees only need to report on Outputs, Output Performance Measures and Output Targets. They are not required to report Immediate Outcomes, Outcome Performance Measures and Outcome Targets.

Action Item 84	Work Plan Template for Pandemic Flu Guidance Grantees should fill out a separate template for each Action Item
Grantee Input	
	Goal:
Pull Down Menu	**Pandemic Influenza Preparedness Goal 4: DETECT AND REPORT**
	Improve the timeliness and accuracy of communications regarding the threat posed by an influenza outbreak with pandemic.
	Target Capability:
Pull Down Menu	**4A Target Capability: Communications**
	(links to HHS State and Local Pandemic Influenza Planning Checklist, Public Health Communications.)
	Associated CDC Performance Measure:
Pull Down Menu	For each PHIN Functional Area, the percent of critical functional requirements that have been achieved based on either the Functional Self Assessment Tool or the PHIN certification process.
	Critical Task:
Pull Down Menu	Develop plans to address gaps in achieving PHIN certification.
	Action Item: The program efforts conducted to achieve the critical tasks that result in the creation of a product or service.
Fill In Box	ACTION LINKED TO 4A:CT7:: We need to purchase seven copies of Visual Studio and Source Safe to support increased development staff.
	Description
Fill In Box	What: PURPOSE OF THE ACTION ITEM: Support increased development activities.
Fill In Box	Who: TARGET AUDIENCE: Additional developers.
Fill In Box	STAKEHOLDERS CRITICAL TO SUCCESS: Additional developers.
Fill In Box	WHO IS RESPONSIBLE FOR OUTPUTS: This provides the tools need for the additional developers.
Fill In Box	When: TIME PERIOD OF PROJECT: 08/31/2006 - 08/30/2007
Fill In Box	Where: VENUE: The software will be installed at the ISDH.
Fill In Box	LOCATION: The software will be installed at the ISDH.
Fill In Box	Why: WHAT EVIDENCE DO YOU HAVE TO SUPPORT THE PROPOSED INTERVENTION/COURSE OF ACTION/OUTCOME FOR THIS ACTION ITEM?: This is required for additional development staff.
Fill In Box	WHAT IS THE CAPACITY OF THE RECIPIENT TO DEAL WITH THIS PROBLEM/OPPORTUNITY?: The equipment will have sufficient capacity to support the software.

Fill In Box		WHY DOES THIS ACTION ITEM DESERVE THE RECIPIENTS ATTENTION NOW?: It is required to support additional developers.
Fill In Box		SUMMARY: We need to purchase seven copies of Visual Studio and Source Safe to support increased development staff.
	Success Factors for Action Item	
Fill In Box	Outputs	WHAT DOES THIS PRODUCE?: This produces the environment needed for application development.
Fill In Box	Output Performance Measure	MEASURE OF QUANTITY/QUALITY: This will be installed on each PC.
Fill In Box	Output Target	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM WILL ACCOMPLISH A PERFORMANCE MEASURE: If development can be done it will be a measure of a successful installation.
Fill In Box	Immediate Outcome*	DESCRIBE THE INTENDED RESULT:
Fill In Box	Immediate Outcome Performance Measure*	IMMEDIATE OUTCOME EFFECTIVENESS:
Fill In Box	Outcome Target*	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM MUST ACCOMPLISH A PERFORMANCE MEASURE:
	Progress Report- To be Reported Mid Year and End of Year	
Fill In Box	Progress Report- Outputs	PROVIDE QUANTIFIABLE EXTENT THAT OUTPUTS HAVE BEEN ACHIEVED:
Fill In Box	Progress Report- Barriers	BRIEFLY EXPLAIN BARRIERS/PROBLEMS FACED IN ACHIEVING THE TARGET OUTPUT:

Note: *Grantees only need to report on Outputs, Output Performance Measures and Output Targets. They are not required to report Immediate Outcomes, Outcome Performance Measures and Outcome Targets.

Action Item 85	Work Plan Template for Pandemic Flu Guidance Grantees should fill out a separate template for each Action Item
Grantee Input	
	Goal:
Pull Down Menu	**Pandemic Influenza Preparedness Goal 4: DETECT AND REPORT**
	Improve the timeliness and accuracy of communications regarding the threat posed by an influenza outbreak with pandemic.
	Target Capability:
Pull Down Menu	**4A Target Capability: Communications**
	(links to HHS State and Local Pandemic Influenza Planning Checklist, Public Health Communications.)
	Associated CDC Performance Measure:
Pull Down Menu	For each PHIN Functional Area, the percent of critical functional requirements that have been achieved based on either the Functional Self Assessment Tool or the PHIN certification process.
	Critical Task:
Pull Down Menu	Have or have access to interoperable information systems that comply with PHIN Preparedness Functional Area Countermeasure and
	Action Item: The program efforts conducted to achieve the critical tasks that result in the creation of a product or service.
Fill In Box	ACTION LINKED TO 4A:CT7:: Upgrade technical support / development equipment used for PHIN Certification and related applications..
	Description
Fill In Box	What: PURPOSE OF THE ACTION ITEM: The current equipment we use for PHIN Certification and PHIN development is old and has slower processors and limited memory. It is barely able to support our current environment. We need to upgrade to current releases of MS Studio and other products. This release is necessary for continued PHIN Certification and related development. As part of our testing of the new releases, we discovered that we are having capacity problems with the existing equipment. The equipment is old enough that it is not a viable option to upgrade it. We need four laptops and two desktop units. The laptops are required for those individuals that are part of our Department Operations Center or Strategic National Stockpile; they are required to relocate to the DOC or SNS facility with their laptop.
Fill In Box	Who: TARGET AUDIENCE: The target audience is the technicians that support PHIN applications and PHIN Certification.
Fill In Box	STAKEHOLDERS CRITICAL TO SUCCESS: The technicians
Fill In Box	WHO IS RESPONSIBLE FOR OUTPUTS: The technicians are responsible for using the equipment.
Fill In Box	When: TIME PERIOD OF PROJECT: 08/31/06 - 10/31/06
Fill In Box	Where: VENUE: The installations will be done by support staff at the developer's desk.
Fill In Box	LOCATION: The installations will be done by the support staff at the technician's desk.
Fill In Box	Why: WHAT EVIDENCE DO YOU HAVE TO SUPPORT THE PROPOSED INTERVENTION/COURSE OF ACTION/OUTCOME FOR THIS ACTION ITEM?: We created a test environment and loaded the new release of the software. We ran the software and had major performance programs on the current equipment. We already are having some performance problems with the current release and there is enough different with the new release to create major performance problems. This is necessary to support our PHIN Certification Plan.
Fill In Box	WHAT IS THE CAPACITY OF THE RECIPIENT TO DEAL WITH THIS PROBLEM/OPPORTUNITY?: The new equipment will have sufficinet capacity to support our immediate and projected future needs.

Fill In Box		WHY DOES THIS ACTION ITEM DESERVE THE RECIPIENTS ATTENTION NOW?: The equipment performance issues with the new software erleases will impact our ability to do development work in support of PHIN Certification and PHIN related projects.
Fill In Box		SUMMARY: Our PHIN technical / development group is currently using old equipment with slow processors and limited memory. We have not upgraded our development / support software in a while and need to do so as soon as possible. During our testing of the software upgrades, we discovered that we have performance problems with the current equipment. This was not a surprise and we need to upgrade our PCs used to support PHIN Certification and related PHIN projects.
	Success Factors for Action Item	
Fill In Box	Outputs	WHAT DOES THIS PRODUCE?: The upgraded PCs will allow us to be more productive in activities for PHIN Certification and related PHIN projects.
Fill In Box	Output Performance Measure	MEASURE OF QUANTITY/QUALITY: The key measure will be providing an environment that allows us to complete PHIN Certification and related PHIN projects on schedule.
Fill In Box	Output Target	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM WILL ACCOMPLISH A PERFORMANCE MEASURE: Our output target is completing PHIN Certification earlier than our five year certification plan.
Fill In Box	Immediate Outcome*	DESCRIBE THE INTENDED RESULT:
Fill In Box	Immediate Outcome Performance Measure*	IMMEDIATE OUTCOME EFFECTIVENESS:
Fill In Box	Outcome Target*	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM MUST ACCOMPLISH A PERFORMANCE MEASURE:
	Progress Report- To be Reported Mid Year and End of Year	
Fill In Box	Progress Report-Outputs	PROVIDE QUANTIFIABLE EXTENT THAT OUTPUTS HAVE BEEN ACHIEVED:
Fill In Box	Progress Report-Barriers	BRIEFLY EXPLAIN BARRIERS/PROBLEMS FACED IN ACHIEVING THE TARGET OUTPUT:

Note: *Grantees only need to report on Outputs, Output Performance Measures and Output Targets. They are not required to report Immediate Outcomes, Outcome Performance Measures and Outcome Targets.

Action Item 11	Work Plan Template for Pandemic Flu Guidance Grantees should fill out a separate template for each Action Item
Grantee Input	
	Goal:
Pull Down Menu	**Pandemic Influenza Preparedness Goal 6: CONTROL**
	Decrease the time needed to implement rapid outbreak response actions and provide other countermeasures, including personnel, risk communications, and health interventions and guidance to those at risk of pandemic influenza
	Target Capability:
Pull Down Menu	**6A Target Capability: Medical Surge**
	(link to HHS State and Local Pandemic Influenza Planning Checklist, Healthcare and Public Health Partners)
	Associated CDC Performance Measure:
Pull Down Menu	Percent of HRSA National Bioterrorism Hospital Preparedness Program (NBHPP) awardee hospitals that transmit hospital utilization data in near real time to BioSense.
	Critical Task:
Pull Down Menu	Before March 31, 2007, coordinate with the HRSA Bioterrorism coordinator to detail the gaps identified in the HRSA NBHPP program
	Action Item: The program efforts conducted to achieve the critical tasks that result in the creation of a product or service.
Fill In Box	ACTION LINKED TO 6A:CT1a,i.,ii.,iii., & v.:: In concert with public health partners, ensure that healthcare entities are a key component in the exe
	Description
Fill In Box	What: PURPOSE OF THE ACTION ITEM: To exercise many components of healthcare facility pan flu plans.
Fill In Box	Who: TARGET AUDIENCE: Hospitals, community health centers, rural health clinics, and local public health departments
Fill In Box	STAKEHOLDERS CRITICAL TO SUCCESS: Hospital staff, volunteer organizations, suppliers
Fill In Box	WHO IS RESPONSIBLE FOR OUTPUTS: Hospital administrators, volunteer organization leaders, suppliers
Fill In Box	When: TIME PERIOD OF PROJECT: 8/31/06 through 3/31/07
Fill In Box	Where: VENUE: Hospitals
Fill In Box	LOCATION: Urban and rural. A minimum of one hospital or hospital system in each of 10 districts in the state.
Fill In Box	Why: WHAT EVIDENCE DO YOU HAVE TO SUPPORT THE PROPOSED INTERVENTION/COURSE OF ACTION/OUTCOME FOR THIS ACTION ITEM?: Plans cannot be judged to be in final form without testing.
Fill In Box	WHAT IS THE CAPACITY OF THE RECIPIENT TO DEAL WITH THIS PROBLEM/OPPORTUNITY?: Every hospital must complete 2 disaster exercises each year for accreditation so exercising the pan flu plan can easily be accomplished as one of these exercises.

Fill In Box		WHY DOES THIS ACTION ITEM DESERVE THE RECIPIENTS ATTENTION NOW?: We are working closely with the local hospitals to complete pan flu plans and testing many of the components will validate their planning efforts.
Fill In Box		SUMMARY: Exercising pan flu plans is essential to validation of their content.
	Success Factors for Action Item	
Fill In Box	Outputs	WHAT DOES THIS PRODUCE?: Documentation that the pan flu plans are well done or identification of opportunities for improvement.
Fill In Box	Output Performance Measure	MEASURE OF QUANTITY/QUALITY: Percent of participating HRSA hospitals that successfully complete an exercise of the identified critical tasks resulting in validation or identification of opportunities for improvement
Fill In Box	Output Target	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM WILL ACCOMPLISH A PERFORMANCE MEASURE: 100% of participating HRSA identified will successfully execute the exercise.
Fill In Box	Immediate Outcome*	DESCRIBE THE INTENDED RESULT:
Fill In Box	Immediate Outcome Performance Measure*	IMMEDIATE OUTCOME EFFECTIVENESS:
Fill In Box	Outcome Target*	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM MUST ACCOMPLISH A PERFORMANCE MEASURE:
	Progress Report- To be Reported Mid Year and End of Year	
Fill In Box	Progress Report-Outputs	PROVIDE QUANTIFIABLE EXTENT THAT OUTPUTS HAVE BEEN ACHIEVED:
Fill In Box	Progress Report-Barriers	BRIEFLY EXPLAIN BARRIERS/PROBLEMS FACED IN ACHIEVING THE TARGET OUTPUT:

Note: *Grantees only need to report on Outputs, Output Performance Measures and Output Targets. They are not required to report Immediate Outcomes, Outcome Performance Measures and Outcome Targets.

Action Item 12	Work Plan Template for Pandemic Flu Guidance Grantees should fill out a separate template for each Action Item
Grantee Input	
	Goal:
Pull Down Menu	**Pandemic Influenza Preparedness Goal 6: CONTROL**
	Decrease the time needed to implement rapid outbreak response actions and provide other countermeasures, including personnel, risk communications, and health interventions and guidance to those at risk of pandemic influenza
	Target Capability:
Pull Down Menu	**6A Target Capability: Medical Surge**
	(link to HHS State and Local Pandemic Influenza Planning Checklist, Healthcare and Public Health Partners)
	Associated CDC Performance Measure:
Pull Down Menu	Percent of HRSA National Bioterrorism Hospital Preparedness Program (NBHPP) awardee hospitals that transmit hospital utilization data in near real time to BioSense.
	Critical Task:
Pull Down Menu	Before March 31, 2007, coordinate with the HRSA Bioterrorism coordinator to detail the gaps identified in the HRSA NBHPP program
	Action Item: The program efforts conducted to achieve the critical tasks that result in the creation of a product or service.
Fill In Box	ACTION LINKED TO 6A:CT1a,iv.:: We need to improve the capabilities of hospitals and Local Health Departmetns in using the ESAR-VHP volun
	Description
Fill In Box	What: PURPOSE OF THE ACTION ITEM: We will develop training materials and provide training on adding local volunteers, handling volunteers loaded from our state licensing systems and accessing the ESAR-VHP system.
Fill In Box	Who: TARGET AUDIENCE: We will bring in a contractor for 120 hours to develop training materials and set up training sessions focused on Local Helath Department and Hospital IHAN Coordinators and LPHCs.
Fill In Box	STAKEHOLDERS CRITICAL TO SUCCESS: The manager of the ESAR-VHP program.
Fill In Box	WHO IS RESPONSIBLE FOR OUTPUTS: The contractor is responsible for developing the training materials, the ESAR-VHP manager is responsible for insuring they are accurate and complete.
Fill In Box	When: TIME PERIOD OF PROJECT: 08/31/06 - 11/30/06
Fill In Box	Where: VENUE: Training will be at central and district sites. We are pursuing the use of Webinars for training sessions.
Fill In Box	LOCATION: Centralized training will be at the ISDH. Localized training will be at a Local Health Department or Hospital.
Fill In Box	Why: WHAT EVIDENCE DO YOU HAVE TO SUPPORT THE PROPOSED INTERVENTION/COURSE OF ACTION/OUTCOME FOR THIS ACTION ITEM?: We need to bring the LHD and hospital staff up to speed on how they can effectively use the ESAR-VHP volunteer system.
Fill In Box	WHAT IS THE CAPACITY OF THE RECIPIENT TO DEAL WITH THIS PROBLEM/OPPORTUNITY?: We are planning 160 hours to develop the training materials and conduct training.

Fill In Box		WHY DOES THIS ACTION ITEM DESERVE THE RECIPIENTS ATTENTION NOW?: The ability to effectively use volunteers is critical to the Local Helath Departments and Hospitals.
Fill In Box		SUMMARY: We need to improve the capabilities of Local Health Departments and hospitals to use the ESAR-VHP system. Having a list of reliable volunteers is important to the Local Health Departments in the event of an incident or to support ongoing programs. Our proposal is to develop additional training materials and conduct training sessions on how to effectively use ESAR-VHP.
	Success Factors for Action Item	
Fill In Box	Outputs	WHAT DOES THIS PRODUCE?: We will produce training materials and conduct training sessions.
Fill In Box	Output Performance Measure	MEASURE OF QUANTITY/QUALITY: We will provide for feedback at the end of each training sessions. This will critique both the training materials and the training session.
Fill In Box	Output Target	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM WILL ACCOMPLISH A PERFORMANCE MEASURE: We want to reach 100% of the Local Health Departments and hospitals.
Fill In Box	Immediate Outcome*	DESCRIBE THE INTENDED RESULT:
Fill In Box	Immediate Outcome Performance Measure*	IMMEDIATE OUTCOME EFFECTIVENESS:
Fill In Box	Outcome Target*	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM MUST ACCOMPLISH A PERFORMANCE MEASURE:
	Progress Report- To be Reported Mid Year and End of Year	
Fill In Box	Progress Report-Outputs	PROVIDE QUANTIFIABLE EXTENT THAT OUTPUTS HAVE BEEN ACHIEVED:
Fill In Box	Progress Report-Barriers	BRIEFLY EXPLAIN BARRIERS/PROBLEMS FACED IN ACHIEVING THE TARGET OUTPUT:

Note: *Grantees only need to report on Outputs, Output Performance Measures and Output Targets. They are not required to report Immediate Outcomes, Outcome Performance Measures and Outcome Targets.

Action Item 13	Work Plan Template for Pandemic Flu Guidance Grantees should fill out a separate template for each Action Item
Grantee Input	
	Goal:
Pull Down Menu	**Pandemic Influenza Preparedness Goal 6: CONTROL**
	Decrease the time needed to implement rapid outbreak response actions and provide other countermeasures, including personnel, risk communications, and health interventions and guidance to those at risk of pandemic influenza
	Target Capability:
Pull Down Menu	**6A Target Capability: Medical Surge**
	(link to HHS State and Local Pandemic Influenza Planning Checklist, Healthcare and Public Health Partners)
	Associated CDC Performance Measure:
Pull Down Menu	
	Critical Task:
Pull Down Menu	Before March 31, 2007, coordinate with the HRSA Bioterrorism coordinator to detail the gaps identified in the HRSA NBHPP program
	Action Item: The program efforts conducted to achieve the critical tasks that result in the creation of a product or service.
Fill In Box	ACTION LINKED TO 6A:CT1a,vi.:: In concert with public health partners, ensure that healthcare entities are a key component in the exercising of
	Description
	What
Fill In Box	PURPOSE OF THE ACTION ITEM: To help hospitals explore opportunities for purchasing supplies needed for expanding patient load during a pandemic.
	Who
Fill In Box	TARGET AUDIENCE: Hospitals, Indiana State Department of Health and vendors
Fill In Box	STAKEHOLDERS CRITICAL TO SUCCESS: Indiana State Department of Health, hospitals, vendors
Fill In Box	WHO IS RESPONSIBLE FOR OUTPUTS: Indiana State Department of Health, hospitals, vendors
	When
Fill In Box	TIME PERIOD OF PROJECT: 8/31/06 through 3/31/07
	Where
Fill In Box	VENUE: Local hospitals throughout Indiana
Fill In Box	LOCATION: Statewide
	Why
Fill In Box	WHAT EVIDENCE DO YOU HAVE TO SUPPORT THE PROPOSED INTERVENTION/COURSE OF ACTION/OUTCOME FOR THIS ACTION ITEM?: Hospitals have few stockpiles of equipment for expanded patient care. The Indiana State Department of Health has an opportunity to assist in the acquisition of needed patient care items.
Fill In Box	WHAT IS THE CAPACITY OF THE RECIPIENT TO DEAL WITH THIS PROBLEM/OPPORTUNITY?: Funding available from Pandemic Influenza Guidance, Phase II

Fill In Box		WHY DOES THIS ACTION ITEM DESERVE THE RECIPIENTS ATTENTION NOW?: Advance planning and preparation for a pandemic is essential. Waiting until the beginning of a pandemic is too late to purchase needed supplies.
Fill In Box		SUMMARY: Hospitals need extra patient care items during the pandemic and the Indiana State Department of Health has the ability to assist with that purchase through Phase II of the Pandemic Influenza Guidance.
	Success Factors for Action Item	
Fill In Box	Outputs	WHAT DOES THIS PRODUCE?: Additional equipment to support the medical care of pandemic flu victims
Fill In Box	Output Performance Measure	MEASURE OF QUANTITY/QUALITY: Amount of patient care equipment purchased for hospitals.
Fill In Box	Output Target	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM WILL ACCOMPLISH A PERFORMANCE MEASURE: # of equipment pieces successfully purchased
Fill In Box	Immediate Outcome*	DESCRIBE THE INTENDED RESULT:
Fill In Box	Immediate Outcome Performance Measure*	IMMEDIATE OUTCOME EFFECTIVENESS:
Fill In Box	Outcome Target*	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM MUST ACCOMPLISH A PERFORMANCE MEASURE:
	Progress Report- To be Reported Mid Year and End of Year	
Fill In Box	Progress Report-Outputs	PROVIDE QUANTIFIABLE EXTENT THAT OUTPUTS HAVE BEEN ACHIEVED:
Fill In Box	Progress Report-Barriers	BRIEFLY EXPLAIN BARRIERS/PROBLEMS FACED IN ACHIEVING THE TARGET OUTPUT:

Note: *Grantees only need to report on Outputs, Output Performance Measures and Output Targets. They are not required to report Immediate Outcomes, Outcome Performance Measures and Outcome Targets.

Action Item 14	Work Plan Template for Pandemic Flu Guidance Grantees should fill out a separate template for each Action Item
Grantee Input	
	Goal:
Pull Down Menu	**Pandemic Influenza Preparedness Goal 6: CONTROL**
	Decrease the time needed to implement rapid outbreak response actions and provide other countermeasures, including personnel, risk communications, and health interventions and guidance to those at risk of pandemic influenza
	Target Capability:
Pull Down Menu	**6A Target Capability: Medical Surge**
	(link to HHS State and Local Pandemic Influenza Planning Checklist, Healthcare and Public Health Partners)
	Associated CDC Performance Measure:
Pull Down Menu	
	Critical Task:
Pull Down Menu	Before March 31, 2007, coordinate with the HRSA Bioterrorism coordinator to detail the gaps identified in the HRSA NBHPP program
	Action Item: The program efforts conducted to achieve the critical tasks that result in the creation of a product or service.
Fill In Box	ACTION LINKED TO 6A:CT1b:: Exercise communication systems, plans and procedures to ensure that hospitals, health care systems and public
	Description
Fill In Box	What: PURPOSE OF THE ACTION ITEM: It is important during a pandemic, when health care facilities will be overwhelmed with patients, that communication regarding the bed availability in a community and the means to access healthcare in a community be readily availbable to local officials and the general public. The messages relaying this information must be accurate, frequent, and consistent among all stakeholders.
Fill In Box	Who: TARGET AUDIENCE: Involved participants will include a minimum of one hospital per district and the associated local health department staff, local government officials, and the media.
Fill In Box	STAKEHOLDERS CRITICAL TO SUCCESS: Hospital administrators, local government officials, media representatives, and the local health department spokesperson.
Fill In Box	WHO IS RESPONSIBLE FOR OUTPUTS: The local hospital are the chief agent of change because all information is based on the status of the hospital at any point in time. It will be up to the spokespersons of the aboved entities to make sure the information is released in an accurate and timely fashion.
Fill In Box	When: TIME PERIOD OF PROJECT: 08/31/06 to 03/31/07
Fill In Box	Where: VENUE: Exercises will occur at various locations throughout the state as the plan evolves.
Fill In Box	LOCATION: Urban, rural, county, district, statewide
Fill In Box	Why: WHAT EVIDENCE DO YOU HAVE TO SUPPORT THE PROPOSED INTERVENTION/COURSE OF ACTION/OUTCOME FOR THIS ACTION ITEM?: In any disaster exercise, communications is always the most difficult area to perform effectively. Since communication of information is key to the control of a pandemic, it becomes the most essential part of the plan to develop, exercise, and improve.
Fill In Box	WHAT IS THE CAPACITY OF THE RECIPIENT TO DEAL WITH THIS PROBLEM/OPPORTUNITY?: New tools are being developed to assist healthcare facilities in determining their capacity, triggers for instituting alternate standards of care, and sharing this information with others. Hospitals need to test these new tools.

Fill In Box		WHY DOES THIS ACTION ITEM DESERVE THE RECIPIENTS ATTENTION NOW?: New tools must be tested to prove efficacy and the more practice before the arrival of the pandemic the better.
Fill In Box		SUMMARY: We must be able to provide accurate bed availability information to all residents of Indiana in order to maximize limited resources during a pandemic.
	Success Factors for Action Item	
Fill In Box	Outputs	WHAT DOES THIS PRODUCE?: Bed availability during a pandemic and the successful communication of this information.
Fill In Box	Output Performance Measure	MEASURE OF QUANTITY/QUALITY: Percent of HRSA hospitals participating in a given exercise that report hospital bed availability, ventilators available, and staff available twice daily.
Fill In Box	Output Target	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM WILL ACCOMPLISH A PERFORMANCE MEASURE: 100% of HRSA hospitals participating in a given exercise will report hospital bed availability, ventilators available, and staff available twice daily.
Fill In Box	Immediate Outcome*	DESCRIBE THE INTENDED RESULT:
Fill In Box	Immediate Outcome Performance Measure*	IMMEDIATE OUTCOME EFFECTIVENESS:
Fill In Box	Outcome Target*	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM MUST ACCOMPLISH A PERFORMANCE MEASURE:
	Progress Report- To be Reported Mid Year and End of Year	
Fill In Box	Progress Report- Outputs	PROVIDE QUANTIFIABLE EXTENT THAT OUTPUTS HAVE BEEN ACHIEVED:
Fill In Box	Progress Report- Barriers	BRIEFLY EXPLAIN BARRIERS/PROBLEMS FACED IN ACHIEVING THE TARGET OUTPUT:

Note: *Grantees only need to report on Outputs, Output Performance Measures and Output Targets. They are not required to report Immediate Outcomes, Outcome Performance Measures and Outcome Targets.

Action Item 15	Work Plan Template for Pandemic Flu Guidance Grantees should fill out a separate template for each Action Item
Grantee Input	
	Goal:
Pull Down Menu	**Pandemic Influenza Preparedness Goal 6: CONTROL**
	Decrease the time needed to implement rapid outbreak response actions and provide other countermeasures, including personnel, risk communications, and health interventions and guidance to those at risk of pandemic influenza
	Target Capability:
Pull Down Menu	**6A Target Capability: Medical Surge**
	(link to HHS State and Local Pandemic Influenza Planning Checklist, Healthcare and Public Health Partners)
	Associated CDC Performance Measure:
Pull Down Menu	
	Critical Task:
Pull Down Menu	Before March 31, 2007, coordinate with the HRSA Bioterrorism coordinator to detail the gaps identified in the HRSA NBHPP program
	Action Item: The program efforts conducted to achieve the critical tasks that result in the creation of a product or service.
Fill In Box	ACTION LINKED TO 6A:CT1c:: Exercise vaccination and prophylaxis plans to cover healthcare staff and patients.
	Description
Fill In Box	What: PURPOSE OF THE ACTION ITEM: Pandemic flu vaccinations and antiviral medicine will be in limited supply during a pandemic. Difficult decisions must be made regarding who will receive the vaccinations and antivirals. This exercise will give hospitals a chance to test their prioritization and distribution using the guidelines they have developed.
Fill In Box	Who: TARGET AUDIENCE: Hospital staff
Fill In Box	STAKEHOLDERS CRITICAL TO SUCCESS: Hospital administrative and nursing staff, local health department officials, state health department guidelines, guidelines from federal agencies
Fill In Box	WHO IS RESPONSIBLE FOR OUTPUTS: Hospital staff
Fill In Box	When: TIME PERIOD OF PROJECT: 8/31/06 through 3/31/07
Fill In Box	Where: VENUE: Two hospitals from District 5
Fill In Box	LOCATION: Urban, suburban
Fill In Box	Why: WHAT EVIDENCE DO YOU HAVE TO SUPPORT THE PROPOSED INTERVENTION/COURSE OF ACTION/OUTCOME FOR THIS ACTION ITEM?: 40% of hospitals have not yet reported sufficient supply of medication for staff.
Fill In Box	WHAT IS THE CAPACITY OF THE RECIPIENT TO DEAL WITH THIS PROBLEM/OPPORTUNITY?: Each hospital will have different capacity issues, some will have staff issues, some will have storage issues, some will have difficulty with the decision process.

Fill In Box		WHY DOES THIS ACTION ITEM DESERVE THE RECIPIENTS ATTENTION NOW?: 40% of hospitals have not yet recognized this as an important issue.
Fill In Box		SUMMARY: Limited medication availability will make choices of distribution difficult. When these decisions are made early in a calm, pre-incident atmosphere, they will be easier to disseminate and understand. Therefore, practicing distribution in a calm atmosphere will enhance understanding of the process.
	Success Factors for Action Item	
Fill In Box	Outputs	WHAT DOES THIS PRODUCE?: Exercising vaccination and prophylaxis plans will give hospitals the opportunity to make adjustments to their plans prior to the arrival of the pandemic.
Fill In Box	Output Performance Measure	MEASURE OF QUANTITY/QUALITY: Percent of HRSA hospitals participating in the exercise who successfully complete the exercise and document lessons learned and consequently make needed changes in the plan.
Fill In Box	Output Target	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM WILL ACCOMPLISH A PERFORMANCE MEASURE: 100% of participating HRSA hospitals complete the exercise, document lessons learned and make needed changes in the plan.
Fill In Box	Immediate Outcome*	DESCRIBE THE INTENDED RESULT:
Fill In Box	Immediate Outcome Performance Measure*	IMMEDIATE OUTCOME EFFECTIVENESS:
Fill In Box	Outcome Target*	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM MUST ACCOMPLISH A PERFORMANCE MEASURE:
	Progress Report- To be Reported Mid Year and End of Year	
Fill In Box	Progress Report-Outputs	PROVIDE QUANTIFIABLE EXTENT THAT OUTPUTS HAVE BEEN ACHIEVED:
Fill In Box	Progress Report-Barriers	BRIEFLY EXPLAIN BARRIERS/PROBLEMS FACED IN ACHIEVING THE TARGET OUTPUT:

Note: *Grantees only need to report on Outputs, Output Performance Measures and Output Targets. They are not required to report Immediate Outcomes, Outcome Performance Measures and Outcome Targets.

Action Item 36	Work Plan Template for Pandemic Flu Guidance Grantees should fill out a separate template for each Action Item
Grantee Input	
	Goal:
Pull Down Menu	**Pandemic Influenza Preparedness Goal 6: CONTROL**
	Decrease the time needed to implement rapid outbreak response actions and provide other countermeasures, including personnel, risk communications, and health interventions and guidance to those at risk of pandemic influenza
	Target Capability:
Pull Down Menu	**6A Target Capability: Medical Surge**
	(link to HHS State and Local Pandemic Influenza Planning Checklist, Healthcare and Public Health Partners)
	Associated CDC Performance Measure:
Pull Down Menu	#N/A
	Critical Task:
Pull Down Menu	Before March 31, 2007, coordinate with the HRSA Bioterrorism coordinator to detail the gaps identified in the HRSA NBHPP program
	Action Item: The program efforts conducted to achieve the critical tasks that result in the creation of a product or service.
Fill In Box	ACTION LINKED TO 6A:CT1e & LOCAL GAP:: Identify the location, set-up, staffing and operation of alternate care sites during a pandemic.
	Description
Fill In Box	What: PURPOSE OF THE ACTION ITEM: During a pandemic, hospitals will be overwhelmed with patients and the need to provide medical care outside the hospital is likely to become common across the U.S. Without the ability to transfer patients to other facilities, hospitals and health departments must work together to establish alternate care sites for patients.
Fill In Box	Who: TARGET AUDIENCE: Hospitals and health departments must work together to arrange alternate care locations for patients in need of medical care during a pandemic.
Fill In Box	STAKEHOLDERS CRITICAL TO SUCCESS: Local hospitals, local health departments, local government officials, local businesses, local volunteer organizations, local Red Cross chapters, and suppliers.
Fill In Box	WHO IS RESPONSIBLE FOR OUTPUTS: Local hospitals will be the lead in the process of setting up alternate care sites. Contributions from all above listed entities will help ensure the success of the operation.
Fill In Box	When: TIME PERIOD OF PROJECT: 08/31/06 to 03/31/07
Fill In Box	Where: VENUE: Exercises will occur statewide on several occasions throughout the year.
Fill In Box	LOCATION: Urban, rural, county, district.
Fill In Box	Why: WHAT EVIDENCE DO YOU HAVE TO SUPPORT THE PROPOSED INTERVENTION/COURSE OF ACTION/OUTCOME FOR THIS ACTION ITEM?: Less than half of our HRSA hospitals have established alternate care sites as part of their pandemic flu plan.
Fill In Box	WHAT IS THE CAPACITY OF THE RECIPIENT TO DEAL WITH THIS PROBLEM/OPPORTUNITY?: In many areas of the state the capacity of hospitals to set up alternate care sites is limited.

Fill In Box		WHY DOES THIS ACTION ITEM DESERVE THE RECIPIENTS ATTENTION NOW?: Because of the anticipated increase in number of ill persons requiring hospital care during a pandemic, it will be necessary for hospitals to provide additional locations to care for patients. Perfecting this system of providing additional healthcare services is important to accomplish prior to the arrival of a pandemic.
Fill In Box		SUMMARY: Because less than half of HRSA hospitals have reported that they have arrangements for alternate care sites during a pandemic, this is a critical gap that must be addressed in a timely fashion.
	Success Factors for Action Item	
Fill In Box	Outputs	WHAT DOES THIS PRODUCE?: Each HRSA participating hospital will have addressed the issue of providing an alternate care site during a pandemic.
Fill In Box	Output Performance Measure	MEASURE OF QUANTITY/QUALITY: Percent of HRSA hospitals in Indiana will have plans addressing the surge of patients during a pandemic.
Fill In Box	Output Target	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM WILL ACCOMPLISH A PERFORMANCE MEASURE: 100% of HRSA hospitals in Indiana will have plans addressing the surge of patients during a pandemic.
Fill In Box	Immediate Outcome*	DESCRIBE THE INTENDED RESULT:
Fill In Box	Immediate Outcome Performance Measure*	IMMEDIATE OUTCOME EFFECTIVENESS:
Fill In Box	Outcome Target*	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM MUST ACCOMPLISH A PERFORMANCE MEASURE:
	Progress Report- To be Reported Mid Year and End of Year	
Fill In Box	Progress Report-Outputs	PROVIDE QUANTIFIABLE EXTENT THAT OUTPUTS HAVE BEEN ACHIEVED:
Fill In Box	Progress Report-Barriers	BRIEFLY EXPLAIN BARRIERS/PROBLEMS FACED IN ACHIEVING THE TARGET OUTPUT:

Note: *Grantees only need to report on Outputs, Output Performance Measures and Output Targets. They are not required to report Immediate Outcomes, Outcome Performance Measures and Outcome Targets.

Action Item 37	Work Plan Template for Pandemic Flu Guidance Grantees should fill out a separate template for each Action Item
Grantee Input	
	Goal:
Pull Down Menu	**Pandemic Influenza Preparedness Goal 6: CONTROL**
	Decrease the time needed to implement rapid outbreak response actions and provide other countermeasures, including personnel, risk communications, and health interventions and guidance to those at risk of pandemic influenza
	Target Capability:
Pull Down Menu	**6A Target Capability: Medical Surge**
	(link to HHS State and Local Pandemic Influenza Planning Checklist, Healthcare and Public Health Partners)
	Associated CDC Performance Measure:
Pull Down Menu	#N/A
	Critical Task:
Pull Down Menu	Before March 31, 2007, coordinate with the HRSA Bioterrorism coordinator to detail the gaps identified in the HRSA NBHPP program
	Action Item: The program efforts conducted to achieve the critical tasks that result in the creation of a product or service.
Fill In Box	ACTION LINKED TO 6A:CT1f:: f) Identify how public health, hospitals and healthcare systems will establish systems for healthcare facility level ir
	Description
	What
Fill In Box	PURPOSE OF THE ACTION ITEM: To permit hospitals to practice infection control and triage plans to be used in a pandemic. Because of the infectious nature of the disease, hospitals are not accustomed to such a high level of infection control and restricted access. Because of the expected overwhelming patient load, difficult triage decisions will have to be made and must be exercised in advance in a calm and controlled environment.
	Who
Fill In Box	TARGET AUDIENCE: Hospital staff and local public health
Fill In Box	STAKEHOLDERS CRITICAL TO SUCCESS: Hospital infection control departments, hospital emergency departments, hospital administrators and decision makers
Fill In Box	WHO IS RESPONSIBLE FOR OUTPUTS: Local health departments for guidance and hospital staff for implementation
	When
Fill In Box	TIME PERIOD OF PROJECT: 8/31/06 through 3/31/07
	Where
Fill In Box	VENUE: Local hospitals throughout the state
Fill In Box	LOCATION: Urban and rural
	Why
Fill In Box	WHAT EVIDENCE DO YOU HAVE TO SUPPORT THE PROPOSED INTERVENTION/COURSE OF ACTION/OUTCOME FOR THIS ACTION ITEM?: Infection control policies are fairly well established and need to be exercises. Triage and admission plans are in the early stages of development and going through a table top program will promote discussion and resolution of difficult issues.
Fill In Box	WHAT IS THE CAPACITY OF THE RECIPIENT TO DEAL WITH THIS PROBLEM/OPPORTUNITY?: The Indiana State Department of Health would like to develop workgroups to address these issues so that hospital decisions in this regard will be consistent throughout the state. Support staff will be needed to coordinate the meetings and outputs of the workgroups.

Fill In Box		WHY DOES THIS ACTION ITEM DESERVE THE RECIPIENTS ATTENTION NOW?: Infection control and triage decisions must be made prior to the start of a pandemic so they can be made in a calm and controlled environment. Waiting until the start of the pandemic will be too late.
Fill In Box		SUMMARY: Appropriate access to hospitals during an infectious disease outbreak must be planned for and tested in a calm environment prior to the onset of the disease.
	Success Factors for Action Item	
Fill In Box	Outputs	WHAT DOES THIS PRODUCE?: Efficient processing of infectious disease patients during a pandemic with the best protection possible for patients and staff.
Fill In Box	Output Performance Measure	MEASURE OF QUANTITY/QUALITY: Percent of HRSA hospitals who successfully complete and exercise infection control and triage plans for a pandemic influenza
Fill In Box	Output Target	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM WILL ACCOMPLISH A PERFORMANCE MEASURE: 100% of participating HRSA hospitals who exercise their plans will successfully complete the exercise and an after action report. Hospitals will then identify what worked well and incorporate opportunities for improvement into their plan.
Fill In Box	Immediate Outcome*	DESCRIBE THE INTENDED RESULT:
Fill In Box	Immediate Outcome Performance Measure*	IMMEDIATE OUTCOME EFFECTIVENESS:
Fill In Box	Outcome Target*	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM MUST ACCOMPLISH A PERFORMANCE MEASURE:
	Progress Report- To be Reported Mid Year and End of Year	
Fill In Box	Progress Report-Outputs	PROVIDE QUANTIFIABLE EXTENT THAT OUTPUTS HAVE BEEN ACHIEVED:
Fill In Box	Progress Report-Barriers	BRIEFLY EXPLAIN BARRIERS/PROBLEMS FACED IN ACHIEVING THE TARGET OUTPUT:

Note: *Grantees only need to report on Outputs, Output Performance Measures and Output Targets. They are not required to report Immediate Outcomes, Outcome Performance Measures and Outcome Targets.

Action Item 16	Work Plan Template for Pandemic Flu Guidance Grantees should fill out a separate template for each Action Item
Grantee Input	
	Goal:
Pull Down Menu	**Pandemic Influenza Preparedness Goal 6: CONTROL**
	Decrease the time needed to implement rapid outbreak response actions and provide other countermeasures, including personnel, risk communications, and health interventions and guidance to those at risk of pandemic influenza
	Target Capability:
Pull Down Menu	**6B Target Capability: Isolation and Quarantine**
	(Link to HHS State and Local Pandemic Influenza Planning Checklist, Infection Control and Clinical Guidelines, and Community Disease
	Associated CDC Performance Measure:
Pull Down Menu	Public health officials recommend school closure when pandemic influenza case counts reach pre-determined levels.
	Critical Task:
Pull Down Menu	Develop and exercise an operational plan for community mitigation of pandemic influenza using non-pharmacological.
	Action Item: The program efforts conducted to achieve the critical tasks that result in the creation of a product or service.
Fill In Box	ACTION LINKED TO PRIORITY 2:i., 6B:CT1:: Utilize the Community Containment Plan and Statewide Pandemic Influenza Exercise to exercise o
	Description
Fill In Box	What: PURPOSE OF THE ACTION ITEM: The Indiana State Department of Health, in partnership with the Indiana Department of Homeland Security and the Indiana National Guard will utilize the Community Containment Plan to exercise operational plans for community mitigation of pandemic influenza using non-pharmacological interventions. This exercise is part of the Statewide Pandemic Influenza Exercise, which is designed to include testing on home isolation and quarantine, social distancing measures such as the closure of schools and workplaces, reducing public transport, canceling mass gatherings, and public education on hand and respiratory hygiene measures.
Fill In Box	Who: TARGET AUDIENCE: Indiana State Department of Health, Indiana Department of Homeland Security, Indiana National Guard, district health jurisdictions, emergency management agencies, law enforcement agencies, the health care sector, and others as selected.
Fill In Box	STAKEHOLDERS CRITICAL TO SUCCESS: Indiana State Department of Health, Indiana Department of Homeland Security, Indiana National Guard, district health jurisdictions, emergency management agencies, law enforcement agencies, the health care sector, and other partners as selected.
Fill In Box	WHO IS RESPONSIBLE FOR OUTPUTS: Indiana State Department of Health, Indiana Department of Homeland Security, and district health jurisdictions.
Fill In Box	When: TIME PERIOD OF PROJECT: 08/31/06 - 11/30/06
Fill In Box	Where: VENUE: The exercise will be conducted statewide to include participants in each of the 10 Indiana preparedness districts. The state participants will be located at Camp Atterbury and district participants will be located at various National Guard Armories throughout the state.
Fill In Box	LOCATION: This exercise will target district jurisdictions statewide to include 10 Indiana preparedness districts.
Fill In Box	Why: WHAT EVIDENCE DO YOU HAVE TO SUPPORT THE PROPOSED INTERVENTION/COURSE OF ACTION/OUTCOME FOR THIS ACTION ITEM?: Need to ensure that state and district health jurisdictions are better prepared to implement non-pharmacological interventions such as home isolation and quarantine, social distancing measures such as closure of schools and workplaces, reducing public transport, canceling mass gatherings, and public education on hand and respiratory hygiene measures.
Fill In Box	WHAT IS THE CAPACITY OF THE RECIPIENT TO DEAL WITH THIS PROBLEM/OPPORTUNITY?: The Indiana State Department of Health has a Community Containment Plan, the subject matter expertise, the appropriate partnerships, and infrastructure to create and exercise operational plans for community mitigation of pandemic influenza using non-pharmacological interventions at the district level.

Fill In Box		WHY DOES THIS ACTION ITEM DESERVE THE RECIPIENTS ATTENTION NOW?: The operational plan for community mitigation of pandemic influenza using non-pharmacological intervention needs to be exercised in order to identify gaps, corrective actions, and to improve state and district capabilities.
Fill In Box		SUMMARY: Utilize the Statewide Pandemic Influenza Exercise to exercise operational plans for community mitigation of pandemic influenza using non-pharmacological interventions to ensure that district health jurisdictions are better prepared to implement home isolation and quarantine, social distancing measures such as closure of schools and workplaces, reducing public transport, canceling mass gatherings, and public education on hand and respiratory hygiene measures.
	Success Factors for Action Item	
Fill In Box	Outputs	WHAT DOES THIS PRODUCE?: A statewide district table top exercise that incorporates the Community Containment Plan and test the operational plan for community mitigation of pandemic influenza using non-pharmacological interventions.
Fill In Box	Output Performance Measure	MEASURE OF QUANTITY/QUALITY: % of district health jurisdictions that participate in the exercise
Fill In Box	Output Target	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM WILL ACCOMPLISH A PERFORMANCE MEASURE: 80% of district health jurisdictions participate in the exercise.
Fill In Box	Immediate Outcome*	DESCRIBE THE INTENDED RESULT:
Fill In Box	Immediate Outcome Performance Measure*	IMMEDIATE OUTCOME EFFECTIVENESS:
Fill In Box	Outcome Target*	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM MUST ACCOMPLISH A PERFORMANCE MEASURE:
	Progress Report- To be Reported Mid Year and End of Year	
Fill In Box	Progress Report-Outputs	PROVIDE QUANTIFIABLE EXTENT THAT OUTPUTS HAVE BEEN ACHIEVED:
Fill In Box	Progress Report-Barriers	BRIEFLY EXPLAIN BARRIERS/PROBLEMS FACED IN ACHIEVING THE TARGET OUTPUT:

Note: *Grantees only need to report on Outputs, Output Performance Measures and Output Targets. They are not required to report Immediate Outcomes, Outcome Performance Measures and Outcome Targets.

Action Item 17	Work Plan Template for Pandemic Flu Guidance Grantees should fill out a separate template for each Action Item
Grantee Input	
	Goal:
Pull Down Menu	**Pandemic Influenza Preparedness Goal 6: CONTROL**
	Decrease the time needed to implement rapid outbreak response actions and provide other countermeasures, including personnel, risk communications, and health interventions and guidance to those at risk of pandemic influenza
	Target Capability:
Pull Down Menu	**6B Target Capability: Isolation and Quarantine**
	(Link to HHS State and Local Pandemic Influenza Planning Checklist, Infection Control and Clinical Guidelines, and Community Disease
	Associated CDC Performance Measure:
Pull Down Menu	Public health officials recommend school closure when pandemic influenza case counts reach pre-determined levels.
	Critical Task:
Pull Down Menu	Exercise and improve the ability to implement infection control guidelines and public health measures at the State, local and tribal levels
	Action Item: The program efforts conducted to achieve the critical tasks that result in the creation of a product or service.
Fill In Box	ACTION LINKED TO CT 4: Conduct Indiana Health Alert Network exercise to improve the ability to implement infection control guidelines and put
	Description
Fill In Box	What: PURPOSE OF THE ACTION ITEM: Conduct state to local exercise on the implementation of infection control guidelines and public health measures through the Indiana Health Alert Network.
Fill In Box	Who: TARGET AUDIENCE: Indiana State Department of Health, local health jurisdictions, and other partners as selected.
Fill In Box	STAKEHOLDERS CRITICAL TO SUCCESS: Indiana State Department of Health, local health jurisdictions, and others as selected.
Fill In Box	WHO IS RESPONSIBLE FOR OUTPUTS: Indiana State Department of Health and local health jurisdictions.
Fill In Box	When: TIME PERIOD OF PROJECT: 08/31/06-08/30/07
Fill In Box	Where: VENUE: The exercise will be initiated by the Indiana State Department of Health and will use the Indiana Health Alert Network to implement infection control guidelines at local health jurisdictions.
Fill In Box	LOCATION: The exercise will be initiated at the state level and will target local health jurisdictions statewide to include participants in the 10 Indiana preparedness districts.
Fill In Box	Why: WHAT EVIDENCE DO YOU HAVE TO SUPPORT THE PROPOSED INTERVENTION/COURSE OF ACTION/OUTCOME FOR THIS ACTION ITEM?: Need to improve state to local ability to implement infection control guidelines and public health measures.
Fill In Box	WHAT IS THE CAPACITY OF THE RECIPIENT TO DEAL WITH THIS PROBLEM/OPPORTUNITY?: The Indiana State Department of Health has the capacity to implement infection control guidelines and public health measures through the Indiana Health Alert Network system.

Fill In Box		WHY DOES THIS ACTION ITEM DESERVE THE RECIPIENTS ATTENTION NOW?: The implementation of infection control guidelines and public health measures should be exercised in order to identify gaps and corrective actions in order to improve the ability to implement such measures.
Fill In Box		SUMMARY: The state has a general need to improve the ability to implement infection control guidelines and public health measures. The Indiana State Department of Health has the capacity through the Indiana Health Alert Network to exercise this ability and will conduct an exercise to improve state to local ability to implement infection control guidelines and public health measures.
	Success Factors for Action Item	
Fill In Box	Outputs	WHAT DOES THIS PRODUCE?: An Indiana Health Alert Network exercise that improves upon the state to local ability to implement infection control guidelines and public health measures.
Fill In Box	Output Performance Measure	MEASURE OF QUANTITY/QUALITY: A % of local health jurisdictions that receive Indiana Health Alert Network message to implement infection control and public health measures.
Fill In Box	Output Target	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM WILL ACCOMPLISH A PERFORMANCE MEASURE: 80% of local health jurisdictions receive IHAN message from ISDH to implement infection control guidelines and public health measures.
Fill In Box	Immediate Outcome*	DESCRIBE THE INTENDED RESULT:
Fill In Box	Immediate Outcome Performance Measure*	IMMEDIATE OUTCOME EFFECTIVENESS:
Fill In Box	Outcome Target*	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM MUST ACCOMPLISH A PERFORMANCE MEASURE:
	Progress Report- To be Reported Mid Year and End of Year	
Fill In Box	Progress Report-Outputs	PROVIDE QUANTIFIABLE EXTENT THAT OUTPUTS HAVE BEEN ACHIEVED:
Fill In Box	Progress Report-Barriers	BRIEFLY EXPLAIN BARRIERS/PROBLEMS FACED IN ACHIEVING THE TARGET OUTPUT:

Note: *Grantees only need to report on Outputs, Output Performance Measures and Output Targets. They are not required to report Immediate Outcomes, Outcome Performance Measures and Outcome Targets.

Action Item 18	Work Plan Template for Pandemic Flu Guidance Grantees should fill out a separate template for each Action Item
Grantee Input	
	Goal:
Pull Down Menu	**Pandemic Influenza Preparedness Goal 6: CONTROL**
	Decrease the time needed to implement rapid outbreak response actions and provide other countermeasures, including personnel, risk communications, and health interventions and guidance to those at risk of pandemic influenza
	Target Capability:
Pull Down Menu	**6B Target Capability: Isolation and Quarantine**
	(Link to HHS State and Local Pandemic Influenza Planning Checklist, Infection Control and Clinical Guidelines, and Community Disease
	Associated CDC Performance Measure:
Pull Down Menu	
	Critical Task:
Pull Down Menu	Develop and exercise an operational plan for isolation and quarantine.
	Action Item: The program efforts conducted to achieve the critical tasks that result in the creation of a product or service.
Fill In Box	ACTION LINKED TO 6B:CT6:: Utilize the Hoosier Guardian Statewide Exercise to test operational plans for isolation and quarantine.
	Description
Fill In Box	What: PURPOSE OF THE ACTION ITEM: The Indiana State Department of Health in partnership with the Indiana Department of Homeland Security and the Indiana National Guard will participate in Hoosier Guardian, a statewide full-scale exercise, in order to test operational plans for the implementation of isolation and quarantine to include criteria for isolation and quarantine, procedures and legal authorities for implementing and enforcing these containment procedures, and methods to provide support, service, and monitoring of those affected by isolation and quarantine.
Fill In Box	Who: TARGET AUDIENCE: Indiana State Department Health, Indiana Department of Homeland Security, Indiana National Guard, district health jurisdictions, emergency management agencies, law enforcement agencies, the health care sector, and others as selected.
Fill In Box	STAKEHOLDERS CRITICAL TO SUCCESS: Indiana State Department of Health, Indiana Department of Homeland Security, Indiana National Guard, district health jurisdictions, emergency management agencies, law enforcement agencies, the health care sector, and other as selected.
Fill In Box	WHO IS RESPONSIBLE FOR OUTPUTS: Indiana State Department of Health, Indiana Department of Homeland Security, and district health jurisdictions.
Fill In Box	When: TIME PERIOD OF PROJECT: 08/31/06-08/30/07
Fill In Box	Where: VENUE: The statewide exercise will be conducted at the Muscaktatuck Urban Training Center and will include participants from various Indiana preparedness districts.
Fill In Box	LOCATION: The exercise will be conducted statewide and will test district level capabilities to respond to an emergency event at the community and county level.
Fill In Box	Why: WHAT EVIDENCE DO YOU HAVE TO SUPPORT THE PROPOSED INTERVENTION/COURSE OF ACTION/OUTCOME FOR THIS ACTION ITEM?: State need to test district capabilities to ensure that state and district health jurisdictions are better prepared to implement non-pharmacological interventions such as isolation and quarantine.
Fill In Box	WHAT IS THE CAPACITY OF THE RECIPIENT TO DEAL WITH THIS PROBLEM/OPPORTUNITY?: The Indiana State Department of Health has a Community Containment Plan, the subject matter expertise, the appropriate partnerships, and infrastructure to exercise operational plans for isolation and quarantine.

Fill In Box		WHY DOES THIS ACTION ITEM DESERVE THE RECIPIENTS ATTENTION NOW?: State and district jurisdictions need to understand the criteria for isolation and quarantine, procedures and legal authorities for implementing and enforcing these containment procedures, and methods to provide support, service, and monitoring of those affected by isolation and quarantine.
Fill In Box		SUMMARY: The Indiana State Department of Health will participate in the Hoosier Guardian exercise to test operational plans for isolation and quarantine to ensure that state and district jurisdictions understand the criteria for isolation and quarantine, procedures and legal authorities for implementing and enforcing these containment procedures, and methods to provide support, service, and monitor those affected by isolation and quarantine.
	Success Factors for Action Item	
Fill In Box	Outputs	WHAT DOES THIS PRODUCE?: A statewide full-scale exercise that test operational plans for isolation and quarantine.
Fill In Box	Output Performance Measure	MEASURE OF QUANTITY/QUALITY: # of district health jurisdictions that participate in the Hoosier Guardian exercise to test the operational plan for isolation and quarantine.
Fill In Box	Output Target	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM WILL ACCOMPLISH A PERFORMANCE MEASURE: Paticipation from at least 2 Indiana Homeland Security districts will participate in the Hoosier Guardian exercise to test operational plans for isolation and quarantine.
Fill In Box	Immediate Outcome*	DESCRIBE THE INTENDED RESULT:
Fill In Box	Immediate Outcome Performance Measure*	IMMEDIATE OUTCOME EFFECTIVENESS:
Fill In Box	Outcome Target*	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM MUST ACCOMPLISH A PERFORMANCE MEASURE:
	Progress Report- To be Reported Mid Year and End of Year	
Fill In Box	Progress Report-Outputs	PROVIDE QUANTIFIABLE EXTENT THAT OUTPUTS HAVE BEEN ACHIEVED:
Fill In Box	Progress Report-Barriers	BRIEFLY EXPLAIN BARRIERS/PROBLEMS FACED IN ACHIEVING THE TARGET OUTPUT:

Note: *Grantees only need to report on Outputs, Output Performance Measures and Output Targets. They are not required to report Immediate Outcomes, Outcome Performance Measures and Outcome Targets.

Action Item 19	Work Plan Template for Pandemic Flu Guidance Grantees should fill out a separate template for each Action Item
Grantee Input	
	Goal:
Pull Down Menu	**Pandemic Influenza Preparedness Goal 6: CONTROL**
	Decrease the time needed to implement rapid outbreak response actions and provide other countermeasures, including personnel, risk communications, and health interventions and guidance to those at risk of pandemic influenza
	Target Capability:
Pull Down Menu	**6B Target Capability: Isolation and Quarantine**
	(Link to HHS State and Local Pandemic Influenza Planning Checklist, Infection Control and Clinical Guidelines, and Community Disease
	Associated CDC Performance Measure:
Pull Down Menu	#N/A
	Critical Task:
Pull Down Menu	Develop and exercise an operational plan for implementing social distancing measures in a jurisdiction that addresses school and
	Action Item: The program efforts conducted to achieve the critical tasks that result in the creation of a product or service.
Fill In Box	ACTION LINKED TO 6B:CT9:: Utilize the Community Containment Plan and the Statewide Pandemic Influenza Exercise to exercise operational p
	Description
Fill In Box	What: PURPOSE OF THE ACTION ITEM: The Indiana State Department of Health, in partnership with the Indiana Department of Homeland Security and the Indiana National Guard will utilize the Community Containment Plan to exercise operational plans for implementing social distancing measures. This exercise is part of the Statewide Pandemic Influenza Exercise designed to test decisions that addressess school and workplace closures and cancellations of public gatherings withing a jurisdiction.
Fill In Box	Who: TARGET AUDIENCE: Indiana State Department of Health, Indiana Department of Homeland Security, Indiana National Guard, district health jurisdictions, school corporations, emergency management agencies, law enforcement agencies, the health care sector, and others as selected.
Fill In Box	STAKEHOLDERS CRITICAL TO SUCCESS: Indiana State Department of Health, Indiana Department of Homeland Security, local health jurisdictions, emergency management agencies; law enforcement agencies; the health care sector, and other as selected.
Fill In Box	WHO IS RESPONSIBLE FOR OUTPUTS: Indiana State Department of Health, Indiana Department of Homeland Security, and district health jurisdictions.
Fill In Box	When: TIME PERIOD OF PROJECT: 08/31/06-11/30/06
Fill In Box	Where: VENUE: The exercise will be conducted statewide to include participants in each of the 10 Indiana preparedness districts. The state participants will be located at Camp Atterbury and district participants will be located at various National Guard Armories throughout the state.
Fill In Box	LOCATION: The exercise will be conducted on the district health jurisdictions statewide to include the 10 Indiana preparedness districts.
Fill In Box	Why: WHAT EVIDENCE DO YOU HAVE TO SUPPORT THE PROPOSED INTERVENTION/COURSE OF ACTION/OUTCOME FOR THIS ACTION ITEM?: Need to ensure that state and district health jurisdictions are better prepared to implement social distancing measues in a jurisdiction to address school and workplace closures and the cancellation of public gatherings.
Fill In Box	WHAT IS THE CAPACITY OF THE RECIPIENT TO DEAL WITH THIS PROBLEM/OPPORTUNITY?: The Indiana State Department of Health has a Community Containment Plan, the subject matter expertise, the appropriate partnerships, and infrastructure to create and exercise operational plans for implementing social distancing measures at the district level.

Fill In Box		WHY DOES THIS ACTION ITEM DESERVE THE RECIPIENTS ATTENTION NOW?: State and district health jurisdictions need to exercise operational plans for social distancing measures that addresses school and work closures in order to identify gaps, corrective actions, and to improve state and district capabilities.
Fill In Box		SUMMARY: The Indiana State Department of Health will exercise the operational plan for social distancing measures to ensure that state and district jurisdictions are better prepared to implement social distancing measures that addresses school and workplace closures and the cancellation of public gatherings.
	Success Factors for Action Item	
Fill In Box	Outputs	WHAT DOES THIS PRODUCE?: A statewide district table top exercise that incorporates the Community Containment Plan and test operational plans for social distancing measures that addresses school and workplace closures.
Fill In Box	Output Performance Measure	MEASURE OF QUANTITY/QUALITY: % of district health jurisdictions that participate in the exercise
Fill In Box	Output Target	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM WILL ACCOMPLISH A PERFORMANCE MEASURE: 80% of district health jurisdictions participate in the exercise.
Fill In Box	Immediate Outcome*	DESCRIBE THE INTENDED RESULT:
Fill In Box	Immediate Outcome Performance Measure*	IMMEDIATE OUTCOME EFFECTIVENESS:
Fill In Box	Outcome Target*	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM MUST ACCOMPLISH A PERFORMANCE MEASURE:
	Progress Report- To be Reported Mid Year and End of Year	
Fill In Box	Progress Report-Outputs	PROVIDE QUANTIFIABLE EXTENT THAT OUTPUTS HAVE BEEN ACHIEVED:
Fill In Box	Progress Report-Barriers	BRIEFLY EXPLAIN BARRIERS/PROBLEMS FACED IN ACHIEVING THE TARGET OUTPUT:

Note: *Grantees only need to report on Outputs, Output Performance Measures and Output Targets. They are not required to report Immediate Outcomes, Outcome Performance Measures and Outcome Targets.

Action Item 26	Work Plan Template for Pandemic Flu Guidance Grantees should fill out a separate template for each Action Item
Grantee Input	
	Goal:
Pull Down Menu	**Pandemic Influenza Preparedness Goal 6: CONTROL**
	Decrease the time needed to implement rapid outbreak response actions and provide other countermeasures, including personnel, risk communications, and health interventions and guidance to those at risk of pandemic influenza
	Target Capability:
Pull Down Menu	**6C Target Capability: Mass Prophylaxis**
	(link to HHS State and Local Pandemic Influenza Planning Checklist, Vaccine Distribution and Use, and Antiviral Drug Distribution and Use)
	Associated CDC Performance Measure:
Pull Down Menu	Adequacy of State and local plans to receive and dispense medical countermeasures as demonstrated through assessment by the Strategic National Stockpile/Cities Readiness Initiative (CRI)
	Critical Task:
Pull Down Menu	Describe the receipt, distribution, storage, security, monitoring and administration of pandemic influenza vaccines.
	Action Item: The program efforts conducted to achieve the critical tasks that result in the creation of a product or service.
Fill In Box	ACTION LINKED TO PRIORITY 3: 6C:CT1:: To provide anti-virals to the state population, as determined in the state plan, as quickly as possible.
	Description
Fill In Box	What: PURPOSE OF THE ACTION ITEM: To receive, stage, store the SNS 12 Hour Push Pack at our RSS warehouse, provide security to the site, monitor and administrate pandemic influenza vaccines including plans for limited vaccine availability and prioitization of population groups and provide distribution as required by the plan.
Fill In Box	Who: TARGET AUDIENCE: Medical Responders, Populations most at risk then the population as a whole.
Fill In Box	STAKEHOLDERS CRITICAL TO SUCCESS: Indiana State Department of Health, Indiana Department of Transportation, Indiana State Police, Indiana Department of Homeland Security, RSS Warehouse contractor all are primary participants.
Fill In Box	WHO IS RESPONSIBLE FOR OUTPUTS: Indiana State Department of Health, Public Health Preparedness and Emergency Response.
Fill In Box	When: TIME PERIOD OF PROJECT: 08/31/06 - 08/30/07
Fill In Box	Where: VENUE: Locations throughout the State of Indiana.
Fill In Box	LOCATION: Statewide, districts, counties, towns and cities.
Fill In Box	Why: WHAT EVIDENCE DO YOU HAVE TO SUPPORT THE PROPOSED INTERVENTION/COURSE OF ACTION/OUTCOME FOR THIS ACTION ITEM?: The potential of a pandemic influenza is serious and deserves serious planning, training and exercising of the states capability to provide anti-virals as required and quickly.
Fill In Box	WHAT IS THE CAPACITY OF THE RECIPIENT TO DEAL WITH THIS PROBLEM/OPPORTUNITY?: The capacity of the recepient is growing and the ability to meet the responsibility increases daily.

Fill In Box		WHY DOES THIS ACTION ITEM DESERVE THE RECIPIENTS ATTENTION NOW?: Pandemic influenza could start and overwhelm our population very quickly. Time is of the essence. It could start today.
Fill In Box		SUMMARY: A great deal of planning and training is required in a very short period of time. Response timing is going to be critical to protect our population. Coordination and exercising of all key participants to assure the understanding of responsibilties and the effectiveness of the planning through testing of all elements will assure we can respond as expected.
	Success Factors for Action Item	
Fill In Box	Outputs	WHAT DOES THIS PRODUCE?: Properly planned, coordinated, trained and exercised - the receipt, stage and storage of the antivirals, the inventory control, and predetermined apportionment
Fill In Box	Output Performance Measure	MEASURE OF QUANTITY/QUALITY: To increase our state CDC SNS Assessment Function Rating in every Section of the CDC SNS State Assessment Tool with no section being rated as Red.
Fill In Box	Output Target	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM WILL ACCOMPLISH A PERFORMANCE MEASURE: Function ratings that have been rated Green will remain Green, section ratings that have been rated as amber will increase in average ratings or become Green. Red ratings will become Amber or Green.
Fill In Box	Immediate Outcome*	DESCRIBE THE INTENDED RESULT: The outcome of obtaining target outputs will be a more responsive and capable antiviral distribution system. The planning, coordination, training and exercising the of the distribution plan will assure the best possible opportunity to meet the states obligation to provide for and protect our population.
Fill In Box	Immediate Outcome Performance Measure*	IMMEDIATE OUTCOME EFFECTIVENESS:
Fill In Box	Outcome Target*	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM MUST ACCOMPLISH A PERFORMANCE MEASURE:
	Progress Report- To be Reported Mid Year and End of Year	
Fill In Box	Progress Report-Outputs	PROVIDE QUANTIFIABLE EXTENT THAT OUTPUTS HAVE BEEN ACHIEVED:
Fill In Box	Progress Report-Barriers	BRIEFLY EXPLAIN BARRIERS/PROBLEMS FACED IN ACHIEVING THE TARGET OUTPUT:

Note: *Grantees only need to report on Outputs, Output Performance Measures and Output Targets. They are not required to report Immediate Outcomes, Outcome Performance Measures and Outcome Targets.

Action Item 27	Work Plan Template for Pandemic Flu Guidance Grantees should fill out a separate template for each Action Item
Grantee Input	
	Goal:
Pull Down Menu	**Pandemic Influenza Preparedness Goal 6: CONTROL**
	Decrease the time needed to implement rapid outbreak response actions and provide other countermeasures, including personnel, risk communications, and health interventions and guidance to those at risk of pandemic influenza
	Target Capability:
Pull Down Menu	**6C Target Capability: Mass Prophylaxis**
	(link to HHS State and Local Pandemic Influenza Planning Checklist, Vaccine Distribution and Use, and Antiviral Drug Distribution and Use)
	Associated CDC Performance Measure:
Pull Down Menu	Percent of estimated patient throughput actually achieved for each shift during mass vaccination clinic
	Critical Task:
Pull Down Menu	Collaborate in mass prophylaxis planning and exercising with community-wide partners, bordering jurisdictions, IHS and tribal nations
	Action Item: The program efforts conducted to achieve the critical tasks that result in the creation of a product or service.
Fill In Box	ACTION LINKED TO PRIORITY 2:iii., 6C:CT2:: Exercise mass vaccination capabilites, including PODs, in three urban and two rural Local Health
	Description
	What
Fill In Box	PURPOSE OF THE ACTION ITEM: Identify deficiencies and incorporate corrective actions into LHD's Mass Prophylaxis Plans by testing and exercising plan components, including POD activation/operations, security, mass vaccinations, and public information procedures.
	Who
Fill In Box	TARGET AUDIENCE: Target audiences will be identified based on current recommendations for immunization practices for distribution/delivery of seasonal influenza vaccines.
Fill In Box	STAKEHOLDERS CRITICAL TO SUCCESS: The Indiana State Department of Health (ISDH), Local Health Departments, POD volunteers, law enforcement, media, the Indiana Department of Homeland Security, local Emergency Management Agencies (EMAs), and other local health care providers.
Fill In Box	WHO IS RESPONSIBLE FOR OUTPUTS: The Indiana State Department of Health and the selected Local Health Departments
	When
Fill In Box	TIME PERIOD OF PROJECT: 8/31/06 - 8/30/07
	Where
Fill In Box	VENUE: Selected POD sites in three urban and two rural local health jurisdictions.
Fill In Box	LOCATION: Sites will be identified by 9/30/06.
	Why
Fill In Box	WHAT EVIDENCE DO YOU HAVE TO SUPPORT THE PROPOSED INTERVENTION/COURSE OF ACTION/OUTCOME FOR THIS ACTION ITEM?: To test capabilities to deliver vaccines to the general population in a manner consistent with mass prophylaxis, including PODs.
Fill In Box	WHAT IS THE CAPACITY OF THE RECIPIENT TO DEAL WITH THIS PROBLEM/OPPORTUNITY?: Local Health Departments in 86 of 94 local health jurisdictions across the state have developed Mass Prophylaxis Plans and have begun conducting drills and exercises to test various components of their plans.

Fill In Box		WHY DOES THIS ACTION ITEM DESERVE THE RECIPIENTS ATTENTION NOW?: Provides opportunties to train and exercise POD staff and volunteers in the implementation of mass vaccination programs.
Fill In Box		SUMMARY:
	Success Factors for Action Item	
Fill In Box	Outputs	WHAT DOES THIS PRODUCE?: After Action Reports (AARs) from mass vaccination clinic exercises from three urban and two rural local health departments.
Fill In Box	Output Performance Measure	MEASURE OF QUANTITY/QUALITY: Successful completion of five mass vaccination clinic exercises with resulting AARs identifying at least three deficiencies for each exercise.
Fill In Box	Output Target	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM WILL ACCOMPLISH A PERFORMANCE MEASURE: All five, or 100 percent, of the local health departments selected to participate in these exercises will conduct seasonal influenza vaccination clinics to test patient through-put.
Fill In Box	Immediate Outcome*	DESCRIBE THE INTENDED RESULT:
Fill In Box	Immediate Outcome Performance Measure*	IMMEDIATE OUTCOME EFFECTIVENESS:
Fill In Box	Outcome Target*	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM MUST ACCOMPLISH A PERFORMANCE MEASURE:
	Progress Report- To be Reported Mid Year and End of Year	
Fill In Box	Progress Report-Outputs	PROVIDE QUANTIFIABLE EXTENT THAT OUTPUTS HAVE BEEN ACHIEVED:
Fill In Box	Progress Report-Barriers	BRIEFLY EXPLAIN BARRIERS/PROBLEMS FACED IN ACHIEVING THE TARGET OUTPUT:

Note: *Grantees only need to report on Outputs, Output Performance Measures and Output Targets. They are not required to report Immediate Outcomes, Outcome Performance Measures and Outcome Targets.

Action Item 28	Work Plan Template for Pandemic Flu Guidance Grantees should fill out a separate template for each Action Item
Grantee Input	
	Goal:
Pull Down Menu	**Pandemic Influenza Preparedness Goal 6: CONTROL**
	Decrease the time needed to implement rapid outbreak response actions and provide other countermeasures, including personnel, risk communications, and health interventions and guidance to those at risk of pandemic influenza
	Target Capability:
Pull Down Menu	**6C Target Capability: Mass Prophylaxis**
	(link to HHS State and Local Pandemic Influenza Planning Checklist, Vaccine Distribution and Use, and Antiviral Drug Distribution and Use)
	Associated CDC Performance Measure:
Pull Down Menu	Percent of estimated patient throughput actually achieved for each shift during mass vaccination clinic
	Critical Task:
Pull Down Menu	Collaborate in mass prophylaxis planning and exercising with community-wide partners, bordering jurisdictions, IHS and tribal nations
	Action Item: The program efforts conducted to achieve the critical tasks that result in the creation of a product or service.
Fill In Box	ACTION LINKED TO 6C:CT2:: Develop an online Pan Flu Simulation Exercise which functions as a drill, in accordance with HSEEP standards to
	Description
	What
Fill In Box	PURPOSE OF THE ACTION ITEM: It is necessary to provide multiple venues for building and honing NIMS compliant skills through practical application at little or no expense to local and state level preparedness staff and volunteers.
	Who
Fill In Box	TARGET AUDIENCE: The simulation drill will be targeted toward Local and District Public Health Coordinators, designated local health department and hospital preparedness staff, mental health support staff, Point of Dispensing volunteers and staff responsible for incident command, medical screening, medication dispensing, forms review, and station captains.
Fill In Box	STAKEHOLDERS CRITICAL TO SUCCESS: IN Family & Social Srvs. Agcy-Mental Health & Addictions, Public Health Coor.'s Training Plan Adv Grp, IN State Dept of Health-Epidemiology Resource Ctr & Public Health Preparedness & Emergency Resp (PHPER) staff, IN Dept of Homeland Sec, University of Illinois at Chicago-Ctr for Advancement of Distance Educ (UIC-CADE), Medical Reserve Corps, & Community Health Ctrs.
Fill In Box	WHO IS RESPONSIBLE FOR OUTPUTS: WHO IS RESPONSIBLE FOR OUTPUTS: TBD, the Indiana Family & Social Services Agency-Division of Mental Health & Addictions, Indiana Department of Homeland Security-Training Division, ISDH Public Health Preparedness & Emergency Response Division, IN local health department staff, and the ISDH ILCMS Coordinator
	When
Fill In Box	TIME PERIOD OF PROJECT: 08/31/06 - 08/30/08
	Where
Fill In Box	VENUE: TBD - Available statewide through Indiana's online Learning/Content Management System or via the ISDH Health Data Portal.
Fill In Box	LOCATION: Statewide/National
	Why
Fill In Box	WHAT EVIDENCE DO YOU HAVE TO SUPPORT THE PROPOSED INTERVENTION/COURSE OF ACTION/OUTCOME FOR THIS ACTION ITEM?: The military is an example for successful use of simulations to ensure competency & capability. It's also a more sound time & dollar investment to train & drill key POD staff & volunteers by increasing the opportunity for practice prior to & after exercises/drills. Last, an individual can easily practice varying roles should s/he be placed in an alternate role during an actual event
Fill In Box	WHAT IS THE CAPACITY OF THE RECIPIENT TO DEAL WITH THIS PROBLEM/OPPORTUNITY?: We currently has an ILCMS which the simulation can be incorporated. The ISDH ILCMS Coordinator has public health education/methods, & training expertise including the technical expertise with the state's CLMS. UIC-CADE owns & manages the overall ILCMS. Its staff could be an intregal part, and a potential candidate for simulation development, of integrating whatever simulation selected into the existing ILCMS

Fill In Box		WHY DOES THIS ACTION ITEM DESERVE THE RECIPIENTS ATTENTION NOW?: To increase capability and efficiency of the preparedness staff and volunteers during full scale POD & Mass Prophylaxis drills, exercises related to an influenza pandemic response or other Public Health Event requiring Mass Prophylaxis.
Fill In Box		SUMMARY: This action item will ultimately help to decrease the time needed to implement rapid outbreak response actions, to those at risk of the pan flu, by increasing the capability& efficiency of preparedness staff & volunteers. An online simulation will be available through the ILCLMS to drill POD staff in the following roles: station captains, site coordinator/clinic set-up, medical screener/triage, medication dispensing, & forms reviewer.
	Success Factors for Action Item	
Fill In Box	Outputs	WHAT DOES THIS PRODUCE?: An online simulation drill that will be available for use by POD staff with the following roles: station captains, site coordinator/ clinic set-up, medical screener/triage, medication dispensing, and forms reviewer
Fill In Box	Output Performance Measure	MEASURE OF QUANTITY/QUALITY: Within the pilot sites, there will be a % increase in capability of POD staff (see roles above) to perform their job responsibilities as per the Job Action Sheets (JAS) including a % improvement in overall POD function compared with full scale exercises with no prior online simulation drill.
Fill In Box	Output Target	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM WILL ACCOMPLISH A PERFORMANCE MEASURE: Within the pilot sites, there will be a 25% increase in capability of POD staff (see roles above) to perform their job responsibilities as per the JAS including a 25% improvement in POD function compared with full scale exercises with no prior online simulation drill.
Fill In Box	Immediate Outcome*	DESCRIBE THE INTENDED RESULT:
Fill In Box	Immediate Outcome Performance Measure*	IMMEDIATE OUTCOME EFFECTIVENESS:
Fill In Box	Outcome Target*	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM MUST ACCOMPLISH A PERFORMANCE MEASURE:
	Progress Report- To be Reported Mid Year and End of Year	
Fill In Box	Progress Report-Outputs	PROVIDE QUANTIFIABLE EXTENT THAT OUTPUTS HAVE BEEN ACHIEVED:
Fill In Box	Progress Report-Barriers	BRIEFLY EXPLAIN BARRIERS/PROBLEMS FACED IN ACHIEVING THE TARGET OUTPUT:

Note: *Grantees only need to report on Outputs, Output Performance Measures and Output Targets. They are not required to report Immediate Outcomes, Outcome Performance Measures and Outcome Targets.

Action Item 29	Work Plan Template for Pandemic Flu Guidance Grantees should fill out a separate template for each Action Item
Grantee Input	
	Goal:
Pull Down Menu	**Pandemic Influenza Preparedness Goal 6: CONTROL**
	Decrease the time needed to implement rapid outbreak response actions and provide other countermeasures, including personnel, risk communications, and health interventions and guidance to those at risk of pandemic influenza
	Target Capability:
Pull Down Menu	**6C Target Capability: Mass Prophylaxis**
	(link to HHS State and Local Pandemic Influenza Planning Checklist, Vaccine Distribution and Use, and Antiviral Drug Distribution and Use)
	Associated CDC Performance Measure:
Pull Down Menu	Influenza vaccination coverage levels reported by BRFSS for each age and risk group.
	Critical Task:
Pull Down Menu	Maintain PHIN compliant information systems for tracking vaccine distribution and administration
	Action Item: The program efforts conducted to achieve the critical tasks that result in the creation of a product or service.
Fill In Box	ACTION LINKED TO 6C:CT3:: We have an application that provides vaccine management information. However, it is not PHIN complaint and do
	Description
Fill In Box	What: PURPOSE OF THE ACTION ITEM: We need a contractor to work with us on defining both our internal needs and PHIN Certification needs. Part of this assessment will be an evaluation of our current application and others systems. Based upon this analysis, we will make a recommendation, which we will then implement.
Fill In Box	Who: TARGET AUDIENCE: The CHIRP area that monitors vaccine management.
Fill In Box	STAKEHOLDERS CRITICAL TO SUCCESS: The CHIRP manager and the CRA PHIN Certification team are the primary stakeholders.
Fill In Box	WHO IS RESPONSIBLE FOR OUTPUTS: The CHIRP area is responsible.
Fill In Box	When: TIME PERIOD OF PROJECT: 11/1/2006 - 8/30/2007
Fill In Box	Where: VENUE: All system work will be done at the ISDH.
Fill In Box	LOCATION: All system and implementation work will be done at the ISDH.
Fill In Box	Why: WHAT EVIDENCE DO YOU HAVE TO SUPPORT THE PROPOSED INTERVENTION/COURSE OF ACTION/OUTCOME FOR THIS ACTION ITEM?: As part of the CRA PHIN Certification review, we identified the vaccine management areas the we need to address to achieve certification. Part of this review included an initial evaluation of our current applications. We know what we need to do.
Fill In Box	WHAT IS THE CAPACITY OF THE RECIPIENT TO DEAL WITH THIS PROBLEM/OPPORTUNITY?: We do not expect any technical capacity issues concerning the development and implementation of the application.

Fill In Box		WHY DOES THIS ACTION ITEM DESERVE THE RECIPIENTS ATTENTION NOW?: This is a certification requirement and should be done in conjunction with other CRA certification activities.
Fill In Box		SUMMARY: As part of our review of CRA PHIN Certification requirements, we determined that our current applications meet certification requirements. Even with some pending software changes in the current applications, we will not be PHIN compliant. We need to do an initial evaluation to determine if we can modify our existing applications or implement a PHIN complaint software solution; we then need to implement the recommendation from the evaluation.
	Success Factors for Action Item	
Fill In Box	Outputs	WHAT DOES THIS PRODUCE?: The application will provide the PHIN compliant tools that we need for vaccine management.
Fill In Box	Output Performance Measure	MEASURE OF QUANTITY/QUALITY: The measure of success will be if the implementation provides the management tools required to achieve PHIN Certification.
Fill In Box	Output Target	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM WILL ACCOMPLISH A PERFORMANCE MEASURE: The measurable statistic will be if 100% of mandatory PHIN Certification requirements are met.
Fill In Box	Immediate Outcome*	DESCRIBE THE INTENDED RESULT:
Fill In Box	Immediate Outcome Performance Measure*	IMMEDIATE OUTCOME EFFECTIVENESS:
Fill In Box	Outcome Target*	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM MUST ACCOMPLISH A PERFORMANCE MEASURE:
	Progress Report- To be Reported Mid Year and End of Year	
Fill In Box	Progress Report-Outputs	PROVIDE QUANTIFIABLE EXTENT THAT OUTPUTS HAVE BEEN ACHIEVED:
Fill In Box	Progress Report-Barriers	BRIEFLY EXPLAIN BARRIERS/PROBLEMS FACED IN ACHIEVING THE TARGET OUTPUT:

Note: *Grantees only need to report on Outputs, Output Performance Measures and Output Targets. They are not required to report Immediate Outcomes, Outcome Performance Measures and Outcome Targets.

Action Item 30	Work Plan Template for Pandemic Flu Guidance Grantees should fill out a separate template for each Action Item
Grantee Input	
	Goal:
Pull Down Menu	**Pandemic Influenza Preparedness Goal 6: CONTROL**
	Decrease the time needed to implement rapid outbreak response actions and provide other countermeasures, including personnel, risk communications, and health interventions and guidance to those at risk of pandemic influenza
	Target Capability:
Pull Down Menu	**6C Target Capability: Mass Prophylaxis**
	(link to HHS State and Local Pandemic Influenza Planning Checklist, Vaccine Distribution and Use, and Antiviral Drug Distribution and Use)
	Associated CDC Performance Measure:
Pull Down Menu	Adequacy of State and local plans to receive and dispense medical countermeasures as demonstrated through assessment by the Strategic National Stockpile/Cities Readiness Initiative (CRI)
	Critical Task:
Pull Down Menu	Describe the receipt, distribution, storage, security, monitoring and administration of pandemic influenza vaccines.
	Action Item: The program efforts conducted to achieve the critical tasks that result in the creation of a product or service.
Fill In Box	In conjunction with the CDC SNS RSS SOP vaccines will be received, stored, staged and distributed in a similar manor to the 12 Hour Push Pack
	Description
Fill In Box	What: PURPOSE OF THE ACTION ITEM: To quickly distribute to any potentially affected population.
Fill In Box	Who: TARGET AUDIENCE: Population of the state as may be required.
Fill In Box	STAKEHOLDERS CRITICAL TO SUCCESS: Indiana State Departmment of Health, Indiana State Department of Transportation, Indiana State Police, Indiana Department of Homeland Security, county and local health departments, hospitals, law enforcement agencies and other commuinty partners. All elements are meeting with cross jurisdictional planning in each of our 10 State Health Districts. Each District has a coordinator to assure all counties are working and planning together.
Fill In Box	WHO IS RESPONSIBLE FOR OUTPUTS: Indiana State Department of Health with all local health departments
Fill In Box	When: TIME PERIOD OF PROJECT: 09/2006 - 08/2007
Fill In Box	Where: VENUE: Statewide
Fill In Box	LOCATION: State, county and cities
Fill In Box	Why: WHAT EVIDENCE DO YOU HAVE TO SUPPORT THE PROPOSED INTERVENTION/COURSE OF ACTION/OUTCOME FOR THIS ACTION ITEM?: SNS RSS and Distribution systems have been tested and times checked
Fill In Box	WHAT IS THE CAPACITY OF THE RECIPIENT TO DEAL WITH THIS PROBLEM/OPPORTUNITY?: That will depend on the scope of an event requiring vaccinations. As is planned at this time the capacities should be met.

Fill In Box		WHY DOES THIS ACTION ITEM DESERVE THE RECIPIENTS ATTENTION NOW?: Pre planning for an event allows for quicker response and fewer people placed at risk.
Fill In Box		SUMMARY: Building on the basic SNS SOP and refelecting only changes for medical vaccination administrative requirements this should be able to be accomplished if the scope of the event is within the capacity of the state and federal government to provide required assets.
	Success Factors for Action Item	
Fill In Box	Outputs	WHAT DOES THIS PRODUCE?: More people vaccinated in a shorter time
Fill In Box	Output Performance Measure	MEASURE OF QUANTITY/QUALITY: Vaccinating the targeted population in as short a period of time as possible.
Fill In Box	Output Target	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM WILL ACCOMPLISH A PERFORMANCE MEASURE:
Fill In Box	Immediate Outcome*	DESCRIBE THE INTENDED RESULT:
Fill In Box	Immediate Outcome Performance Measure*	IMMEDIATE OUTCOME EFFECTIVENESS:
Fill In Box	Outcome Target*	QUANTIFIABLE or MEASUREABLE CHARACTERISTICS (# or %) THAT TELL HOW WELL THE PROGRAM MUST ACCOMPLISH A PERFORMANCE MEASURE:
	Progress Report- To be Reported Mid Year and End of Year	
Fill In Box	Progress Report-Outputs	PROVIDE QUANTIFIABLE EXTENT THAT OUTPUTS HAVE BEEN ACHIEVED:
Fill In Box	Progress Report-Barriers	BRIEFLY EXPLAIN BARRIERS/PROBLEMS FACED IN ACHIEVING THE TARGET OUTPUT:

Note: *Grantees only need to report on Outputs, Output Performance Measures and Output Targets. They are not required to report Immediate Outcomes, Outcome Performance Measures and Outcome Targets.

Pandemic Influenza Phase 2_Budget Justification_Report Supplement to Template
Indiana State Department of Health
Report Date: 09/06/2006

Pandemic Influenza Phase 2 Supplemental Funds for Fiscal Year 2006/2007

Financial Assistance: Personnel | **Detail**

Item #	Position / Title	Name	Annual Salary	% FTE	Months	Fringe %	$ Fringe	Total Fringe	$ Requested	Subcategory	Organization ID	Budget Justification
1	PCN 10054430: C Nurse Cnslt 2/Chief Nurse Consultant:	Janet Archer	$46,803	100%	12	42%		$19,859	$46,803	Pandemic Influenza	10054430	Public Health Nurse, Nurse Educator. This position will be filled by a public health nurse educator with training and/or experience in emergency preparedness and communicable disease. This position will develop education and training tools related to pandemic influenza, avian influenza, communicable disease control, and public health preparation and response to a pandemic. Position will provide education and training to public health workforce and community response partners, hospital and provider workforce, school administrators and school nurses, business and community groups, community leaders, student groups and constituents. Position will develop and present train the trainer programs to maximize penetration throughout state and in local communities. Position will work with physicians and

													other public health professionals within the ISDH, contractors hired by the ISDH, and ISDH response partners to develop and implement state policy regarding pandemic response, and to support agency compliance with CDC and HRSA pandemic preparedness. For vacant positions, fringe is calculated at 17.91% of the salary (Life Insurance (0.36%), Social Security (7.65%), PERF (8.00%), Disability Insurance (1.9%)) plus $10,518 for Health, Dental, and Vision insurance. However, for positions currently filled, fringe is calculated based on the percentage consistent with the benefits package that each individual carried as of the last State open enrollment period which began on 01/01/06 or the insurance package they selected upon hire (if after 01/01/06).
2								$0	$0				
3								$0	$0				
4								$0	$0				
	Totals							**$19,859**	**$46,803**				

	Financial Assistance: Travel						$0.40	Enter Mileage Reimbursement Rate					**Detail**		
Item #	**Location**	**Travel Type**	**Trips**	**People**	**Days**	**Nights**	**Miles**	**$ Airfare**	**$ Lodging**	**$ Per Diem**	**$ Other**	**$ Total**	**Sub-category**	**Organization ID**	**Budget Justification**
1												$0			

2												$0			
3												$0			
4												$0			
5												$0			
	Totals							**$0**	**$0**	**$0**	**$0**	**$0**			

	Financial Assistance: Equipment				**Detail**		
Item #	**Item Description**	**Quantity**	**Unit Cost**	**$ Requested**	**Sub-category**	**Org. ID**	**Budget Justification**
1	ABI 7500 Fast	2	$51,000	$102,000	Lab		PCR real-time equipment for the detection of influenza and the subtyping of isolates to replace obsolete equipment no supported by the manufacturer.
2	Qiagen BioRobot	1	$120,000	$120,000	Lab		The instrument will be used for to automate extractions from influenza samples for PCR reactions. Not only will it allow for increased productivity, but will also allow for more consistent extractions.
3	LightCycler 480 384 well Block kit	2	$20,000	$40,000	Lab		Adapter that allows for the real-time PCR testing of 384 samples.
4	Laptops for Credentialing	14	$1,954	$27,356	IT		We are in the process of implementing a credentialing system as part of our PHIN certification requirements. We have an operational prototype and determined that we need PCs to serve as the repository for the collection / verification / transmission of credentialing data. We have eleven Salamander systems that are integrated into our credentialing process. We need eleven laptops to drive the credentialing system. The laptops control issuing badges, verification and transmission of credentialing information. The laptops need to have a sufficient capacity to capture and store credentialing information. We are looking at a Dell D520 laptop with additional memory and disk space.
5	CRA System Development Scanners	12	$4,000	$48,000	IT		We have completed a preliminary study to establish the scope of our CRA effort which includes developing a paper form and using scanners to capture the medication dispensed. This will be a "back office" function that utilizes ICR / OCR technology to create data files which will be consolidated centrally. The scanning activities will be done in a back office at district sites. We will need a scanner with a base read rate of 80 – 100 documents per minute. We will need scanners that can feed into a data capture process. We are looking for 12 scanning system at $4000 each.

6	Webinar capabilities - 3 servers (Production, Test, Disaster Recovery)	3	$4,000	$12,000	IT		"We have a need to provide ongoing training to our local Health Departments and hospitals. This is critical to the expansion of our volunteer (ESAR-VHP) and communication (IHAN) programs. We want to develop Webinar capabilities and also include these capabilities at our Disaster Recovery Site and Recovery Area to supplement current communication procedures. We are looking at three servers to support our Webinar capabilities: o Presentation development, o Production Webinar, o DR site. All three servers will be Dell SC1425 or comparable at $4,000 each.
7	PHIN Development team laptops	4	$2,487	$9,948	IT		The current equipment we use for PHIN Certification and PHIN development is old and has slower processors and limited memory. It is barely able to support our current environment. We need to upgrade to current releases of MS Studio and other products. This release is necessary for continued PHIN Certification and related development. As part of our testing of the new releases, we discovered that we are having capacity problems with the existing equipment. The equipment is old enough that it is not a viable option to upgrade it. We need four laptops and two desktop units. The laptops are required for those individuals that are part of our Department Operations Center or Strategic National Stockpile; they are required to relocate to the DOC or SNS facility with their laptop. In addition, we are in the process of upgrading our .net development environment. As part of our impact assessment of the new development environment, we discovered that our current equipment does not operate effectively; The applications run very slow and are prone to time errors. Our development equipment is old and it is not viable to upgrade it. Therefore, we are requesting four laptops and two desktop units with fast processors and additional memory. The cost for these machines are based on similar specifications for equipment purchased within the last month for a different project.
8	PHIN Development team desktop computers	2	$2,298	$4,596	IT		The current equipment we use for PHIN Certification and PHIN development is old and has slower processors and limited memory. It is barely able to support our current environment. We need to upgrade to current releases of MS Studio and other products. This release is necessary for continued PHIN Certification and related development. As part of our testing of the new releases, we discovered that we are having capacity problems with the existing equipment. The equipment is old enough that it is not a viable option to upgrade it. We need four laptops and two desktop units. The laptops are required for those individuals that are part of our Department Operations Center or Strategic National Stockpile; they are required to relocate to the DOC or SNS facility with their laptop. In addition, we are in the process of upgrading our .net development environment. As part of our impact assessment of the new development environment, we discovered that our

							current equipment does not operate effectively; The applications run very slow and are prone to time errors. Our development equipment is old and it is not viable to upgrade it. Therefore, we are requesting four laptops and two desktop units with fast processors and additional memory. The cost for these machines are based on similar specifications for equipment purchased within the last month for a different project.
9	Cisco 2950 12 port router	1	$750	$750	IT		We have a number of fixed PCs in our recovery area that are imaged and ready to run. We need to add a switch that will allow field staff and others to plug in their laptop when they arrive. This allows for a mobile workforce that already has laptops and does not require us to have additional PCs in the recovery area. Specifically we are looking at a Cisco 2950 12 port router which will provide us with the capacity that we need.
10							
11							
	Totals	**41**	**$206,489**	**$364,650**			

	Financial Assistance: Supplies				**Detail**		
Item #	**Item Description**	**QTY**	**Unit Cost**	**$ Requested**	**Sub-category**	**Org. ID**	**Budget Justification**
1	Pandemic Influenza Lab Supplies for PCR testing	12	$3,340.90	$40,091	Lab		"This figure is based on an estimated number of samples for pandemic influenza. Includes cell cultures, disposables, mailers and containers, postage, reagents, infectious agent shippers, etc. An exact quantity cannot be provided as these supplies are purchased on an as needed basis as their shelf life is not very long. Therefore, the cost is based on the annual cost of supplies purchased under the previous fiscal year. The following is a list of examples including their itemized cost: ITEM DESCRIPTION/COST PER UNIT Medium 199 with Hanks Salts/$121 per case Primer Name: H1 HA Forward (5'>3')/$13 each Primer Name: H1 HA Reverse (5'>3')/$13 each Primer Name: H3 HA Forward (5'>3')/$12 each Primer Name: H3 HA Reverse (5'>3')/$13 each Primer Name: H5 HA Forward (5'>3')/$13 each Primer Name: H5 HA Reverse (5'>3')/$12 each

							Primer Name: H7 HA Forward (5'>3')/$13 each Primer Name: H7 HA Reverse (5'>3')/$13 each EZ1 Virus MiniKit/$239 each EZ1 Cell MiniKit/$242 each Qiagen Quantitect Probe RT-PCR Kit/$468 each Primary Rhesus Monkey Kidney Cell Line Tube (weekly)/$155 each or up to $8,060 annually MDCK Cell Line Tube (weekly)/$110 each or up to $5,720 annually Primer Name: FluA Forward (5'>3')/$13 each Primer Name: FluA Reverse (5'>3')/$13 each Primer Name: FluB Forward (5'>3')/$12 each Primer Name: FluB Reverse (5'>3')/$12 each Probe Name: Flu A Probe (5'>3')/ $250 each Probe Name: Flu B Probe (5'>3')/ $250 each H1 HA Probe/$855 each H3 HA Probe/$855 each H5 HA Probe/$855 each H7 HA Probe/$855 each
2	DHS Statewide Pan Flu Table-Top Printing - Situation Manual	300	$7.50	$2,250	Evaluation / Assessment		The ISDH in collaboration with a number of other State agencies will be participating in a statewide Pandemic Influenza Table Top Exercise on October 24
3	DHS Table-Top Printing - EEG	50	$7.50	$375	Evaluation / Assessment		The ISDH in collaboration with a number of other State agencies will be participating in a statewide Pandemic Influenza Table Top Exercise on October 24
4	DHS Table-Top Printing - Evaluation Tools	50	$4.00	$200	Evaluation / Assessment		The ISDH in collaboration with a number of other State agencies will be participating in a statewide Pandemic Influenza Table Top Exercise on October 24
5	DHS Table-Top Printing - After Action Report	350	$7.50	$2,625	Evaluation / Assessment		The ISDH in collaboration with a number of other State agencies will be participating in a statewide Pandemic Influenza Table Top Exercise on October 24
6	DHS Table-Top Printing - Miscellaneous Reports	100	$7.50	$750	Evaluation / Assessment		The ISDH in collaboration with a number of other State agencies will be participating in a statewide Pandemic Influenza Table Top Exercise on October 24
7	DHS Table-Top Identification Cards	375	$1.25	$469	Evaluation / Assessment		The ISDH in collaboration with a number of other State agencies will be participating in a statewide Pandemic Influenza Table Top Exercise on October 24
8	CRA System Development Supplies	1	$540.00	$540	IT		We have completed a preliminary study to establish the scope of our CRA effort which includes developing a paper form and using scanners to capture the medication dispensed. This will be a "back office" function that utilizes ICR / OCR technology to create data files which will be consolidated centrally. Initial funds for supplies are needed to support bulk scanning

							including special paper
9							
10							
	Totals	**1238**	**$3,916**	**$47,300**			

	Financial Assistance: Contractual							**Detail**		
Item #	**Contractor**	**Selection**	**Type**	**Starts On**	**Ends On**	**Accountability**	**$ Requested**	**Sub-category**	**Org. ID**	**Budget Justification**
1	LPHC Grant - Adams County Health Department - (NEW) 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$5,680	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health & emergency preparedness activities within local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK:** Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in & assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements & maintain volunteer/partner contact information, etc. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine CDC Outcomes,

										& all local measures identified by CDC in the preparedness & pandemic influenza grant guidance are incorporated into the LPHC grants. **ACCOUNTABILITY** will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET:** The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county employee. Due to the nature of activities outlined in these grant agreements the total cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness and Pandemic Influenza Preparedness. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. This allocation represents 10% of the award that will be made to this LHD. The other 90% was allocated under Indiana's Base Public Health Preparedness cooperative agreement application on July 15, 2006. As a "New" Grantee, this county will receive up to an additional $1,000 to make alterations to their existing space, & purchase a desk that has a side return, chair, bookcase, & file cabinet. The total amount of this award (100%) is $56,800.
2	LPHC Grant - Bartholomew County Health Department - 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$5,580	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health & emergency preparedness activities within local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK:**

										Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in & assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements & maintain volunteer/partner contact information, etc. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine CDC Outcomes, & all local measures identified by CDC in the preparedness & pandemic influenza grant guidance are incorporated into the LPHC grants. **ACCOUNTABILITY** will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET:** The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county employee. Due to the nature of activities outlined in these grant agreements the total cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health

										Preparedness and Pandemic Influenza Preparedness. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. This allocation represents 10% of the award that will be made to this LHD. The other 90% was allocated under Indiana's Base Public Health Preparedness cooperative agreement application on July 15, 2006. The total amount of this award (100%) is $55,800.
3	LPHC Grant - Blackford County Health Department - 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$3,925	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health & emergency preparedness activities within local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK:** Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in & assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements & maintain volunteer/partner contact information, etc. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine CDC Outcomes, & all local measures identified by CDC in the preparedness & pandemic influenza grant guidance are incorporated into the LPHC grants. **ACCOUNTABILITY** will be

										measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET:** The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county employee. Due to the nature of activities outlined in these grant agreements the total cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness and Pandemic Influenza Preparedness. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. This allocation represents 10% of the award that will be made to this LHD. The other 90% was allocated under Indiana's Base Public Health Preparedness cooperative agreement application on July 15, 2006. The total amount of this award (100%) is $39,254.
4	LPHC Grant - Boone County Health Department - 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$5,158	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health & emergency preparedness activities within local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK:** Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in & assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency communications & operations plans, mass

										prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements & maintain volunteer/partner contact information, etc. LPHCs & other LHD staff shall participate in CDC SNS CRI site visits and assessments, and further develop, test and enhance their scalable mass prophylaxis/POD plans to support antibiotic distributions to their entire populations within 48 hours. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine CDC Outcomes, & all local measures identified by CDC in the preparedness/CRI & pandemic influenza grant guidance are incorporated into the LPHC grants. **ACCOUNTABILITY** will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET:** The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county employee. Due to the nature of activities outlined in these grant agreements the total cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness, Pandemic Influenza Preparedness, and Cities Readiness Initiative (CRI) activities. The standard formula used

										for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. However, 20 of the LHDs including the LHD referenced in this line item are part of a CRI jurisdiction (7 in the Chicago, IL MSA, 10 in the Indianapolis, IN MSA, and 3 in the Cincinnati, OH MSA). These LHDs have adjusted activities, and will receive 80% Public Health Preparedness funds, 10% Pandemic Influenza funds, and 10% Cities Readiness Initiative funds. This allocation represents 10% of the award that will be made to this LHD. The other 90% was allocated under Indiana's Base Public Health Preparedness cooperative agreement application on July 15, 2006. The total cost of this agreement is $51,578.
5	LPHC Grant - Brown County Health Department - 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$5,580	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health & emergency preparedness activities within local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK:** Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in & assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements & maintain volunteer/partner contact information, etc. LPHCs & other LHD staff shall participate in CDC SNS CRI site visits and assessments, and further develop, test and enhance their scalable mass prophylaxis/POD

										plans to support antibiotic distributions to their entire populations within 48 hours. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine CDC Outcomes, & all local measures identified by CDC in the preparedness/CRI & pandemic influenza grant guidance are incorporated into the LPHC grants. **ACCOUNTABILITY** will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET:** The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county employee. Due to the nature of activities outlined in these grant agreements the total cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness, Pandemic Influenza Preparedness, and Cities Readiness Initiative (CRI) activities. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. However, 20 of the LHDs including the LHD referenced in this line item are part of a CRI jurisdiction (7 in the Chicago, IL MSA, 10 in the Indianapolis, IN MSA, and 3 in the Cincinnati, OH MSA). These LHDs have adjusted activities, and will receive 80% Public Health Preparedness funds, 10% Pandemic Influenza funds, and 10% Cities

										Readiness Initiative funds. This allocation represents 10% of the award that will be made to this LHD. The other 90% was allocated under Indiana's Base Public Health Preparedness cooperative agreement application on July 15, 2006. The total cost of this agreement is $55,800.
6	LPHC Grant - Carroll County Health Department - 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$4,233	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health & emergency preparedness activities within local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK:** Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in & assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements & maintain volunteer/partner contact information, etc. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine CDC Outcomes, & all local measures identified by CDC in the preparedness & pandemic influenza grant guidance are incorporated into the LPHC grants. **ACCOUNTABILITY** will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect

										data on specific local measures set out in the grant attachment. **DETAILED BUDGET:** The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county employee. Due to the nature of activities outlined in these grant agreements the total cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness and Pandemic Influenza Preparedness. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. This allocation represents 10% of the award that will be made to this LHD. The other 90% was allocated under Indiana's Base Public Health Preparedness cooperative agreement application on July 15, 2006. The total amount of this award (100%) is $42,333.
7	LPHC Grant - Cass County Health Department - 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$5,435	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health & emergency preparedness activities within local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK:** Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in & assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral

										distribution; identify & work with community partners; prepare mutual aid agreements & maintain volunteer/partner contact information, etc. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine CDC Outcomes, & all local measures identified by CDC in the preparedness & pandemic influenza grant guidance are incorporated into the LPHC grants. **ACCOUNTABILITY** will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET:** The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county employee. Due to the nature of activities outlined in these grant agreements the total cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness and Pandemic Influenza Preparedness. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. This allocation represents 10% of the award that will be made to this LHD. The other 90% was allocated under Indiana's Base Public Health Preparedness cooperative agreement application on July 15, 2006. The total amount of this award (100%) is $54,349.
8	LPHC Grant - Clark County Health	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$4,550	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build

	Department - 10%									critical infrastructure needs for public health & emergency preparedness activities within local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK:** Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in & assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements & maintain volunteer/partner contact information, etc. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine CDC Outcomes, & all local measures identified by CDC in the preparedness & pandemic influenza grant guidance are incorporated into the LPHC grants. **ACCOUNTABILITY** will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET:** The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county

										employee. Due to the nature of activities outlined in these grant agreements the total cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness and Pandemic Influenza Preparedness. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. This allocation represents 10% of the award that will be made to this LHD. The other 90% was allocated under Indiana's Base Public Health Preparedness cooperative agreement application on July 15, 2006. The total amount of this award (100%) is $45,504.
9	LPHC Grant - Clay County Health Department - 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$5,085	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health & emergency preparedness activities within local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK:** Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in & assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements & maintain volunteer/partner contact information, etc. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks &

										measures that track the nine CDC Outcomes, & all local measures identified by CDC in the preparedness & pandemic influenza grant guidance are incorporated into the LPHC grants. **ACCOUNTABILITY** will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET:** The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county employee. Due to the nature of activities outlined in these grant agreements the total cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness and Pandemic Influenza Preparedness. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. This allocation represents 10% of the award that will be made to this LHD. The other 90% was allocated under Indiana's Base Public Health Preparedness cooperative agreement application on July 15, 2006. The total amount of this award (100%) is $50,852.
10	LPHC Grant - Clinton County Health Department - 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$5,580	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health & emergency preparedness activities within local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK:** Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public

										Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in & assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements & maintain volunteer/partner contact information, etc. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine CDC Outcomes, & all local measures identified by CDC in the preparedness & pandemic influenza grant guidance are incorporated into the LPHC grants. **ACCOUNTABILITY** will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET:** The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county employee. Due to the nature of activities outlined in these grant agreements the total cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness and Pandemic Influenza Preparedness. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. This

										allocation represents 10% of the award that will be made to this LHD. The other 90% was allocated under Indiana's Base Public Health Preparedness cooperative agreement application on July 15, 2006. The total amount of this award (100%) is $55,800.
11	LPHC Grant - Crawford County Health Department - 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$5,580	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health & emergency preparedness activities within local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK:** Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in & assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements & maintain volunteer/partner contact information, etc. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine CDC Outcomes, & all local measures identified by CDC in the preparedness & pandemic influenza grant guidance are incorporated into the LPHC grants. **ACCOUNTABILITY** will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the

										grant attachment. **DETAILED BUDGET:** The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county employee. Due to the nature of activities outlined in these grant agreements the total cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness and Pandemic Influenza Preparedness. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. This allocation represents 10% of the award that will be made to this LHD. The other 90% was allocated under Indiana's Base Public Health Preparedness cooperative agreement application on July 15, 2006. The total amount of this award (100%) is $55,800.
12	LPHC Grant - Daviess County Health Department - 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$5,220	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health & emergency preparedness activities within local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK:** Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in & assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community

										partners; prepare mutual aid agreements & maintain volunteer/partner contact information, etc. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine CDC Outcomes, & all local measures identified by CDC in the preparedness & pandemic influenza grant guidance are incorporated into the LPHC grants. **ACCOUNTABILITY** will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET:** The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county employee. Due to the nature of activities outlined in these grant agreements the total cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness and Pandemic Influenza Preparedness. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. This allocation represents 10% of the award that will be made to this LHD. The other 90% was allocated under Indiana's Base Public Health Preparedness cooperative agreement application on July 15, 2006. The total amount of this award (100%) is $52,205.
13	LPHC Grant - Dearborn County Health Department - 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$5,580	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health

										& emergency preparedness activities within local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK:** Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in & assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements & maintain volunteer/partner contact information, etc. LPHCs & other LHD staff shall participate in CDC SNS CRI site visits and assessments, and further develop, test and enhance their scalable mass prophylaxis/POD plans to support antibiotic distributions to their entire populations within 48 hours. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine CDC Outcomes, & all local measures identified by CDC in the preparedness/CRI & pandemic influenza grant guidance are incorporated into the LPHC grants. **ACCOUNTABILITY** will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET:** The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous

										(communication, rent or facilities use, average supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county employee. Due to the nature of activities outlined in these grant agreements the total cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness, Pandemic Influenza Preparedness, and Cities Readiness Initiative (CRI) activities. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. However, 20 of the LHDs including the LHD referenced in this line item are part of a CRI jurisdiction (7 in the Chicago, IL MSA, 10 in the Indianapolis, IN MSA, and 3 in the Cincinnati, OH MSA). These LHDs have adjusted activities, and will receive 80% Public Health Preparedness funds, 10% Pandemic Influenza funds, and 10% Cities Readiness Initiative funds. This allocation represents 10% of the award that will be made to this LHD. The other 90% was allocated under Indiana's Base Public Health Preparedness cooperative agreement application on July 15, 2006. The total cost of this agreement is $55,800.
14	LPHC Grant - Decatur County Health Department - 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$5,580	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health & emergency preparedness activities within local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK:** Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in &

										assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements & maintain volunteer/partner contact information, etc. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine CDC Outcomes, & all local measures identified by CDC in the preparedness & pandemic influenza grant guidance are incorporated into the LPHC grants. **ACCOUNTABILITY** will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET:** The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county employee. Due to the nature of activities outlined in these grant agreements the total cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness and Pandemic Influenza Preparedness. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. This allocation represents 10% of the award that will be made to this LHD. The other 90% was

										allocated under Indiana's Base Public Health Preparedness cooperative agreement application on July 15, 2006. The total amount of this award (100%) is $55,800.
15	LPHC Grant - Delaware County Health Department - 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$4,703	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health & emergency preparedness activities within local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK:** Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in & assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements & maintain volunteer/partner contact information, etc. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine CDC Outcomes, & all local measures identified by CDC in the preparedness & pandemic influenza grant guidance are incorporated into the LPHC grants. **ACCOUNTABILITY** will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET:** The costs within these agreements will be

										used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county employee. Due to the nature of activities outlined in these grant agreements the total cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness and Pandemic Influenza Preparedness. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. This allocation represents 10% of the award that will be made to this LHD. The other 90% was allocated under Indiana's Base Public Health Preparedness cooperative agreement application on July 15, 2006. The total amount of this award (100%) is $47,031.
16	LPHC Grant - Dubois County Health Department - 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$4,343	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health & emergency preparedness activities within local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK:** Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in & assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements & maintain volunteer/partner contact

										information, etc. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine CDC Outcomes, & all local measures identified by CDC in the preparedness & pandemic influenza grant guidance are incorporated into the LPHC grants. **ACCOUNTABILITY** will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET:** The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county employee. Due to the nature of activities outlined in these grant agreements the total cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness and Pandemic Influenza Preparedness. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. This allocation represents 10% of the award that will be made to this LHD. The other 90% was allocated under Indiana's Base Public Health Preparedness cooperative agreement application on July 15, 2006. The total amount of this award (100%) is $43,433.
17	LPHC Grant - East Chicago City Health Department - 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$5,237	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health & emergency preparedness activities within local (county & municipal) jurisdictions. Only

										88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK:** Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in & assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements & maintain volunteer/partner contact information, etc. LPHCs & other LHD staff shall participate in CDC SNS CRI site visits and assessments, and further develop, test and enhance their scalable mass prophylaxis/POD plans to support antibiotic distributions to their entire populations within 48 hours. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine CDC Outcomes, & all local measures identified by CDC in the preparedness/CRI & pandemic influenza grant guidance are incorporated into the LPHC grants. **ACCOUNTABILITY** will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET:** The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average supply costs, & other operational costs). These

										rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county employee. Due to the nature of activities outlined in these grant agreements the total cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness, Pandemic Influenza Preparedness, and Cities Readiness Initiative (CRI) activities. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. However, 20 of the LHDs including the LHD referenced in this line item are part of a CRI jurisdiction (7 in the Chicago, IL MSA, 10 in the Indianapolis, IN MSA, and 3 in the Cincinnati, OH MSA). These LHDs have adjusted activities, and will receive 80% Public Health Preparedness funds, 10% Pandemic Influenza funds, and 10% Cities Readiness Initiative funds. This allocation represents 10% of the award that will be made to this LHD. The other 90% was allocated under Indiana's Base Public Health Preparedness cooperative agreement application on July 15, 2006. The total cost of this agreement is $52,363.
18	LPHC Grant - Elkhart County Health Department - 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$5,580	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health & emergency preparedness activities within local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK:** Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in & assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency

										communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements & maintain volunteer/partner contact information, etc. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine CDC Outcomes, & all local measures identified by CDC in the preparedness & pandemic influenza grant guidance are incorporated into the LPHC grants. **ACCOUNTABILITY** will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET:** The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county employee. Due to the nature of activities outlined in these grant agreements the total cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness and Pandemic Influenza Preparedness. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. This allocation represents 10% of the award that will be made to this LHD. The other 90% was allocated under Indiana's Base Public Health Preparedness cooperative agreement

										application on July 15, 2006. The total amount of this award (100%) is $55,800.
19	LPHC Grant - Fayette County Health Department - 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$5,580	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health & emergency preparedness activities within local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK:** Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in & assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements & maintain volunteer/partner contact information, etc. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine CDC Outcomes, & all local measures identified by CDC in the preparedness & pandemic influenza grant guidance are incorporated into the LPHC grants. **ACCOUNTABILITY** will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET:** The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average

										supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county employee. Due to the nature of activities outlined in these grant agreements the total cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness and Pandemic Influenza Preparedness. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. This allocation represents 10% of the award that will be made to this LHD. The other 90% was allocated under Indiana's Base Public Health Preparedness cooperative agreement application on July 15, 2006. The total amount of this award (100%) is $55,800.
20	LPHC Grant - Floyd County Health Department - 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$4,714	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health & emergency preparedness activities within local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK:** Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in & assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements & maintain volunteer/partner contact information, etc. LPHCs will engage in these activities for the LHD for their local

										jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine CDC Outcomes, & all local measures identified by CDC in the preparedness & pandemic influenza grant guidance are incorporated into the LPHC grants. **ACCOUNTABILITY** will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET:** The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county employee. Due to the nature of activities outlined in these grant agreements the total cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness and Pandemic Influenza Preparedness. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. This allocation represents 10% of the award that will be made to this LHD. The other 90% was allocated under Indiana's Base Public Health Preparedness cooperative agreement application on July 15, 2006. The total amount of this award (100%) is $47,136.
21	LPHC Grant - Ft. Wayne/Allen County Health Department - 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$3,890	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health & emergency preparedness activities within local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK:**

										Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in & assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements & maintain volunteer/partner contact information, etc. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine CDC Outcomes, & all local measures identified by CDC in the preparedness & pandemic influenza grant guidance are incorporated into the LPHC grants. **ACCOUNTABILITY** will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET:** The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county employee. Due to the nature of activities outlined in these grant agreements the total cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health

										Preparedness and Pandemic Influenza Preparedness. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. This allocation represents 10% of the award that will be made to this LHD. The other 90% was allocated under Indiana's Base Public Health Preparedness cooperative agreement application on July 15, 2006. The total amount of this award (100%) is $38,899.
22	LPHC Grant - Fountain/Warren County Health Department - 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$5,506	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health & emergency preparedness activities within local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK:** Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in & assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements & maintain volunteer/partner contact information, etc. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine CDC Outcomes, & all local measures identified by CDC in the preparedness & pandemic influenza grant guidance are incorporated into the LPHC grants. **ACCOUNTABILITY** will be

										measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET:** The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county employee. Due to the nature of activities outlined in these grant agreements the total cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness and Pandemic Influenza Preparedness. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. This allocation represents 10% of the award that will be made to this LHD. The other 90% was allocated under Indiana's Base Public Health Preparedness cooperative agreement application on July 15, 2006. The total amount of this award (100%) is $55,062.
23	LPHC Grant - Franklin County Health Department - (NEW) 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$5,680	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health & emergency preparedness activities within local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK:** Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in & assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency communications & operations plans, mass

										prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements & maintain volunteer/partner contact information, etc. LPHCs & other LHD staff shall participate in CDC SNS CRI site visits and assessments, and further develop, test and enhance their scalable mass prophylaxis/POD plans to support antibiotic distributions to their entire populations within 48 hours. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine CDC Outcomes, & all local measures identified by CDC in the preparedness/CRI & pandemic influenza grant guidance are incorporated into the LPHC grants. **ACCOUNTABILITY** will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET:** The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county employee. Due to the nature of activities outlined in these grant agreements the total cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness, Pandemic Influenza Preparedness, and Cities Readiness Initiative (CRI) activities. The standard formula used

										for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. However, 20 of the LHDs including the LHD referenced in this line item are part of a CRI jurisdiction (7 in the Chicago, IL MSA, 10 in the Indianapolis, IN MSA, and 3 in the Cincinnati, OH MSA). These LHDs have adjusted activities, and will receive 80% Public Health Preparedness funds, 10% Pandemic Influenza funds, and 10% Cities Readiness Initiative funds. As a "New" Grantee, this county will receive up to an additional $1,000 to make alterations to their existing space, & purchase a desk that has a side return, chair, bookcase, & file cabinet. This allocation represents 10% of the award that will be made to this LHD. The other 90% was allocated under Indiana's Base Public Health Preparedness cooperative agreement application on July 15, 2006. The total cost of this agreement is $56,800.
24	LPHC Grant - Fulton County Health Department - 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$4,112	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health & emergency preparedness activities within local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK:** Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in & assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements & maintain volunteer/partner contact

										information, etc. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine CDC Outcomes, & all local measures identified by CDC in the preparedness & pandemic influenza grant guidance are incorporated into the LPHC grants. **ACCOUNTABILITY** will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET:** The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county employee. Due to the nature of activities outlined in these grant agreements the total cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness and Pandemic Influenza Preparedness. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. This allocation represents 10% of the award that will be made to this LHD. The other 90% was allocated under Indiana's Base Public Health Preparedness cooperative agreement application on July 15, 2006. The total amount of this award (100%) is $41,120.
25	LPHC Grant - Gary City Health Department - 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$5,580	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health & emergency preparedness activities within local (county & municipal) jurisdictions. Only

										88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK:** Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in & assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements & maintain volunteer/partner contact information, etc. LPHCs & other LHD staff shall participate in CDC SNS CRI site visits and assessments, and further develop, test and enhance their scalable mass prophylaxis/POD plans to support antibiotic distributions to their entire populations within 48 hours. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine CDC Outcomes, & all local measures identified by CDC in the preparedness/CRI & pandemic influenza grant guidance are incorporated into the LPHC grants. **ACCOUNTABILITY** will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET:** The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average supply costs, & other operational costs). These

										rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county employee. Due to the nature of activities outlined in these grant agreements the total cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness, Pandemic Influenza Preparedness, and Cities Readiness Initiative (CRI) activities. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. However, 20 of the LHDs including the LHD referenced in this line item are part of a CRI jurisdiction (7 in the Chicago, IL MSA, 10 in the Indianapolis, IN MSA, and 3 in the Cincinnati, OH MSA). These LHDs have adjusted activities, and will receive 80% Public Health Preparedness funds, 10% Pandemic Influenza funds, and 10% Cities Readiness Initiative funds. This allocation represents 10% of the award that will be made to this LHD. The other 90% was allocated under Indiana's Base Public Health Preparedness cooperative agreement application on July 15, 2006. The total cost of this agreement is $55,800.
26	LPHC Grant - Gibson County Health Department - 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$5,580	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health & emergency preparedness activities within local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK:** Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in & assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency

										communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements & maintain volunteer/partner contact information, etc. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine CDC Outcomes, & all local measures identified by CDC in the preparedness & pandemic influenza grant guidance are incorporated into the LPHC grants. **ACCOUNTABILITY** will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET:** The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county employee. Due to the nature of activities outlined in these grant agreements the total cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness and Pandemic Influenza Preparedness. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. This allocation represents 10% of the award that will be made to this LHD. The other 90% was allocated under Indiana's Base Public Health Preparedness cooperative agreement

										application on July 15, 2006. The total amount of this award (100%) is $55,800.
27	LPHC Grant - Grant County Health Department - 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$5,055	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health & emergency preparedness activities within local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK:** Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in & assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements & maintain volunteer/partner contact information, etc. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine CDC Outcomes, & all local measures identified by CDC in the preparedness & pandemic influenza grant guidance are incorporated into the LPHC grants. **ACCOUNTABILITY** will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET:** The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average

										supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county employee. Due to the nature of activities outlined in these grant agreements the total cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness and Pandemic Influenza Preparedness. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. This allocation represents 10% of the award that will be made to this LHD. The other 90% was allocated under Indiana's Base Public Health Preparedness cooperative agreement application on July 15, 2006. The total amount of this award (100%) is $50,547.
28	LPHC Grant - Greene County Health Department - 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$5,580	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health & emergency preparedness activities within local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK:** Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in & assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency

										communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements & maintain volunteer/partner contact information, etc. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine CDC Outcomes, & all local measures identified by CDC in the preparedness & pandemic influenza grant guidance are incorporated into the LPHC grants. **ACCOUNTABILITY** will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET:** The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county employee. Due to the nature of activities outlined in these grant agreements the total cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness and Pandemic Influenza Preparedness. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. This allocation represents 10% of the award that will be made to this LHD. The other 90% was allocated under Indiana's Base Public Health Preparedness cooperative agreement

										application on July 15, 2006. The total amount of this award (100%) is $55,800.
29	LPHC Grant - Hamilton County Health Department - 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$5,580	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health & emergency preparedness activities within local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK:** Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in & assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements & maintain volunteer/partner contact information, etc. LPHCs & other LHD staff shall participate in CDC SNS CRI site visits and assessments, and further develop, test and enhance their scalable mass prophylaxis/POD plans to support antibiotic distributions to their entire populations within 48 hours. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine CDC Outcomes, & all local measures identified by CDC in the preparedness/CRI & pandemic influenza grant guidance are incorporated into the LPHC grants. **ACCOUNTABILITY** will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports

										to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET:** The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county employee. Due to the nature of activities outlined in these grant agreements the total cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness, Pandemic Influenza Preparedness, and Cities Readiness Initiative (CRI) activities. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. However, 20 of the LHDs including the LHD referenced in this line item are part of a CRI jurisdiction (7 in the Chicago, IL MSA, 10 in the Indianapolis, IN MSA, and 3 in the Cincinnati, OH MSA). These LHDs have adjusted activities, and will receive 80% Public Health Preparedness funds, 10% Pandemic Influenza funds, and 10% Cities Readiness Initiative funds. This allocation represents 10% of the award that will be made to this LHD. The other 90% was allocated under Indiana's Base Public Health Preparedness cooperative agreement application on July 15, 2006. The total cost of this agreement is $55,800.
30	LPHC Grant - Hammond City Health Department - 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$5,580	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health & emergency preparedness activities within local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK:** Specific critical tasks and measures are set out

										in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in & assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements & maintain volunteer/partner contact information, etc. LPHCs & other LHD staff shall participate in CDC SNS CRI site visits and assessments, and further develop, test and enhance their scalable mass prophylaxis/POD plans to support antibiotic distributions to their entire populations within 48 hours. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine CDC Outcomes, & all local measures identified by CDC in the preparedness/CRI & pandemic influenza grant guidance are incorporated into the LPHC grants. **ACCOUNTABILITY** will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET:** The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county

										employee. Due to the nature of activities outlined in these grant agreements the total cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness, Pandemic Influenza Preparedness, and Cities Readiness Initiative (CRI) activities. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. However, 20 of the LHDs including the LHD referenced in this line item are part of a CRI jurisdiction (7 in the Chicago, IL MSA, 10 in the Indianapolis, IN MSA, and 3 in the Cincinnati, OH MSA). These LHDs have adjusted activities, and will receive 80% Public Health Preparedness funds, 10% Pandemic Influenza funds, and 10% Cities Readiness Initiative funds. This allocation represents 10% of the award that will be made to this LHD. The other 90% was allocated under Indiana's Base Public Health Preparedness cooperative agreement application on July 15, 2006. The total cost of this agreement is $55,800.
31	LPHC Grant - Hancock County Health Department - 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$5,580	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health & emergency preparedness activities within local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK:** Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in & assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation

										& quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements & maintain volunteer/partner contact information, etc. LPHCs & other LHD staff shall participate in CDC SNS CRI site visits and assessments, and further develop, test and enhance their scalable mass prophylaxis/POD plans to support antibiotic distributions to their entire populations within 48 hours. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine CDC Outcomes, & all local measures identified by CDC in the preparedness/CRI & pandemic influenza grant guidance are incorporated into the LPHC grants. **ACCOUNTABILITY** will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET**: The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county employee. Due to the nature of activities outlined in these grant agreements the total cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness, Pandemic Influenza Preparedness, and Cities Readiness Initiative (CRI) activities. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza.

										However, 20 of the LHDs including the LHD referenced in this line item are part of a CRI jurisdiction (7 in the Chicago, IL MSA, 10 in the Indianapolis, IN MSA, and 3 in the Cincinnati, OH MSA). These LHDs have adjusted activities, and will receive 80% Public Health Preparedness funds, 10% Pandemic Influenza funds, and 10% Cities Readiness Initiative funds. This allocation represents 10% of the award that will be made to this LHD. The other 90% was allocated under Indiana's Base Public Health Preparedness cooperative agreement application on July 15, 2006. The total cost of this agreement is $55,800.
32	LPHC Grant - Harrison County Health Department - 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$5,477	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health & emergency preparedness activities within local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK:** Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in & assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements & maintain volunteer/partner contact information, etc. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks &

										measures that track the nine CDC Outcomes, & all local measures identified by CDC in the preparedness & pandemic influenza grant guidance are incorporated into the LPHC grants. **ACCOUNTABILITY** will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET:** The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county employee. Due to the nature of activities outlined in these grant agreements the total cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness and Pandemic Influenza Preparedness. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. This allocation represents 10% of the award that will be made to this LHD. The other 90% was allocated under Indiana's Base Public Health Preparedness cooperative agreement application on July 15, 2006. The total amount of this award (100%) is $54,770.
33	LPHC Grant - Hendricks County Health Department - 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$5,580	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health & emergency preparedness activities within local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK**: Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public

										Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in & assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements & maintain volunteer/partner contact information, etc. LPHCs & other LHD staff shall participate in CDC SNS CRI site visits and assessments, and further develop, test and enhance their scalable mass prophylaxis/POD plans to support antibiotic distributions to their entire populations within 48 hours. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine CDC Outcomes, & all local measures identified by CDC in the preparedness/CRI & pandemic influenza grant guidance are incorporated into the LPHC grants. ACCOUNTABILITY will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET**: The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county employee. Due to the nature of activities outlined in these grant agreements the total cost for this allocation has been split based on

										an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness, Pandemic Influenza Preparedness, and Cities Readiness Initiative (CRI) activities. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. However, 20 of the LHDs including the LHD referenced in this line item are part of a CRI jurisdiction (7 in the Chicago, IL MSA, 10 in the Indianapolis, IN MSA, and 3 in the Cincinnati, OH MSA). These LHDs have adjusted activities, and will receive 80% Public Health Preparedness funds, 10% Pandemic Influenza funds, and 10% Cities Readiness Initiative funds. This allocation represents 10% of the award that will be made to this LHD. The other 90% was allocated under Indiana's Base Public Health Preparedness cooperative agreement application on July 15, 2006. The total cost of this agreement is $55,800.
34	LPHC Grant - Henry County Health Department - 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$5,580	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health & emergency preparedness activities within local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK**: Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in & assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements &

										maintain volunteer/partner contact information, etc. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine CDC Outcomes, & all local measures identified by CDC in the preparedness & pandemic influenza grant guidance are incorporated into the LPHC grants. ACCOUNTABILITY will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET**: The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county employee. Due to the nature of activities outlined in these grant agreements the total cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness and Pandemic Influenza Preparedness. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. This allocation represents 10% of the award that will be made to this LHD. The other 90% was allocated under Indiana's Base Public Health Preparedness cooperative agreement application on July 15, 2006. The total amount of this award (100%) is $55,800.
35	LPHC Grant - Howard County Health Department - 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$5,580	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health & emergency preparedness activities within

										local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK**: Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in & assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements & maintain volunteer/partner contact information, etc. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine CDC Outcomes, & all local measures identified by CDC in the preparedness & pandemic influenza grant guidance are incorporated into the LPHC grants. ACCOUNTABILITY will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET**: The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county employee. Due to the nature of activities outlined in these grant agreements the total

										cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness and Pandemic Influenza Preparedness. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. This allocation represents 10% of the award that will be made to this LHD. The other 90% was allocated under Indiana's Base Public Health Preparedness cooperative agreement application on July 15, 2006. The total amount of this award (100%) is $55,800.
36	LPHC Grant - Huntington County Health Department - 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$5,243	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health & emergency preparedness activities within local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK**: Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in & assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements & maintain volunteer/partner contact information, etc. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine CDC Outcomes, & all local measures identified by CDC in the

										preparedness & pandemic influenza grant guidance are incorporated into the LPHC grants. ACCOUNTABILITY will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET**: The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county employee. Due to the nature of activities outlined in these grant agreements the total cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness and Pandemic Influenza Preparedness. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. This allocation represents 10% of the award that will be made to this LHD. The other 90% was allocated under Indiana's Base Public Health Preparedness cooperative agreement application on July 15, 2006. The total amount of this award (100%) is $52,427.
37	LPHC Grant - Jackson County Health Department - 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$4,367	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health & emergency preparedness activities within local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK**: Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in &

										assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements & maintain volunteer/partner contact information, etc. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine CDC Outcomes, & all local measures identified by CDC in the preparedness & pandemic influenza grant guidance are incorporated into the LPHC grants. ACCOUNTABILITY will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET**: The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county employee. Due to the nature of activities outlined in these grant agreements the total cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness and Pandemic Influenza Preparedness. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. This allocation represents 10% of the award that will be made to this LHD. The other 90% was

										allocated under Indiana's Base Public Health Preparedness cooperative agreement application on July 15, 2006. The total amount of this award (100%) is $43,669.
38	LPHC Grant - Jasper County Health Department - 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$3,904	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health & emergency preparedness activities within local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK**: Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in & assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements & maintain volunteer/partner contact information, etc. LPHCs & other LHD staff shall participate in CDC SNS CRI site visits and assessments, and further develop, test and enhance their scalable mass prophylaxis/POD plans to support antibiotic distributions to their entire populations within 48 hours. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine CDC Outcomes, & all local measures identified by CDC in the preparedness/CRI & pandemic influenza grant guidance are incorporated into the LPHC grants. ACCOUNTABILITY will be measured

										through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET**: The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county employee. Due to the nature of activities outlined in these grant agreements the total cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness, Pandemic Influenza Preparedness, and Cities Readiness Initiative (CRI) activities. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. However, 20 of the LHDs including the LHD referenced in this line item are part of a CRI jurisdiction (7 in the Chicago, IL MSA, 10 in the Indianapolis, IN MSA, and 3 in the Cincinnati, OH MSA). These LHDs have adjusted activities, and will receive 80% Public Health Preparedness funds, 10% Pandemic Influenza funds, and 10% Cities Readiness Initiative funds. This allocation represents 10% of the award that will be made to this LHD. The other 90% was allocated under Indiana's Base Public Health Preparedness cooperative agreement application on July 15, 2006. The total cost of this agreement is $39,040.
39	LPHC Grant - Jay County Health Department - 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$5,189	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health & emergency preparedness activities within local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4

										new to the program. **SCOPE OF WORK**: Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in & assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements & maintain volunteer/partner contact information, etc. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine CDC Outcomes, & all local measures identified by CDC in the preparedness & pandemic influenza grant guidance are incorporated into the LPHC grants. ACCOUNTABILITY will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET**: The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county employee. Due to the nature of activities outlined in these grant agreements the total cost for this allocation has been split based on an estimated amount of time the LPHCs will

										spend working on basic Public Health Preparedness and Pandemic Influenza Preparedness. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. This allocation represents 10% of the award that will be made to this LHD. The other 90% was allocated under Indiana's Base Public Health Preparedness cooperative agreement application on July 15, 2006. The total amount of this award (100%) is $51,893.
40	LPHC Grant - Jennings County Health Department - 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$5,580	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health & emergency preparedness activities within local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK**: Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in & assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements & maintain volunteer/partner contact information, etc. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine CDC Outcomes, & all local measures identified by CDC in the preparedness & pandemic influenza grant guidance are incorporated into the LPHC

										grants. ACCOUNTABILITY will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET**: The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county employee. Due to the nature of activities outlined in these grant agreements the total cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness and Pandemic Influenza Preparedness. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. This allocation represents 10% of the award that will be made to this LHD. The other 90% was allocated under Indiana's Base Public Health Preparedness cooperative agreement application on July 15, 2006. The total amount of this award (100%) is $55,800.
41	LPHC Grant - Johnson County Health Department - 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$5,580	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health & emergency preparedness activities within local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK**: Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in & assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency

										communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements & maintain volunteer/partner contact information, etc. LPHCs & other LHD staff shall participate in CDC SNS CRI site visits and assessments, and further develop, test and enhance their scalable mass prophylaxis/POD plans to support antibiotic distributions to their entire populations within 48 hours. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine CDC Outcomes, & all local measures identified by CDC in the preparedness/CRI & pandemic influenza grant guidance are incorporated into the LPHC grants. ACCOUNTABILITY will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET**: The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county employee. Due to the nature of activities outlined in these grant agreements the total cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness, Pandemic Influenza Preparedness, and Cities Readiness Initiative

										(CRI) activities. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. However, 20 of the LHDs including the LHD referenced in this line item are part of a CRI jurisdiction (7 in the Chicago, IL MSA, 10 in the Indianapolis, IN MSA, and 3 in the Cincinnati, OH MSA). These LHDs have adjusted activities, and will receive 80% Public Health Preparedness funds, 10% Pandemic Influenza funds, and 10% Cities Readiness Initiative funds. This allocation represents 10% of the award that will be made to this LHD. The other 90% was allocated under Indiana's Base Public Health Preparedness cooperative agreement application on July 15, 2006. The total cost of this agreement is $55,800.
42	LPHC Grant - Knox County Health Department - 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$5,580	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health & emergency preparedness activities within local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK**: Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in & assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements & maintain volunteer/partner contact information, etc. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to

										LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine CDC Outcomes, & all local measures identified by CDC in the preparedness & pandemic influenza grant guidance are incorporated into the LPHC grants. ACCOUNTABILITY will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET**: The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county employee. Due to the nature of activities outlined in these grant agreements the total cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness and Pandemic Influenza Preparedness. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. This allocation represents 10% of the award that will be made to this LHD. The other 90% was allocated under Indiana's Base Public Health Preparedness cooperative agreement application on July 15, 2006. The total amount of this award (100%) is $55,800.
43	LPHC Grant - LaGrange County Health Department - 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$5,564	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health & emergency preparedness activities within local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK**: Specific critical tasks and measures are set out

										in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in & assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements & maintain volunteer/partner contact information, etc. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine CDC Outcomes, & all local measures identified by CDC in the preparedness & pandemic influenza grant guidance are incorporated into the LPHC grants. ACCOUNTABILITY will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET**: The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county employee. Due to the nature of activities outlined in these grant agreements the total cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness and Pandemic Influenza

										Preparedness. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. This allocation represents 10% of the award that will be made to this LHD. The other 90% was allocated under Indiana's Base Public Health Preparedness cooperative agreement application on July 15, 2006. The total amount of this award (100%) is $55,641.
44	LPHC Grant - Lake County Health Department - 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$5,471	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health & emergency preparedness activities within local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK**: Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in & assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements & maintain volunteer/partner contact information, etc. LPHCs & other LHD staff shall participate in CDC SNS CRI site visits and assessments, and further develop, test and enhance their scalable mass prophylaxis/POD plans to support antibiotic distributions to their entire populations within 48 hours. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine

										CDC Outcomes, & all local measures identified by CDC in the preparedness/CRI & pandemic influenza grant guidance are incorporated into the LPHC grants. ACCOUNTABILITY will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET**: The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county employee. Due to the nature of activities outlined in these grant agreements the total cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness, Pandemic Influenza Preparedness, and Cities Readiness Initiative (CRI) activities. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. However, 20 of the LHDs including the LHD referenced in this line item are part of a CRI jurisdiction (7 in the Chicago, IL MSA, 10 in the Indianapolis, IN MSA, and 3 in the Cincinnati, OH MSA). These LHDs have adjusted activities, and will receive 80% Public Health Preparedness funds, 10% Pandemic Influenza funds, and 10% Cities Readiness Initiative funds. This allocation represents 10% of the award that will be made to this LHD. The other 90% was allocated under Indiana's Base Public Health Preparedness cooperative agreement application on July 15, 2006. The total cost of this agreement is $54,712.
45	LPHC Grant - La Porte	Sole	Local	8/31/2	8/30/20	Quarterly	$5,580	Pandemic		All 94 Indiana LHDs were invited to

	County Health Department - 10%	Source	Health	006	07	Report		Influenza		participate in this grant program to build critical infrastructure needs for public health & emergency preparedness activities within local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK**: Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in & assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements & maintain volunteer/partner contact information, etc. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine CDC Outcomes, & all local measures identified by CDC in the preparedness & pandemic influenza grant guidance are incorporated into the LPHC grants. ACCOUNTABILITY will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET**: The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was

										a state staff member rather than a county employee. Due to the nature of activities outlined in these grant agreements the total cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness and Pandemic Influenza Preparedness. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. This allocation represents 10% of the award that will be made to this LHD. The other 90% was allocated under Indiana's Base Public Health Preparedness cooperative agreement application on July 15, 2006. The total amount of this award (100%) is $55,800.
46	LPHC Grant - Lawrence County Health Department - 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$5,580	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health & emergency preparedness activities within local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK**: Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in & assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements & maintain volunteer/partner contact information, etc. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the

										LPHC include specific critical tasks & measures that track the nine CDC Outcomes, & all local measures identified by CDC in the preparedness & pandemic influenza grant guidance are incorporated into the LPHC grants. ACCOUNTABILITY will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET**: The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county employee. Due to the nature of activities outlined in these grant agreements the total cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness and Pandemic Influenza Preparedness. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. This allocation represents 10% of the award that will be made to this LHD. The other 90% was allocated under Indiana's Base Public Health Preparedness cooperative agreement application on July 15, 2006. The total amount of this award (100%) is $55,800.
47	LPHC Grant - Madison County Health Department - 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$4,839	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health & emergency preparedness activities within local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK**: Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD

										grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in & assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements & maintain volunteer/partner contact information, etc. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine CDC Outcomes, & all local measures identified by CDC in the preparedness & pandemic influenza grant guidance are incorporated into the LPHC grants. ACCOUNTABILITY will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET**: The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county employee. Due to the nature of activities outlined in these grant agreements the total cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness and Pandemic Influenza Preparedness. The standard formula used for these grants is 90% Public Health

										Preparedness, 10% Pandemic Influenza. This allocation represents 10% of the award that will be made to this LHD. The other 90% was allocated under Indiana's Base Public Health Preparedness cooperative agreement application on July 15, 2006. The total amount of this award (100%) is $48,392.
48	LPHC Grant - Marion County Health Department - 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$5,248	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health & emergency preparedness activities within local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK**: Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in & assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements & maintain volunteer/partner contact information, etc. LPHCs & other LHD staff shall participate in CDC SNS CRI site visits and assessments, and further develop, test and enhance their scalable mass prophylaxis/POD plans to support antibiotic distributions to their entire populations within 48 hours. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine CDC Outcomes, & all local measures identified by CDC in the preparedness/CRI &

										pandemic influenza grant guidance are incorporated into the LPHC grants. ACCOUNTABILITY will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET**: The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county employee. Due to the nature of activities outlined in these grant agreements the total cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness, Pandemic Influenza Preparedness, and Cities Readiness Initiative (CRI) activities. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. However, 20 of the LHDs including the LHD referenced in this line item are part of a CRI jurisdiction (7 in the Chicago, IL MSA, 10 in the Indianapolis, IN MSA, and 3 in the Cincinnati, OH MSA). These LHDs have adjusted activities, and will receive 80% Public Health Preparedness funds, 10% Pandemic Influenza funds, and 10% Cities Readiness Initiative funds. This allocation represents 10% of the award that will be made to this LHD. The other 90% was allocated under Indiana's Base Public Health Preparedness cooperative agreement application on July 15, 2006. The total cost of this agreement is $52,485.
49	LPHC Grant - Marshall County Health Department - 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$5,454	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health

										& emergency preparedness activities within local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK**: Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in & assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements & maintain volunteer/partner contact information, etc. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine CDC Outcomes, & all local measures identified by CDC in the preparedness & pandemic influenza grant guidance are incorporated into the LPHC grants. **ACCOUNTABILITY** will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET**: The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county employee. Due to the nature of activities

										outlined in these grant agreements the total cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness and Pandemic Influenza Preparedness. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. This allocation represents 10% of the award that will be made to this LHD. The other 90% was allocated under Indiana's Base Public Health Preparedness cooperative agreement application on July 15, 2006. The total amount of this award (100%) is $54,536.
50	LPHC Grant - Martin County Health Department - 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$5,580	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health & emergency preparedness activities within local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK**: Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in & assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements & maintain volunteer/partner contact information, etc. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine CDC Outcomes,

										& all local measures identified by CDC in the preparedness & pandemic influenza grant guidance are incorporated into the LPHC grants. **ACCOUNTABILITY** will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET**: The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county employee. Due to the nature of activities outlined in these grant agreements the total cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness and Pandemic Influenza Preparedness. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. This allocation represents 10% of the award that will be made to this LHD. The other 90% was allocated under Indiana's Base Public Health Preparedness cooperative agreement application on July 15, 2006. The total amount of this award (100%) is $55,800.
51	LPHC Grant - Miami County Health Department - 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$4,465	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health & emergency preparedness activities within local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK**: Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in

										all hazards planning; become trained in & assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements & maintain volunteer/partner contact information, etc. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine CDC Outcomes, & all local measures identified by CDC in the preparedness & pandemic influenza grant guidance are incorporated into the LPHC grants. **ACCOUNTABILITY** will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET**: The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county employee. Due to the nature of activities outlined in these grant agreements the total cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness and Pandemic Influenza Preparedness. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. This allocation represents 10% of the award that

										will be made to this LHD. The other 90% was allocated under Indiana's Base Public Health Preparedness cooperative agreement application on July 15, 2006. The total amount of this award (100%) is $44,655.
52	LPHC Grant - Monroe County Health Department - 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$4,729	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health & emergency preparedness activities within local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK**: Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in & assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements & maintain volunteer/partner contact information, etc. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine CDC Outcomes, & all local measures identified by CDC in the preparedness & pandemic influenza grant guidance are incorporated into the LPHC grants. **ACCOUNTABILITY** will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET**:

										The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county employee. Due to the nature of activities outlined in these grant agreements the total cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness and Pandemic Influenza Preparedness. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. This allocation represents 10% of the award that will be made to this LHD. The other 90% was allocated under Indiana's Base Public Health Preparedness cooperative agreement application on July 15, 2006. The total amount of this award (100%) is $47,293.
53	LPHC Grant - Montgomery County Health Department - 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$5,580	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health & emergency preparedness activities within local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK**: Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in & assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements &

										maintain volunteer/partner contact information, etc. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine CDC Outcomes, & all local measures identified by CDC in the preparedness & pandemic influenza grant guidance are incorporated into the LPHC grants. **ACCOUNTABILITY** will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET**: The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county employee. Due to the nature of activities outlined in these grant agreements the total cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness and Pandemic Influenza Preparedness. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. This allocation represents 10% of the award that will be made to this LHD. The other 90% was allocated under Indiana's Base Public Health Preparedness cooperative agreement application on July 15, 2006. The total amount of this award (100%) is $55,800.
54	LPHC Grant - Morgan County Health Department - 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$5,580	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health & emergency preparedness activities within

										local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK**: Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in & assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements & maintain volunteer/partner contact information, etc. LPHCs & other LHD staff shall participate in CDC SNS CRI site visits and assessments, and further develop, test and enhance their scalable mass prophylaxis/POD plans to support antibiotic distributions to their entire populations within 48 hours. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine CDC Outcomes, & all local measures identified by CDC in the preparedness/CRI & pandemic influenza grant guidance are incorporated into the LPHC grants. **ACCOUNTABILITY** will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET**: The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average

										supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county employee. Due to the nature of activities outlined in these grant agreements the total cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness, Pandemic Influenza Preparedness, and Cities Readiness Initiative (CRI) activities. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. However, 20 of the LHDs including the LHD referenced in this line item are part of a CRI jurisdiction (7 in the Chicago, IL MSA, 10 in the Indianapolis, IN MSA, and 3 in the Cincinnati, OH MSA). These LHDs have adjusted activities, and will receive 80% Public Health Preparedness funds, 10% Pandemic Influenza funds, and 10% Cities Readiness Initiative funds. This allocation represents 10% of the award that will be made to this LHD. The other 90% was allocated under Indiana's Base Public Health Preparedness cooperative agreement application on July 15, 2006. The total cost of this agreement is $55,800.
55	LPHC Grant - Newton County Health Department - 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$5,423	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health & emergency preparedness activities within local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK**: Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in & assist LHD staff to become trained in NIMS &

										PPE; prepare & exercise LHD emergency communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements & maintain volunteer/partner contact information, etc. LPHCs & other LHD staff shall participate in CDC SNS CRI site visits and assessments, and further develop, test and enhance their scalable mass prophylaxis/POD plans to support antibiotic distributions to their entire populations within 48 hours. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine CDC Outcomes, & all local measures identified by CDC in the preparedness/CRI & pandemic influenza grant guidance are incorporated into the LPHC grants. **ACCOUNTABILITY** will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET**: The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county employee. Due to the nature of activities outlined in these grant agreements the total cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness, Pandemic Influenza

										Preparedness, and Cities Readiness Initiative (CRI) activities. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. However, 20 of the LHDs including the LHD referenced in this line item are part of a CRI jurisdiction (7 in the Chicago, IL MSA, 10 in the Indianapolis, IN MSA, and 3 in the Cincinnati, OH MSA). These LHDs have adjusted activities, and will receive 80% Public Health Preparedness funds, 10% Pandemic Influenza funds, and 10% Cities Readiness Initiative funds. This allocation represents 10% of the award that will be made to this LHD. The other 90% was allocated under Indiana's Base Public Health Preparedness cooperative agreement application on July 15, 2006. The total cost of this agreement is $54,224.
56	LPHC Grant - Noble County Health Department - 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$5,580	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health & emergency preparedness activities within local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK**: Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in & assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements & maintain volunteer/partner contact information, etc. LPHCs will engage in these activities for the LHD for their local

										jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine CDC Outcomes, & all local measures identified by CDC in the preparedness & pandemic influenza grant guidance are incorporated into the LPHC grants. **ACCOUNTABILITY** will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET**: The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county employee. Due to the nature of activities outlined in these grant agreements the total cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness and Pandemic Influenza Preparedness. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. This allocation represents 10% of the award that will be made to this LHD. The other 90% was allocated under Indiana's Base Public Health Preparedness cooperative agreement application on July 15, 2006. The total amount of this award (100%) is $55,800.
57	LPHC Grant - Ohio County Health Department (NEW) - 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$5,680	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health & emergency preparedness activities within local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK**:

										Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in & assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements & maintain volunteer/partner contact information, etc. LPHCs & other LHD staff shall participate in CDC SNS CRI site visits and assessments, and further develop, test and enhance their scalable mass prophylaxis/POD plans to support antibiotic distributions to their entire populations within 48 hours. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine CDC Outcomes, & all local measures identified by CDC in the preparedness/CRI & pandemic influenza grant guidance are incorporated into the LPHC grants. **ACCOUNTABILITY** will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET**: The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was

										a state staff member rather than a county employee. Due to the nature of activities outlined in these grant agreements the total cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness, Pandemic Influenza Preparedness, and Cities Readiness Initiative (CRI) activities. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. However, 20 of the LHDs including the LHD referenced in this line item are part of a CRI jurisdiction (7 in the Chicago, IL MSA, 10 in the Indianapolis, IN MSA, and 3 in the Cincinnati, OH MSA). These LHDs have adjusted activities, and will receive 80% Public Health Preparedness funds, 10% Pandemic Influenza funds, and 10% Cities Readiness Initiative funds. As a "New" Grantee, this county will receive up to an additional $1,000 to make alterations to their existing space, & purchase a desk that has a side return, chair, bookcase, & file cabinet. This allocation represents 10% of the award that will be made to this LHD. The other 90% was allocated under Indiana's Base Public Health Preparedness cooperative agreement application on July 15, 2006. The total cost of this agreement is $56,800.
58	LPHC Grant - Orange County Health Department - 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$5,547	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health & emergency preparedness activities within local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK**: Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in &

										assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements & maintain volunteer/partner contact information, etc. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine CDC Outcomes, & all local measures identified by CDC in the preparedness & pandemic influenza grant guidance are incorporated into the LPHC grants. **ACCOUNTABILITY** will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET**: The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county employee. Due to the nature of activities outlined in these grant agreements the total cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness and Pandemic Influenza Preparedness. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. This allocation represents 10% of the award that will be made to this LHD. The other 90% was

										allocated under Indiana's Base Public Health Preparedness cooperative agreement application on July 15, 2006. The total amount of this award (100%) is $55,470.
59	LPHC Grant - Parke County Health Department - 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$5,580	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health & emergency preparedness activities within local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK**: Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in & assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements & maintain volunteer/partner contact information, etc. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine CDC Outcomes, & all local measures identified by CDC in the preparedness & pandemic influenza grant guidance are incorporated into the LPHC grants. **ACCOUNTABILITY** will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET**: The costs within these agreements will be

										used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county employee. Due to the nature of activities outlined in these grant agreements the total cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness and Pandemic Influenza Preparedness. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. This allocation represents 10% of the award that will be made to this LHD. The other 90% was allocated under Indiana's Base Public Health Preparedness cooperative agreement application on July 15, 2006. The total amount of this award (100%) is $55,800.
60	LPHC Grant - Perry County Health Department - 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$5,580	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health & emergency preparedness activities within local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK**: Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in & assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements & maintain volunteer/partner contact

										information, etc. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine CDC Outcomes, & all local measures identified by CDC in the preparedness & pandemic influenza grant guidance are incorporated into the LPHC grants. **ACCOUNTABILITY** will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET**: The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county employee. Due to the nature of activities outlined in these grant agreements the total cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness and Pandemic Influenza Preparedness. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. This allocation represents 10% of the award that will be made to this LHD. The other 90% was allocated under Indiana's Base Public Health Preparedness cooperative agreement application on July 15, 2006. The total amount of this award (100%) is $55,800.
61	LPHC Grant - Pike County Health Department - 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$5,580	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health & emergency preparedness activities within local (county & municipal) jurisdictions. Only

										88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK**: Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in & assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements & maintain volunteer/partner contact information, etc. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine CDC Outcomes, & all local measures identified by CDC in the preparedness & pandemic influenza grant guidance are incorporated into the LPHC grants. **ACCOUNTABILITY** will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET**: The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county employee. Due to the nature of activities outlined in these grant agreements the total cost for this allocation has been split based on

										an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness and Pandemic Influenza Preparedness. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. This allocation represents 10% of the award that will be made to this LHD. The other 90% was allocated under Indiana's Base Public Health Preparedness cooperative agreement application on July 15, 2006. The total amount of this award (100%) is $55,800.
62	LPHC Grant - Porter County Health Department - 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$5,580	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health & emergency preparedness activities within local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK**: Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in & assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements & maintain volunteer/partner contact information, etc. LPHCs & other LHD staff shall participate in CDC SNS CRI site visits and assessments, and further develop, test and enhance their scalable mass prophylaxis/POD plans to support antibiotic distributions to their entire populations within 48 hours. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a

										coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine CDC Outcomes, & all local measures identified by CDC in the preparedness/CRI & pandemic influenza grant guidance are incorporated into the LPHC grants. **ACCOUNTABILITY** will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET**: The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county employee. Due to the nature of activities outlined in these grant agreements the total cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness, Pandemic Influenza Preparedness, and Cities Readiness Initiative (CRI) activities. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. However, 20 of the LHDs including the LHD referenced in this line item are part of a CRI jurisdiction (7 in the Chicago, IL MSA, 10 in the Indianapolis, IN MSA, and 3 in the Cincinnati, OH MSA). These LHDs have adjusted activities, and will receive 80% Public Health Preparedness funds, 10% Pandemic Influenza funds, and 10% Cities Readiness Initiative funds. This allocation represents 10% of the award that will be made to this LHD. The other 90% was allocated under Indiana's Base Public Health Preparedness cooperative agreement

										application on July 15, 2006. The total cost of this agreement is $55,800.
63	LPHC Grant - Pulaski County Health Department - 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$4,631	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health & emergency preparedness activities within local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK**: Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in & assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements & maintain volunteer/partner contact information, etc. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine CDC Outcomes, & all local measures identified by CDC in the preparedness & pandemic influenza grant guidance are incorporated into the LPHC grants. **ACCOUNTABILITY** will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET**: The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average

										supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county employee. Due to the nature of activities outlined in these grant agreements the total cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness and Pandemic Influenza Preparedness. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. This allocation represents 10% of the award that will be made to this LHD. The other 90% was allocated under Indiana's Base Public Health Preparedness cooperative agreement application on July 15, 2006. The total amount of this award (100%) is $46,312.
64	LPHC Grant - Putnam County Health Department - 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$4,268	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health & emergency preparedness activities within local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK**: Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in & assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements & maintain volunteer/partner contact information, etc. LPHCs & other LHD staff shall participate in CDC SNS CRI site visits

										and assessments, and further develop, test and enhance their scalable mass prophylaxis/POD plans to support antibiotic distributions to their entire populations within 48 hours. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine CDC Outcomes, & all local measures identified by CDC in the preparedness/CRI & pandemic influenza grant guidance are incorporated into the LPHC grants. **ACCOUNTABILITY** will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET**: The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county employee. Due to the nature of activities outlined in these grant agreements the total cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness, Pandemic Influenza Preparedness, and Cities Readiness Initiative (CRI) activities. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. However, 20 of the LHDs including the LHD referenced in this line item are part of a CRI jurisdiction (7 in the Chicago, IL MSA, 10 in the Indianapolis, IN MSA, and 3 in the Cincinnati, OH MSA). These LHDs have adjusted activities, and will receive 80%

										Public Health Preparedness funds, 10% Pandemic Influenza funds, and 10% Cities Readiness Initiative funds. This allocation represents 10% of the award that will be made to this LHD. The other 90% was allocated under Indiana's Base Public Health Preparedness cooperative agreement application on July 15, 2006. The total cost of this agreement is $42,680.
65	LPHC Grant - Randolph County Health Department - 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$5,402	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health & emergency preparedness activities within local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK**: Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in & assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements & maintain volunteer/partner contact information, etc. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine CDC Outcomes, & all local measures identified by CDC in the preparedness & pandemic influenza grant guidance are incorporated into the LPHC grants. **ACCOUNTABILITY** will be measured through site visits by ISDH staff to

										LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET**: The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county employee. Due to the nature of activities outlined in these grant agreements the total cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness and Pandemic Influenza Preparedness. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. This allocation represents 10% of the award that will be made to this LHD. The other 90% was allocated under Indiana's Base Public Health Preparedness cooperative agreement application on July 15, 2006. The total amount of this award (100%) is $54,021.
66	LPHC Grant - Ripley County Health Department - 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$4,268	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health & emergency preparedness activities within local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK**: Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in & assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency communications & operations plans, mass prophylaxis & other emergency response

										plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements & maintain volunteer/partner contact information, etc. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine CDC Outcomes, & all local measures identified by CDC in the preparedness & pandemic influenza grant guidance are incorporated into the LPHC grants. **ACCOUNTABILITY** will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET**: The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county employee. Due to the nature of activities outlined in these grant agreements the total cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness and Pandemic Influenza Preparedness. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. This allocation represents 10% of the award that will be made to this LHD. The other 90% was allocated under Indiana's Base Public Health Preparedness cooperative agreement application on July 15, 2006. The total amount of this award (100%) is $42,680.

67	LPHC Grant - Rush County Health Department - 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$4,735	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health & emergency preparedness activities within local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK**: Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in & assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements & maintain volunteer/partner contact information, etc. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine CDC Outcomes, & all local measures identified by CDC in the preparedness & pandemic influenza grant guidance are incorporated into the LPHC grants. **ACCOUNTABILITY** will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET**: The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average supply costs, & other operational costs). These rates are consistent with standard rates for

										what the state would pay if this individual was a state staff member rather than a county employee. Due to the nature of activities outlined in these grant agreements the total cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness and Pandemic Influenza Preparedness. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. This allocation represents 10% of the award that will be made to this LHD. The other 90% was allocated under Indiana's Base Public Health Preparedness cooperative agreement application on July 15, 2006. The total amount of this award (100%) is $47,413.
68	LPHC Grant - Scott County Health Department - 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$5,580	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health & emergency preparedness activities within local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK**: Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in & assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements & maintain volunteer/partner contact information, etc. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among

										multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine CDC Outcomes, & all local measures identified by CDC in the preparedness & pandemic influenza grant guidance are incorporated into the LPHC grants. **ACCOUNTABILITY** will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET**: The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county employee. Due to the nature of activities outlined in these grant agreements the total cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness and Pandemic Influenza Preparedness. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. This allocation represents 10% of the award that will be made to this LHD. The other 90% was allocated under Indiana's Base Public Health Preparedness cooperative agreement application on July 15, 2006. The total amount of this award (100%) is $55,800.
69	LPHC Grant - Shelby County Health Department - 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$4,060	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health & emergency preparedness activities within local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK**: Specific critical tasks and measures are set out in the grant for the following purposes. These

										grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in & assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements & maintain volunteer/partner contact information, etc. LPHCs & other LHD staff shall participate in CDC SNS CRI site visits and assessments, and further develop, test and enhance their scalable mass prophylaxis/POD plans to support antibiotic distributions to their entire populations within 48 hours. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine CDC Outcomes, & all local measures identified by CDC in the preparedness/CRI & pandemic influenza grant guidance are incorporated into the LPHC grants. **ACCOUNTABILITY** will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET**: The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county employee. Due to the nature of activities

										outlined in these grant agreements the total cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness, Pandemic Influenza Preparedness, and Cities Readiness Initiative (CRI) activities. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. However, 20 of the LHDs including the LHD referenced in this line item are part of a CRI jurisdiction (7 in the Chicago, IL MSA, 10 in the Indianapolis, IN MSA, and 3 in the Cincinnati, OH MSA). These LHDs have adjusted activities, and will receive 80% Public Health Preparedness funds, 10% Pandemic Influenza funds, and 10% Cities Readiness Initiative funds. This allocation represents 10% of the award that will be made to this LHD. The other 90% was allocated under Indiana's Base Public Health Preparedness cooperative agreement application on July 15, 2006. The total cost of this agreement is $40,600.
70	LPHC Grant - Spencer County Health Department - 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$3,914	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health & emergency preparedness activities within local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK**: Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in & assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral

										distribution; identify & work with community partners; prepare mutual aid agreements & maintain volunteer/partner contact information, etc. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine CDC Outcomes, & all local measures identified by CDC in the preparedness & pandemic influenza grant guidance are incorporated into the LPHC grants. **ACCOUNTABILITY** will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET**: The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county employee. Due to the nature of activities outlined in these grant agreements the total cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness and Pandemic Influenza Preparedness. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. This allocation represents 10% of the award that will be made to this LHD. The other 90% was allocated under Indiana's Base Public Health Preparedness cooperative agreement application on July 15, 2006. The total amount of this award (100%) is $39,140.
71	LPHC Grant - St. Joseph County Health	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$4,925	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build

	Department - 10%									critical infrastructure needs for public health & emergency preparedness activities within local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK**: Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in & assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements & maintain volunteer/partner contact information, etc. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine CDC Outcomes, & all local measures identified by CDC in the preparedness & pandemic influenza grant guidance are incorporated into the LPHC grants. **ACCOUNTABILITY** will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET**: The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county

										employee. Due to the nature of activities outlined in these grant agreements the total cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness and Pandemic Influenza Preparedness. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. This allocation represents 10% of the award that will be made to this LHD. The other 90% was allocated under Indiana's Base Public Health Preparedness cooperative agreement application on July 15, 2006. The total amount of this award (100%) is $49,247.
72	LPHC Grant - Starke County Health Department - 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$4,900	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health & emergency preparedness activities within local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK**: Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in & assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements & maintain volunteer/partner contact information, etc. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks &

										measures that track the nine CDC Outcomes, & all local measures identified by CDC in the preparedness & pandemic influenza grant guidance are incorporated into the LPHC grants. **ACCOUNTABILITY** will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET**: The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county employee. Due to the nature of activities outlined in these grant agreements the total cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness and Pandemic Influenza Preparedness. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. This allocation represents 10% of the award that will be made to this LHD. The other 90% was allocated under Indiana's Base Public Health Preparedness cooperative agreement application on July 15, 2006. The total amount of this award (100%) is $48,996.
73	LPHC Grant - Steuben County Health Department - 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$5,131	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health & emergency preparedness activities within local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK**: Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public

										Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in & assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements & maintain volunteer/partner contact information, etc. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine CDC Outcomes, & all local measures identified by CDC in the preparedness & pandemic influenza grant guidance are incorporated into the LPHC grants. **ACCOUNTABILITY** will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET**: The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county employee. Due to the nature of activities outlined in these grant agreements the total cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness and Pandemic Influenza Preparedness. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. This

										allocation represents 10% of the award that will be made to this LHD. The other 90% was allocated under Indiana's Base Public Health Preparedness cooperative agreement application on July 15, 2006. The total amount of this award (100%) is $51,311.
74	LPHC Grant - Sullivan County Health Department - 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$5,580	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health & emergency preparedness activities within local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK**: Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in & assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements & maintain volunteer/partner contact information, etc. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine CDC Outcomes, & all local measures identified by CDC in the preparedness & pandemic influenza grant guidance are incorporated into the LPHC grants. **ACCOUNTABILITY** will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the

										grant attachment. **DETAILED BUDGET**: The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county employee. Due to the nature of activities outlined in these grant agreements the total cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness and Pandemic Influenza Preparedness. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. This allocation represents 10% of the award that will be made to this LHD. The other 90% was allocated under Indiana's Base Public Health Preparedness cooperative agreement application on July 15, 2006. The total amount of this award (100%) is $55,800.
75	LPHC Grant - Switzerland County Health Department - 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$3,871	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health & emergency preparedness activities within local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK**: Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in & assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community

										partners; prepare mutual aid agreements & maintain volunteer/partner contact information, etc. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine CDC Outcomes, & all local measures identified by CDC in the preparedness & pandemic influenza grant guidance are incorporated into the LPHC grants. **ACCOUNTABILITY** will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET**: The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county employee. Due to the nature of activities outlined in these grant agreements the total cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness and Pandemic Influenza Preparedness. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. This allocation represents 10% of the award that will be made to this LHD. The other 90% was allocated under Indiana's Base Public Health Preparedness cooperative agreement application on July 15, 2006. The total amount of this award (100%) is $38,707.
76	LPHC Grant - Tippecanoe County Health Department - 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$5,580	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health

										& emergency preparedness activities within local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK**: Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in & assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements & maintain volunteer/partner contact information, etc. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine CDC Outcomes, & all local measures identified by CDC in the preparedness & pandemic influenza grant guidance are incorporated into the LPHC grants. **ACCOUNTABILITY** will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET**: The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county employee. Due to the nature of activities

										outlined in these grant agreements the total cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness and Pandemic Influenza Preparedness. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. This allocation represents 10% of the award that will be made to this LHD. The other 90% was allocated under Indiana's Base Public Health Preparedness cooperative agreement application on July 15, 2006. The total amount of this award (100%) is $55,800.
77	LPHC Grant - Tipton County Health Department - 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$5,580	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health & emergency preparedness activities within local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK**: Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in & assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements & maintain volunteer/partner contact information, etc. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine CDC Outcomes,

										& all local measures identified by CDC in the preparedness & pandemic influenza grant guidance are incorporated into the LPHC grants. **ACCOUNTABILITY** will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET**: The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county employee. Due to the nature of activities outlined in these grant agreements the total cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness and Pandemic Influenza Preparedness. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. This allocation represents 10% of the award that will be made to this LHD. The other 90% was allocated under Indiana's Base Public Health Preparedness cooperative agreement application on July 15, 2006. The total amount of this award (100%) is $55,800.
78	LPHC Grant - Union County Health Department - 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$4,710	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health & emergency preparedness activities within local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK**: Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in

										all hazards planning; become trained in & assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements & maintain volunteer/partner contact information, etc. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine CDC Outcomes, & all local measures identified by CDC in the preparedness & pandemic influenza grant guidance are incorporated into the LPHC grants. **ACCOUNTABILITY** will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET**: The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county employee. Due to the nature of activities outlined in these grant agreements the total cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness and Pandemic Influenza Preparedness. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. This allocation represents 10% of the award that

										will be made to this LHD. The other 90% was allocated under Indiana's Base Public Health Preparedness cooperative agreement application on July 15, 2006. The total amount of this award (100%) is $47,097.
79	LPHC Grant - Vanderburg County Health Department - 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$4,555	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health & emergency preparedness activities within local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK**: Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in & assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements & maintain volunteer/partner contact information, etc. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine CDC Outcomes, & all local measures identified by CDC in the preparedness & pandemic influenza grant guidance are incorporated into the LPHC grants. **ACCOUNTABILITY** will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET**:

										The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county employee. Due to the nature of activities outlined in these grant agreements the total cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness and Pandemic Influenza Preparedness. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. This allocation represents 10% of the award that will be made to this LHD. The other 90% was allocated under Indiana's Base Public Health Preparedness cooperative agreement application on July 15, 2006. The total amount of this award (100%) is $45,554.
80	LPHC Grant - Vermillion County Health Department - 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$5,580	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health & emergency preparedness activities within local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK**: Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in & assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements &

										maintain volunteer/partner contact information, etc. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine CDC Outcomes, & all local measures identified by CDC in the preparedness & pandemic influenza grant guidance are incorporated into the LPHC grants. **ACCOUNTABILITY** will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET**: The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county employee. Due to the nature of activities outlined in these grant agreements the total cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness and Pandemic Influenza Preparedness. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. This allocation represents 10% of the award that will be made to this LHD. The other 90% was allocated under Indiana's Base Public Health Preparedness cooperative agreement application on July 15, 2006. The total amount of this award (100%) is $55,800.
81	LPHC Grant - Vigo County Health Department - 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$5,580	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health & emergency preparedness activities within

										local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK**: Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in & assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements & maintain volunteer/partner contact information, etc. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine CDC Outcomes, & all local measures identified by CDC in the preparedness & pandemic influenza grant guidance are incorporated into the LPHC grants. **ACCOUNTABILITY** will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET**: The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county employee. Due to the nature of activities outlined in these grant agreements the total

										cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness and Pandemic Influenza Preparedness. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. This allocation represents 10% of the award that will be made to this LHD. The other 90% was allocated under Indiana's Base Public Health Preparedness cooperative agreement application on July 15, 2006. The total amount of this award (100%) is $55,800.
82	LPHC Grant - Wabash County Health Department - 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$3,426	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health & emergency preparedness activities within local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK**: Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in & assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements & maintain volunteer/partner contact information, etc. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine CDC Outcomes, & all local measures identified by CDC in the

										preparedness & pandemic influenza grant guidance are incorporated into the LPHC grants. **ACCOUNTABILITY** will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET**: The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county employee. Due to the nature of activities outlined in these grant agreements the total cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness and Pandemic Influenza Preparedness. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. This allocation represents 10% of the award that will be made to this LHD. The other 90% was allocated under Indiana's Base Public Health Preparedness cooperative agreement application on July 15, 2006. The total amount of this award (100%) is $34,256.
83	LPHC Grant - Warrick County Health Department - 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$3,904	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health & emergency preparedness activities within local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK**: Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in &

										assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements & maintain volunteer/partner contact information, etc. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine CDC Outcomes, & all local measures identified by CDC in the preparedness & pandemic influenza grant guidance are incorporated into the LPHC grants. **ACCOUNTABILITY** will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET**: The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county employee. Due to the nature of activities outlined in these grant agreements the total cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness and Pandemic Influenza Preparedness. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. This allocation represents 10% of the award that will be made to this LHD. The other 90% was

										allocated under Indiana's Base Public Health Preparedness cooperative agreement application on July 15, 2006. The total amount of this award (100%) is $39,040.
84	LPHC Grant - Washington County Health Department - 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$5,506	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health & emergency preparedness activities within local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK**: Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in & assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements & maintain volunteer/partner contact information, etc. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine CDC Outcomes, & all local measures identified by CDC in the preparedness & pandemic influenza grant guidance are incorporated into the LPHC grants. **ACCOUNTABILITY** will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET**: The costs within these agreements will be

										used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county employee. Due to the nature of activities outlined in these grant agreements the total cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness and Pandemic Influenza Preparedness. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. This allocation represents 10% of the award that will be made to this LHD. The other 90% was allocated under Indiana's Base Public Health Preparedness cooperative agreement application on July 15, 2006. The total amount of this award (100%) is $55,056.
85	LPHC Grant - Wayne County Health Department - 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$5,463	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health & emergency preparedness activities within local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK**: Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in & assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements & maintain volunteer/partner contact

										information, etc. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine CDC Outcomes, & all local measures identified by CDC in the preparedness & pandemic influenza grant guidance are incorporated into the LPHC grants. **ACCOUNTABILITY** will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET**: The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county employee. Due to the nature of activities outlined in these grant agreements the total cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness and Pandemic Influenza Preparedness. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. This allocation represents 10% of the award that will be made to this LHD. The other 90% was allocated under Indiana's Base Public Health Preparedness cooperative agreement application on July 15, 2006. The total amount of this award (100%) is $54,630.
86	LPHC Grant - Wells County Health Department - 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$5,580	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health & emergency preparedness activities within local (county & municipal) jurisdictions. Only

										88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK**: Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in & assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements & maintain volunteer/partner contact information, etc. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine CDC Outcomes, & all local measures identified by CDC in the preparedness & pandemic influenza grant guidance are incorporated into the LPHC grants. **ACCOUNTABILITY** will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET**: The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county employee. Due to the nature of activities outlined in these grant agreements the total cost for this allocation has been split based on

										an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness and Pandemic Influenza Preparedness. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. This allocation represents 10% of the award that will be made to this LHD. The other 90% was allocated under Indiana's Base Public Health Preparedness cooperative agreement application on July 15, 2006. The total amount of this award (100%) is $55,800.
87	LPHC Grant - White County Health Department - 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$5,444	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health & emergency preparedness activities within local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK**: Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in & assist LHD staff to become trained in NIMS & PPE; prepare & exercise LHD emergency communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements & maintain volunteer/partner contact information, etc. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine CDC Outcomes, & all local measures identified by CDC in the preparedness & pandemic influenza grant

										guidance are incorporated into the LPHC grants. **ACCOUNTABILITY** will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET**: The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county employee. Due to the nature of activities outlined in these grant agreements the total cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness and Pandemic Influenza Preparedness. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. This allocation represents 10% of the award that will be made to this LHD. The other 90% was allocated under Indiana's Base Public Health Preparedness cooperative agreement application on July 15, 2006. The total amount of this award (100%) is $54,438.
88	LPHC Grant - Whitley County Health Department - (NEW) 10%	Sole Source	Local Health	8/31/2006	8/30/2007	Quarterly Report	$5,680	Pandemic Influenza		All 94 Indiana LHDs were invited to participate in this grant program to build critical infrastructure needs for public health & emergency preparedness activities within local (county & municipal) jurisdictions. Only 88 have decided to participate, 84 existing & 4 new to the program. **SCOPE OF WORK**: Specific critical tasks and measures are set out in the grant for the following purposes. These grants will generally provide for LHD grantees to fund one or more Local Public Health Coordinators (LPHC(s)) to engage in all hazards planning; become trained in & assist LHD staff to become trained in NIMS &

										PPE; prepare & exercise LHD emergency communications & operations plans, mass prophylaxis & other emergency response plans including pandemic influenza, isolation & quarantine, medical surge, & anti-viral distribution; identify & work with community partners; prepare mutual aid agreements & maintain volunteer/partner contact information, etc. LPHCs will engage in these activities for the LHD for their local jurisdiction, or grants may also be provided to LHDs to fund & share a coordinator among multiple jurisdictions. Responsibilities for the LPHC include specific critical tasks & measures that track the nine CDC Outcomes, & all local measures identified by CDC in the preparedness & pandemic influenza grant guidance are incorporated into the LPHC grants. **ACCOUNTABILITY** will be measured through site visits by ISDH staff to LHD grantees, & through quarterly progress reports to assess status of activities & collect data on specific local measures set out in the grant attachment. **DETAILED BUDGET**: The costs within these agreements will be used to pay for Salary, Fringe, Miscellaneous (communication, rent or facilities use, average supply costs, & other operational costs). These rates are consistent with standard rates for what the state would pay if this individual was a state staff member rather than a county employee. Due to the nature of activities outlined in these grant agreements the total cost for this allocation has been split based on an estimated amount of time the LPHCs will spend working on basic Public Health Preparedness and Pandemic Influenza Preparedness. The standard formula used for these grants is 90% Public Health Preparedness, 10% Pandemic Influenza. This allocation represents 90% of the award that will be made to this LHD. The other 10% will be allocated under the Indiana's Pandemic

										Influenza Supplemental application on August 31, 2006. As a “New” Grantee, this county will receive up to an additional $1,000 to make alterations to their existing space, & purchase a desk that has a side return, chair, bookcase, & file cabinet. This allocation represents 10% of the award that will be made to this LHD. The other 90% was allocated under Indiana’s Base Public Health Preparedness cooperative agreement application on July 15, 2006. The total amount of this award (100%) is $56,800.
89	Genesis Systems, Inc. - Electronic Death Registry	Bid	Commercial	9/1/2006	8/30/2007	Quarterly Report	$122,280	Pandemic Influenza		**NAME OF CONTRACTOR:** Genesis Systems, Inc; **METHOD OF SELECTION:** The contract proposal is the result of a competitive procurement process that involved the release of a Request for Proposal. Fourteen vendors responded. Genesis was chosen based on application of selection criteria applied to all responders; **PERIOD OF PERFORMANCE:** The funding period for this portion of the contract will be for August 31, 2006 through August 30, 2007; **SCOPE OF WORK:** The vendor will complete the following actions to implement an electronic death certificate database system: * Document current death certificate processes and database requirements * Develop a master work plan to guide implementation * Develop a project schedule with benchmarks to manage implementation * Prepare a detailed design and development plan * Prepare a detailed system design * Prepare system implementation plan * Develop and conduct pilot test plan

										* Convert legacy data to new death certificate database system * Provide system documentation. * Develop and provide a train-the-trainer instruction on using the new system * Provide troubleshooting and systems manuals * Conduct acceptance testing for implementation; **METHOD OF ACCOUNTABILITY:** Implementation will be based on an agreed to work plan. Each deliverable will be reviewed by the ISDH project manager and team for acceptance. Each system element will be tested before acceptance; **ITEMIZED BUDGET AND JUSTIFICATION:** This portion of the system costs $122,280. This was based on a competitive procurement process. Details for breakout of costs per activity will be refined during contract negotiations.
90	University of Illinois - Lab Course & Training Development	Sole Source	Other Public Entity	8/31/2006	8/30/2007	Quarterly Report	$142,845	Training		**NAME OF CONTRACTOR:** University of Illinois at Chicago - CADE; **METHOD OF SELECTION:** This contractor is a sole source as they own the Learning Management System which we have enhanced and developed over the last 3 years. The work plan proposal and upgrades for the following outlined capabilities are specific to this system; **PERIOD OF PERFORMANCE:** August 31, 2006 through August 30, 2007; **SCOPE OF WORK:** In collaboration with the ISDH, the vendor will select, adapt, and develop an online competency-based training for public health & clinical laboratory staff. This is as an enhancement to the current face-to-face training, which serves as an annual

										review for staff. This training course will include Modules on Influenza Diagnostic Testing (virus isolation, flu kits, Do Kits pick up H5N1?), Bio-safety Containment (bio-safety cabinet, safety reminders, and spills), Bio-monitoring Protocols (incident reporting, fever watch), and a Course Exam. Further details are contained within this application under work plan Action Items 6 and 7; **METHOD OF ACCOUNTABILITY:** The contractor will work directly with the Indiana Learning Content Management System (ILCMS) Director, Barb Gibson, to implement all required changes as well as other representatives from the ISDH information technology staff and laboratory staff to ensure implementation of both the Pan Flu Mass Prophylaxis Simulation and Laboratory Training; **ITEMIZED BUDGET AND JUSTIFICATION:** The total for this contract is $142,845. Please see Appendix J of this application for a **DETAILED BUDGET** breakdown for this proposal.
91	***TBD* -** Volunteer Management Program	Bid	Other Public Entity	8/31/2006	8/30/2007	Quarterly Report	$250,000	Pandemic Influenza		**NAME OF CONTRACTOR:** TBD; **METHOD OF SELECTION:** Competitive. The ISDH will develop specific criteria and enhance the **SCOPE OF WORK** to solicit cost proposals from various public partners, educational institutions, and private sector companies. These proposals will be evaluated by PHPER and ISDH management, for vendor selection; **PERIOD OF PERFORMANCE:** August 31, 2006, to August 30, 2007; **SCOPE OF WORK:** Contractor will develop a Community Volunteer Emergency Management Program that integrates and coordinates the volunteer needs of public health and emergency management. Contractor will identify volunteer needs regarding **SCOPE OF WORK** and number

										needed within each required skill set, assess risk to volunteers and propose strategies to support them, assess recruiting and retention issues and propose strategies to address them, design job action sheets and training for volunteers in required roles, design exercises to reinforce and refine training, and design a volunteer management and credentialing program. Contractor will implement program in selected counties within each of the 10 Indiana Homeland Security Districts; **METHOD OF ACCOUNTABILITY: ACCOUNTABILITY** will be reviewed through monthly claim vouchers and progress reports submitted by the contractor; **ITEMIZED BUDGET AND JUSTIFICATION:** The proposed budget for this project is $250,000. It is assumed that funding proposals will include labor, travel, material, and indirect or F & A costs, but the details are currently unknown. However, as a prior approval line item, the ISDH will provide proposed budget and required contract information as soon as it becomes available.
92	PHSI - Exercise Project	Sole Source	Other Public Entity	8/31/2006	8/30/2007	Quarterly Report	$503,542	Pandemic Influenza		**NAME OF CONTRACTOR:** Purdue Homeland Security Institute; **METHOD OF SELECTION:** Sole Source; **PERIOD OF PERFORMANCE:** August 31, 2006, to August 30, 2007; **SCOPE OF WORK:** Contractor will implement a public health exercise program that will significantly improve statewide preparedness by addressing identified gaps and deficiencies at the local level. Contractor will develop a series of templates in the form of focused drills and tabletop exercises to be distributed to all 94 Indiana local health departments for use and implementation during budget year. Contractor will provide direct assistance to pilot the implementation of at least one drill utilizing each drill template, and will facilitate all 94 tabletop exercises, including documentation and After Action Review using

										DHS HSEEP guidelines. Contractor will develop 10 “Mixed Reality” decision support tabletops for ISDH-identified counties in each of the state’s 10 Homeland Security Districts for use and implementation during budget year. Contractor will utilize Mixed Reality Decision Making Support Software for this purpose, and will provide analysis of results for future functional exercises. Contractor will develop a “Train the Facilitator” course to increase the speed and efficiency of delivering these exercises statewide, for use and implementation during the current budget year. Contractor will present course to ISDH district coordinators for subsequent training at local level. Contractor will engage in planning activities and development of 10 district functional exercises for use and implementation during the budget year beginning August 31, 2007. All exercises will utilize a pandemic influenza scenario and engage multiple disciplines and jurisdictions at the local level. Contractor will work in collaboration with the Regenstrief Center for Healthcare Engineering, the Center for Computational Homeland Security and the Center for Military and Law Enforcement Technology, Tactics and Training; M**ETHOD OF ACCOUNTABILITY: ACCOUNTABILITY** will be reviewed through monthly claim vouchers and progress reports submitted by the contractor, and through direct participation in exercises and training by ISDH program staff; **ITEMIZED BUDGET AND JUSTIFICATION:** The proposed budget for this project is $503,542. This includes each of the following line items: Personnel, $356,727; Graduate Fee Remissions and Insurance, $29,880; Travel, $20,000; Supplies and Expenses, $45,000; and Indirect (11.5%), $51,935. The Personnel line item includes support for PHSI program management and

										exercise facilitation and three professors, one from Health Sciences, one from Nursing and one from Organizational Leadership and Supervision. It also includes support for one DNP research assistant at 50% from Purdue's School of Nursing, one healthcare operations MBA graduate student at 50% from the Krannert Graduate School of Management, one graduate research assistant from the School of Health Sciences, and one graduate research assistant from the School of Science. Support for the "Mixed Reality" decision support personnel is also included. The budget also includes secretarial support for a total of $9,160. The Supplies and Expenses include costs for programming, database, word processing, report generation, communication, facility rental and catering needs.
93	***TBD*** - Mass Fatality Management	Bid	Other Public Entity	8/31/2006	8/30/2007	Quarterly Report	$250,000	Pandemic Influenza		**NAME OF CONTRACTOR:** TBD; **METHOD OF SELECTION:** Competitive. The ISDH will develop specific criteria and enhance the **SCOPE OF WORK** to solicit cost proposals from various public partners, educational institutions, and private sector companies. These proposals will be evaluated by PHPER and ISDH management, for vendor selection; **PERIOD OF PERFORMANCE:** August 31, 2006, to August 30, 2007; **SCOPE OF WORK:** Contractor will develop alternatives for handling mass fatalities at the district and at local levels to support pandemic planning in Indiana. Contractor will analyze multiple factors related to a mass fatality event and identify required steps that must occur for response and recovery, required resources, the most critical potential shortages, and opportunities for mass storage, stockpiling supplies, and cost sharing among jurisdictions. Contractor will also analyze and assess religious, cultural and psychological aspects. Contractor will formulate recommendations and strategies for handling mass fatalities, and will develop a mass

										fatality planning template that can be used by public health and emergency management personnel in creating comprehensive mass fatality plans. **METHOD OF ACCOUNTABILITY: ACCOUNTABILITY** will be reviewed through monthly claim vouchers and progress reports submitted by the contractor. **ITEMIZED BUDGET AND JUSTIFICATION:** The proposed budget for this project is $250,000. It is assumed that funding proposals will include labor, travel, material, and indirect or F & A costs, but the details are currently unknown. However, as a prior approval line item, the ISDH will provide proposed budget and required contract information as soon as it becomes available.
94	PHSI - Alternate Care Site Development	Sole Source	Other Public Entity	8/31/2006	8/30/2007	Quarterly Report	$240,097	Pandemic Influenza		**NAME OF CONTRACTOR:** Purdue University, Healthcare Technical Assistance Program; **METHOD OF SELECTION:** Sole Source; **PERIOD OF PERFORMANCE:** August 31, 2006, to August 30, 2007; **SCOPE OF WORK:** Contractor will develop a coordinated Alternative Care Site planning process for Indiana. Contractor will work within selected districts and collaborate with local emergency and health partners to assess ACS needs, project the number, size and location of sites needed, develop staffing and resource models, and delineate planning, exercise and deployment responsibilities; **METHOD OF ACCOUNTABILITY: ACCOUNTABILITY** will be reviewed through monthly claim vouchers and progress reports submitted by the contractor; **ITEMIZED BUDGET AND JUSTIFICATION:** The proposed budget for this project is $240,097. This includes each of the following line items: Personnel, $195,833; Travel, $10,000; Computers; 4,500; Supplies and Expenses, $5,000; and Indirect (11.5%), $24,764. The Personnel line item

										includes salary and fringe benefit support for three professors, two from Engineering and one from Nursing, each at $20%. It also includes support for four graduate assistants at 50%. The budget also includes funds for Healthcare TAP administrative and secretarial support. The Supplies and Expenses include costs for programming, database, word processing, report generation, and communication needs.
95	***TBD*** - Pan Flu Community Level Public Education Campaign	Bid	Other Public Entity	8/31/2006	8/30/2007	Quarterly Report	$375,000	Pandemic Influenza		**NAME OF CONTRACTOR:** TBD; **METHOD OF SELECTION:** Competitive. The ISDH will develop specific criteria and enhance the **SCOPE OF WORK** to solicit cost proposals from various public partners, educational institutions, and private sector companies. These proposals will be evaluated by PHPER managers and other ISDH management, for vendor selection; **PERIOD OF PERFORMANCE:** August 31, 2006, to August 30, 2007; **SCOPE OF WORK:** Contractor will develop and implement a structured public education program on pandemic influenza preparedness and response targeting various business and community sectors to address identified gaps and deficiencies at the local level. Contractor will utilize a "Train-the-Trainer" concept and identify, adapt, and/or develop a pandemic influenza pubic education toolkit, public education materials, and health promotion campaign to be distributed to all 94 Indiana local health departments for use and implementation during budget year. Contractor will develop a "Train-the-Trainer" course to increase the speed and efficiency of delivering public education on a statewide basis, for use and implementation during the current budget year. Contractor, in conjunction with identified state level staff, will provide direct assistance to pilot the initial training of community pan flu educators. Contractor will present the course

										to LPHCs, DPHCs, and other identified community education partners as appropriate, for subsequent training at local level. Contractor will also develop and present courses for business and community sectors, facilitate community meetings to support pandemic influenza education for planning and response, and provide direct assistance to public and private sector entities developing continuity of operations planning and education on pandemic influenza. In developing and implementing public education program, contractor will partner with not for profit, public and private entities to provide for diversity in disciplines and multi-faceted methodologies for presenting material. Education program shall build on ISDH Tool Kit and local pandemic influenza summits and town hall meetings held from March to August of 2006. **METHOD OF ACCOUNTABILITY: ACCOUNTABILITY** will be reviewed through monthly claim vouchers and progress reports submitted by the contractor. **ITEMIZED BUDGET AND JUSTIFICATION:** The proposed budget for this project is $375,000. It is assumed that funding proposals will include labor, travel, material, and indirect or F & A costs, but the details are currently unknown. However, as a prior approval line item, the ISDH will provide proposed budget and required contract information as soon as it becomes available.
96	Indiana University Center for BioEthics - Community Advisory Group	Sole Source	Other Public Entity	10/1/2006	8/30/2007	Quarterly Report	$50,000	Pandemic Influenza		**NAME OF CONTRACTOR:** Indiana University Center for Bioethics; **METHOD OF SELECTION:** The Indiana University Center for Bioethics is the only center in the state of Indiana with the expertise and resources to address ethical, medical and health policy issues in pandemic influenza planning and response. The uniqueness of a center for bioethics is its interdisciplinary character, with expertise in medicine, science,

										public health, law, health policy, and ethics. The Indiana University Center for Bioethics is the ONLY center for bioethics in Indiana and thus the only such center capable of addressing the unique health policy, ethical, and medical issue related to pandemic influenza; **PERIOD OF PERFORMANCE:** 10/01/06 – 08/30/07; **SCOPE OF WORK:** • Develop an Ethical Framework for Decision Making During Pandemic Influenza. • Develop and facilitate 1 Table Top Exercise (TTX) for ISDH focused on ethical issues and decision making during pandemic influenza. • Assist in the development, and facilitate a Community Advisory Group (CAG) to address the critical ethical issues and produce 5 Technical Assistance documents. • Develop 1 Ethical Framework for Pandemic Influenza Planning: A Guide for Local Health Departments and Hospitals document that identifies critical ethical issues, provides guidance, and recommendations on strategies. • Conduct 5 training sessions at the district level on the Ethical Framework for Pandemic Influenza Planning: A Guide for Local Health Departments and Hospitals document to include Indiana's 10 preparedness districts.; **METHOD OF ACCOUNTABILITY:** By regular participation and collaboration with ISDH and by the completion of deliverables. **ITEMIZED BUDGET AND JUSTIFICATION:** • $5,000 – Ethical Framework Document • $5,000 – TTX, ISDH • $25,000 – Community Advisory Group and 5 Technical Guidance Documents ($5,000 per document estimating 100 hours per document, $50 per hour) • $5,000 – Ethics Framework LHD & Hospital Guidance Document • $10,000 – 5 District Training Session ($2,000 per session)
97	***TBD*** - Pan Flu/Mass Prophylaxis Simulation	Bid	Other Public	10/1/2006	8/30/2007	Quarterly Report	$235,000	Pandemic Influenza		**NAME OF CONTRACTOR:** TBD; **METHOD OF SELECTION:** Competitive.

	Exercise		Entity							The ISDH will develop specific criteria and enhance the **SCOPE OF WORK** to solicit cost proposals from various public partners, educational institutions, and private sector companies. These proposals will be evaluated by PHPER managers and other ISDH management, for vendor selection; **PERIOD OF PERFORMANCE:** August 31, 2006 through August 30, 2007; **SCOPE OF WORK:** In collaboration with the ISDH, the vendor will develop an online Pan Flu Simulation which functions as a drill, in accordance with HSEEP standards. This functionality will be added to regular training provided for staff and included within the Indiana Learning Content Management System (ILCMS). This interactive simulation will allow on-line education for personnel to train on their specific role in a Mass Prophylaxis Clinic setting as well as learn the roles and collaborate with other entities who are also participating. Much like a game, this simulation has the capacity for a single individual or multiple people to be involved within the same session. Further details are contained within this application under work plan Action Item 28; **METHOD OF ACCOUNTABILITY:** The contractor will work directly with the ISDH ILCMS Director, Barb Gibson, to implement all required changes as well as other PHPER Managers, and representatives from the ISDH information technology staff to ensure proper implementation and evaluation methods of the Pan Flu Mass Prophylaxis Simulation; **ITEMIZED BUDGET AND JUSTIFICATION**: The total for this contract is estimated at $235,000. It is assumed that funding proposals will include labor, travel, material, and indirect or F & A costs, but the details are currently unknown. However, as a prior approval line item, the ISDH will provide proposed budget and required contract

										information as soon as it becomes available.
98										
99										
100										
	Totals						**$2,623,143**			

	Financial Assistance: Consultant					**Detail**		
Item #	**Name or Org**	**# of Days**	**$ Daily Rate**	**$ Other**	**$ Requested**	**Sub-category**	**Org ID**	**Budget Justification**
1	Management Info Disciplines - Documentation & Training Developer - Ellie Hashman	209	$480	$2,000	$102,320	IT		Selected from the IN State Dept. of Administrations Temporary Technical Services Quantity Purchase Award List. The QPA are competitive bid contracts managed by the Indiana Department of Administration that provide specified services for specified periods of time, at specified prices: **NAME OF CONSULTANT:** Ellie Hashman; **ORGANIZATIONAL AFFILIATION:** Management Information Developers (MID); **NATURE OF SERVICES TO BE RENDERED & RELEVANCE OF SERVICE TO PROJECT:** With the implementation of INEDSS and ESAR-VHP, there will be major training and documentation requirements. We will need to develop a support structure, and provide training for State and Local personnel. Therefore, we are requesting a training specialist for development of a training plan to establish the scope of training, training approach, training material development, and conduct training throughout the state; **NUMBER OF DAYS OF CONSULTATION:** This is an extension of an existing consultant for the period of 11/01/06 – 08/30/07. Based on a 8 hour work day, there are approximately 212 working days for this period. However savings from her previous assignment will be used to cover the difference of 3 working days proposed on this budget line item. **EXPECTED RATE OF COMPENSATION:** $60 per hour or $480 per day as well as a travel allowance of $2,000 for in-state travel throughout the state to conduct local level training; **METHOD OF ACCOUNTABILITY:** This consultant will report for daily

								work within the ISDH PHIN Coordination Section of the PHPER division. Timesheets are verified and signed by division managers weekly or bi-weekly for review prior to employee's submission to Vendor for invoicing to the ISDH.
2	TEKSYSTEMS - LIMS Project Manager - John Vitka	209	$680	$2,000	$144,120	IT		Selected from the IN State Dept. of Administrations Temporary Technical Services Quantity Purchase Award List. The QPA are competitive bid contracts managed by the Indiana Department of Administration that provide specified services for specified periods of time, at specified prices. **NAME OF CONSULTANT:** John Vitka; **ORGANIZATIONAL AFFILIATION:** TEK Systems; **NATURE OF SERVICES TO BE RENDERED:** The consultant will provide project management services to facilitate timely and successful implementation of the LIMS software. The project manager will be responsible for the following activities: • Coordinate activities of the organization members on the project team. • Communicate project status to the Executive Sponsor. • Schedule releases of the software. • Approve functionality to be included in each release. • Approve Inputs to Factory Acceptance Testing (FAT) • Validate the completion of milestones • Manage risk to keep project on track. • Approves Site Acceptance Test • Approves Validation of Installation Packages; **RELEVANCE OF SERVICE TO PROJECT:** The consultant will serve as Project Manager for LIMS implementation. This will permit the ISDH Labs staff to address functionalities and technical aspects related to the LIMS implementation; **NUMBER OF DAYS OF CONSULTATION:** This is an extension of an existing consultant for the period of 11/01/06 – 08/30/07. Based on an 8 hour work day, there are approximately 1696 Hours or 212 working days through 08/30/07. However, savings exists on the previous agreement with this consultant that we will use to cover the 3 day difference as proposed on this line item; **EXPECTED RATE OF COMPENSATION:** $85 per hour or $680 per day; **METHOD OF ACCOUNTABILITY:** This consultant will report for daily work within the ISDH Information Technology Division. Timesheets are verified and signed by division managers weekly or bi-weekly for review prior to employee's submission to Vendor for invoicing to the ISDH.
3	**TBD** - LIMS SPECIFICATIONS MANAGER	59	$680		$40,120	IT		Selected from the IN State Dept. of Administrations Temporary Technical Services Quantity Purchase Award List. The QPA are competitive bid contracts managed by the Indiana Department

								of Administration that provide specified services for specified periods of time, at specified prices. **NAME OF CONSULTANT:** TBD; **ORGANIZATIONAL AFFILIATION:** TBD; **NATURE OF SERVICES TO BE RENDERED:** The LIMS Specifications Manager will document user specifications; Translate user specifications to facilitate the creation of accurate technical specifications prior to programming; Refine Inputs to FAT; Generate Site Acceptance Test; and Administer Site Acceptance Test to Validate the ISDH LIMS System; **RELEVANCE OF SERVICE TO PROJECT:** This position is needed for the LIMS implementation and integration necessary to provide the state laboratory with a flexible comprehensive database system that addresses the workflow and communication needs of a public health laboratory. StarLIMS system will replace existing laboratory data management systems used in microbiology and chemistry and emergency preparedness and will implement central accessioning as well as add new functionalities that are required to fulfill the public health laboratory mission of disease control and prevention, outbreak investigation, emergency preparedness and terrorism response; **NUMBER OF DAYS OF CONSULTATION:** This is an extension of a consultant that will be identified within the next 30 days for the period of 11/01/06 – 01/31/07. Based on an 8 hour work day, there are approximately 480 Hours or 60 working days through 01/31/07, however we are only requesting 59 days and will use savings from the original agreement to cover the cost difference for the single day difference; **EXPECTED RATE OF COMPENSATION:** $85 per hour or $680 per day; **METHOD OF ACCOUNTABILITY:** This consultant will report for daily work within the ISDH Information Technology Division. Timesheets are verified and signed by division managers weekly or bi-weekly for review prior to employee's submission to Vendor for invoicing to the ISDH.
4	**TBD** - LIMS TEST ENGINEER	59	$680		$40,120	IT		Selected from the IN State Dept. of Administrations Temporary Technical Services Quantity Purchase Award List. The QPA are competitive bid contracts managed by the Indiana Department of Administration that provide specified services for specified periods of time, at specified prices: **NAME OF CONSULTANT:** TBD; **ORGANIZATIONAL AFFILIATION:** TBD; **NATURE OF SERVICES TO BE RENDERED:** The LIMS Test Engineer will perform integration tests and acceptance tests (SAT) on the installed

								LIMS application and Document results of LIMS tests; **RELEVANCE OF SERVICE TO PROJECT:** This position is needed for the LIMS implementation and integration necessary to provide the state laboratory with a flexible comprehensive database system that addresses the workflow and communication needs of a public health laboratory. StarLIMS system will replace existing laboratory data management systems used in microbiology and chemistry and emergency preparedness and will implement central accessioning as well as add new functionalities that are required to fulfill the public health laboratory mission of disease control and prevention, outbreak investigation, emergency preparedness and terrorism response; **NUMBER OF DAYS OF CONSULTATION:** This is an extension of a consultant that will be identified within the next 30 days for the period of 11/01/06 – 01/31/07. Based on an 8 hour work day, there are approximately 480 Hours or 60 working days through 01/31/07, however we are only requesting 59 days and will use savings from the original agreement to cover the cost difference for the single day difference; **EXPECTED RATE OF COMPENSATION:** $85 per hour or $680 per day; **METHOD OF ACCOUNTABILITY:** This consultant will report for daily work within the ISDH Information Technology Division. Timesheets are verified and signed by division managers weekly or bi-weekly for review prior to employee's submission to Vendor for invoicing to the ISDH.
5	**TBD** - LIMS STATIC DATA MANAGER	59	$680		$40,120	IT		Selected from the IN State Dept. of Administrations Temporary Technical Services Quantity Purchase Award List. The QPA are competitive bid contracts managed by the Indiana Department of Administration that provide specified services for specified periods of time, at specified prices: **NAME OF CONSULTANT:** TBD; **ORGANIZATIONAL AFFILIATION:** TBD; **NATURE OF SERVICES TO BE RENDERED:** The LIMS Static Data Manager will document static data conventions; Insure the accuracy of static table data; Write procedures to ensure conventions are implemented and static table data remains accurate; Implement procedures for populating and maintaining static data; **RELEVANCE OF SERVICE TO PROJECT:** This position is needed for the LIMS implementation and integration necessary to provide the state laboratory with a flexible comprehensive database system that addresses the workflow and communication needs of a public health laboratory. StarLIMS system will replace existing

								laboratory data management systems used in microbiology and chemistry and emergency preparedness and will implement central accessioning as well as add new functionalities that are required to fulfill the public health laboratory mission of disease control and prevention, outbreak investigation, emergency preparedness and terrorism response; **NUMBER OF DAYS OF CONSULTATION:** This is an extension of a consultant that will be identified within the next 30 days for the period of 11/01/06 – 01/31/07. Based on an 8 hour work day, there are approximately 480 Hours or 60 working days through 01/31/07, however we are only requesting 59 days and will use savings from the original agreement to cover the cost difference for the single day difference; **EXPECTED RATE OF COMPENSATION:** $85 per hour or $680 per day; **METHOD OF ACCOUNTABILITY:** This consultant will report for daily work within the ISDH Information Technology Division. Timesheets are verified and signed by division managers weekly or bi-weekly for review prior to employee's submission to Vendor for invoicing to the ISDH.
6	**TBD** - CRA Primary Developer_Senior Level - **TBD**	194	$520		$100,880	IT		Selected from the IN State Dept. of Administrations Temporary Technical Services Quantity Purchase Award List. The QPA are competitive bid contracts managed by the Indiana Department of Administration that provide specified services for specified periods of time, at specified prices: **NAME OF CONSULTANT:** TBD; **ORGANIZATIONAL AFFILIATION:** TBD; **NATURE OF SERVICES TO BE RENDERED & RELEVANCE OF SERVICE TO PROJECT:** Based upon our preliminary study we will need two additional developers to support our CRA PHIN certification efforts. We currently have one person doing the system requirements phase. The development environment will be primarily VB.net with some work done with Access. We will need a lead developer who is familiar with Oracle and Access databases as well as handling / parsing flat ASCII files; **NUMBER OF DAYS OF CONSULTATION:** This is a new consultant which we will have to post, interview, and select a qualified candidate for. Therefore it is anticipated that the identified candidate will not begin until 12/01/06 and extend through 08/30/07. Based on an 8 hour work day, there are approximately 1552 working hours available over the course of 194 working days through 08/30/07; **EXPECTED RATE OF COMPENSATION:** This position should be for a Senior Level Developer at an estimated rate of $65 per hour or $520 per day;

								METHOD OF ACCOUNTABILITY: This consultant will report for daily work within the ISDH PHIN Coordination Section of the PHPER division. Timesheets are verified and signed by division managers weekly or bi-weekly for review prior to employee's submission to Vendor for invoicing to the ISDH.
7	**TBD** - CRA Secondary Developer - **TBD**	194	$480		$93,120	IT		Selected from the IN State Dept. of Administrations Temporary Technical Services Quantity Purchase Award List. The QPA are competitive bid contracts managed by the Indiana Department of Administration that provide specified services for specified periods of time, at specified prices: **NAME OF CONSULTANT:** TBD; **ORGANIZATIONAL AFFILIATION:** TBD; **NATURE OF SERVICES TO BE RENDERED & RELEVANCE OF SERVICE TO PROJECT:** Based upon our preliminary study we will need two additional developers to support our CRA certification efforts. We currently have one person doing the system requirements phase. The development environment will be primarily VB.net with some work done with Access. We will need a secondary developer who is familiar with Oracle and Access databases as well as handling / parsing flat ASCII files who can work concurrently with the primary; **NUMBER OF DAYS OF CONSULTATION:** This is a new consultant which we will have to post, interview, and select a qualified candidate for. Therefore it is anticipated that the identified candidate will not begin until 12/01/06 and extend through 08/30/07. Based on an 8 hour work day, there are approximately 1552 working hours available over the course of 194 working days through 08/30/07; **EXPECTED RATE OF COMPENSATION:** This position should be for a Mid-Level Developer at an estimated rate of $60 per hour or $480 per day; **METHOD OF ACCOUNTABILITY:** This consultant will report for daily work within the ISDH PHIN Coordination Section of the PHPER division. Timesheets are verified and signed by division managers weekly or bi-weekly for review prior to employee's submission to Vendor for invoicing to the ISDH.
8	**TBD** - OMS Certification Consultant - **TBD**	194	$520		$100,880	IT		Selected from the IN State Dept. of Administrations Temporary Technical Services Quantity Purchase Award List. The QPA are competitive bid contracts managed by the Indiana Department of Administration that provide specified services for specified periods of time, at specified prices: **NAME OF CONSULTANT:** TBD; **ORGANIZATIONAL AFFILIATION:** TBD; **NATURE OF SERVICES TO BE**

								RENDERED & RELEVANCE OF SERVICE TO PROJECT: We currently have an internally developed OMS system that is not PHIN compliant and does not deliver all the functionality that we need. We need to start by evaluating the current CDC OMS system. We need to determine if we want to convert to the CDC system or enhance our system to make it PHIN compatible. We need a Web-based developer with good analytical and Project Management skills. We have already completed an initial review of PHIN certification requirements. This person will need to do the analysis to determine if we want to modify our existing application or implement the CDC application. Based upon this recommendation this person will either make the necessary modifications or install the CDC system. The development environment will be VB.net and Oracle; **NUMBER OF DAYS OF CONSULTATION:** This is a new consultant which we will have to post, interview, and select a qualified candidate for. Therefore it is anticipated that the identified candidate will not begin until 12/01/06 and extend through 08/30/07. Based on an 8 hour work day, there are approximately 1552 working hours available over the course of 194 working days through 08/30/07; **EXPECTED RATE OF COMPENSATION:** This position should be for a Senior Level Developer at an estimated rate of $65 per hour or $520 per day; **METHOD OF ACCOUNTABILITY:** This consultant will report for daily work within the ISDH PHIN Coordination Section of the PHPER division. Timesheets are verified and signed by division managers weekly or bi-weekly for review prior to employee's submission to Vendor for invoicing to the ISDH.
9	**TBD** - Secondary Indiana NEDSS Developer - **TBD**	194	$520		$100,880	IT		Selected from the IN State Dept. of Administrations Temporary Technical Services Quantity Purchase Award List. The QPA are competitive bid contracts managed by the Indiana Department of Administration that provide specified services for specified periods of time, at specified prices: **NAME OF CONSULTANT:** TBD; **ORGANIZATIONAL AFFILIATION:** TBD; **NATURE OF SERVICES TO BE RENDERED & RELEVANCE OF SERVICE TO PROJECT:** We have received the NEDSS system that Pennsylvania developed and are in the process of implementing it in Indiana. This is a key requirement for us to achieve PHIN certification in Early Event Detection (EED). Our current plan is to not even start certification efforts until the next grant year. By accelerating the implementation of NEDSS, we will

								accelerate our certification efforts and start them in the current grant year. We are looking at accelerating both the development / implementation activities and the preparation of documentation and training materials. We need a senior Web-based developer to accelerate the implementation of INEDSS. The implementation of INEDSS is the critical path for starting PHIN Early Event Detection certification activities. The development environment will be VB.net using an Oracle database; **NUMBER OF DAYS OF CONSULTATION:** This is a new consultant which we will have to post, interview, and select a qualified candidate for. Therefore it is anticipated that the identified candidate will not begin until 12/01/06 and extend through 08/30/07. Based on an 8 hour work day, there are approximately 1552 working hours available over the course of 194 working days through 08/30/07; **EXPECTED RATE OF COMPENSATION:** This position should be for a Senior Level Developer at an estimated rate of $65 per hour or $520 per day; **METHOD OF ACCOUNTABILITY:** This consultant will report for daily work within the ISDH PHIN Coordination Section of the PHPER division. Timesheets are verified and signed by division managers weekly or bi-weekly for review prior to employee's submission to Vendor for invoicing to the ISDH.
10	**TBD** - STARLIMS Web developer - **TBD**	194	$520		$100,880	IT		Selected from the IN State Dept. of Administrations Temporary Technical Services Quantity Purchase Award List. The QPA are competitive bid contracts managed by the Indiana Department of Administration that provide specified services for specified periods of time, at specified prices: **NAME OF CONSULTANT:** TBD; **ORGANIZATIONAL AFFILIATION:** TBD; **NATURE OF SERVICES TO BE RENDERED & RELEVANCE OF SERVICE TO PROJECT:** There are a number of Web based applications we need to develop to support the STARLIMS implementation. These include establishing a flexible, comprehensive database that addresses the workflow and communication needs of a public health laboratory. We will also provide additional functionality such as central accessioning and remote Web based pan flu pre-accessioning. The development environment will be VB.net. We need a Web-based developer with some Project Management skills; **NUMBER OF DAYS OF CONSULTATION:** This is a new consultant which we will have to post, interview, and select a qualified candidate for. Therefore it is anticipated that the identified candidate will not

								begin until 12/01/06 and extend through 08/30/07. Based on an 8 hour work day, there are approximately 1552 working hours available over the course of 194 working days through 08/30/07; **EXPECTED RATE OF COMPENSATION:** This position should be for a Senior Level Developer at an estimated rate of $65 per hour or $520 per day; **METHOD OF ACCOUNTABILITY:** This consultant will report for daily work within the ISDH PHIN Coordination Section of the PHPER division. Timesheets are verified and signed by division managers weekly or bi-weekly for review prior to employee's submission to Vendor for invoicing to the ISDH.
11	**TBD** - Lab web page changes - **TBD**	89	$480		$42,720	IT		Selected from the IN State Dept. of Administrations Temporary Technical Services Quantity Purchase Award List. The QPA are competitive bid contracts managed by the Indiana Department of Administration that provide specified services for specified periods of time, at specified prices: **NAME OF CONSULTANT:** TBD; **ORGANIZATIONAL AFFILIATION:** TBD; **NATURE OF SERVICES TO BE RENDERED & RELEVANCE OF SERVICE TO PROJECT:** We are installing the STARLIMS system in the state lab. This is required to improve lab operations and meet the requirements needed for PHIN Certification. To support STARLIMS we need to change the ISDH Web page to provide additional information. This includes a variety of information including instructions on handling samples and shipping procedures. We need a Web-based developer to modify existing Web pages. The activity will require analysis to determine what to display and design skills to determine how to display it. The development environment will be VB.net; **NUMBER OF DAYS OF CONSULTATION:** This is a new consultant which we will have to post, interview, and select a qualified candidate for. Therefore it is anticipated that the identified candidate will not begin until 12/01/06 and extend through 03/31/07. Based on an 8 hour work day, there are approximately 672 working hours available over the course of 89 working days through 03/31/07; **EXPECTED RATE OF COMPENSATION:** This position should be for a Mid-Level Developer at an estimated rate of $60 per hour or $480 per day; **METHOD OF ACCOUNTABILITY:** This consultant will report for daily work within the ISDH PHIN Coordination Section of the PHPER division. Timesheets are verified and signed by division managers weekly or bi-weekly for review prior to employee's submission to Vendor for invoicing to the ISDH.

12	**TBD** - PHIN MS coordinator & PHIN Coordinator - **TBD**	194	$520		$100,880	IT		Selected from the IN State Dept. of Administrations Temporary Technical Services Quantity Purchase Award List. The QPA are competitive bid contracts managed by the Indiana Department of Administration that provide specified services for specified periods of time, at specified prices: **NAME OF CONSULTANT:** TBD; **ORGANIZATIONAL AFFILIATION:** TBD; **NATURE OF SERVICES TO BE RENDERED & RELEVANCE OF SERVICE TO PROJECT:** One of the key items in the Cross Functional Component (CFC) part of PHIN Certification is PHIN MS messaging protocols. This is a technical process that wraps a communications protocol around an exiting message. It requires a number of setup procedures for establishing communications with every communications partner. We need someone to manage the PHIN MS tables and oversee the implementation of PHIN MS with all our partners. This is part of our overall approach to managing our PHIN certification efforts. We need a person to oversee for all six certification areas. This is a critical part of our overall certification plan and this person will act as our PHIN certification project manager; **NUMBER OF DAYS OF CONSULTATION:** This is a new consultant which we will have to post, interview, and select a qualified candidate for. Therefore it is anticipated that the identified candidate will not begin until 12/01/06 and extend through 08/30/07. Based on an 8 hour work day, there are approximately 1552 working hours available over the course of 1949 working days through 08/30/07; **EXPECTED RATE OF COMPENSATION:** This position should be for a Senior-Level Developer at an estimated rate of $65 per hour or $520 per day; **METHOD OF ACCOUNTABILITY:** This consultant will report for daily work within the ISDH PHIN Coordination Section of the PHPER division. Timesheets are verified and signed by division managers weekly or bi-weekly for review prior to employee's submission to Vendor for invoicing to the ISDH.
13	**TBD** - Interface Developer - **TBD**	194	$560		$108,640	IT		Selected from the IN State Dept. of Administrations Temporary Technical Services Quantity Purchase Award List. The QPA are competitive bid contracts managed by the Indiana Department of Administration that provide specified services for specified periods of time, at specified prices: **NAME OF CONSULTANT:** TBD; **ORGANIZATIONAL AFFILIATION:** TBD; **NATURE OF SERVICES TO BE RENDERED & RELEVANCE OF SERVICE TO PROJECT:** There are major requirements to pass data between

								the applications running in the six functional PHIN Certification areas. Rather than develop them individually we need to design a global approach for providing access to the data and then implement it in each of the six areas. We need to have a senior technician with both database administration (DBA) and application development skills. This person will design an overall approach for interfacing between the various application systems and then work with each of the functional areas on the detailed interfaces.; **NUMBER OF DAYS OF CONSULTATION:** This is a new consultant which we will have to post, interview, and select a qualified candidate for. Therefore it is anticipated that the identified candidate will not begin until 12/01/06 and extend through 08/30/07. Based on an 8 hour work day, there are approximately 1552 working hours available over the course of 1949 working days through 08/30/07; **EXPECTED RATE OF COMPENSATION:** This position should be for a Senior-Level position at an estimated rate of $70 per hour or $580 per day; **METHOD OF ACCOUNTABILITY:** This consultant will report for daily work within the ISDH PHIN Coordination Section of the PHPER division. Timesheets are verified and signed by division managers weekly or bi-weekly for review prior to employee's submission to Vendor for invoicing to the ISDH.
14	**TBD** - Vaccine Distribution System (CRA) developer - **TBD**	194	$520		$100,880	IT		Selected from the IN State Dept. of Administrations Temporary Technical Services Quantity Purchase Award List. The QPA are competitive bid contracts managed by the Indiana Department of Administration that provide specified services for specified periods of time, at specified prices: **NAME OF CONSULTANT:** TBD; **ORGANIZATIONAL AFFILIATION:** TBD; **NATURE OF SERVICES TO BE RENDERED & RELEVANCE OF SERVICE TO PROJECT:** As part of our Countermeasure Response Administration (CRA) we need to have a PHIN compliant vaccine management system. We currently have an application and the CDC has a new application they will provide us. We need a contractor to work with us on evaluating of our current application and the new CDC system. Based upon this analysis, we will need to implement the recommendation. We need a senior Web developer with strong analytical skills that can provide the analysis required to deliver and implement recommendations on a Vaccine Management system. This person will then need to implement the recommendation. We need a senior developer that is familiar with VB.net and Oracle.;

								NUMBER OF DAYS OF CONSULTATION: This is a new consultant which we will have to post, interview, and select a qualified candidate for. Therefore it is anticipated that the identified candidate will not begin until 12/01/06 and extend through 08/30/07. Based on an 8 hour work day, there are approximately 1552 working hours available over the course of 194 working days through 08/30/07; **EXPECTED RATE OF COMPENSATION:** This position should be for a Senior Level Developer at an estimated rate of $65 per hour or $520 per day; **METHOD OF ACCOUNTABILITY:** This consultant will report for daily work within the ISDH PHIN Coordination Section of the PHPER division. Timesheets are verified and signed by division managers weekly or bi-weekly for review prior to employee's submission to Vendor for invoicing to the ISDH.
15								
	Totals			**$4,000**	**$1,216,560**			

	Financial Assistance: Other		**Detail**		
Item #	**Item Description**	**$ Requested**	**Sub-category**	**Org ID**	**Budget Justification**
1	CRA System Development Scanning/OCR/ICR software		$10,000		We have completed a preliminary study to establish the scope of our CRA effort. We are focusing on two areas. First, we will develop a paper form and use scanners to capture the medication dispensed. This will be a "back office" function that utilizes ICR / OCR technology to create data files which will be consolidated centrally. Second we will upgrade our existing STC software to make it PHIN compliant. We will need software to batch ICR / OCR data capture. The software will include tools to design / layout forms for data capture. We will also need workflow or some customization to support our process flow. We are projecting this software will cost $10,000.
2	Webinar capabilities - Adobe bundle Software (3 Licenses @ $1,899 each) and Run-Time licenses (100 @$50 each)		$10,697		We have a need to provide ongoing training to our local Health Departments and hospitals. This is critical to the expansion of our volunteer (ESAR-VHP) and communication (IHAN) programs. We want to develop Webinar capabilities and also include these capabilities at our Disaster Recovery Site and Recovery Area to supplement current communication procedures. Our direction will be to use Breeze for our Webinar broadcasts. Breeze is included as part of the Adobe Web bundle. This will provide us with all the tools needed to establish a Webinar environment and create presentations. We are requesting three copies of the software (development, production and Disaster Recovery site) and 100 runtime licenses for a total of $10,697

3	Microsoft Visual Source Safe software (7 @ $124 each)		$868		As part of our efforts to accelerate PHIN certification, we are bringing in additional contractors. We need establish a development environment for them which will require additional copies of Microsoft Visual Studio and Source Safe. We will need seven copies of Visual Studio and Source Safe to support the application developers we are bringing in to support PHIN certification. The cost for this allocation is based on the actual cost of $124 per license based on a recent purchase of this software for the permanent PHIN related positions here at ISDH.
4	Microsoft Visual Studio Professional 2005 (7 @ $349 each)		$2,443		As part of our efforts to accelerate PHIN certification, we are bringing in additional contractors. We need establish a development environment for them which will require additional copies of Microsoft Visual Studio and Source Safe. We will need seven copies of Visual Studio and Source Safe to support the application developers we are bringing in to support PHIN certification. The cost for this allocation is based on the actual cost of $349 per license based on a recent purchase of this software for the permanent PHIN related positions here at ISDH.
5	Phone and Data Service for 15 IT Consultants ($36.75/month x 15 x 10 months)		$5,513		The cost allocation for this is based on an average monthly cost of $36.75 per month for local and long distance phone service, voicemail, and network access per ISDH PHPER program staff or consultant stationed at ISDH & the ISDH Central Laboratory.
6	Outlook & Exchange Email Service Fees for 15 Consultants ($4.18 per month x 10 months x 15 consultants)		$627		As part of the Information Technology services consolidation that is occurring throughout State government here in Indiana as a means of saving money by purchasing software and services at a reduced cost due to quantity purchased, some standardized software is being purchased and then allocated back to programs within each agency. One such software used is MS Exchange for Outlook email capability. The cost for this allocation is based on the standardized rate of $4.18 per month multiplied by the number of full time equivalent staff and consultants (15 consultants for a period of 10 months).
7	IOT Server hosting Fees for 2 of 3 Webinar servers (Production & Test) ($250/mo. x 10 months x 2 servers)		$5,000		As part of the Information Technology services consolidation that is occurring throughout State government here in Indiana, The majority of hardware is required to be maintained in a central location in order to perform maintenance, repairs, ensure functionality, and disaster recovery to State Agencies throughout the state. The cost for this allocation is based on a fixed cost of $250 per month per server, and estimating that hosting fees for this fiscal year will only be for 10 months since the fees will not occur until after the equipment is procured, received, and installed.
8	Rent Allocation for PHIN Consultants ($324.75/mo. x 10 mo. x 15 consultants)		$48,713		We are requesting funds to cover the Rent allocation for the IT Consultants that we will be hiring temporarily to fast-track installation of the IN LIMS, as well as PHIN Certify a number of IT systems. During their employment period they will be stationed in the 2 N. Meridian facilities in which the Public Health Preparedness program will be allocated a portion of the rent similarly to the rent allocation that occurs to all other programs within the Indiana State Department of Health. The allocation is usually charged to the various programs on a monthly basis, thus creating 12 monthly payments for the period of 08/31/06 through 08/30/07. The CDC Public Health Preparedness program's costs were determined based on calculating the percentage of positions In-House and field within each division within the agency that exists to determine the percentage of chargeable positions within the whole. That percentage is then multiplied to the total lease agreement amount to determine a cost associated with each division. Finally the division cost is proportioned out to each of

					the various agency programs based on the number of positions a program has working within the division that utilize the 2 N. Meridian Facilities. The CDC Public Health Preparedness programs cost per position equates to approximately $324.75 per month per position.
9	Parking Allocation for PHIN Consultants ($64.17/mo. x 10 mo. x 15 consultants)		$9,626		We are requesting funds to cover the parking lease allocation for the IT Consultants that we will be hiring temporarily to fast-track installation of the IN LIMS, as well as PHIN Certify a number of IT systems. Similar to facility and work space leases the Indiana State Department of Health leases parking space from a property owner in Downtown Indianapolis, and contracts with that vendor to provide shuttle service from the parking lot to the agency which is approximately a mile away. Using similar methodology to the rent allocation, a percentage of the Parking services agreement is charged back to the Public Health Preparedness program based on the number of positions/consultants within that program. The allocation is usually charged to the various programs on a monthly basis in alignment with the State Fiscal year, thus creating 12 quarterly payments during the budget cycle to cover the period of 08/31/06 through 08/30/07. The CDC Public Health Preparedness program's cost was determined based on determining the percentage of positions within each agency division that exist to determine the percentage of chargeable positions within the whole agency. That percentage is then multiplied to the total Parking agreement amount to determine a cost associated with each division. Finally the division cost is proportioned out to each of the various agency programs based on the number of positions that program has working in each division. The CDC Public Health Preparedness program's portion of the annual parking agreement works out to approximately $64.17 monthly per position.
10	Avian Flu call center - monthly phone line costs for 12 lines ($25.76/line x 12 lines x 12 months)		$3,709		Basic Land line phone service fees for telephones used to stage for risk and public health communications in the event of an influenza pandemic. Dedicated lines will need to be maintained as active and will be used to support equipment that will be used by ISDH staff and volunteer health professionals to alert and respond to communications to and from medical professionals and the general public regarding the steps to take in the event of a pandemic and with other information relevant to a response and recovery. Service lines will augment existing agency service lines without surging or occupying lines dedicated to the Department Operations Center for event emergency response and emergency responders. The cost for this service is based on the basic monthly cost of $36.75 per line (12 lines) per month.
11	IT Help Desk Support, Microsoft Office, & McAfee Anti-virus Cost Allocation ($79.92 per month x 10 months x 15 consultants)		$11,988		As part of a statewide consolidation of IT functions and resources, all ITS network support functions and LAN support functions will become centralized under the Indiana Office of Technology (IOT). Therefore, rather than having an individual staff member at ISDH, we will pay an annual fee of $959 per position (approximately $79.91 monthly) and consultant within the agency. This fee includes help desk support, Microsoft Operating System software, Microsoft Office, and Mc Afee Anti-virus software. The cost for this allocation was determined by multiplying the monthly cost of $79.91 by the number of IT consultants that we are adding as part of this budget for the period they will be on staff (estimated at 10 months).

12	Warehousing and Storage space modification			$7,800		We are requesting funds to modify and add security specifications to our current storage facility to incorporate additional space needed for PPE Pallet storage and SNS distribution exercise materials. The cost for this line item was based on a quote received from the ISDH Director of Administrative Services to include fencing, motion detectors, and cameras for security purposes. These measures are necessary as the facility is used for other storage and is accessible by multiple state agencies. Utilizing these extra measures will ensure that these materials are not tampered with, and that the materials are used only for Public Health preparedness and emergency response activities.
13						
	Totals		**$116,984**			

	Financial Assistance: Indirect		Detail		
Item #	**Item Description**	**$ Requested**	**Sub-category**	**Org ID**	**Budget Justification**
1	Pandemic Influenza Preparedness Phase 2 Indirect Costs	$166,463	Pandemic Influenza		Indiana's current indirect cost rate is 11.5%, charged against a direct cost base. This base excludes equipment, contracts and renovations. A copy of our current Indirect Cost Rate Proposal is on file in the Procurement and Grants office at CDC, and was attached to our primary CDC cooperative agreement application as "Appendix I." This rate is in effect through 06/30/07, and is anticipated to be the same rate from 07/01/07-08/30/07. However if the new rate is changed, proper notification and budget reallocation will be submitted to CDC accordingly.
	Totals	**$166,463**			

2005 Progress Report for Phase 1 Pandemic Flu for Indiana

Privileged Communication
Centers for Disease Control and Prevention
Public Health Preparedness and Emergency Response for Bioterrorism
Program Announcement AA154
Report Date: 9/6/2006 Grantee: Indiana

Pan Flu Progress Assessment

Question #	Question Text	Answer
1	**Please report on progress achieved in each of the following areas:**	
1A	**Establishment of Pandemic Influenza Coordinating Committee:**	

The ISDH and the Indiana Department of Homeland Security have collaborated and established a Pandemic Influenza Coordinating Committee. The committee structure is developed, and individual members are in the process of being named. In the interim, the ISDH immediately utilized the Strategic Advisory Committee established for general preparedness to support multi-disciplinary pandemic influenza planning and coordination and to serve as the PICC. This committee meets quarterly and is comprised of representatives from not-for-profit organizations and multiple state and local agencies, including public health, public safety, emergency management, mental health, hospitals, pharmacy and medical schools, nursing schools, public education and schools, public health associations, rural health associations, and so on. This committee has reviewed the pandemic influenza guidance and made recommendations for planning activities designed to fill gaps in preparedness. ISDH also utilizes the State's Counter Terrorism and Advisory Council (CTASC) for policy development related to multi-disciplinary state planning and response. The CTASC is chaired by the Lt. Governor, and its membership is composed of a state senator and state representative, and state, local and federal agency heads including representatives from the United States Attorney's Office, the Transportation Safety Agency, public health, environmental management, animal health, law enforcement, emergency management, and the like. The CTASC has reviewed the state's coordinated multi-disciplinary draft pandemic influenza plan, and is scheduled to discuss and vote to adopt that plan at its next meeting. These established committees flexed at the request of the State Health Commissioner and the Governor to take on the role of coordinating for pandemic influenza.

1B	**Integration with Other Entities:**	

The ISDH meets bi-weekly with other state agency emergency planners and responders to coordinate pandemic influenza planning and exercises. These include state homeland security, state police, natural resources, animal health, and the like. Together, these agencies have collaborated on a draft state pandemic influenza plan that will be presented to the larger Counter Terrorism and Security Council chaired by the Lt. Governor, where it will be adopted as state policy. The ISDH has requested that all 94 local health departments in the state prepare local pandemic influenza plans that support the ESF8. Eighty-seven of those agencies have done so by August 30, 2006. The Indiana Department of Homeland Security has required all 92 county emergency management agencies to collaborate with the local health departments and incorporate their local public health plans into a county pandemic influenza emergency response plan. Both the ISDH and the IDHS provided local partners with a template for their plans. The ISDH and local health departments have partnered with local

community leaders, businesses and other entities and held local summits and town halls for purposes of energizing local communities to prepare for a pandemic. All 94 local health departments have partnered with local emergency response partners and hospitals and conducted tabletop exercises utilizing a pandemic influenza scenario. The ISDH has partnered with state mental health, the Indiana Hospital Association, and the Indiana Healthy and Hospice Association to begin planning and implementing alternate care sites. Other partnerships are ongoing and being developed.

1C	Working with Tribes (if applicable):

Not applicable

1D	Dissemination of funds to Local Public Health:

The ISDH distributed the majority of funds to local health departments in the form of direct assistance. This included funding 94 local health department exercises, funding the development of a gap analysis for each local health department and their jurisdictions, funding the development of local pandemic influenza plans in all 94 local health departments, producing and airing throughout the state a public service announcement on preparing for and mitigating the threat of a pandemic influenza, purchasing PPE for local distribution, purchasing volunteer credentialing hardware and software for local distribution, purchasing mobile communications gear for local distribution, and supporting local pan flu summits and town hall meetings through development and dissemination of a pan flu educational tool kit with forms and power point slides and other resources for the local health department and community. Eighty-seven of the 94 local health departments have a pandemic influenza plan and have now exercised their plan or some component of their plan or planning. The remaining seven jurisdictions have also participated in pandemic influenza exercises of their planning, and are continuing to develop their plans. All 94 local health departments have submitted their local assessments. All 94 local health departments have been provided with a local gap analysis that identifies key gaps and key strategies to close those gaps. The ISDH also provided financial assistance in grants of $2,000 each to all 94 local health departments for local assessment activities and to fill immediately identified gaps, and in additional funds to support the supplies and materials to convene local pan flu summits. All of these uses were suggested by a majority of the local health departments after collaboration with the ISDH.

1E	Collaboration Across State, Tribal, Military, and International Borders:

The ISDH has held one multi-state tabletop exercise utilizing a pandemic influenza scenario. The ISDH and local health departments within Indiana counties that are in the Cincinnati (Ohio), Chicago (Illinois) and Louisville (Kentucky) CRI jurisdictions have met with and initiated planning with those border states regarding pandemic influenza surveillance and response. Discussions have included collaborating on the purchase and use of anti-virals in those jurisdictions. The ISDH epidemiology and preparedness nursing staff have participated in conference calls with Canadian border states and in meetings to collaborate on international border planning.

2005 Cooperative Agreement Progress Report – Pan Flu Phase 1 Mid-Year Progress Report

Privileged Communication
Centers for Disease Control and Prevention
Public Health Emergency Preparedness
Program Announcement AA154
Report Date: 9/6/2006
Grantee: Indiana

Pan Flu

Pandemic Influenza

Outcome 15A: Pandemic Influenza

15A::CT1: Conduct a Pandemic Influenza Preparedness Summit to facilitate community-wide planning efforts throughout the recipient jurisdiction. Note that the Summits currently being convened by the respective Governors and the Secretary of the United States Department of Health and Human Services (HHS) satisfy this requirement. If a recipient has already held a summit with HHS, an additional summit is not required. The costs of the summits held prior to the official notice of award for funds can be charged to the supplemental allocation.

Est. Completion Date:	03/23/2006
Activity Status:	Completed
Percent Complete:	100%
Grantee Activity Id:	76519
Grantee Activity:	The Governor of Indiana, the Indiana Department of Homeland Security, and the Indiana State Department of Health hosted a Statewide Pandemic Influenza Preparedness Summit on March 23, 2006, at Purdue University. The summit brought together more than 400 leaders from the public and private sector in public health, healthcare, public safety, business, education, human services and other sectors.
Grantee Activity Progress:	The Governor of Indiana, the Indiana Department of Homeland Security, and the Indiana State Department of Health hosted a Statewide Pandemic Influenza Preparedness Summit on March 23, 2006, at Purdue University. The summit brought together more than 400 leaders from the public and private sector in public health, healthcare, public safety, business, education, human services and other sectors.
Barriers:	This was a joint funded endeavor between the Indiana Governor's Office, the Indiana Department of Homeland Security, and the Indiana State Department of Health. Although we were part of the coordination

	of this Summit, we were not the point of contact with the vendor hosting the conference. As a result there has been some difficulty in working through the logistical and payment issues associated with this summit. No claims have been submitted at this time.
Evaluation Progress:	Evaluation plan was not a requirement of the application. Activity is 100% complete. The state summit was followed by contact with community and business leaders including elected officials in attendance. Additional local summits were requested across the state. The ISDH developed a tool kit and provided those resources to 94 local health departments for presentation of local summits to mirror the state summit. To date, 263 local meetings have been held with more than 9,000 in attendance. Four additional meetings are scheduled. Additional meetings are desired and requested. Local education and information has been identified as a primary gap. Pan Flu 2 funds will be dedicated to continuing this activity.

15A::CT2: Exercise the state/territory-level pandemic influenza preparedness plan and prepare an After-Action Report (AAR) highlighting necessary corrective actions. (Los Angeles County, New York City, Chicago and the District of Columbia should exercise and prepare an AAR regarding their respective municipal-level plans). Note that this information will be pertinent to the performance-based allocation later this year of the $250 million remaining in the emergency supplemental appropriation for state and local pandemic influenza preparedness.

Est. Completion Date:	08/30/2006
Activity Status:	Completed
Percent Complete:	100%
Grantee Activity Id:	76520
Grantee Activity:	The ISDH and its various partners have exercised components of the state's pandemic influenza plan and/or planning no fewer than eight (8) times. These exercises have been local or district (regional) exercises that test both local pandemic influenza plans and planning through local agency participation, and the state's plan and planning through state agency participation. On each occasion the ISDH participated in or conducted an AAR of the exercise on the same day. Three (3) of these exercises were conducted by a vendor who provided an immediate oral AAR review as part of the exercise, and were not followed with a written AAR report. With the exception of the most recent exercise, the remaining exercises were followed by a written AAR report well within the CDC target of sixty (60) days. The most recent exercise occurred on March 30, 2006. The ISDH is preparing a draft AAR report of that exercise, and anticipates that it will be completed on or before Friday, April 14, 2006, well within the CDC target of sixty (60) days. The ISDH is currently planning a statewide tabletop pandemic influenza exercise for April 26, 2006. This exercise will test both the state and local plans and/or planning. A written AAR report will be completed within sixty (60) days of the exercise as required by the CDC. The local health departments within Indiana Homeland

	Security District 1 are currently planning a district tabletop pandemic influenza exercise for May 18, 2006. The ISDH will participate to test the state plan and/or planning as part of this exercise, and will prepare an AAR report within sixty (60) days of the exercise as required by the CDC. The ISDH is planning 10 additional district level exercises that will test the state and all local health department pandemic influenza plans prior to August 30, 2006.
Grantee Activity Progress:	The ISDH completed a state pandemic influenza exercise and a multi-state pandemic influenza exercise. All 94 local health departments have completed pandemic influenza exercises in 10 district tabletop scenarios. All exercises have been followed by an After Action Review and AAR report.
Barriers:	No barriers were encountered with this activity.
Evaluation Progress:	Evaluation plan was not a requirement of the application. Project is being evaluated by review of AARs and progress reports submitted by vendors, and through participation in exercises and activities.

15A::CT3: Update, as necessary, the assessment submitted with the application. In addition, States and Territories must compile and analyze local-level assessment resulting from the use of the Local Pandemic Influenza Assessment Tool in Attachment 4. Note that this information will be pertinent in receipt of performance-based allocations later this year of the $250 million remaining in the emergency supplemental appropriation for State and Local pandemic influenza preparedness.

Est. Completion Date:	08/30/2006
Activity Status:	Completed
Percent Complete:	100%
Grantee Activity Id:	76521
Grantee Activity:	The ISDH is submitting the state self assessment with its grant application. The ISDH has prepared and is submitting a gap analysis with its grant application. The ISDH will update the state's self assessment as work supported by this grant progresses to close the state's gaps and enhance its preparedness. The ISDH has distributed the CDC local assessment tool to all 94 local health departments in Indiana with a request that the local health departments prepare the assessment for submission to the state and to the CDC on or before August 30, 2006. The ISDH will utilize ISDH staff to assist local health departments prepare the assessment. The ISDH proposes to use Pan flu Supplemental funding to support consultants to prepare and/or assist local health departments in preparing a detailed gap analysis with strategies for closing gaps in their local pandemic influenza plans and planning. The ISDH proposes to further use Pan flu Supplemental funding to support a consultant to prepare and/or assist local health departments in preparing or refining local pandemic influenza plans. The ISDH proposes to use Pan flu Supplemental funding to support a consultant to conduct district exercises involving all 94 local health departments and local health

	department pandemic influenza plans and planning. The ISDH proposes to use Pan flu Supplemental funding to provide financial assistance to each of Indiana's 94 local health departments to enable them to purchase products or services to further assist in building plans and capacity for a pandemic influenza response. Such assistance will be conditioned upon goods or services closing local gaps as identified in the local assessments.
Grantee Activity Progress:	Local Self-Assessments for all 94 Counties were completed and submitted to ISDH for completion of the Gap analysis project. All 94 were submitted to the vendor identified to complete formal Gap Analysis and submitted to ISDH by 08/30/06. The ISDH, Public Health Preparedness and Emergency Response Business Manager has uploaded copies of all Local Level Assessments into the MIS "Grant Management - Miscellaneous Attachments" section, organized by Indiana's 10 Homeland Security districts. In addition a copy of the State Self-assessment and Gap Analysis were also uploaded into the aforementioned area of the MIS. The Purdue Homeland Security Institute contract, for completion of the Pandemic Influenza tabletop exercises for all 10 of Indiana's homeland security district's, was fully executed, and all exercises complete as of 08/24/06. Counties throughout Indiana have been completing Local level summits/townhall meetings on Pandemic Influenza preparedness for public education purposes, presenting information to local government, business partners, collaborating preparedness personnel, faith based organizations, as well the general public. Funds for completion of local summits are being disbursed as claims are received from Local Health Departments, to cover the costs of educational materials distributed during those meetings, and with adequate documentation to ensure levels of participation during each presentation. 100% of identified Local Health Department funding for completion of the Local Self-assessment and to initiate further planning and preparation for filling identified preparedness gaps has been disbursed. These funds must be used by the LHDs to purchase materials and resources needed to plan for local response to the pandemic. Dr. Bailey's contract has been fully executed. He has developed a template for the Local Health Departments (LHDs)throughout the state to used in preparing the Pandemic Influenza chapters of their Emergency Response all-hazards operational plans. He has traveled throughout the state to present this template to LHDs in each of the 10 districts, has been assisting LHDs in completing their draft plans, and is currently assessing the level of plan completion within each district. Eighty-seven of 94 local health departments have pandemic influenza plans utilizing this template or another planning document. The remaining seven are in the process of developing written plans.
Barriers:	No barriers were encountered with this activity.

Evaluation Progress:	Evaluation plan was not a requirement of the application. Project is being evaluated by review of AARs and progress reports submitted by vendors, and through participation in exercises and activities. Consultant supporting local pan flu planning met daily with ISDH program staff. ISDH conducted site visits with vendor preparing gap analysis, and received a mid-project briefing.

15A::CT4: Initiate and catalyze the development and exercising of pandemic influenza preparedness plans for local communities within the recipient jurisdiction. Public health authorities should enlist representatives of all major sectors of the respective communities to this end. (A single community-wide plan will suffice for Los Angeles County, New York City, Chicago, and the District of Columbia).

Est. Completion Date:	08/30/2006
Activity Status:	Completed
Percent Complete:	100%
Grantee Activity Id:	76522
Grantee Activity:	The ISDH is currently planning a statewide tabletop pandemic influenza exercise for April 26, 2006. This exercise will test both the state and local plans and/or planning. The local health departments within Indiana Homeland Security District 1 are currently planning a district tabletop pandemic influenza exercise for May 18, 2006. The ISDH proposes to use Pan flu Supplemental funding to support a consultant to prepare and/or assist local health departments in preparing or refining local pandemic influenza plans. The ISDH proposes to use Pan flu Supplemental funding to support a consultant to conduct district exercises involving all 94 local health departments and local health department pandemic influenza plans and planning. The ISDH is planning 10 additional district level exercises that will test the state and all local health department pandemic influenza plans prior to August 30, 2006.
Grantee Activity Progress:	The state and multi-state exercises were completed as scheduled. The Purdue Homeland Security Institute contract, for completion of the Pandemic Influenza tabletop exercises for all 10 of Indiana's homeland security district's, was fully executed, and all exercises complete as of 08/24/06. All exercises have AARs. Dr. Bailey's contract has been fully executed. He has developed a template for the Local Health Departments (LHDs)throughout the state to used in preparing the Pandemic Influenza chapters of their Emergency Response all-hazards operational plans. He has traveled throughout the state to present this template to LHDs in each of the 10 districts, has been assisting LHDs in completing their draft plans. Eighty-seven of 94 local health departments have pandemic influenza plans. The remaining seven are preparing written plans.

Barriers:	No barriers were encountered in this activity.
Evaluation Progress:	Evaluation plan was not a requirement of the application. Project is being evaluated by review of AARs and progress reports submitted by vendors, and through participation in exercises and activities.

15A::CT5: Determine whether to purchase antiviral drugs in concert with HHS and, if so, report to the CDC Project Officer by July 1, 2006, the number of treatment courses that the recipient wishes to acquire in this manner. Note that most or all of the recipient's purchase will be eligible for a 25% subsidy by HHS.

Est. Completion Date:	08/01/2006
Activity Status:	Completed
Percent Complete:	100%
Grantee Activity Id:	76523
Grantee Activity:	The ISDH is consulting with an internal Pandemic Influenza Planning Committee convened by the State Health Commissioner to determine whether to purchase antiviral drugs in concert with HHS and at what amount. The ISDH will report its decision to Indiana's CDC project officer on or before July 1, 2006.
Grantee Activity Progress:	Indiana did decide to participate in the HHS Anti-Viral purchase program. As required, our letter of intent was generated identifying our Entity Authorizing Agent, Ordering Officer, and Alternative Ordering Officer. It also identified Indiana's intent to purchase 585,821 doses of Tamiflu, and 65,091 doses of Relenza at the subsidized rate. This letter was mailed to Ms. Rose Mary Mann on July 21, 2006, and an email confirming receipt of our letter was received from Ms. Mann on 07/27/06. A copy of this letter was also emailed to Mr. John Scott, and Mr. Keesler King on 07/21/06, which was acknowledged by an email from Mr. King the same day.
Barriers:	No barriers were encountered with this activity.
Evaluation Progress:	Evaluation plan was not a requirement of the application. Activity is 100% complete. CDC accepted submission without further requirements.

15A::CT6: Identify loci throughout the jurisdiction in which the recipient plans to pre-position antiviral drugs if an influenza pandemic were judged imminent – e.g., hospitals, skilled nursing facilities, community health centers, and pharmacies. Note that antiviral drugs will be most effective if used promptly to treat victims of an influenza pandemic and thus need to be pre-positioned at or near healthcare sites at some appropriate time before the onset of the pandemic.

Est. Completion Date:	08/30/2006
Activity Status:	In Progress
Percent Complete:	greater than 75%
Grantee Activity Id:	76524
Grantee Activity:	The ISDH is consulting with an internal Pandemic Influenza Planning Committee convened by the State Health Commissioner to determine locations throughout the state to pre-position antiviral drugs if an influenza pandemic were judged imminent â€“ e.g., hospitals, skilled nursing facilities, community health centers, and pharmacies. The ISDH is working to convene an external Pandemic Preparedness Coordinating Committee with representation from all relevant stakeholders to further support this effort. The ISDH will work with the state's Bio Terrorism Advisory Committee and Hospital Planning and Preparedness Committee to identify locations for this effort. The ISDH will determine whether sites require support and security for pre-positioning anti-virals, and will identify strategies and funding sources to provide any required enhancements.
Grantee Activity Progress:	ISDH has established committee to review purchase, pre-positioning and distribution considerations. ISDH has identified purchasing personnel, and has submitted letter to CDC indicating intent to procure full allotment. ISDH has secured a storage location for receipt and staging of anti-virals. ISDH is negotiating with partners to identify sites for pre-positioning anti-virals. ISDH has convened pandemic influenza planning committee to address ongoing issues with procurement, pre-positioning, and distribution. ISDH has developed a summary timeline for development of the anti-viral distribution plan.
Barriers:	Uncertainty created by changing direction and delayed negotiations with vendor regarding availability of anti-virals have delayed partnerships to establish sites for pre-positioning anti-virals within state. Need additional guidance and standards regarding pre-positioning, storage requirements, security requirements, and distribution.
Evaluation Progress:	Evaluation plan was not a requirement of the application.

15A::CT7: Develop a plan for allocating among those pre-positioning loci the recipient's share of the cache of antiviral drugs maintained in the Strategic National Stockpile (SNS). Note that each recipient will be allocated a share of the total of 20 million treatment courses that HHS intends to acquire for the recipients at no cost to them. Also, any particular recipient can acquire additional antiviral drugs from the pertinent vendor(s) in concert with HHS.

Est. Completion Date:	08/30/2006
Activity Status:	In Progress

Percent Complete:	greater than 75%
Grantee Activity Id:	76525
Grantee Activity:	The ISDH is consulting with an internal Pandemic Influenza Planning Committee convened by the State Health Commissioner to plan for the allocation of pre-positioned antiviral drugs if an influenza pandemic were judged imminent. The ISDH is working to convene an external Pandemic Preparedness Coordinating Committee with representation from all relevant stakeholders to further support this effort. The ISDH will also work with the state's Bio Terrorism Advisory Committee and Hospital Planning and Preparedness Committee to support this effort. The ISDH has identified a consultant to conduct two conferences with relevant stakeholders on ethical considerations in a pandemic influenza response, including addressing the allocation of scarce resources such as anti-virals. These sessions are scheduled for April 26. 2006, and May 10, 2006.
Grantee Activity Progress:	ISDH has held two sessions on ethical considerations regarding purchase, pre-positioning and distribution of anti-virals. ISDH has established committee to review purchase, pre-positioning and distribution considerations. ISDH has identified purchasing personnel, and has submitted letter to CDC indicating intent to procure full allotment. ISDH has secured a storage location for receipt and staging of anti-virals. ISDH is negotiating with partners to identify sites for pre-positioning anti-virals. ISDH has developed a summary timeline for development of the anti-viral distribution plan.
Barriers:	Uncertainty created by changing direction and delayed negotiations with vendor regarding availability of anti-virals have delayed partnerships to establish sites for pre-positioning anti-virals within state. Need additional guidance and standards regarding pre-positioning, storage requirements, security requirements, and distribution.
Evaluation Progress:	Evaluation plan was not a requirement of the application.

APPENDIX A – SF 424: Application For Federal Assistance

Version 7/03

APPLICATION FOR FEDERAL ASSISTANCE

2. DATE SUBMITTED 09/06/06	**Applicant Identifier** *3610/103200:* PS Project 400361010320070
3. DATE RECEIVED BY STATE	**State Application Identifier**
4. DATE RECEIVED BY FEDERAL AGENCY	**Federal Identifier** U90/CCU517024-07

1. TYPE OF SUBMISSION:

Application	Pre-application
[ ] Construction	[ ] Construction
[X] Non-Construction	[ ] Non-Construction

5. APPLICANT INFORMATION

Legal Name: Indiana State Department of Health	**Organizational Unit:**
Organizational DUNS: 82-479-9407	**Department:** Indiana State Department of Health
Address:	**Division:** Public Health Preparedness & Emergency Response (PHPER)
Street: 2 N. Meridian Street, 6F	**Name and telephone number of the person to be contacted on matters involving this application *(give area code)*:**
City: Indianapolis	**Prefix:** Mr. / **First Name:** Michael
County: Marion County	**Middle Name:** A.
State: Indiana / **ZIP:** 46204	**Last Name:** Hurst
Country: United States of America	**Suffix:**
6. EMPLOYER IDENTIFICATION NUMBER *(EIN)*: 3 5 -- 6 0 0 0 1 5 8	**Phone Number *(give area code)*:** (317) 234-3545 / **FAX Number *(give area code)*:** (317) 233-7873

8. TYPE OF APPLICATION:

[ ] New [ ] Continuation [X] Revision

If Revision, enter appropriate letter(s) in box(es): [A] [ ]
(See back of form for description of letters)
Other *(specify)*: **Supplement**

7. TYPE OF APPLICANT *(See back of form for Application Types)*
State
Other *(specify)*:

9. NAME OF FEDERAL AGENCY:
Department of Health & Human Services, Centers for Disease Control and Prevention

10. CATALOG OF FEDERAL DOMESTIC ASSISTANCE 9 3 . 2 8 3
TITLE: Centers for Disease Control & Prevention_Investigations and Technical Assistance

11. DESCRIPTIVE TITLE OF APPLICANT'S PROJECT:
Public Health Preparedness and Emergency Response_Phase 2 Pandemic Influenza

12. AREAS AFFECTED BY PROJECT *(cities, counties, states, etc.)*:
Statewide

13. PROPOSED PROJECT:

Start Date:	Ending Date:
08/31/2006	08/30/2007

14. CONGRESSIONAL DISTRICTS OF:

a. Applicant:	b. Project:
Tenth	State of Indiana

15. ESTIMATED FUNDING:

a.	Federal	$ 4,601,761 .00
b.	Applicant	$ .00
c.	State	$ .00
d.	Local	$ .00
e.	Other:	$ .00
f.	Program Income	$ .00
g.	TOTAL	$ 4,601,761 .00

16. Is Application Subject To Review By State Executive Order 12372 Process?

a. [ ] YES. This Preapplication/Application was made available to the State Executive Order 12372 Process for review on:

DATE: _____

b. [X] NO. Program is not covered by E.O. 12372
OR Program has not been selected state for review

17. IS APPLICATION DELINQUENT ON ANY FEDERAL DEBT?

[ ] YES If "Yes," attach an explanation [X] NO

18. TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL DATA IN THIS APPLICATION/PREAPPLICATION ARE TRUE AND CORRECT. THE DOCUMENT HAS BEEN DULY AUTHORIZED BY THE GOVERNING BODY OF THE APPLICANT, AND THE APPLICANT WILL COMPLY WITH THE ATTACHED ASSURANCES IF THE ASSISTANCE IS AWARDED.

a. Authorized Representative

Prefix	**First Name** Sue	**Middle Name** E.
Last Name Uhl		**Suffix**
b. Title Deputy State Health Commissioner		**c. Telephone Number (give area code)** (317) 233-7102
d. Signiture of Authorized Representative Sue Uhl		**e. Date signed** 9/6/2006

Indiana State Department of Health
Public Health Preparedness & Emergency Response –
Pandemic Influenza Supplemental Funding
08/31/06 through 08/30/07

APPENDIX B – SF 424A:
Budget Information – Non-Construction Programs

OMB Approval No. 0348-0044

BUDGET INFORMATION - Non-Construction Programs

SECTION A - BUDGET SUMMARY

Grant Program Function or Activity (a)	Catalog of Federal Domestic Assistance Number (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal (e)	Non-Federal (f)	TOTAL (g)
1. U90/CCU517024-07 **FA**	93.283	$ 0	$	$ 14,333,573	$ 0	$ 14,333,573
2.	93.283	0	0	**4,601,761**	0	**4,601,761**
3. U90/CCU517024-07 **DA**	93.283	0	0	13,203	0	13,203
4.		0	0	0	0	0
5. TOTALS		$ 0	$ 0	$ 18,948,537	$ 0	$ 18,948,537

SECTION B - BUDGET CATEGORIES

6. Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY				TOTAL
	(1) **Base**	(2) **CRI**	(3) **PAN FLU**	(4)	(5)
A. Personnel	$ 3,613,178	$ 40,421	$ **46,803**	$	$ 3,700,402
B. Fringe Benefits	1,335,835	19,344	**19,859**		1,375,037
Consultants	494,440	0	**1,216,560**		1,711,000
C. Travel	257,809	0	**0**		257,809
D. Equipment	664	0	**364,650**		365,314
E. Supplies	236,511	0	**47,300**		283,811
F. Contractual	4,824,423	598,071	**2,623,143**		8,045,637
G. Construction	0	0	**0**		0
H. Other	1,993,866	0	**116,984**		2,110,850
I. Total Direct Charges (sum of 6A-6H)	$ 12,756,725	$ 657,836	$ **4,435,298**	$ 0	$ 17,849,859
J. Indirect Charges	912,138	6,873	**166,463**		1,085,474
K. TOTALS (sum of 6 I and 6 J)	$ 13,668,864	$ 664,709	$ **4,601,761**	$ 0	$ 18,935,334
7. Program Income	$ 0	$ 0	$ 0	$ 0	$ 0

SECTION C - NON-FEDERAL RESOURCES

(a) Grant Program	(b) Applicant	(c) State	(d) Other Sources	(e) TOTALS
8.	$	$	$	$ 0
9.				0
10.				0
11.				0
12. TOTALS *(sum of lines 8 - 11)*	$ 0	$ 0	$ 0	$ 0

SECTION D - FORECASTED CASH NEEDS

		Total for 1st Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
13. Federal	**FA=**$18,935,334 **DA=**$13,203	$ 18,935,334	$ 4,733,833	$ 4,733,833	$ 4,733,833	$ 4,733,833
14. Non-Federal		0	0	0	0	0
15. TOTAL *(sum of lines 13-14)*		$ 18,935,334	$ 4,733,833	$ 4,733,833	$ 4,733,833	$ 4,733,833

(A) Grant Program	FUTURE FUNDING PERIODS (Years)			
	(B) First	(C) Second	(D) Third	(E) Fourth
16. U90/CCU517024-07 **F**ederal **A**ssistance	$ 18,935,334	$	$	$
17. U90/CCU517024-07 **D**irect **A**ssistance	13,203			
18.				
19.				
20. TOTALS *(sum of lines 16-19)*	$ 18,948,537	$ 0	$ 0	$ 0

SECTION F - OTHER BUDGET INFORMATION

21. Direct Charges:	$17,849,859	**22.** Indirect Charges:	$1,085,474

23. Remarks: Please See "Appendix I" to reference a copy of the state's current Indirect Cost Agreement. Indirect Cost is computed at the current rate of 11.5% against a Federal Assistance direct cost base, which excludes equipment, renovations, and contracts. The current rate is effective through 06/30/07, and is subject to change.

APPENDIX C: PHS-5161-1
Assurances, Certifications & Lobbying Disclosure

OMB Approval No. 0348-0040

ASSURANCES -- NON-CONSTRUCTION PROGRAMS

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial, and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§ 4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (**a**) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color, or national origin; (**b**) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§ 1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (**c**) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§ 794), which prohibits discrimination on the basis of handicaps; (**d**) the Age Discrimination act of 1975, as amended (42 U.S.C. §§ 6101-6107), which prohibits discrimination on the basis of age; (E) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (**f**) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (P.L. 91-616) as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (**g**) §§ 523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (**h**) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§ 3601 et seq.), as amended, relating to nondiscrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (**j**) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply, with the provisions of the Hatch Act (5 U.S.C. §§ 1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.

10 Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973. (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more. or more.

11 Will comply with environmental standards which may be prescribed pursuant to the following: (**a**) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (**b**) notification of violating facilities pursuant to EO 11738; (**c**) protection of wetland pursuant to EO 11990; (**d**) evaluation of flood hazards in floodplains in accordance with EO 11988; (**e**) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§ 1451 et seq.); (**f**) conformity of Federal actions to State (Clean Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§ 7401 et seq.); (**g**) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (**h**) protection of the endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12 Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§ 1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.

13 Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. § 470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.)

14 Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15 Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§ 2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16 Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§ 4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

17 Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18 Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE	
	Deputy State Health Commissioner	
APPLICANT ORGANIZATION		DATE SUBMITTED
Indiana State Department of Health		09/06/2006

CERTIFICATIONS

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

(a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;

(b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgement rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

(c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and

(d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why, should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, In eligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with sub- grantees and/or contractors) and in all solicitations for lower tier covered transaction in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by:

(a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

(b) Establishing an ongoing drug-free awareness program to inform employees about--
   (1) The dangers of drug abuse in the workplace;
   (2) The grantee's policy of maintaining a drug-free workplace;
   (3) Any available drug counseling, rehabilitation, and employee assistance programs; and
   (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

(c) Making it a requirement that each employee, to be engaged in the performance of the grant, be given a copy of the statement required by paragraph (a) above;

(d) Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   (1) Abide by the terms of the statement; and
   (2) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

(E) Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central

point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

(f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted--
   (1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   (2) Requiring such an employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

(g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For the purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget
Department of Health and Human Services
200 Independence Avenue, S.W., Room 517-D
Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93)

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements, or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education, or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote a non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE
Sue Uell	Deputy State Health Commissioner
APPLICANT ORGANIZATION	DATE SUBMITTED
Indiana State Department of Health	09/06/2006

DISCLOSURE OF LOBBYING ACTIVITIES

Approved by OMB
0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure.)

1. Type of Federal Action:

[C]
a. Contract
b. Grant
c. Cooperative Agreement
d. Loan
e. Loan Guarantee
f. Loan Insurance

2. Status of Federal Action:

[A]
a. Bid/Offer/**Application**
b. Initial Award
c. Post-Award

3. Report Type:

[A]
a. Initial Filing
b. Material Change

For Material Change Only:
Year _____ Quarter _____
Date of Last Report _____

4. Name and Address of Reporting Entity:

[X] Prime [ ] Subawardee

Tier _____, *if known:*

*****ISDH is an agency of the State of Indiana. It is Illegal for an agency of the state to Lobby.**

Congressional District, *if known:*

5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:

Congressional District, *if known:*

6. Federal Department/Agency:

Department of Health & Human Services, Centers for Disease Control and Prevention

7. Federal Program Name/ Description:

Centers for Disease Control & Prevention_Investigations and Technical Assistance

CFDA Number, *if applicable:* 93.283

8. Federal Action Number, ***if known:***

U90/CCU517024-07

9. Award Amount, ***if known:***

$ 4,601,761

10. a. Name and Address of Lobbying Entity
(if individual, last name, first name, MI):

b. Individuals Providing Services *(including address of different from No. 10a.)*
(if individual, last name, first name, MI):

11. Information requested through this form is authorized by title 31 U.S.C. Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Signature: Sue Uhl

Print Name: Sue E. Uhl

Title: Deputy State Health Commissioner

Telephone No.: 317-233-7102 Date: 09/06/2006

Federal Use Only:

Authorized for Local Reproduction
Standard Form - LLL (Rev. 7-97)

OMB Approval No. 0920-0428

CHECKLIST

Public Burden Statement: Public reporting burden of this collection of information is estimated to average 4 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate, or any other aspect of this collection of information, including suggestions for reducing this burden, to CDC, Clearance Officer, 1600 Clifton Road, MS D-24, Atlanta, GA 30333, ATTN: PRA (0920-0428). Do not send the completed form to this address.

NOTE TO APPLICANT: This form must be completed and submitted with the original of your application. Be sure to complete both sides of this form. Check the appropriate boxes, and provide the information requested. This form should be attached as the last page of the signed original of the application. This page is reserved for PHS staff use only.

Type of Application: [ ] NEW [ ] Noncompeting Continuation [ ] Competing Continuation [X] Supplemental

PART A: The following checklist is provided to assure that proper signatures, assurances, and certifications have been submitted.

		Included	NOT Applicable
1.	Proper Signature and Date for Item 18 on SF 424 (FACE PAGE)	X	
2.	Proper Signature and Date on PHS-5161-1 "Certifications" page	X	
3.	Proper Signatures and Date on appropriate "Assurances" page, i.e., SF-424B (Non-Construction Programs) or SF-424D (Construction Programs)	X	
4.	If your organization currently has on file with DHHS the following assurances, please identify which have been filed by indicating the date of such filing on the line provided. (All four have been consolidated into a single form, HHS Form 690)		
	[X] Civil Rights Assurance (45 CFR 80)	On File	
	[X] Assurance Concerning the Handicapped (45 CFR 84)	On File	
	[X] Assurance Concerning Sex Discrimination (45 CFR 86)	On File	
	[X] Assurance Concerning Age Discrimination (45 CFR 90 & 45 CFR 91)	On File	
5.	Human Subjects Certification, when applicable (45 CFR 46)		X

PART B: This part is provided to assure that pertinent information has been addressed and included in the application.

		Included	NOT Applicable
1.	Has a Public Health System Impact Statement for the proposed program/project been completed and distributed as required?		X
2.	Has the appropriate box been checked for item #16 on the SF-424 (FACE PAGE) regarding intergovernmental review under E.O. 12372? (45 CFR Part 100)	X	
3.	Has the entire proposed project period been identified in item #13 of the SF-424 (FACE PAGE)?	X	
4.	Have biographical sketch(es) with job description(s) been attached, when required?		X
5.	Has the "Budget Information" page, SF-424A (Non-Construction Programs) or SF-424C (Construction Programs), been completed and included?	X	
6.	Has the 12 month detailed budget been provided?	X	
7.	Has the budget for the entire proposed project period with sufficient detail been provided?	X	
8.	For a Supplemental application, does the detailed budget address only the additional funds requested?	X	
9.	For Competing Continuation and Supplemental applications, has a progress report been included?	X	

PART C: In the spaces provided below, please provide the requested information.

Business Official to be notified if an award is to be made.

Name	Linda L. Brown
Title	Director of Finance
Organization	Indiana State Department of Health
Address	2 N. Meridian St. Indianapolis, IN 46204
E-mail Address	Lbrown@isdh.state.in.us
Telephone Number	(317) 233-7113
Fax Number	(317) 233-7477

APPLICANT ORGANIZATION'S 12-DIGIT DHHS EIN (If already assigned)

1	3	5	6	0	0	0	1	5	8	A	8

Program Director/Project Director/Principal Investigator designated to direct the proposed project or program.

Name	Michael A. Hurst
Title	Preparedness & Response Executive Director
Organization	Indiana State Department of Health
Address	2 N. Meridian St. Indianapolis, IN 46204
E-mail Address	mhurst@isdh.state.in.us
Telephone Number	(317) 234-3545
Fax Number	(317) 233-7873

[redacted]

HIGHEST DEGREE EARNED: J.D.

(OVER)

PART D: **A private, nonprofit organization must include evidence of its nonprofit status with the application. Any of the following is acceptable evidence. Check the appropriate box or complete the "Previously Filed" section, whichever is applicable.**

☐ (a) A reference to the organization's listing in the Internal Revenue Service's (IRS) most recent list of tax-exempt organizations, described in section 501(C)(3) of the IRS Code.

☐ (b) A copy of a currently valid Internal Revenue Service Tax exemption certificate.

☐ (c) A Statement from a State taxing body, State Attorney General, or other appropriate State official certifying that the applicant organization has a nonprofit status and that none of the net earnings accrue to any private shareholders or individuals.

☐ (d) A certified copy of the organization's certificate of incorporation or similar document if it clearly establishes the nonprofit status of the organization.

☐ (e) Any of the above proof for a State or national parent organization, and a statement signed by the parent organization that the applicant organization is a local nonprofit affiliate.

If an applicant has evidence of current nonprofit status on file with an agency of PHS, it will not be necessary to file similar papers again, but the place and date of filing must be indicated.

Previously Filed with: *(Agency)* on *(Date)*

INVENTIONS

If this is an application for continued support, include: (1) the report of inventions conceived or reduced to practice required by the terms and conditions of the grant; or (2) a list of inventions already reported; or (3) a negative certification.

EXECUTIVE ORDER 12372

Effective September 30, 1983, Executive Order 12372 (Intergovernmental Review of Federal Programs) directed OMB to abolish OMB Circular A-95 and establish a new process for consulting with State and local elected officials on proposed Federal financial assistance. The Department of Health and Human Services implemented the Executive Order through regulations at 45 CFR Part 100 (Intergovernmental Review of Department of Health and Human Services Programs and Activities). The objectives of the Executive Order are to (1) increase State flexibility to design a consultation process and select the programs it wishes to review; (2) increase the ability of State and local elected officials to influence Federal decisions; and (3) compel Federal officials to be responsive to State concerns, or explain the reasons.

The regulations at 45 CFR Part 100 were published in the Federal *Register* on June 24, 1983, along with a notice identifying the Department's programs that are subject to the provisions of Executive Order 12372. Information regarding PHS programs subject to Executive Order 12372 is also available from the appropriate awarding office.

States participating in this program establish State Single Points of Contact (SPOCs) to coordinate and manage the review and comment on proposed Federal financial assistance. Applicants should contact the Governor's office for information regarding the SPOC, programs selected for review, and the consultation (review) process designed by their State.

Applicants are to certify on the face page of the SF-424 (attached) whether the request is for a program covered under Executive Order 12372 and, where appropriate, whether the State has been given an opportunity to comment.

APPENDIX D – Local Health Consensus Spreadsheet

Pandemic Influenza Funding for Fiscal Year 2006/2007

Department of Health and Human Services
Centers for Disease Control and Prevention

Indiana	
Total State Population:	**6,237,569**
Percent of Population in concurrence:	**80.26%**

Description how you get consensus with Local Health Departments
The ISDH holds Bi-monthly conference calls with all 94 local health departments in Indiana. Following receipt of the Phase 2 Pandemic Influenza, Public Health Preparedness supplemental cooperative agreement guidance, and distribution of the guidance to our Local partners, Phase 1 Completion and Phase 2 planning and preparation became the central agenda item for the conference calls. During those calls and in subsequent written communications, the state health commissioner and staff described the purpose and parameters of the funding guidance. The ISDH explained that the grant was intended to support increasing capacity and capability of state and local health departments and medical entities to respond to an influenza pandemic, and to continue enhancements to community-wide preparedness planning and exercises. The ISDH further described the focus of the funding to be used to purchase goods and services to allow the state and each local community to increase the use and development of interventions known to prevent influenza, decrease the time to detect and report an influenza outbreak with pandemic potential, improve partner communications and increase response times, and decrease the time that it will take our communities to restore health services and environmental safety to pre-pandemic levels. The ISDH solicited comments and suggestions from local health departments on how to apply the funds in a manner that would support local planning and close gaps in local pandemic influenza preparedness. In addition, the ISDH described the projects that had been identified through collaborative efforts up to that point, and solicited further input on those projects and for other uses of the funds. The state health commissioner also solicited input via email and by letter addressed to the local health officers for all 94 local health departments. The ISDH staff also met with representatives from local health departments in individual and district meetings involving multiple departments and other stakeholders. The state health commissioner asked local health departments supportive of the state's application for these supplemental funds to submit a letter of consensus. Local health departments representing 80.26% of the state's population have submitted letters of support.

	Local Health Department	Population
1	Adams County Health Department	
2	Allen County Health Department	
3	Bartholomew County Health Department	72,987
4	Benton County Health Department	
5	Blackford County Health Department	13,841
6	Boone County Health Department	50,847
7	Brown County Health Department	15,228
8	Carroll County Health Department	20,331
9	Cass County Health Department	40,417
10	Clark County Health Department	100,706
11	Clay County Health Department	27,210
12	Clinton County Health Department	34,148
13	Crawford County Health Department	11,167

14	Daviess County Health Department	30,245
15	Dearborn County Health Department	48,583
16	Decatur County Health Department	24,970
17	Dekalb County Health Department	41,524
18	Delaware County Health Department	117,774
19	Dubois County Health Department	40,771
20	Elkhart County Health Department	
21	Fayette County Health Department	24,934
22	Floyd County Health Department	
23	Fountain-Warren County Combined Health Department	26,431
24	Franklin County Health Department	22,852
25	Fulton County Health Department	20,581
26	Gibson County Health Department	33,286
27	Grant County Health Department	71,543
28	Greene County Health Department	33,500
29	Hamilton County Health Department	
30	Hancock County Health Department	60,915
31	Harrison County Health Department	36,376
32	Hendricks County Health Department	123,476
33	Henry County Health Department	
34	Howard County Health Department	84,615
35	Huntington County Health Department	38,124
36	Jackson County Health Department	41,959
37	Jasper County Health Department	31,624
38	Jay County Health Department	
39	Jefferson County Health Department	32,110
40	Jennings County Health Department	
41	Johnson County Health Department	125,864
42	Knox County Health Department	38,442
43	Kosciusko County Health Department	75,667
44	LaGrange County Health Department	36,515
45	Lake County Health Department	278,970
46	LaPorte County Health Department	109,755
47	Lawrence County Health Department	46,398
48	Madison County Health Department	130,602
49	Marion County Health Department	863,596

50	Marshall County Health Department	46,732
51	Martin County Health Department	10,467
52	Miami County Health Department	35,955
53	Monroe County Health Department	121,013
54	Montgomery County Health Department	37,937
55	Morgan County Health Department	69,424
56	Newton County Health Department	14,421
57	Noble County Health Department	47,297
58	Ohio County Health Department	5,849
59	Orange County Health Department	
60	Owen County Health Department	23,074
61	Parke County Health Department	17,254
62	Perry County Health Department	18,999
63	Pike County Health Department	
64	Porter County Health Department	154,961
65	Posey County Health Department	
66	Pulaski County Health Department	13,825
67	Putnam County Health Department	36,786
68	Randolph County Health Department	26,697
69	Ripley County Health Department	27,549
70	Rush County Health Department	
71	St. Joseph County Health Department	266,431
72	Scott County Health Department	23,604
73	Shelby County Health Department	43,717
74	Spencer County Health Department	20,310
75	Starke County Health Department	22,903
76	Steuben County Health Department	33,722
77	Sullivan County Health Department	21,862
78	Switzerland County Health Department	9,508
79	Tippecanoe County Health Department	
80	Tipton County Health Department	
81	Union County Health Department	
82	Vanderburgh County Health Department	173,157
83	Vermillion County Health Department	16,500
84	Vigo County Health Department	103,195
85	Wabash County Health Department	34,169

86	Warrick County Health Department	55,465
87	Washington County Health Department	27,882
88	Wayne County Health Department	69,778
89	Wells County Health Department	27,963
90	White County Health Department	24,846
91	Whitley County Health Department	31,955
92	East Chicago City Health Department	31,366
93	Gary City Health Department	99,961
94	Hammond City Health Department	80,547
	Total	**5,005,965**

APPENDIX E –Executive Summary of Health Chapter of the Statewide Pandemic Influenza Response Plan

Indiana State Department of Health
Pandemic Influenza Plan
Executive Summary

Staff from the Indiana State Department of Health (ISDH) developed the Pandemic Influenza Plan (Panflu Plan) to guide the collaborative work of the ISDH, local health departments, hospitals, and other key partners in preparing for a possible influenza pandemic.

The Panflu Plan includes an overview of the current status of state, national, and international concern about the H5N1 influenza virus, as well as projections of sickness rates, hospitalizations, and deaths that might occur during an influenza pandemic.

The Panflu Plan is organized into the following sections and appendices:

1. Strategies and Policies
2. Planning, Coordination, and Command Structure
3. Surveillance and Investigation
4. Vaccine and Antivirals
5. Containment During a Pandemic
6. Communication
7. Education
8. Appendices
    A. FluSurge Population Projections
    B. Indiana Partners for Pandemic Influenza Planning and Preparedness
    C. Activities Related to WHO Pandemic Influenza Periods
    D. Indiana Local Health Department Pandemic Influenza Checklist
    E. Hospital and Health Care Provider Information
    F. Likely Questions Before and During an Influenza Pandemic

The Panflu Plan provides an overview of how the State of Indiana should prepare for an influenza pandemic. This preparation includes strategies to improve disease surveillance and timely reporting of influenza-like illnesses; criteria for determining who should receive antiviral medicines or vaccines that may be in short supply; strategies to use isolation and quarantine authority or limiting public gatherings to control or slow the spread of the disease; methods for providing timely, accurate information to the public about a pandemic; and education programs to promote awareness of the risks and steps individuals and organizations can take to minimize the impact of a pandemic.

The ISDH has prepared and is implementing a detailed work plan to address critical preparedness issues. Local health departments have completed a checklist that will guide development of pandemic influenza action plans in their jurisdictions. In addition, the ISDH has asked hospitals to update their emergency response plans to include preparations for an influenza pandemic.

The ISDH will monitor implementation of work plans and provide assistance to local health departments, hospitals, and others as they prepare for an influenza pandemic.

APPENDIX F – State Pandemic Influenza Self-Assessment

PANDEMIC INFLUENZA PLANNING
SELF-ASSESSMENT – STATE PUBLIC HEALTH

PUBLIC HEALTH ROLES AND RESPONSIBILITIES

This self-assessment contains activities that are conducted at the state level, local level, or both. Because the level at which they take place may vary across states, states are asked to determine for each whether the responsibility lies at the state or local level (or both), thus creating a state and a local version of the checklist. States are responsible for returning both the completed state self-assessment, and aggregated results for the local assessment.

Notes:
1. All references to operational plans or planning in the checklist could refer to the State's separate Pandemic Influenza Plan or a component of the State's overall All-Hazards Plan.
2. Direct-funded metropolitan areas (i.e., the District of Columbia, New York City, Los Angeles County, and Chicago) should NOT use this form (i.e., the Self-Assessment-State Public Health form). Instead, they should use the Self-Assessment-Local Public Health form.

Project:	**Indiana**
Assessment Completed By:	Joe Hunt
Title:	Asst Commissioner, PH Surveillance & Emgcy Resp
Telephone:	(317) 233-7524
Email Address:	jhunt@isdh.in.gov
Date:	

Community Preparedness Leadership and Networking [Preparedness Goal 1—Increase the use and development of interventions known to prevent human illness from chemical, biological, radiological agents, and naturally occurring health threats]

▪ A Pandemic Preparedness Coordinating Committee representing all relevant stakeholders in the jurisdiction and accountable for articulating strategic priorities and overseeing the development and execution of the jurisdiction's operational pandemic plan has been developed.		COMPLETED
	x	IN-PROGRESS
		NOT STARTED
		N/A LOCAL PH RESPONSIBILITY
▪ The accountability and responsibility for key stakeholders engaged in planning and executing specific components of the operational plan are delineated, and the plan includes timelines, deliverables, and performance measures.		COMPLETED
	x	IN-PROGRESS
		NOT STARTED
		N/A LOCAL PH RESPONSIBILITY
▪ It is clear which activities will occur at state, local, or coordinated level.		COMPLETED
	x	IN-PROGRESS
		NOT STARTED
		N/A LOCAL PH RESPONSIBILITY
▪ State role in providing guidance and assistance to local/regional level is defined.		COMPLETED
	x	IN-PROGRESS
		NOT STARTED
		N/A LOCAL PH RESPONSIBILITY
▪ The operational plan for pandemic influenza response is an integral element of the overall state and local emergency response plan established under Federal Emergency Support Function 8 (ESF8) and compliant with NIMS.		COMPLETED
	x	IN-PROGRESS
		NOT STARTED
		N/A LOCAL PH RESPONSIBILITY
▪ The operational plan addresses integration of state, local, tribal, territorial, and regional plans across jurisdictional boundaries.		COMPLETED
	x	IN-PROGRESS
		NOT STARTED
		N/A LOCAL PH RESPONSIBILITY

PANDEMIC INFLUENZA PLANNING
SELF-ASSESSMENT – STATE PUBLIC HEALTH

PUBLIC HEALTH ROLES AND RESPONSIBILITIES

PANDEMIC INFLUENZA PLANNING
SELF-ASSESSMENT – STATE PUBLIC HEALTH

PUBLIC HEALTH ROLES AND RESPONSIBILITIES

▪ Agreements with neighboring jurisdictions are formalized and address communication, mutual aid, and other cross-jurisdictional needs.		COMPLETED
	x	IN-PROGRESS
		NOT STARTED
		N/A LOCAL PH RESPONSIBILITY
▪ Legal authorities for executing the operational plan, especially those relevant to case identification, isolation, quarantine, movement restriction, healthcare services, emergency care, and mutual aid, are transparent to all stakeholders.		COMPLETED
	x	IN-PROGRESS
		NOT STARTED
		N/A LOCAL PH RESPONSIBILITY
▪ The process for requesting, coordinating, and approving requests for resources to state and federal agencies has been made clear to all stakeholders.		COMPLETED
	x	IN-PROGRESS
		NOT STARTED
		N/A LOCAL PH RESPONSIBILITY
▪ An Incident Command System for the pandemic plan that is based on the National Incident Management System has been created.		COMPLETED
	x	IN-PROGRESS
		NOT STARTED
		N/A LOCAL PH RESPONSIBILITY
▪ This system has been exercised along with other operational elements of the plan.		COMPLETED
	x	IN-PROGRESS
		NOT STARTED
		N/A LOCAL PH RESPONSIBILITY
▪ The authority responsible for declaring a public health emergency at the state and local levels and for officially activating the pandemic influenza response plan has been identified.	x	COMPLETED
		IN-PROGRESS
		NOT STARTED
		N/A LOCAL PH RESPONSIBILITY
▪ State and local law enforcement personnel who will maintain public order and help implement control measures have been identified.		COMPLETED
	x	IN-PROGRESS
		NOT STARTED
		N/A LOCAL PH RESPONSIBILITY
▪ What will constitute a "law enforcement" emergency has been determined and law enforcement officials have been educated so they can pre-plan for their families to sustain themselves during the emergency.		COMPLETED
	x	IN-PROGRESS
		NOT STARTED
		N/A LOCAL PH RESPONSIBILITY
▪ Plans are flexible so they can be adapted to the magnitude and severity of the pandemic and to available resources.		COMPLETED
	x	IN-PROGRESS
		NOT STARTED
		N/A LOCAL PH RESPONSIBILITY
▪ Provision of psychosocial support services for the community, including parents and their families, and those affected by community containment procedures are addressed.		COMPLETED
	x	IN-PROGRESS
		NOT STARTED
		N/A LOCAL PH RESPONSIBILITY

PANDEMIC INFLUENZA PLANNING
SELF-ASSESSMENT – STATE PUBLIC HEALTH

PUBLIC HEALTH ROLES AND RESPONSIBILITIES

▪ The State Public Health Agency, with animal health sectors (including but not limited to industry, veterinary diagnostic laboratories, state departments of agriculture) have developed an operational plan to prevent, detect and respond to reports of disease in animals as a early warning of threat to human health including: o education of and risk communication to the poultry owning public, especially small operations o a plan for surveillance in birds o disease reporting and data sharing o triggers for action to contain disease within the animal sector o triggers to perform heightened surveillance to detect human illness.		COMPLETED
	x	IN-PROGRESS
		NOT STARTED
		N/A LOCAL PH RESPONSIBILITY
Surveillance [HHS Supplement 1. Preparedness Goal 3—Decrease the time needed to detect and report chemical, biological, radiological agents in tissue, food, or environmental samples that cause threats to the public's health. Preparedness Goal 5—Decrease the time to identify causes, risk factors, and appropriate interventions for those affected by threats to the public's health.]		
▪ Traditional surveillance for seasonal influenza (e.g., virologic, outpatient visits, hospitalization, and mortality) including electronic reporting, is conducted year round.		COMPLETED
	x	IN-PROGRESS
		NOT STARTED
		N/A LOCAL PH RESPONSIBILITY
▪ Capacity for rapid identification of unusual influenza strains has been improved by working with federal partners to enhance laboratory-based monitoring of seasonal influenza subtypes.		COMPLETED
	x	IN-PROGRESS
		NOT STARTED
		N/A LOCAL PH RESPONSIBILITY
▪ Procedures to implement enhanced surveillance once a pandemic is detected to ensure recognition of the first cases of pandemic virus infection in time to initiate appropriate containment protocols have been developed.		COMPLETED
	x	IN-PROGRESS
		NOT STARTED
		N/A LOCAL PH RESPONSIBILITY
▪ Animal and human health surveillance systems are linked and information is routinely shared.		COMPLETED
	x	IN-PROGRESS
		NOT STARTED
		N/A LOCAL PH RESPONSIBILITY
▪ Systems to obtain and track information daily during a pandemic on the following items has been developed: o the numbers of newly hospitalized cases, o newly quarantined persons, and o hospitals with pandemic influenza cases		COMPLETED
	x	IN-PROGRESS
		NOT STARTED
		N/A LOCAL PH RESPONSIBILITY
Public Health and Clinical Laboratories [HHS Supplement 2. Preparedness Goal 3—Decrease the time needed to detect and report chemical, biological, radiological agents in tissue, food, or environmental samples that cause threats to the public's health.]		
▪ Surveillance for influenza-like illnesses (ILI) among laboratory personnel working with novel influenza viruses has been instituted.		COMPLETED
	x	IN-PROGRESS
		NOT STARTED
		N/A LOCAL PH RESPONSIBILITY

PANDEMIC INFLUENZA PLANNING
SELF-ASSESSMENT – STATE PUBLIC HEALTH

PUBLIC HEALTH ROLES AND RESPONSIBILITIES

▪ An operational plan to augment the capacity of public health and clinical laboratories to meet the needs of the jurisdiction during a pandemic has been developed.		COMPLETED
	x	IN-PROGRESS
		NOT STARTED
		N/A LOCAL PH RESPONSIBILITY
▪ This operational plan has been exercised.		COMPLETED
	x	IN-PROGRESS
		NOT STARTED
		N/A LOCAL PH RESPONSIBILITY
▪ The influenza diagnostic testing proficiency and adherence to biosafety containment and biomonitoring protocols is assessed in all public health and clinical laboratories at least annually.		COMPLETED
	x	IN-PROGRESS
		NOT STARTED
		N/A LOCAL PH RESPONSIBILITY
▪ Frontline clinicians and laboratory personnel are aware of protocols for safe specimen collection and testing, know how and to whom a potential case of novel influenza should be reported, and know the indications and mechanism for submitting specimens to referral laboratories.		COMPLETED
	x	IN-PROGRESS
		NOT STARTED
		N/A LOCAL PH RESPONSIBILITY
Healthcare and Public Health Partners [HHS Supplement 3. Preparedness Goal 6—Decrease the time needed to provide countermeasures and health guidance to those affected by threats to the public's health.]		
▪ The role of public health in coordinating with the healthcare sector in delivery of care during a pandemic has been defined.		COMPLETED
	x	IN-PROGRESS
		NOT STARTED
		N/A LOCAL PH RESPONSIBILITY
▪ Public health knows what the healthcare sector needs or expects of it before and during a pandemic.		COMPLETED
	x	IN-PROGRESS
		NOT STARTED
		N/A LOCAL PH RESPONSIBILITY
▪ The necessary memoranda of agreement/understanding between public health and the healthcare sector are in place.		COMPLETED
	x	IN-PROGRESS
		NOT STARTED
		N/A LOCAL PH RESPONSIBILITY
▪ An operational plan for the healthcare sector that addresses the following elements has been developed: o healthcare of persons with influenza during a pandemic, o legal issues that can affect staffing and patient care o continuity of services for other patients, o protection of the healthcare workforce, and o medical supply contingency plans		COMPLETED
	x	IN-PROGRESS
		NOT STARTED
		N/A LOCAL PH RESPONSIBILITY
▪ This operational plan has been exercised.		COMPLETED
	x	IN-PROGRESS
		NOT STARTED
		N/A LOCAL PH RESPONSIBILITY

PANDEMIC INFLUENZA PLANNING
SELF-ASSESSMENT – STATE PUBLIC HEALTH

PUBLIC HEALTH ROLES AND RESPONSIBILITIES

▪ All components of the healthcare delivery network (e.g., hospitals, long-term care, home care, emergency care) are included in the operational plan, and the special needs of vulnerable and hard-to-reach patients are addressed.		COMPLETED
	x	IN-PROGRESS
		NOT STARTED
		N/A LOCAL PH RESPONSIBILITY
▪ A plan for ensuring real-time situational awareness of patient visits, hospital bed and intensive care needs, medical supply needs, and medical staffing needs during a pandemic has been developed.		COMPLETED
	x	IN-PROGRESS
		NOT STARTED
		N/A LOCAL PH RESPONSIBILITY
▪ An operational plan for provision of mortuary services during a pandemic has been developed.		COMPLETED
	x	IN-PROGRESS
		NOT STARTED
		N/A LOCAL PH RESPONSIBILITY
▪ The plan for mortuary services has been tested.		COMPLETED
	x	IN-PROGRESS
		NOT STARTED
		N/A LOCAL PH RESPONSIBILITY
▪ A current roster of all active and formerly active healthcare personnel available for emergency healthcare services is maintained.		COMPLETED
	x	IN-PROGRESS
		NOT STARTED
		N/A LOCAL PH RESPONSIBILITY
▪ What will constitute a medical staffing emergency has been defined.		COMPLETED
	x	IN-PROGRESS
		NOT STARTED
		N/A LOCAL PH RESPONSIBILITY
▪ The operational plan to initiate appropriate credentialing of volunteer healthcare personnel (including in-state, out-of-state, international, returning retired, and non-medical volunteers) to meet staffing needs during a pandemic has been exercised.		COMPLETED
	x	IN-PROGRESS
		NOT STARTED
		N/A LOCAL PH RESPONSIBILITY
▪ The healthcare facilities in the jurisdiction have exercised a plan for isolating and/or cohorting patients with known or suspected influenza, training clinicians, and supporting the needs for personal protective equipment.		COMPLETED
	x	IN-PROGRESS
		NOT STARTED
		N/A LOCAL PH RESPONSIBILITY
▪ The healthcare facilities in the jurisdiction have exercised an operational plan to initiate, support, and enforce quarantine of potentially exposed healthcare personnel.		COMPLETED
	x	IN-PROGRESS
		NOT STARTED
		N/A LOCAL PH RESPONSIBILITY

Continued on the Next Page

PANDEMIC INFLUENZA PLANNING
SELF-ASSESSMENT – STATE PUBLIC HEALTH

PUBLIC HEALTH ROLES AND RESPONSIBILITIES

This self-assessment contains activities that are conducted at the state level, local level, or both. Because the level at which they take place may vary across states, states are asked to determine for each whether the responsibility lies at the state or local level (or both), thus creating a state and a local version of the checklist. States are responsible for returning both the completed state self-assessment, and aggregated results for the local assessment.

Notes:
1. All references to operational plans or planning in the checklist could refer to the State's separate Pandemic Influenza Plan or a component of the State's overall All-Hazards Plan.
2. Direct-funded metropolitan areas (i.e., the District of Columbia, New York City, Los Angeles County, and Chicago) should NOT use this form (i.e., the Self-Assessment-State Public Health form). Instead, they should use the Self-Assessment-Local Public Health form.

Infection Control and Clinical Guidelines [HHS Supplements 4 & 5. Preparedness Goal 6—Decrease the time needed to provide countermeasures and health guidance to those affected by threats to the public's health.]

▪ Messages have been crafted to help educate healthcare providers about novel and pandemic influenza, and infection control guidelines.	x	COMPLETED
		IN-PROGRESS
		NOT STARTED
		N/A LOCAL PH RESPONSIBILITY
▪ An operational plan has been developed to regularly update providers as the influenza pandemic unfolds.		COMPLETED
	x	IN-PROGRESS
		NOT STARTED
		N/A LOCAL PH RESPONSIBILITY
▪ This plan has been tested.		COMPLETED
	x	IN-PROGRESS
		NOT STARTED
		N/A LOCAL PH RESPONSIBILITY

Vaccine Distribution and Use [HHS Supplement 6. Preparedness Goal 6—Decrease the time needed to provide countermeasures and health guidance to those affected by threats to the public's health.]

▪ An operational plan for vaccine distribution, use, and monitoring which covers the following elements has been developed: o Plan for vaccinating occupationally-defined and other priority groups o Storage o Security during transport, storage, and administration o Cold chain requirements o Location of vaccination o Personnel who will vaccinate o Availability of necessary equipment and supplies o Training requirements for involved personnel o Tracking number and priority of vaccine recipients o Vaccine safety monitoring o Contingency plan for administration under IND or EUA (Investigational New Drug or Emergency Use Authorization) o Address needs of vulnerable populations		COMPLETED
	x	IN-PROGRESS
		NOT STARTED
		N/A LOCAL PH RESPONSIBILITY

PANDEMIC INFLUENZA PLANNING
SELF-ASSESSMENT – STATE PUBLIC HEALTH

PUBLIC HEALTH ROLES AND RESPONSIBILITIES

▪ This operational plan has been tested		COMPLETED
	x	IN-PROGRESS
		NOT STARTED
		N/A LOCAL PH RESPONSIBILITY
▪ Written agreements document the commitments of participating personnel and organizations in the vaccination operational plan.		COMPLETED
	x	IN-PROGRESS
		NOT STARTED
		N/A LOCAL PH RESPONSIBILITY
▪ Citizens are informed and know in advance where they will be vaccinated.		COMPLETED
		IN-PROGRESS
		NOT STARTED
	x	N/A LOCAL PH RESPONSIBILITY
Antiviral Drug Distribution and Use [HHS Supplement 7. Preparedness Goal 6—Decrease the time needed to provide countermeasures and health guidance to those affected by threats to the public's health.]		
▪ Plans for distribution and use of antiviral drugs during a pandemic via the Strategic National Stockpile (SNS), as appropriate, to healthcare facilities that will administer them to priority groups have been developed. These plans cover: o Storage o Security o Distribution o Tracking o Adverse events monitoring o Contingency plan for administration under IND or EUA (Investigational New Drug or Emergency Use Authorization)		COMPLETED
	x	IN-PROGRESS
		NOT STARTED
		N/A LOCAL PH RESPONSIBILITY
▪ The plans have been tested		COMPLETED
	x	IN-PROGRESS
		NOT STARTED
		N/A LOCAL PH RESPONSIBILITY
Community Disease Control and Prevention (including managing travel-related risk of disease transmission) [HHS Supplements 8 & 9. Preparedness Goal 6—Decrease the time needed to provide countermeasures and health guidance to those affected by threats to the public's health.]		
▪ An operational plan to investigate and contain potential cases or local outbreaks of influenza potentially caused by a novel or pandemic strain has been developed.		COMPLETED
	x	IN-PROGRESS
		NOT STARTED
		N/A LOCAL PH RESPONSIBILITY
▪ This plan has been exercised.		COMPLETED
	x	IN-PROGRESS
		NOT STARTED
		N/A LOCAL PH RESPONSIBILITY

PANDEMIC INFLUENZA PLANNING
SELF-ASSESSMENT – STATE PUBLIC HEALTH

PUBLIC HEALTH ROLES AND RESPONSIBILITIES

▪ A containment operational plan that delineates the following items has been developed: o the criteria for isolation and quarantine, o the procedures and legal authorities for implementing and enforcing these containment measures, and o the methods that will be used to support, service, and monitor those affected by these containment measures in healthcare facilities, other residential facilities, homes, community facilities, and other settings	☐ x ☐ ☐	COMPLETED IN-PROGRESS NOT STARTED N/A LOCAL PH RESPONSIBILITY
▪ This plan has been exercised.	☐ x ☐ ☐	COMPLETED IN-PROGRESS NOT STARTED N/A LOCAL PH RESPONSIBILITY
▪ An operational plan to implement various levels of movement restrictions within, to, and from the jurisdiction.	☐ x ☐ ☐	COMPLETED IN-PROGRESS NOT STARTED N/A LOCAL PH RESPONSIBILITY
▪ This plan has been exercised.	☐ x ☐ ☐	COMPLETED IN-PROGRESS NOT STARTED N/A LOCAL PH RESPONSIBILITY
▪ Citizens have been informed in advance what containment procedures may be used in the community.	☐ x ☐ ☐	COMPLETED IN-PROGRESS NOT STARTED N/A LOCAL PH RESPONSIBILITY
Public Health Communications [HHS Supplement 10. Preparedness Goal 4—Improve the timeliness and accuracy of communications regarding threats to the public's health.]		
▪ Readiness to meet communications needs in preparation for an influenza pandemic has been assessed, including regular review and updating of communications plans.	☐ x ☐ ☐	COMPLETED IN-PROGRESS NOT STARTED N/A LOCAL PH RESPONSIBILITY
▪ Plans for coordinating emergency communication activities with private industry, education, and non-profit partners (e.g., local Red Cross chapters) have been developed.	☐ x ☐ ☐	COMPLETED IN-PROGRESS NOT STARTED N/A LOCAL PH RESPONSIBILITY
▪ Lead subject-specific spokespersons have been identified and trained.	x ☐ ☐ ☐	COMPLETED IN-PROGRESS NOT STARTED N/A LOCAL PH RESPONSIBILITY
▪ Public health communications staff have been provided with training on risk communications for use during an influenza pandemic.	☐ x ☐ ☐	COMPLETED IN-PROGRESS NOT STARTED N/A LOCAL PH RESPONSIBILITY

PANDEMIC INFLUENZA PLANNING
SELF-ASSESSMENT – STATE PUBLIC HEALTH

PUBLIC HEALTH ROLES AND RESPONSIBILITIES

▪ Up-to-date communications contacts of key stakeholders are maintained.		COMPLETED
	x	IN-PROGRESS
		NOT STARTED
		N/A LOCAL PH RESPONSIBILITY
▪ Plan for providing regular updates to key stakeholders as the pandemic unfolds has been developed.		COMPLETED
	x	IN-PROGRESS
		NOT STARTED
		N/A LOCAL PH RESPONSIBILITY
▪ This plan has been tested.		COMPLETED
	x	IN-PROGRESS
		NOT STARTED
		N/A LOCAL PH RESPONSIBILITY
▪ Community resources, such as hotlines and websites to respond to local questions from the public and professional groups have been developed and are maintained.		COMPLETED
	x	IN-PROGRESS
		NOT STARTED
		N/A LOCAL PH RESPONSIBILITY
▪ The Health Alert Network in the jurisdiction reaches at least 80% of all practicing licensed frontline healthcare personnel and links via the communications network to other pandemic responders.		COMPLETED
	x	IN-PROGRESS
		NOT STARTED
		N/A LOCAL PH RESPONSIBILITY
▪ The appropriate local health authorities have access to EPI-X and are trained in its use.		COMPLETED
	x	IN-PROGRESS
		NOT STARTED
		N/A LOCAL PH RESPONSIBILITY
▪ Redundant communications systems/channels that allow for expedited transmission and receipt of information are in place.		COMPLETED
	x	IN-PROGRESS
		NOT STARTED
		N/A LOCAL PH RESPONSIBILITY
Workforce Support: Psychosocial Considerations and Information Needs [HHS Supplement 11. Preparedness Goal 6—Decrease the time needed to provide countermeasures and health guidance to those affected by threats to the public's health.]		
▪ A continuity of operations plan for essential department services, including contingency planning for increasing public health workforce in response to absenteeism among health department staff and stakeholder groups that have key responsibilities under a community's response plan has been developed.	x	COMPLETED
		IN-PROGRESS
		NOT STARTED
		N/A LOCAL PH RESPONSIBILITY
▪ A plan for ensuring availability of psychosocial support services (including educational and training materials) for employees who participate in or provide support for the response to public health emergencies such as influenza pandemics has been developed.		COMPLETED
	x	IN-PROGRESS
		NOT STARTED
		N/A LOCAL PH RESPONSIBILITY

THE END

APPENDIX G – State Pandemic Influenza Gap Analysis

PANDEMIC INFLUENZA SUPPLEMENTAL
GAP ANALYSIS RESULTS
STATE PUBLIC HEALTH

Instructions:
Using the Gap Analysis Results template below, provide a brief summary of key gap(s) identified in each section of your State Self-Assessment tool. Provide a proposed approach (i.e. work plan overview) that describes how your state plans to fill the identified gaps. In addition, grantees are encouraged to provide responses to the bulleted items in section XII Performance Measures.

Section I:

Community Preparedness Leadership and Networking [Preparedness Goal 1—Increase the use and development of interventions known to prevent human illness from chemical, biological, radiological agents, and naturally occurring health threats.

Summary of Key Gap(s):

1. Accountability and responsibility of key stakeholders engaged in planning and executing specific components of operational plan is ongoing; coordination and delineation of state and local responsibilities is ongoing; state role in providing guidance and assistance to local and regional level is in progress and evolving; public and private sector and cross-border agreements and mutual aid is in progress and evolving. Energizing local government and business communities to prepare for response and continuity of operations.

2. Local planning and particularly incorporation of local pandemic influenza plan into overall state and local emergency response plans; local planning for surge and capacity during a pandemic influenza; local planning for cross-border integration of response including mutual aid; identification of local agenc(ies) with responsibility for isolation and quarantine and other response activities; local responsibility for incident command, and request and coordination of resources; local plan exercises.

3. The Indiana State Department of Health (ISDH) has not established an external Pandemic Preparedness Coordinating Committee with representation from all relevant stakeholders.

Proposed Approach(s):

1. The ISDH held the Indiana Pandemic Influenza State Summit on March 23, 2006, with more than 400 participants from the private sector, from non-governmental organizations, and from federal, state and local government, including elected officials. The Summit provided state and federal authorities the opportunity to bring together relevant stakeholders to define the issues and to begin to address gaps in planning and to collaborate on strategies for closing gaps and plan for individual and collaborative responses in the event of a pandemic. The ISDH proposes to utilize Pan flu Supplemental funding to support the state summit. The ISDH further proposes to support a series of local or "sector" pandemic influenza summits throughout the state. These local summits may be hosted by local health departments, school corporations, local chambers of commerce, non-governmental organizations, and other

relevant stakeholders. The purpose of these local summits will be to inform and energize local communities and enterprise sectors to prepare for a pandemic response within the community.

2. The ISDH has distributed the CDC local assessment tool to all 94 local health departments in Indiana with a request that the local health departments prepare the assessment for submission to the state and to the CDC on or before August 30, 2006. The ISDH will utilize ISDH staff to assist local health departments prepare the assessment. The ISDH proposes to use Pan flu Supplemental funding to support consultants to prepare and/or assist local health departments in preparing a detailed gap analysis with strategies for closing gaps in their local pandemic influenza plans and planning. The ISDH proposes to further use Pan flu Supplemental funding to support a consultant to prepare and/or assist local health departments in preparing or refining local pandemic influenza plans. The ISDH proposes to use Pan flu Supplemental funding to support a consultant to conduct district exercises involving all 94 local health departments and local health department pandemic influenza plans and planning. The ISDH proposes to use Pan flu Supplemental funding to provide financial assistance to each of Indiana's 94 local health departments to enable them to purchase products or services to further assist in building plans and capacity for a pandemic influenza response. Such assistance will be conditioned upon goods or services closing local gaps as identified in the local assessments. With a recent change in Indiana law for isolation and quarantine, the ISDH has clarified authority regarding rules governing isolation and quarantine. The ISDH proposes to initiate the rule writing process to include, if appropriate, guidance for public health and the health care community regarding development and testing of operational plans to initiate, support, and implement quarantine of potential exposures. Development of rules will include consultation with public health, health care facilities, health care professional associations, and representatives from the Indiana judicial system. The ISDH may use funding from subsequent grants or grant years to support this effort.

3. The ISDH will establish a Pandemic Preparedness Coordinating Committee with representation from all relevant stakeholders by August 30, 2006. Membership will be drawn from Indiana's existing Bio Terrorism Advisory Committee (including public health, hospitals, NGO's, state and local agencies, emergency management, mental health, and others), as well as from organizations participating in the March 23, 2006, Statewide Pandemic Influenza Summit, and subsequent local and sector summits supported by the Pan flu Supplemental grant.

Section II:

Surveillance [HHS Supplement 1. Preparedness Goal 3—Decrease the time needed to detect and report chemical, biological, radiological agents in tissue, food, or environmental samples that cause threats to the public's health. Preparedness Goal 5—Decrease the time to identify causes, risk factors, and appropriate interventions for those affected by threats to the public's health.

Summary of Key Gap(s):

1. The ISDH needs to expand traditional surveillance for seasonal influenza to include hospitalizations and more rapid analysis of death certificate data.

2. The ISDH does not have a system for routinely obtaining and tracking the numbers and location of hospitalized cases, newly quarantined persons, and hospitals with influenza cases during a pandemic.

3. The ISDH requires increased capacity for rapid identification of unusual influenza strains; the ISDH requires increased capacity to enhance surveillance once a pandemic is detected to ensure likelihood of recognition of first cases and initiate countermeasures.

Proposed Approach(s):

1. The ISDH will contact hospitals and other providers including primary care physicians in private practice and in community and rural health centers regarding participation in influenza reporting. The ISDH will identify strategies to provide new sentinel physicians and clinics with adequate tools to support enhanced surveillance. The ISDH also plans to procure an electronic death certificate system to facilitate timely receipt and analysis of death data. These projects are ongoing and may utilize funding from general preparedness or Phase 2 Pan flu Supplemental funding.

2. The ISDH will contract with the Purdue University Homeland Security Institute and the Purdue University Regional Visualization and Analysis Center (PURVAC) to add modules to include data from multiple sources to track the numbers and location of hospitalized cases, newly quarantined persons, and hospitals with influenza cases during a pandemic. PURVAC will provide an integrated status monitoring during an emergency event. The development of the core elements of PURVAC are supported by the Indiana Department of Homeland Security. The Pan flu Supplemental Grant request includes funds to support enhancements in the PURVAC system and to support Web-based reporting of the required information. Indiana anticipates that this investment will add value to a web-based patient tracking system that can be purchased during the next grant year and implemented in all Indiana hospitals and among emergency medical services.

3. The ISDH is utilizing current resources to add laboratory training and quality assurance to the laboratory, and may utilize funds in subsequent grants or grant years to increase this effort. The ISDH proposes to use Pan flu Supplemental funding to procure laboratory equipment and supplies specific to increasing our capacity and capability to test for and respond to a pandemic influenza event. The ISDH also proposes to use Pan flu Supplemental funding to procure at least 200 additional CLIA approved Influenza Rapid Test Kits for surge in a pandemic influenza event. These kits will provide rapid testing of patient specimens in the influenza sentinel physician surveillance program allowing for quicker investigation and tracking of influenza strains.

Section III:

Public Health and Clinical Laboratories [HHS Supplement 2. Preparedness Goal 3—Decrease the time needed to detect and report chemical, biological, radiological agents in tissue, food, or environmental samples that cause threats to the public's health.]

Summary of Key Gap(s):

1. The ISDH Laboratories have not conducted a test of laboratory surge capacity for public health and clinical labs during a pandemic.

2. The ISDH has not provided training to frontline clinicians and laboratory personnel regarding protocols for safe specimen collection and testing and methods for submitting novel influenza samples to referral laboratories. ISDH has provided written guidance on sample submission.

Proposed Approach(s):

1. The ISDH will work with public health and clinical labs to design and conduct a test of surge capacity for a pandemic within the next 12 months. The ISDH will utilize funding from subsequent grants or grant years to support this effort. The ISDH is currently working on a Continuity of Operations Plan for the entire agency including the ISDH laboratories.

2. The ISDH is utilizing current resources to add laboratory training and quality assurance to the laboratory, and may utilize funds in subsequent grants or grant years to increase this effort. The ISDH has initiated training for Level A labs regarding bioterrorism and chemical terrorism sample handling. The ISDH will develop and provide training to frontline clinicians and laboratory personnel regarding protocols for safe specimen collection and testing and methods for submitting novel influenza samples to referral laboratories. The training will start this summer after the first round of training on bioterrorism and chemical terrorism is completed. The ISDH will utilize funding from subsequent grants or grant years to support this effort.

Section IV:

Healthcare and Public Health Partners [HHS Supplement 3. Preparedness Goal 6—Decrease the time needed to provide countermeasures and health guidance to those affected by threats to the public's health.]

Summary of Key Gap(s):

1. The role of public health in coordination with the healthcare sector in responding to a pandemic influenza is developing and in progress. Public health must increase its capacity to investigate and support its unique role in a pandemic influenza response.

2. Planning for adequate medical staffing during a surge, mental health needs for responders and the public, special needs populations and mortuary services are lacking in most response plans.

3. The ISDH has not developed a real-time system for situational awareness of patient visits, hospital bed and intensive care needs, medical supply needs, and medical staffing needs during a pandemic.

4. The ISDH has not determined what constitutes a medical staffing emergency.

5. The ISDH has not established a system for credentialing volunteer health care personnel.

6. Some Indiana hospitals do not have pandemic influenza plans. Some existing plans have not been exercised. The ISDH has not completed work with health care facilities to develop and test an operational plan to initiate, support, and implement hospital pandemic influenza plans, or plans for quarantine of potentially exposed healthcare personnel.

Proposed Approach(s):

1. The ISDH proposes to use Pan flu Supplemental funding to provide financial assistance to each of Indiana's 94 local health departments to enable them to purchase products or services to further assist in building plans and capacity for a pandemic influenza response. Such assistance will be conditioned upon goods or services closing local gaps as identified in the local assessments.

2. The ISDH held the Indiana Pandemic Influenza State Summit on March 23, 2006, with more than 400 participants from the private sector, from non-governmental organizations, and from federal, state and local government, including elected officials. The Summit provided state and federal authorities the opportunity to bring together relevant stakeholders including hospitals and other representatives from the healthcare sector to define the issues and to begin to address gaps in planning and to collaborate on strategies for closing gaps and plan for individual and collaborative responses in the event of a pandemic. The ISDH proposes to utilize Pan flu Supplemental funding to support the state summit. The ISDH further proposes to support a series of local or "sector" pandemic influenza summits throughout the state. These local summits may be hosted by local health departments, school corporations, county coroners and funeral home directors, local chambers of commerce, non-governmental organizations, and other relevant stakeholders including hospitals. The purpose of these local summits will be to inform and energize local communities and enterprise sectors to prepare for a pandemic response within the community. Particular emphasis may be placed on ensuring adequate medical staffing using professional staff and volunteers, and in planning for mortuary and mental health components of a community response.

3. The ISDH will contract with the Purdue University Homeland Security Institute and the Purdue University Regional Visualization and Analysis Center (PURVAC) to add modules to support routine reporting and tracking the numbers and location of hospitalized cases, newly quarantined persons, and hospitals with influenza cases during a pandemic. PURVAC will include data from multiple sources to provide an integrated status monitoring during an emergency event. The development of the core elements of PURVAC are supported by the Indiana Department of Homeland Security. The Pan flu Supplemental Grant request includes funds to support enhancements in the PURVAC system and to support Web-based reporting of the required information.

4. The ISDH plans to involve the Hospital Bioterrorism Preparedness and Planning Committee to assist in method to determine what constitutes a medical staffing emergency. The results of this effort will be provided to hospitals and other healthcare facilities to assist in identifying medical staffing emergencies and response plans.

5. The Pan flu Supplemental Grant request includes funds to establish a system for credentialing volunteer health care personnel. The ISDH proposes to initially procure six systems to be deployed to and utilized in the 10 Indiana homeland security districts among public health, hospital and other medical response personnel. This system will be integrated with the ESAR-VHP development and Indiana Health Alert Network (IHAN) expansion to include credentialing information about volunteers for responding to a public health emergency and

to provide identification badges for those volunteers. Additional systems may be supported by subsequent grants or in subsequent grant years.

6. Hospitals have been asked to complete pandemic influenza plans by August 30. That process is ongoing. During the preceding and the current grant year, the ISDH has supported district exercises of hospital and public health plans and planning, including three exercises testing hospital plans and utilizing a pandemic influenza scenario. The ISDH proposes to use Pan flu Supplemental funding to support 10 additional district exercises that will test local health department plans and that will include hospital plans and public health/hospital coordination. With a recent change in Indiana law for isolation and quarantine, the ISDH has clarified authority regarding rules governing isolation and quarantine. The ISDH proposes to initiate the rule writing process to include, if appropriate, guidance for health care facilities regarding development and testing of operational plans to initiate, support, and implement quarantine of potentially exposed healthcare personnel. Development of rules will include consultation with healthcare facilities and health care professional associations. The ISDH may use funding from subsequent grants or grant years to support this effort.

Section V:

Infection Control and Clinical Guidelines [HHS Supplements 4 & 5. Preparedness Goal 6- Decrease the time needed to provide countermeasures and health guidance to those affected by threats to the public's health.]

Summary Key Gap(s):

1. The Indiana Health Alert Network (IHAN) currently does not include contact information for all practicing, licensed, frontline healthcare personnel.

2. Volunteer recruitment and staffing for providers is not adequate to meet projected needs, and requires regular updates and exercises.

3. The ISDH has not established a system for credentialing volunteer health care personnel.

Proposed Approach(s):

1. The ISDH plans to expand IHAN coverage to include contact information for all practicing, licensed, frontline healthcare personnel as part of developing and implementing the ESAR-VHP system. The ISDH has already discussed the availability of telephone and e-mail addresses for health professionals licensed through the Indiana Professional Licensing Agency. The ISDH may utilize funding from subsequent grants or grant years to support this effort.

2. The ISDH proposes to use Pan flu Supplemental funding to support a consultant to conduct district exercises involving all 94 local health departments and local health department pandemic influenza plans and planning. These exercises will test components of local plans that address recruitment and information to prospective volunteer providers. The ISDH anticipates that other exercises will be scheduled during the current grant year and in subsequent grant years, and that current general preparedness dollars and subsequent grants will support ongoing exercise activity.

3. The Pan flu Supplemental Grant request includes funds to establish a system for credentialing volunteer health care personnel. The ISDH proposes to initially procure six systems to be deployed to and utilized in the 10 Indiana homeland security districts among public health, hospital and other medical response personnel. This system will be integrated with the ESAR-VHP development and Indiana Health Alert Network (IHAN) expansion to include credentialing information about volunteers for responding to a public health emergency and to provide identification badges for those volunteers. Additional systems may be supported by subsequent grants or in subsequent grant years.

Section VI:

Vaccine Distribution and Use [HHS Supplement 6. Preparedness Goal 6-Decrease the time needed to provide countermeasures and health guidance to those affected by threats to the public's health.]

Summary of Key Gap(s):

1. The ISDH has not functionally tested the expanded SNS distribution plan in a large scale exercise to handle the extended distribution needs during a pandemic. The ISDH has performed limited functional exercises involving single distributions to single points of dispensing (PODS) during local exercises. Further, limited exercises have demonstrated security issues in transport. Local health departments and the ISDH have not exercised scenarios requiring the use of multiple PODS and volunteer recruitment and staffing surge issues in a single incident.

2. The ISDH does not have a system for credentialing volunteer health personnel.

3. The ISDH has not implemented a system for tracking the number and priority of vaccine recipients and who will provide vaccinations. Eighty-three local health departments have recently updated their mass prophylaxis plans using the state's template, and all local health departments are developing or refining plans to address needs during a pandemic.

4. Incorporation of local pandemic influenza plan into overall state and local emergency response plans; local planning for surge and capacity during a pandemic influenza; local planning for cross-border integration of response including mutual aid; identification of local agenc(ies) with responsibility for isolation and quarantine and other response activities; local responsibility for incident command, and request and coordination of resources; local plan exercises.

5. The ISDH and local partners need to increase prevalence of broad-based information to 6.2 million citizens regarding threat of pandemic influenza and steps available to mitigate the event, including plans for vaccination distribution when a vaccine is available.

Proposed Approach(s):

1. The ISDH has begun efforts to assess the impact of the extended distribution needs during a pandemic on the SNS distribution plan. The ISDH has begun discussions with key partners in storage, transport and security to adjust needs to support distribution during a pandemic. The ISDH and key partners are organizing to conduct a test of the expanded distribution requirements. The ISDH will use subsequent grants or grant years to support this effort. The ISDH proposes to use Pan flu Supplemental funding to support a consultant to conduct district exercises involving all 94 local health departments and local health department pandemic influenza plans and planning. These exercises will test distribution and other components of the state's plan, and will test components of multiple local plans within a single district. Such components will include receipt, security, dispensing and volunteer availability and staffing.

2. The Pan flu Supplemental Grant request includes funds to establish a system for credentialing volunteer health care personnel. The ISDH proposes to initially procure six systems to be deployed to and utilized in the 10 Indiana homeland security districts among public health, hospital and other medical response personnel. This system will be integrated with the ESAR-VHP development and Indiana Health Alert Network (IHAN) expansion to include credentialing information about volunteers for responding to a public health emergency and to provide identification badges for those volunteers. Additional systems may be supported by subsequent grants or in subsequent grant years.

3. The ISDH has developed a web-based system for tracking vaccinations provided to children in Indiana, the Children and Hoosier Immunization Registry Program (CHIRP). The Public Health Preparedness Division is working with the ISDH Immunization Program to assess the feasibility of modifying CHIRP to support tracking of vaccinations and antiviral distribution during a pandemic. The Immunization Program has participated in the three most recent pandemic influenza exercises and has utilized CHIRP to track antiviral and vaccine distribution in those exercises. The ISDH will continue to evaluate this partnership and resource and, if feasible, the costs of the modifications may be requested in next year's Panflu Supplemental grant. The modifications will include consideration of changes needed to support implementation of the local health department mass prophylaxis plans.

4. The ISDH proposes to use Pan flu Supplemental funding to provide financial assistance to each of Indiana's 94 local health departments to enable them to purchase products or services to further assist in building plans and capacity for a pandemic influenza response. Such assistance will be conditioned upon goods or services closing local gaps as identified in the local assessments, and will include supporting components of local operation plans regarding PODs and POD operations. The ISDH has identified a consultant to conduct two conferences with relevant stakeholders on ethical considerations in a pandemic influenza response, including addressing the allocation of scarce resources such as anti-virals. These sessions are scheduled for April 26. 2006, and May 10, 2006. The ISDH anticipates that subsequent grants and grant years will support additional sessions in local communities. Through current ISDH district staff, the ISDH is working with local health departments to partner with border jurisdictions and with local health departments in border states.

5. The ISDH plans to procure and distribute informational brochures on pandemic influenza through local health departments, mental health clinics, primary care providers, schools, hospitals, and in other venues with broad-based and diverse audiences. In anticipation of an event, such information will be accompanied by public service messages telling local citizens

where they can receive support and services within their communities. The ISDH will utilize subsequent grants and grant years to support this effort. Following on the strength and energy of Indiana's State Pandemic Influenza Summit and upon anticipated local and sector summits, the ISDH proposes to use Pan flu Supplemental funding to support a public service announcement using Indiana's Governor as the spokesperson to energize the state and local communities to begin planning for a pandemic and to learn more about the services that will be afforded within their local communities.

Section VII:

Antiviral Drug Distribution and Use [HHS Supplement 7. Preparedness Goal 6—Decrease the time needed to provide countermeasures and health guidance to those affected by threats to the public's health.]

Summary of Key Gap(s):

1. The ISDH has not functionally tested the expanded SNS distribution plan in a large scale exercise to handle the extended distribution needs during a pandemic. The ISDH has performed limited functional exercises involving single distributions to single points of dispensing (PODS) during local exercises. Further, limited exercises have demonstrated security issues in transport. Local health departments and the ISDH have not exercised scenarios requiring the use of multiple PODS and volunteer recruitment and staffing surge issues in a single incident.

2. The ISDH does not have a system for credentialing volunteer health personnel.

3. The ISDH has not implemented a system for tracking the number and priority of antiviral drug recipients and who will provide treatment. Eighty-three local health departments have recently updated their mass prophylaxis plans using the state's template, and all local health departments are developing or refining plans to address needs during a pandemic. Hospitals are currently preparing pandemic influenza plans.

4. Incorporation of local pandemic influenza plan into overall state and local emergency response plans; local planning for surge and capacity during a pandemic influenza; local planning for cross-border integration of response including mutual aid; identification of local agenc(ies) with responsibility for isolation and quarantine and other response activities; local responsibility for incident command, and request and coordination of resources; local plan exercises.

Proposed Approach(s):

1. The ISDH has begun efforts to assess the impact of the extended distribution needs during a pandemic on the SNS distribution plan. The ISDH has begun discussions with key partners in storage, transport and security to adjust needs to support distribution during a pandemic. The ISDH and key partners are organizing to conduct a test of the expanded distribution requirements. The ISDH will use subsequent grants or grant years to support this effort. The ISDH proposes to use Pan flu Supplemental funding to support a consultant to conduct district exercises involving all 94 local health departments and local health department pandemic influenza plans and planning. These exercises will test distribution and other

components of the state's plan, and will test components of multiple local plans within a single district. Such components will include receipt, security, dispensing and volunteer availability and staffing. These exercises will involve hospitals and healthcare sectors that will be utilized in the distribution of antivirals for prophylaxis and treatment.

2. The Pan flu Supplemental Grant request includes funds to establish a system for credentialing volunteer health care personnel. The ISDH proposes to initially procure six systems to be deployed to and utilized in the 10 Indiana homeland security districts among public health, hospital and other medical response personnel. This system will be integrated with the ESAR-VHP development and Indiana Health Alert Network (IHAN) expansion to include credentialing information about volunteers for responding to a public health emergency and to provide identification badges for those volunteers. Additional systems may be supported by subsequent grants or in subsequent grant years.

3. The ISDH has developed a web-based system for tracking vaccinations provided to children in Indiana, the Children and Hoosier Immunization Registry Program (CHIRP). The Public Health Preparedness Division is working with the ISDH Immunization Program to assess the feasibility of modifying CHIRP to support tracking of vaccinations and antiviral distribution during a pandemic. The Immunization Program has participated in the three most recent pandemic influenza exercises and has utilized CHIRP to track antiviral and vaccine distribution in those exercises. The ISDH will continue to evaluate this partnership and resource and, if feasible, the costs of the modifications may be requested in next year's Panflu Supplemental grant. The modifications will include consideration of changes needed to support implementation of the local health department mass prophylaxis plans.

4. The ISDH proposes to use Pan flu Supplemental funding to provide financial assistance to each of Indiana's 94 local health departments to enable them to purchase products or services to further assist in building plans and capacity for a pandemic influenza response. Such assistance will be conditioned upon goods or services closing local gaps as identified in the local assessments, and will include supporting components of local operation plans regarding PODs and POD operations. The ISDH has identified a consultant to conduct two conferences with relevant stakeholders on ethical considerations in a pandemic influenza response, including addressing the allocation of scarce resources such as anti-virals. These sessions are scheduled for April 26. 2006, and May 10, 2006. The ISDH anticipates that subsequent grants and grant years will support additional sessions in local communities.

Section VIII:

Community Disease Control and Prevention (including managing travel-related risk of disease transmission) [HHS Supplements 8 & 9. Preparedness Goal 6—Decrease the time needed to provide countermeasures and health guidance to those affected by threats to the public's health.]

Summary of Key Gap(s):

1. The ISDH and local health departments and hospitals have not completed an update or test of an operational plan to delineate procedures for isolation and quarantine, procedures for legal authority for implementing and enforcing containment requirements, and methods used for

containment of the disease and to support, service, and monitor those affected by isolation and quarantine measures.

Proposed Approach(s):

1. With a recent change in Indiana law for isolation and quarantine, the ISDH has clarified authority regarding rules governing isolation and quarantine. The ISDH proposes to initiate the rule writing process to include, as appropriate, delineation of procedures for isolation and quarantine, procedures for legal authority for implementing and enforcing containment requirements, and methods used to support, service, and monitor those affected by isolation and quarantine measures. These rules will be developed in consultation with key partners. The ISDH will use subsequent grants and grant years to support these efforts. The ISDH proposes to use Pan flu Supplemental funding to support a consultant to conduct district exercises involving all 94 local health departments and local health department pandemic influenza plans and planning. These exercises will involve local hospitals and other key stakeholders including emergency management, law enforcement and military support to test disease containment procedures and planning. The ISDH proposes to use Pan flu Supplemental funding to provide financial assistance to each of Indiana's 94 local health departments to enable them to purchase products or services to further assist in building plans and capacity for a pandemic influenza response. Such assistance will be conditioned upon goods or services closing local gaps as identified in the local assessments, and will include supporting components of local operation plans regarding disease containment procedures and planning.

Section IX:

Public Health Communications [HHS Supplement 10. Preparedness Goal 4—Improve the timeliness and accuracy of communications regarding threats to the public's health.]

Project Note: This section of the state assessment tool and gap analysis template governs risk communications and operational communications. These areas are covered in the preparedness grant as outcomes within the "Control" preparedness goal (specifically Preparedness Goal 6, Outcomes 6A, 6B and 6F). This section of both the state assessment tool and of the separate gap analysis template provided by the CDC nonetheless links the activities and gaps to "Preparedness Goal 4." Preparedness Goal 4 is "Detect and Report" and has a sole outcome and activities related to data integration and surveillance. We believe that this discrepancy is a scrivener's error. On the guidance of our CDC Project Officer, we are noting this discrepancy in our gap analysis and work plan, and as possible, within the budget worksheet, and we are linking the projects set forth here to "Preparedness Goal 4, Detect and Report," as indicated in the self-assessment tool and gap analysis template as this is where CDC would expect to find them based on those documents. While doing so in accordance with the guidance and forms provided by CDC, Indiana's linkages in the budget worksheet to "Preparedness Goal 4"are not accurate if those linkages are to be based on the general preparedness goals. The correct linkages for these activities would be to Preparedness Goal 6, Control. Outcomes are indicated in the "Approaches" section below.

Summary of Key Gap(s):

1. ISDH communication efforts regarding pandemic influenza have focused on general awareness of the significance of an influenza pandemic and efforts individuals and

communities can take to be better prepared to respond to the pandemic. These plans have not included specific training for media regarding panflu coverage.

2. The state, because of its geographic terrain in the southern part of the state, is not fully equipped with infrastructure to support a single redundant communications system.

Proposed Approach(s):

1. The ISDH plans to expand communication efforts regarding public awareness and to provide in-service training for media regarding panflu issues and preparedness activities. The ISDH will use current general preparedness grant activity to support media awareness for a pandemic influenza. The ISDH plans to procure and distribute informational brochures on pandemic influenza through local health departments, mental health clinics, primary care providers, schools, hospitals, and in other venues with broad-based and diverse audiences. In anticipation of an event, such information will be accompanied by public service messages telling local citizens where they can receive support and services within their communities. The ISDH will utilize subsequent grants and grant years to support this effort. Following on the strength and energy of Indiana's State Pandemic Influenza Summit and upon anticipated local and sector summits, the ISDH proposes to use Pan flu Supplemental funding to support a public service announcement using Indiana's Governor as the spokesperson to energize the state and local communities to begin planning for a pandemic and to learn more about the services that will be afforded within their local communities. These public service announcements will provide a platform for ongoing communications with the public during an event. ***See Project Note above. Consistent with the state self-assessment and gap analysis templates, a percentage of this project is linked to Preparedness Goal 4 in the accompanying budget worksheet. The correct linkage would be to Preparedness Goal 6, Outcome 6B, making that linkage 100%.***

2. The state is currently building additional towers and zone controllers to complete a redundant communications system. The ISDH has supported some of these activities by funding zone controllers and the purchase of 800 MGH radios for public health and, through HRSA funding, hospital personnel, as the system has expanded. The ISDH will use subsequent grants and grant years to further support these efforts. The ISDH proposes to use Pan flu Supplemental funding to provide financial assistance to each of Indiana's 94 local health departments to enable them to purchase products or services to further assist in building plans and capacity for a pandemic influenza response. Such assistance will be conditioned upon goods or services closing local gaps as identified in the local assessments, and will include supporting components of local communications plans including training and the purchase of additional 800 MGH radios. ***See Project Note above. Consistent with the state self-assessment and gap analysis templates, a percentage of this project is linked to Preparedness Goal 4 in the accompanying budget worksheet. The correct linkage would be to Preparedness Goal 6, Outcome 6A.*** The ISDH further proposes to use Pan flu Supplemental funding to purchase three Tac-Paks, or mobile suitcase communications systems for use during a pandemic influenza. One lesson learned from the ISDH participation in the Hurricane Katrina response was that communications had to be mobile and comprehensive, and could not rely on land lines, scarce cellular availability, or frequency communications that were rendered ineffective by weather or terrain or distance. These Tac-Pak mobile communications systems utilize satellite phones, and include computer, printer, copier, facsimile, camera, cellular phones, and GPS software. It is anticipated that these Tac-Paks would augment communications systems already being deployed for use by public health authorities in each of Indiana's 10 homeland security districts, and that these particular

units would be deployed to mental health and family assistance crisis communications teams and to DMORT or other teams addressing mass fatalities in response to a pandemic influenza. ***See Project Note above. Consistent with the state self-assessment and gap analysis templates, a percentage of this project is linked to Preparedness Goal 4 in the accompanying budget worksheet. The correct linkage would be to Preparedness Goal 6, Outcome 6A.***

Section X:

Workforce Support: Psychosocial Considerations and Information Needs [HHS Supplement 11. Preparedness Goal 6—Decrease the time needed to provide countermeasures and health guidance to those affected by threats to the public's health.]

Summary of Key Gap(s):

1. The ISDH has not completed development and testing of a Continuity of Operations Plan (COOP).

2. The Indiana Department of Mental Health and Addictions (IDMHA) has recently updated plans to provide psychosocial support in communities during a public health emergency or disaster. The plan does not include adjustments that reflect the impact of a pandemic.

Proposed Approach(s):

1. The ISDH is on target to complete a COOP by July 1, 2006. Testing will be conducted in the second half of 2006. The ISDH will utilize existing resources to support these efforts.

2. The ISDH will work with IDMHA to further update the IDMHA plan to include adjustments for an influenza pandemic and test those adjustments. It is anticipated that the ISDH will use subsequent grants and grant years to support these efforts.

Section XI: Performance Measures:

All recipients:

1. **Number of days following the exercise of the State/Territory-level pandemic influenza preparedness plan required to complete an AAR highlighting needs for corrective action (Target: 60 days). Los Angeles County, New York City, Chicago, and the District of Columbia should exercise and develop an AAR regarding the respective municipal plans.**

   - **Provide baseline data for this measure if applicable:**

     1. Exercise AARs and/or AAR reports occur within sixty (60) days.

     2. The ISDH and its various partners have exercised components of the state's pandemic influenza plan and/or planning no fewer than eight (8) times. These

exercises have been local or district (regional) exercises that test both local pandemic influenza plans and planning through local agency participation, and the state's plan and planning through state agency participation. On each occasion the ISDH participated in or conducted an AAR of the exercise on the same day. Three (3) of these exercises were not followed with a written AAR report by design (see below). With the exception of the most recent exercise, the remaining exercises were followed by a written AAR report well within the CDC target of sixty (60) days. The most recent exercise occurred on March 30, 2006. The ISDH is preparing a draft AAR report of that exercise, and anticipates that it will be completed on or before Friday, April 14, 2006, well within the CDC target of sixty (60) days.

3. During the grant year that ended on August 30, 2005, the ISDH participated in three (3) tabletop exercises that involved a pandemic influenza scenario. These were district exercises that tested hospital and state and local health department plans and/or planning. Each of these exercises was immediately followed by an AAR facilitated by the exercise vendor and participated in by all of the exercise participants. These same-day AARs were not reduced to writing, but included deficiencies and required corrective actions that were incorporated and retested in subsequent exercises by the exercise vendor.

4. During the current grant year beginning on August 31, 2005, the ISDH has participated in five (5) additional pandemic influenza exercises. Three (3) of these were functional local exercises, and two (2) of these were district tabletop exercises. Each exercise tested state and local health department plans and/or planning, and involved participants from hospitals, law enforcement, emergency management, the military, non-governmental volunteer organizations, and other relevant stakeholders. Each exercise was followed by a same day AAR. A written AAR report from the most recent exercise which occurred on March 30, 2006, is being drafted, and will be finished on or before April 14, 2006, well within the CDC's sixty (60) day target. Each of the other written AAR reports were completed within thirty (30) days of the exercise, well within the CDC's sixty (60) day target.

5. The ISDH is currently planning a statewide tabletop pandemic influenza exercise for April 26, 2006. This exercise will test both the state and local plans and/or planning. A written AAR report will be completed within sixty (60) days of the exercise as required by the CDC.

6. The local health departments within Indiana Homeland Security District 1 are currently planning a district tabletop pandemic influenza exercise for May 18, 2006. The ISDH will participate to test the state plan and/or planning as part of this exercise, and will prepare an AAR report within sixty (60) days of the exercise as required by the CDC.

7. The ISDH routinely conducts AARs and prepares AAR reports for all exercises and events. These are usually completed within sixty (60) days of the exercise and event. The ISDH completed an AAR report for the ISDH's response to Hurricane Katrina within 60 days after the last deployment of staff to Biloxi, MS.

- **Describe your state's plan to evaluate this measure:**

1. The ISDH will provide training to staff regarding the conduct of an AAR and preparation of an AAR report. The ISDH will track completion of AAR reports and maintain electronic and hard copies to assure compliance with the metric.

State and Territories Only:

2. Number and percentage of municipalities or other communities within the recipient jurisdiction that have developed a written community-wide plan for pandemic influenza preparedness (Target: 80%)

- **Describe how your state will define municipalities and other communities**

1. Indiana statute creates a state health department with a state health commissioner appointed by the Governor of Indiana. Indiana is organized into ninety-two (92) counties. Local public health in Indiana is organized by county with the exception of three (3) municipal health departments. Two (2) counties share a single county health department. There are ninety-four (94) local health departments in the State of Indiana. Indiana statute creates local health departments that exercise concurrent authority with the state health department and within their respective local jurisdictions, but which may act independently from the state health department. Indiana will define "community" for the purpose of this metric to encompass the jurisdiction of each local health department. Local health departments in Indiana engage in planning and are the focus of developing written plans for pandemic preparedness within their respective jurisdictions.

2. The ISDH and the Indiana Department of Homeland Security have divided the state into ten (10) homeland security districts. A district may have as few as five (5) or as many as thirteen (13) local health departments falling within the district. Local health departments and other partners within each district have formed district planning organizations. These stakeholders meet and plan for regional responses and mutual aid on a monthly basis. These district planning organizations are forming into District Planning Councils.

- **Provide baseline data for this measure if applicable**

1. The ISDH is currently assessing the status and availability of local or "community-wide" written pandemic influenza response plans. All ninety-four local health departments in the state have contributed to their home county's comprehensive emergency management plan. All ninety-four (94) local health departments have prepared and submitted survey information to the ISDH evidencing plans and planning for mass prophylaxis which would include pandemic influenza countermeasures. Eighty-three (83) out of ninety-four (94) local health departments recently updated their mass prophylaxis plans using a template provided by the ISDH. Those revised plans include pandemic influenza preparedness. Ninety-one (91) out of ninety-four (94) local health departments have separately completed an ISDH checklist for pandemic influenza planning and preparedness, inclusive of the current status of their influenza preparedness on checklist items, the owner of the activity, and the date of completion or anticipated

completion of the activity. Each local health department has also been provided with a copy of the CDC local assessment tool, and ISDH staff is currently meeting with local health departments to assist them in completing the checklist for submission to the CDC at a later date.

- **Describe your state's plan to evaluate this measure**

1. The ISDH is currently reviewing the pandemic influenza checklist and updated mass prophylaxis plans for gaps and weaknesses. The information from this review will be used to develop targeted technical assistance and to develop or refine pandemic influenza plans or pandemic influenza components of existing plans. The ISDH proposes to use a portion of the Pan flu Supplemental grant to secure the services of consultants to assist the local health departments in assessing preparedness, preparing a detailed gap analysis, and developing or refining and exercising written pandemic influenza response plans as an annex to their all hazards or mass prophylaxis plans. The ISDH will collect and review local health department written pandemic influenza response plans and offer technical assistance as appropriate. The ISDH will also facilitate and/or participate in state, regional and local exercises that test components of local plans.

3. Number and percentage of municipalities or other communities within the recipient jurisdiction that have exercised their pandemic influenza plans and prepared after action reports AARs (Target: 80%)

- **Describe how your state will define municipalities and other communities**

1. Indiana statute creates a state health department with a state health commissioner appointed by the Governor of Indiana. Indiana is organized into ninety-two (92) counties. Local public health in Indiana is organized by county with the exception of three (3) municipal health departments. Two (2) counties share a single county health department. There are ninety-four (94) local health departments in the State of Indiana. Indiana statute creates local health departments that exercise concurrent authority with the state health department and within their respective local jurisdictions, but which may act independently from the state health department. Indiana will define "community" for the purpose of this metric to encompass the jurisdiction of each local health department. Local health departments in Indiana engage in planning and are the focus of developing written plans for pandemic preparedness within their respective jurisdictions.

- **Provide baseline data for this measure if applicable**

1. During the current grant year beginning August 31, 2005, fourteen (14) out of ninety-four (94) local health departments have exercised components of their pandemic influenza plans or planning in either functional or tabletop exercises. These include health departments for Dubois, Perry, Pike and Knox Counties (District Tabletop Exercise, January 26, 2006); Vigo County (Functional Exercise, January 26, 2006); Henry County (Functional Exercise, February 17, 2006); Brown, Monroe, Lawrence, Washington, Bartholomew, Jackson and Orange

Counties (District Tabletop Exercise, March 9, 2006); and Madison County (Functional Exercise, March 30, 2006).

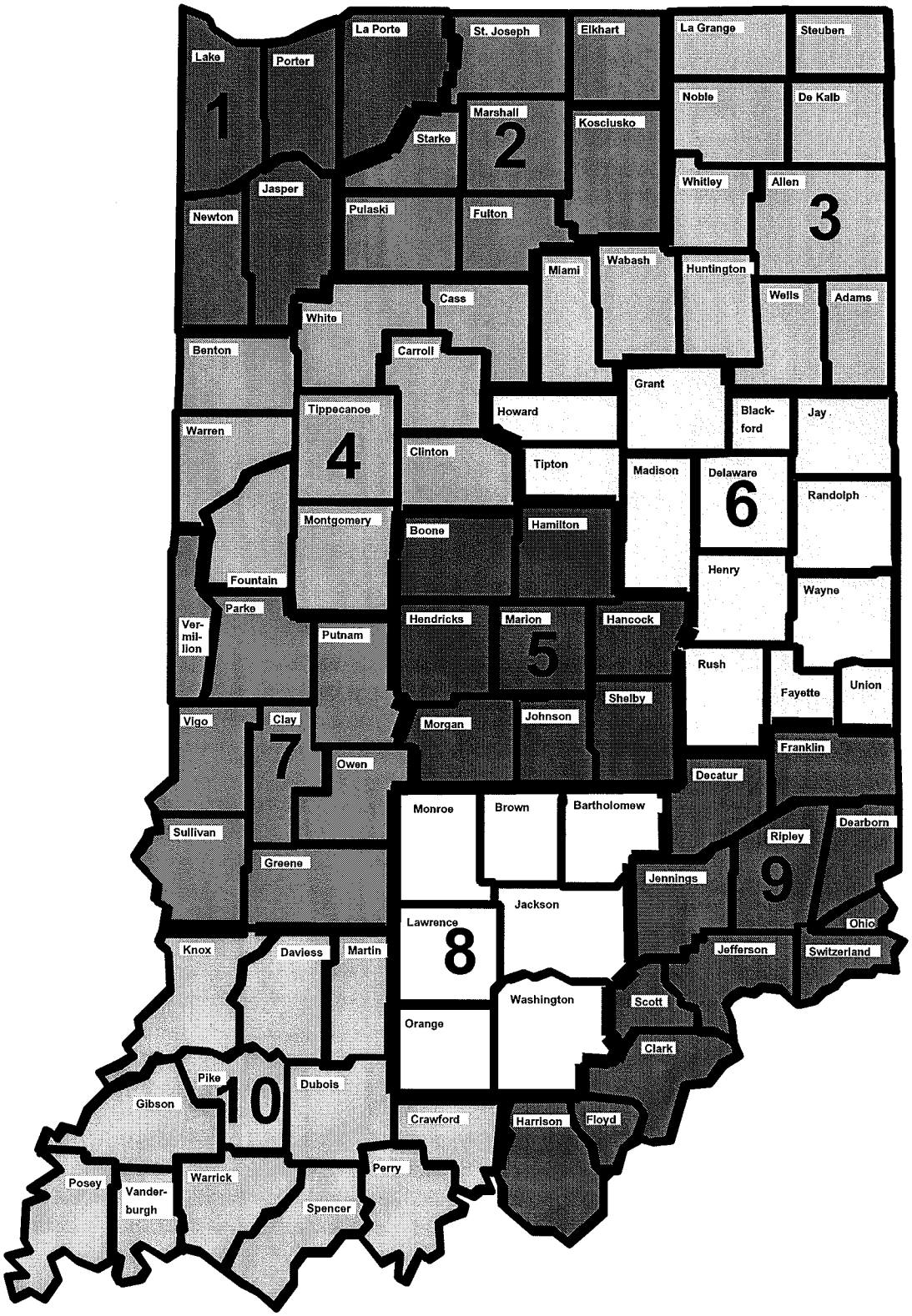
2. The ISDH is facilitating a statewide tabletop pandemic influenza exercise on April 26, 2006, and anticipates participation from additional local health departments where they will test components or their individual local plans and/or planning. Local health departments in Indiana Homeland Security District 1 are planning a district tabletop pandemic influenza exercise to take place on May 15, 2006. That exercise is anticipated to include seven local health departments.

- **Describe your state's plan to evaluate this measure**

1. The ISDH proposes to use a portion of the Pan flu Supplemental grant to secure the services of consultants to assist local health departments in conducting district tabletop exercises of the local pandemic influenza response plans for each jurisdiction in the district. The ISDH will facilitate ten (10) district exercises, each to include every local health department and local plan falling within that district. The ISDH will participate in district and local health department exercises and AARs, and will collect and review exercise AAR reports. These reviews will be used to develop targeted technical assistance and assist local health departments in the further development and/or refinement of their pandemic influenza plans.

APPENDIX H – Local Health Department Gap Analysis Reports

Public Health Preparedness Districts



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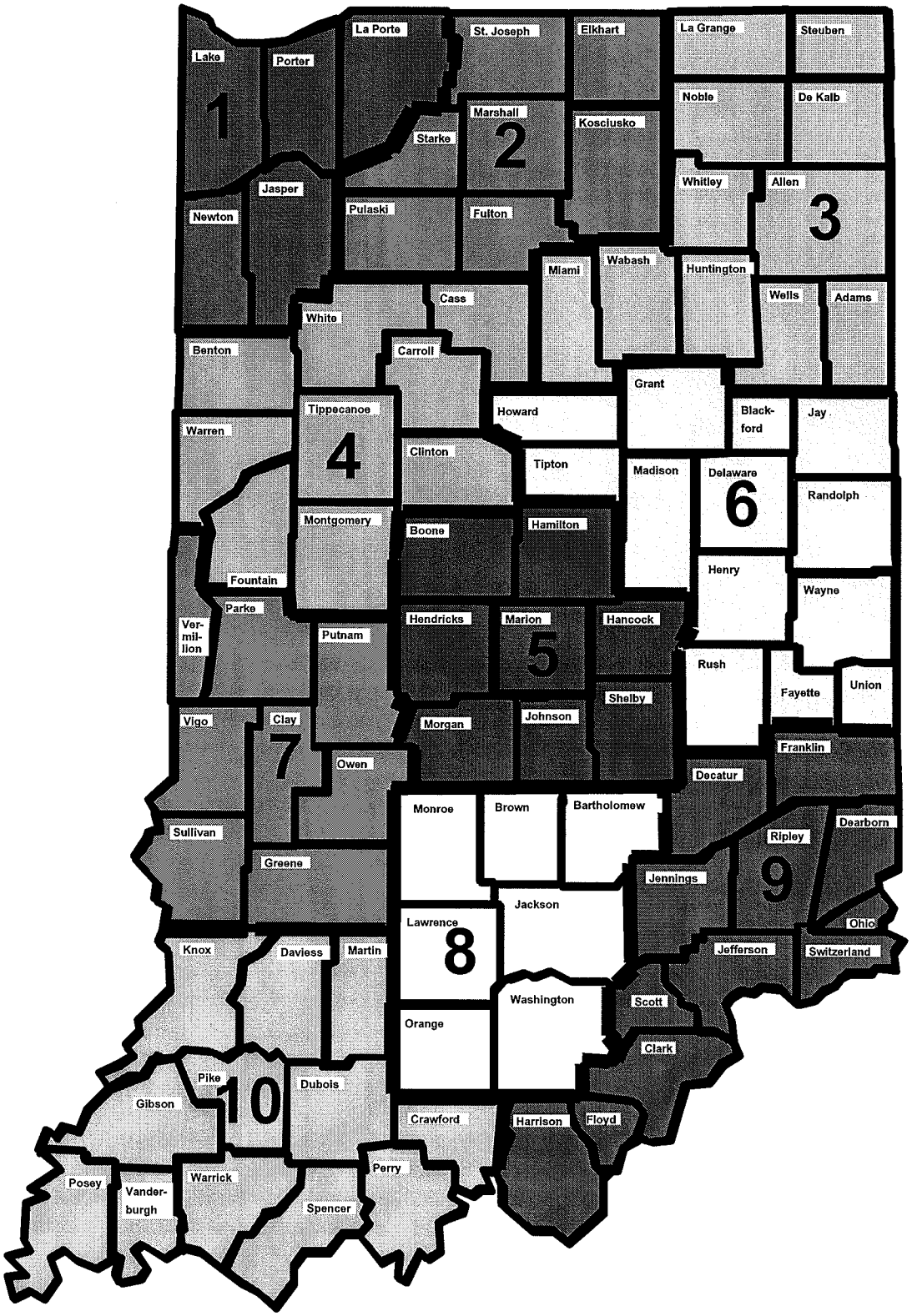

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PANDEMIC INFLUENZA GAP ANALYSIS AND RECOMMENDATIONS

FOR INDIANA LOCAL HEALTH DEPARTMENTS

Prepared for Indiana State Department of Health (ISDH)
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Healthcare Technical Assistance Program
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REGENSTRIEF CENTER
FOR HEALTHCARE ENGINEERING
HEALTHCARE TECHNICAL ASSISTANCE PROGRAM

Purdue Homeland
Security Institute

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1. EXECUTIVE SUMMARY

Purdue University's Technical Assistance Program was contracted by the Indiana State Department of Health (ISDH) to perform pandemic flu planning gap analyses for all local health departments (LHD) in the State of Indiana. By April 2006, each LHD had completed a self-assessment provided to ISDH by the Centers for Disease Control and Prevention. In May 2006, Purdue received these self-assessments as a starting point for the gap analysis procedure, which was designed by the Purdue team. This procedure consisted of two steps: (1) an auditing call or site visit with each LHD, and (2) development of a final gap report for each LHD.

Audits revealed that self-assessments were typically out-of-date or only marginally accurate. Inaccuracies were caused by unclear wording in self-assessment questions as well as insufficient resolution in allowable numerical responses. Thus, self-assessment analyses only roughly represent the state of LHD pandemic planning as of April 2006. Even with these shortcomings, self-assessment analyses did capture state-wide and district patterns, as illustrated in Figure 1 of this report and Figures 18-29 of Appendix G.

Audits revealed more accurate information, which is included in the final gap reports for each LHD in Appendix M. Each report has ten sections, corresponding to the sections in the CDC self-assessment form. Each section summarizes key points discussed during the audit, areas for improvement, and strategies to complete planning. Strengths identified across LHDs include: 1) a clear understanding of the roles of the LHD, LHO, and EMA in pandemic planning and response, 2) identification of local healthcare resources and psychosocial services for pandemic response, 3) memos of understanding (MOU) in place for points of distribution (POD), mutual aid and support of supplies and volunteers, and 4) on-going work to complete written plans and ensure flexibility.

Significant gaps include 1) alternate care site planning, 2) volunteer management, 3) mass fatality planning, 4) public and business education and involvement in LHD planning, 5) identification of homebound or special needs populations, 6) integration of key stakeholders and delineation of roles in LHD plans, 7) identification of priority groups for vaccination and anti-viral, 8) routine surveillance for seasonal influenza at the local level, 9) PPE management, 10) planning or consensus on isolation/quarantine implementation, and 11) depth in plans for continuing operation, particularly with regard to the local health officer. Each of these are discussed in this report and recommendations to ISDH are proposed to address six priority areas: 1) alternate care site planning, 2) volunteer management, 3) mass fatality planning, 4) public education, 5) isolation/quarantine, and 6) state-level coordination.

2. Process Overview

In May 2006, Purdue Healthcare Technical Assistance Program (HTAP) was contracted by the Indiana State Department of Health (ISDH) to complete gap analyses of pandemic influenza plans at each of the 94 local health departments (LHD) in the state (Appendix A). The stated goal of the four-month project was to increase the capability of state and local public health/medical entities to respond to an influenza pandemic, catalyzing community-wide preparedness efforts through development, coordination and testing of state and local pandemic influenza plans.

As the contracted agency, Purdue HTAP agreed to complete the following project tasks:

a) Review CDC Pandemic Influenza Planning Self-Assessment (Appendix B) and written Gap Audit Template (Appendix C).
b) Analyze individual self-assessments completed and submitted by LHDs (Appendix D).
c) Engage in meetings with LHD staff through site visits and telephone interviews, and otherwise obtain additional information supporting local self-assessments as necessary and appropriate to understand the nature and scope of the self-assessment.
d) Prepare a written gap analysis report for each LHD based on that agency's self-assessment and other information. Gap analysis should identify key gaps under each category of the self-assessment tool, and set forth ongoing and/or recommended approaches to close those key gaps (Appendix E).
e) Provide ISDH with hard and electronic copies of an individualized written gap analysis for each LHD.

To accomplish these tasks, ISDH provided Purdue HTAP with a variety of materials, including completed copies of the CDC self-assessment from each of the 94 LHDs. Purdue requested, and ISDH provided, a list of self-assessment items that ISDH deemed "not applicable" (N/A) for LHDs. A discussion of N/A items can be found on page 11 of this report.

Purdue HTAP assembled a team of faculty, staff and students (Appendix F) from the following areas:

a) Purdue Homeland Security Institute (PHSI)
b) Regenstrief Center for Healthcare Engineering at Purdue University (RCHE)
c) Purdue Technical Assistance Program (TAP)
d) College of Engineering
e) School of Nursing

f) Department of Statistics

g) Department of Computer Graphics Technology

The project was completed in two phases; first, LHD self-assessment results were statistically analyzed to present and summarize individual and statewide data. In the second phase, audits were conducted by phone or site visit with each of the 94 LHDs.

2.1 Analysis of Self-Assessment Tool

A questionnaire, *Pandemic Influenza Planning Self-Assessment – Local Public Health, Public Health Roles and Responsibilities* (referred to as the "self-assessment") was completed by each of the 94 LHDs in April 2006 (Appendix B).

Format of collected data

The self-assessment consisted of 72 questions (items) grouped into ten sections:

Table 1. Self-Assessment Sections

Index	Section	Number of Items
1	Community Preparedness Leadership and Networking	18
2	Surveillance	5
3	Public Health and Clinical Laboratories	5
4	Healthcare and Public Health Partners	15
5	Infection Control and Clinical Guidelines	3
6	Vaccine Distribution and Use	4
7	Antiviral Drug Distribution and Use	2
8	Community Disease Control and Prevention	7
9	Public Health Communications	11
10	Workforce Support	2

Respondents were asked to select the choice that best described their preparedness status for each element by placing a mark in the appropriate box as follows:

Table 2. Sample Item Response

	COMPLETED
X	IN-PROGRESS
	NOT STARTED
	N/A – **NOT** LOCAL PH REPONSIBILITY

Coding of responses

Responses were numerically coded in the following way in order to compute averages:

Table 3. Numerical Codes for Responses

2	COMPLETED
1	IN-PROGRESS
0	NOT STARTED
-1	N/A – **NOT** LOCAL PH REPONSIBILITY

A missing value code of 99 was given to items for which there was no response or more than one response. Responses coded as -1 or 99 were not included in statistical computations. Data analysis was completed using SAS and SPSS (statistical software packages), and Microsoft Excel and Access.

2.2 Description of Self-Assessment Summary Report

A summary report, describing responses to the self-assessment, was prepared for each LHD (Appendix D). This report compares LHD responses to a) average responses of the district, b) LHDs of a similar size, and c) all LHDs in the state. Graphs and charts are used to visualize these comparisons and identify gaps.

The Self-Assessment Summary Report had two purposes: a) to summarize progress of each LHD and identify sections needing the most work, and b) to help audit teams prepare by identifying gaps and providing comparisons.

2.3 Audit Procedures

Based upon preliminary statistical analyses, audit procedures were developed by Purdue HTAP to ensure consistent data collection and reporting across audit teams (Appendix H). Audits were completed by conference call or site visit with each of the 94 LHDs in Indiana. Calls or site visits included the local public health coordinator (LPHC) and/or other key individuals as determined by the LHD.

Audit scheduling

Audits were scheduled by Purdue Healthcare TAP; selection of individual counties for phone conference or site visit was determined using stratified random sampling. The order of audits was determined by LHD and audit team availability.

Audit team structure and responsibilities

Audit teams consisted of at least two members: a lead auditor and a recorder (see Appendix F for audit team members). The lead auditor was responsible to ensure that each of the ten sections of the self-assessment was addressed and answers documented. All members of the audit team present during an audit interview recorded findings and observations, and these notes were forwarded to the lead auditor and compiled into the final audit report for each LHD.

Audit description

The goal of each audit was to clarify, update and document progress made by each LHD in the area of pandemic influenza planning. An audit interview guide was used for all audits to ensure consistency among lead auditors (Appendix I).

Prior to each audit, the audit team reviewed pertinent county statistics and self-assessment results for the individual LHD. Based upon this information, the lead auditor selected questions from the Gap Audit Template to address each of the ten sections. Responses were recorded by all audit team members and forwarded to the audit leader.

2.4 Final Audit Reports and Records

The lead auditor and other team members utilized the Self-Assessment Summary Report, audit interview guide and team notes to draft a final audit report for each LHD. Each report summarizes key points for each of the ten sections, identifies areas for improvement, and suggests strategies to advance planning efforts (Appendix E). Audit reports were forwarded to the project leader and lead auditors to create this final summary report, identifying statewide trends, gaps and opportunities.

A file has been created for each LHD, containing the following records and retained at the Purdue Healthcare TAP office:

a) A copy of the completed self-assessment tool;
b) Self-Assessment Summary Report;
c) Audit interview guide;
d) Team notes;
e) Other objective evidence requested of the local LHD; and
f) Final audit report summarizing main points, gaps and recommendations.

3. Gap Findings

Quantitative and qualitative analyses were performed on the self-assessment data and information collected in the audit interviews. A discussion of each and a comparison of the quantitative and qualitative findings follow here.

3.1 Self-Assessment Findings

Analyses of LHD self-assessments were conducted early in the project to provide audit teams with baseline information regarding pandemic planning in individual LHDs. This information was used to guide audit interviews.

Overall averages

Statewide averages were computed for the self-assessment as a whole, and for each individual assessment section. Scores range from 0 (item not started) to 2 (item completed). The statewide average of 0.76 indicates that, on average, a quarter of items have not been started and the remaining are in progress. The map demonstrates that the lower half of the state reported a lower level of completion than the upper half (more dark and medium shades).

Figure 1. Overall Average for each LHD

Dark shade = 0 – 0.2
(least items "in progress" or "completed")

Medium shade = 0.21 – 0.99

Lightest shade = 1.0 – 2.0
(most items "in progress" or "completed")

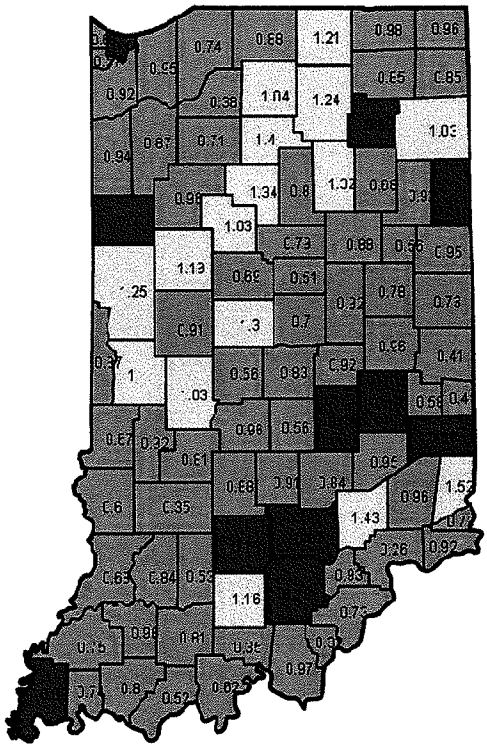
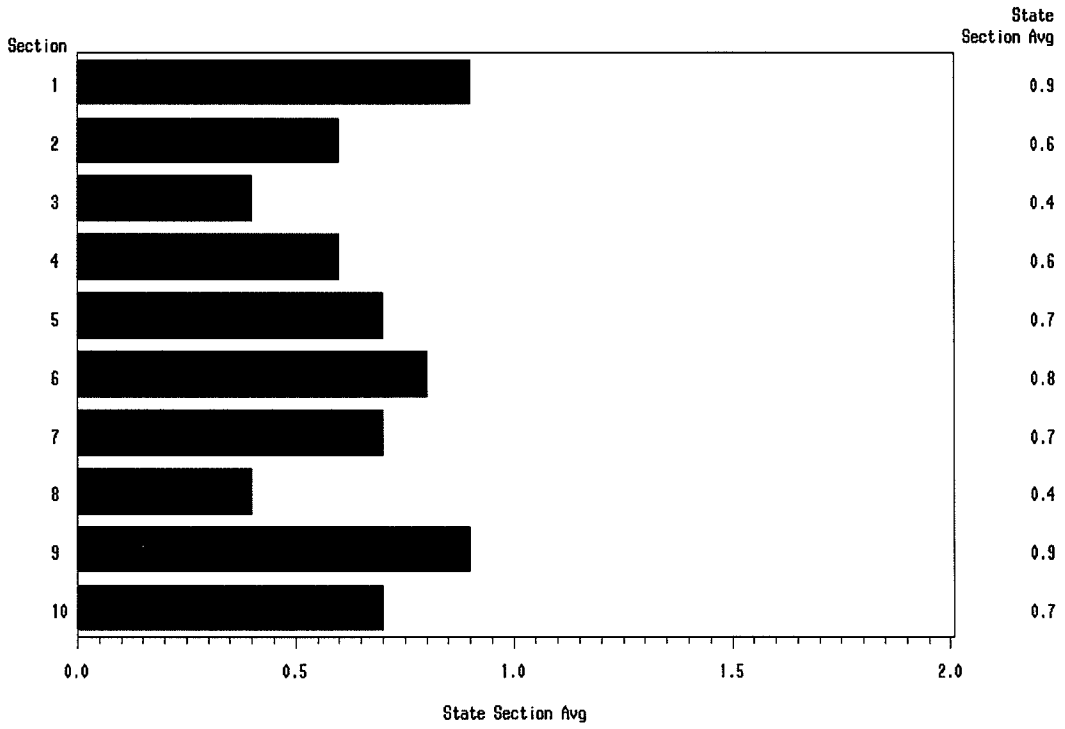


Figure 2 further summarizes statewide averages for each section of the self-assessment. Section 3 (Public Health and Clinical Labs) and Section 8 (Community Disease Control and Prevention) have the lowest averages, indicating that many LHDs reported little or no work in these areas.

Figure 2. Bar Chart of State Section Averages

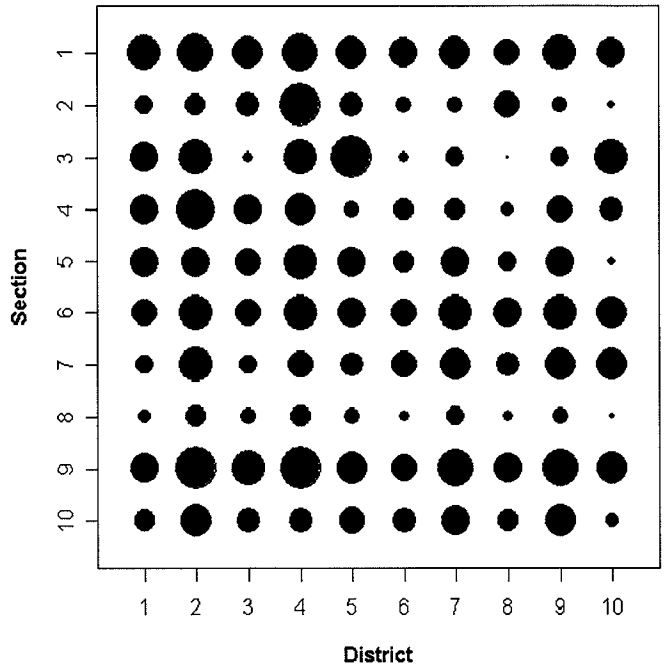


District and size trends

In addition to statewide analysis, self-assessment responses were analyzed by comparing LHDs of similar size; no significant trends emerged from this analysis (see Appendix G for details of this comparison).

Responses were also analyzed by grouping districts. In Figure 3, the size of the "bubble" represents the magnitude of the response (i.e., larger "bubbles" indicate a higher preparedness level). Districts 8 and 10 reported the lowest level of preparedness, and Districts 2 and 4 have relatively high section averages.

Figure 3. Bubble Plot of Section Averages for Districts



Discussion of N/A responses

ISDH specified that 20 of the 72 self-assessment questions were not the responsibility of individual LHDs; thus, an N/A response was expected from the 94 LHDs for these (and only these) items. In Table 4, questions are organized by section number (1-10) and question number. The column labeled 'Actual N/A' shows the number of LHDs that marked the item as N/A.

Note that Section 1 (Community Preparedness Leadership and Networking) and Section 2 (Surveillance) have large differences; few LHDs indicated that these items were not their responsibility. Shaded rows are items that ISDH indicated were local responsibilities, but many LHDs indicated the items were "not applicable" to them. These data suggest much confusion about local and state-level responsibilities.

Table 4. Expected vs. Actual N/A Responses

	Expected N/A	Actual N/A
Section 1		
Q14 Determined "law enforcement' emergency	94	7
Q18 Address animal health –disease	94	18
Section 2		
Q01 Traditional surveillance seasonal flu	94	34
Q02 Improved capacity-ID of new flu	94	67
Q03 Implement enhanced surveillance	94	27
Q04 Animal and human systems linked	94	46
Q05 Obtain and track information daily	94	6
Section 3		
Q01 Surveillance of lab personnel	94	79
Q02 Augment capacity of public health	94	81
Q03 This plan has been exercised	94	80
Q04 Diagnostic testing assessed	94	83
Q05 Frontline personnel aware of protocols	94	67
Section 4		
S04Q01 State defined role clear	0	15
S04Q04 Developed operational plan - 7 items	94	49
S04Q05 Plan for isolating patients	94	44
S04Q06 Quarantine of exposed personnel	94	45
S04Q07 Components of delivery network	0	33
S04Q08 Real-time situational awareness	94	55
S04Q09 Plan developed for mortuary	94	47
S04Q10 Plan tested for mortuary	94	54
S04Q12 Medical staffing emergency defined	0	13
S04Q14 Health facilities plan for isolating	94	49
S04Q15 Health facilities plan for quarantine	94	54

Conclusions

The self-assessment response scale does not allow a LHD to report its progress with much detail. The "in-progress" category covers a wide range of activity; thus, it is difficult to accurately assess progress of any one LHD using only self-assessment data.

3.2 Audit Findings

Gap audit findings are discussed by section below. For each section, the discussion provides an overall assessment of the activities occurring and the gaps that exist throughout the state. These observations are distilled from hundreds of hours of interviews and discussions with people from public health and related areas. Words and phrases such as "typically" and "almost all" are used to indicate that there are LHDs who are exceptions to the observations being made.

Community preparedness and leadership networking

Most Indiana LHDs have established community-based pandemic planning committees that include local hospitals, emergency management agency (EMA), emergency medical services (EMS), law enforcement, local health officers (LHO), coroners, funeral directors, district public health coordinators (DPHC), and local government officials. Stakeholder cooperation in LHD planning is not uniformly good and integration of stakeholders into LHD pandemic plans is limited, although the majority of LHDs are working hard to achieve this. Many LPHCs have received little cooperation from local industries and public response is often skepticism or apathy. Most counties that have completed Town Hall meetings or summits report mediocre attendance by the public. Continuing efforts on the part of LHDs will be required to build effective stakeholder relationships based on trust and mutual need.

During the final eight weeks of the study, a more integrated partnership between LHDs and law enforcement seemed to be emerging as requirements for security in mass prophylaxis (MP) planning were addressed. Although many LHDs have identified the law enforcement personnel who will provide support in an emergency response, many express concern that these officers might not be available for point of distribution (POD) security in an actual pandemic event.

Strengths in this section include defining the role of the LHD within the community for purposes of pandemic planning, acknowledging the LHO as the authority to activate plans and authorize isolation and quarantine, and recognizing the EMA as the lead agency in response. Memos of understanding (MOU) are in place among counties of a given district for mutual aid and support of supplies and volunteers. LPHCs are working to complete written plans and to ensure flexibility to apply effectively to multiple emergency situations. Most LHDs have identified local psychosocial services to be activated in response to a pandemic.

Areas for improvement include written delineation of stakeholder roles and responsibilities in response planning, completion of training to meet updated NIMS requirements, clarity in the process for requesting resources from state and federal agencies, completion and regular exercising of the LHD incident command structure (ICS), and public education.

Further, there is little direction, organization, and support among key stakeholders to address mass fatality planning, and no strategy to guide planning efforts. Most counties have not started in mass fatality planning with the exception of contacting the coroner as a key stakeholder. School and business planning are in the beginning stages, with LPHCs

consistently inviting these audiences to educational presentations. Again, the response to the LHD invitation is often tepid.

Surveillance

Indiana LHDs do not conduct routine surveillance for seasonal influenza at the local level. In most cases, LHDs have no plans for enhanced local surveillance level once a pandemic is detected. There is a general consensus that flu test samples will be forwarded directly from hospitals to the ISDH lab. There are no standard mechanisms through which hospitals notify LHDs that samples are sent, nor by which the ISDH lab notifies LHDs that samples have been received and tested. LHDs express concern regarding their lack of integration into this process, since they feel a breakdown in communication could impede disease containment efforts.

Surveillance mechanisms used on a regular basis include school absenteeism reporting, Indiana Health Alert Network (IHAN), and State Webmail. Epidemic Information Exchange (EPI-X) is not uniformly used. LHDs are often unaware of Sentinel physicians in their county and typically have not considered how these individuals might be used for enhanced surveillance. In addition, most counties are not represented by a Sentinel healthcare provider.

LHDs tend not to be aware of whether their local hospital is participating in Public Health Emergency Syndromic Surveillance (PHESS) and how they might obtain or use information from this system at the local level. Informal reporting exists in many counties between hospital infection control nurses and public health nurses (PHN) or LPHCs. In a select few counties, a formal reporting system has been established to provide for weekly reporting of communicable diseases and seasonal influenza from all healthcare providers and entities directly to the LHD.

Public health and clinical labs

Aside from Marion County, laboratories do not exist within LHDs at the local level. Pandemic planning in relation to local hospital clinical labs is being addressed by hospital facility planning. Indiana LPHCs tend not to be aware of local capability for performing rapid flu testing by hospitals; likewise, they are unaware of the potential and capability of rapid flu testing by healthcare providers at the local level.

Healthcare and public health providers

Nearly all LHDs have identified and/or contacted healthcare entities at the county level. These include hospitals, long-term care facilities, and home health nursing agencies. MOUs are being developed to use these agencies in a cooperative fashion or as a resource in response. Areas

for improvement include identification of homebound or special needs populations, mass fatality planning, clarification of cooperative role in alternate care site (ACS) planning, volunteer acquisition and management, credentialing and daily tracking of pandemic activity.

While some consideration has been given to identification of special populations, this planning remains very loose. Specific lists of these populations and how they will be contacted are not documented in most counties. The Health Information Privacy and Accountability Act (HIPAA) can pose an obstacle to identifying individuals who are homebound.

Mass fatality planning is in very early stages at best and is lacking direction. There is some disagreement regarding the role and responsibility of the county coroner in emergency planning. This is a barrier to planning in a number of counties and is documented as such in the individual reports.

Responsibility for ACS requires clarification. LHDs are unsure about their role in this area, and often cite their lack of resources and inability to staff such facilities. Many hospitals have not actively embraced ACS planning, and those developing ACS plans typically have not integrated the LHD into their plans. In addition, counties without hospitals are working to determine how such issues may be addressed and, with local populations traveling out of county for medical care, how tracking of pandemic activity is best accomplished.

Volunteer acquisition, credentialing and management are an area of concern for most LHDs. Those along the southern border of Indiana are unsure about regulations for nurses who live in Indiana but are licensed to practice in Kentucky. Many other counties are seeking information to address skill sets and liability of retired physicians and nurses. A few LHDs have been prohibited by county government from creating volunteer lists because the county has failed to address liability or worker's compensation issues. These are documented in individual county reports.

While working with local healthcare entities, LHDs have not identified means of tracking daily pandemic activity at the county level. This information is recognized to be a summation of hospital surge, mortuary surge, local physician practice surge and pharmacy status. LPHCs express the need for reporting guidelines to develop this aspect of emergency response and management during a pandemic.

Infection control and clinical guidelines

Almost all LPHCs recognize the importance of planning for infection control. However, many do not feel qualified to craft messages and infection control guidelines for healthcare providers, or to develop plans to regularly update these providers. LHDs often responded "not applicable" or

"not started" for this area of public health practice. In addition, many LPHCs felt that local hospitals should be responsible for keeping their staff updated on infection control guidelines.

LHDs lack clarity as to their role in developing infection control practices and educating staff, key stakeholders, and volunteers. Little PPE has been stockpiled because of a lack of specific recommendations. Likewise, little PPE has been stockpiled for enlisted volunteers.

Vaccination distribution and use & Antiviral distribution and use

LHDs have completed and submitted drafts of MP plans over the past six months. These operational plans address storage, cold chain requirements, and location of vaccines, as indicated in the operational plan of the self-assessment tool. Plans are in various stages of approval with some LPHCs awaiting guidance for revision of initial plans. Security issues are also being addressed. MP plans are being revised to reflect changes necessary to secure received Strategic National Stockpile (SNS), per recent directives.

Areas for improvement in MP planning include clarity about identifying priority groups and writing plans to vaccinate these groups. Current plans reflect CDC guidelines for seasonal influenza vaccination, a unique local list that usually includes first responders, volunteers and families, or no list at this time. This element of planning is not consistent across LHDs.

Volunteer recruitment and management is an additional area of concern. Most do not have an adequate number of volunteers to set-up and run a POD per their written plan. Credentialing of volunteers also lacks clarity and uniformity at the local level. Progress in volunteer management is documented for all counties in individual audit reports.

As counties work to identify supplies and resources to support implementation of their MP plan, challenges occur in rural counties where the Red Cross is available only at a regional level. In addition, LHDs are not able to establish MOUs with "chain" pharmacies and have been directed to corporate offices. Many LHDs have added local pharmacists and pharmacy technicians to volunteer lists, however, crucial MP supplies have not been secured through MOUs, unless through a locally-owned business.

Community disease control and prevention

Most LHDs have done little with respect to community disease control and prevention. LHDs do not feel they have the necessary guidelines to develop operational plans to investigate and contain potential cases or outbreaks of influenza. No LHD has exercised an operational plan to investigate and contain cases. Most LHDs have not established criteria for isolation and quarantine or developed procedures with legal authorities to implement these measures. Nor

have they exercised plans for mitigation of public activity. Further, pre-scripted messages for publicizing disease control and prevention measures have not been written into pandemic plans. LHDs understand that the LHO has authority to activate such measures; however, LHDs are uncertain and doubtful about actual implementation. Legal representatives (local attorneys and judges) have not been integrated into planning, and local law enforcement is skeptical regarding their ability to provide adequate support for enforcement. Public education and communication with local healthcare providers regarding shelter-in-place, isolation and quarantine remain a priority for LPHCs.

Public health communications

LHDs address public health communications by designating a PIO and establishing and exercising crisis communications within the LHD and with the EMA. Although LPHCs can access and use IHAN, other stakeholders cannot, and they could benefit from access. A primary focus has been updating stakeholders by phone tree or blast fax, although this has not been exercised in most counties.

LPHCs are working to identify the most effective media to reach the public. These include local radio, public service announcements (PSA) via cable television, and newspaper. An area for improvement in communications is access to alternative modes of communication such as website display. LHDs do not uniformly have websites and those that do often lack funding to update and maintain current information for public access and reference. Small health departments are not able to provide a dedicated phone line and staffing to service a hotline. While reverse 911 and/or 211 are available in some counties, these are most often cost-prohibitive for smaller counties. Some counties have received radios from ISDH but lack towers or training for their use. This has been documented in LHD audit reports.

Workforce support

LHDs are working to identify essential services, potential strategies for cross-training, and other elements of continuity of operations planning (COOP). Many small health departments lack the depth necessary to accomplish this effectively. In the majority of LHDs, there is minimal to no documentation of COOP plans. Psychosocial support services have not focused on support of LHD staff. This may also include volunteers who are trained to provide LHD support. Additional educational and training materials addressing psychosocial aspects are needed for staff and volunteers who participate in or provide support in a public health emergency response.

3.3 Comparison of Self-Assessment and Audit Results

Written pandemic plans at the county level did not exist at the initiation of this project; thus, qualitative data for analysis was gathered through extensive site visits and phone conference calls. This is in contrast to the self-assessment tool completed by each of the counties where results are reflected in a quantitative manner.

A general lack of clarity existed among LPHCs in completing the self-assessment using the response options provided: "completed," "in progress," "not started" or "not applicable." Specifically, many LPHCs considered pandemic planning documents to be perpetually "in progress," and never scored an objective using the "completed" response. The definition of "in progress" varied widely among LPHCs; to some, it constituted reading one piece of literature on a given area of planning, while to others it was a representation of a significant amount of work toward "completed". In some counties, the "not applicable" response was directed by DPHCs in cooperation with LPHCs, and in other counties it was used when the purpose or intent of a specific item was not understood. This inconsistency of responses brings the reliability of the self-assessment as a solitary tool into question.

It is important to note that self-assessments were completed two to four months prior to audit interviews. Planning is an on-going process, and each report reflects two different points in time and planning. Self-assessments indicated very early stages of planning among most LHDs in April 2006. Initial audit interviews found similar results, but as time progressed, audit interviews revealed greater understanding on the part of LPHCs and more indications that overall planning is "in progress." This may have translated into a statewide average of greater than 1.0.

Audit interviews confirmed that local planning is minimal in Sections 3 (Public Health and Clinical Labs) and 8 (Community Disease Prevention and Control), as indicated in initial self-assessment analysis. LHDs do not have responsibility for clinical labs; thus, little planning has been completed. Most LHDs are awaiting guidelines on disease prevention and control, and planning will likely not progress until these guidelines are received.

No statistically significant trends were noted when comparing counties of comparable size, but qualitative analysis did reveal important gaps unique to small, rural counties, particularly those without hospitals. These counties do not have the same resources as larger counties and rely on collaboration with neighboring counties to address certain aspects of planning. These collaborations are reflected in individual county reports.

4. Recommendations

This section provides recommendations for the most significant gaps identified in the audit procedure. Areas addressed are alternative care sites, volunteer management, mortuary planning, public education, isolation/quarantine, and state-level coordination. For those areas that ISDH is already addressing, these recommendations will provide additional motivation and perhaps new ideas. For those areas not currently being addressed, the recommendations can help ISDH prioritize and understand how best to approach these problem areas. Any of these recommendations can be further developed and expanded at ISDH request.

4.1 Alternative Care Sites

With 45 million Americans currently uninsured, an ongoing nursing shortage expected to worsen, and the fact that nearly 50% of hospitals have been on a 'divert' status sometime during in the past year, the need for effective ACS planning, exercise, and deployment in Indiana is a certainty. The process of ACS planning, practice, and execution requires coordination between hospitals, public health departments, and emergency services at the local, district, and state levels. Although many Indiana hospitals are developing pandemic response plans, it is not reasonable to expect hospitals to carry the burden for ACS planning alone. Indeed, a significant number of Indiana counties have no local hospitals to assess their ACS needs.

Efforts should be made to develop a process for coordinated ACS planning for the State of Indiana. Such a process should specify how state, district, and local health and emergency services can work together to plan for the care of surges of ill patients during a pandemic. Further, ACS needs should be assessed, the required number of sites per county estimated, sizes and locations specified, staffing and resource needs developed, and planning, exercise, and deployment responsibilities delineated.

Once site designs and locations have been determined, an implementation plan should be developed. This requires specification of the likely set of public health scenarios that will require ACS response, the 'trigger' events in each scenario that will initiate site activation, the set of sites that will be activated in response to each trigger, and the order in which those sites will be activated, if multiple sites are involved. The implementation plan should also specify the process of opening a specific ACS.

4.2 Volunteer Management

Sufficient volunteer resources are vital to successful pandemic response at the local level, particularly among counties with limited LHD, law enforcement, healthcare and other

professional personnel. Most counties reported insufficient volunteer resources to operate PODs and ensure back-up for vital records and other essential services. Once volunteers are secured, counties face the challenges of credentialing, training, addressing liability and maintaining communication with the volunteer base.

Volunteer management research is needed to determine the most effective way to recruit, credential, train and maintain active and integrated volunteers. Volunteer management for pandemic influenza is a process by which individuals from outside public health are integrated in a systematic manner into the public health and emergency response infrastructure. Volunteer management should be an on-going, multi-step process that includes the following functions:

- Identifying the work that volunteers will be asked to do in case of emergency and assessing the skill sets necessary to do that work.
- Projecting how many volunteers with each skill set are necessary. This step must take into account the estimated time-span of an emergency, the projected influx of patients from the public, working hours, and volunteer availability and attrition. For example, volunteer requirements for setting up and staffing a POD for 48 hours might be much different than volunteer requirements for an ACS in operation for several weeks.
- Assessing the risk that volunteers will assume during the performance of their duties. During a flu pandemic, many volunteers will be exposed to critically ill patients with a highly contagious infection. Assuring that each volunteer has the appropriate, properly fitted PPE will be absolutely essential. Further, volunteers and their families must have priority for vaccine and anti-viral distribution.
- Recruiting volunteers by identifying those members of the community and district that have the required skills, contacting and persuading candidates, providing incentives, establishing expectations, and answering questions. Recruited candidates should be assessed for leadership skills so that those most able can be assigned backup leadership roles.
- Training volunteers so they understand the work they will be asked to do and how to keep themselves and their families' safe during a pandemic. It must also assure that volunteers are familiar with district and county pandemic plans, the events that will trigger those plans, and how to assume their role in those plans.
- Reinforcing and refining training through exercises. These provide volunteers the opportunity to meet, work together, practice procedures, test PPE, and so forth. Selected

volunteers can work with public health and emergency personnel to plan, staff, execute, and assess these exercise experiences.

- Considering volunteer turnover and retention. A well-managed, up-to-date volunteer group will constantly be adding new people and allowing others to retire. A management program that integrates recruitment, retention, and retirement incentives will serve best.
- Assuring that volunteers have the appropriate credential and are keeping them up-to-date before an emergency occurs.

4.3 Mass Fatality Planning

Lack of mortuary planning emerged as a significant gap across counties. This aspect of planning was often viewed as solely the coroner's responsibility; in many cases, coroners expressed a reliance on state directives for any local planning. Few counties had integrated mortuary planning into pandemic response plans. Advances in this area of planning will require a community-wide effort of coroners, funeral directors and other integral stakeholders to develop independent local plans. Research is needed toward the development of guidelines for local level implementation and coordination of mortuary planning efforts; this should include clarification of roles and responsibilities.

Alternatives for handling mass fatalities in a coordinated manner should be developed at the district and local levels. This should involve identifying the required steps that must occur, the resources required, the most critical potential shortages, and opportunities for mass storage, stockpiling supplies, and cost-sharing among counties. Important religious, cultural, and/or psychological aspects should be taken into account. Factors that should be considered include

- Estimated number of fatalities;
- Individuals with authority to pronounce death and sign death certificate;
- Number and shelf life of body bags;
- Quantity and shelf life of embalming fluid; amount needed per body;
- Where and how families transport bodies resulting from death occurring at home;
- Resources to transport bodies from hospital or homes;
- Morgue location and capacity;
- Location and capacity of alternate morgue sites;
- Location and capacity of funeral homes;
- Location and capacity of alternate funeral home sites;
- Length of time embalmed and un-embalmed bodies can be stored;
- Number of individuals trained to embalm and speed of embalming;

- Speed and capacity of crematoriums;
- Casket availability and barriers to acquisition;
- Resources for grave preparation;
- Temporary caskets alternatives;
- Potential locations for temporary mass burial sites;
- Legal procedures for acquisition of land for mass burial;
- Capacity and time necessary for funeral home memorial service; and
- Social, cultural, and psychological aspects of mass fatality and burial.

4.4 Public Education

Many counties reported community-wide skepticism and apathy regarding pandemic influenza planning, even among key stakeholders. The limited attendance at Town Hall meetings throughout the state appears to confirm this observation. It is difficult to balance a sense of gravity and urgency in communication and education, while avoiding panic and other extreme responses. It is also difficult to sustain long-term public interest and action.

Accurate and consistent communication is needed from the local and state level regarding community planning efforts, individual responsibility and concepts of shelter-in-place, neighborhood networking, and volunteering. A variety of media should be explored to transmit these messages, including:

- PSAs on cable networks and radio stations;
- Regular columns in local newspaper;
- Presentations to community groups and employers;
- Distribution of educational packets at public locations (e.g., library, Chamber of Commerce, grocery stores, and health fairs);
- Flyers in paychecks, utility bills and/or church bulletins; and
- Promotion of LHD, county and district websites.

Using a variety of local, district and state media outlets ensures greater community coverage and consistent reinforcement of messages, and it also conditions the public to access these outlets for crucial information during a pandemic.

Educational efforts on disease prevention should also be targeted to school-age children. This can be accomplished in a number of ways, including:

- State-level collaboration between ISDH and Indiana State Department of Education and Insight Indiana Youth Corps to launch school programs in hand washing, covering mouth with cough, staying home when sick, etc.

- Collaboration between LPHCs, local school nurses and Red Cross to launch educational programs at the local level.

4.5 Isolation/Quarantine

Although awareness of isolation/quarantine legal issues is evolving in Indiana, there is considerable confusion over the current status of quarantine laws. Many LHDs need legal clarification of House Bill 1235 in terms of responsibility and liability, and there is a need to strengthen and assure collaboration and planning between LHDs, hospitals, and law enforcement at the local level. Although many LHDs have some understanding of the legal steps that must be taken in isolation/quarantine, they are uniformly skeptical that isolation/quarantine measures can be implemented. Predominant reasons for this include lack of cooperation from local law enforcement, interference by local judges and politicians, and resistance from the public. Further, many LHDs express concern that isolation/quarantine will not be an effective strategy in a flu pandemic, even if well-implemented.

To address this, the ISDH should work with state associations for health and law enforcement to draft policies and procedures for isolation/quarantine that clarify local roles and responsibilities and ensure standard approaches to care. Further, educational efforts must address skepticism and apathy among key stakeholders, and the effectiveness of well-implemented isolation/quarantine measures in a pandemic scenario should be investigated to ensure standard approaches to care.

4.6 State-Level Coordination

Lists of stakeholders were fairly consistent from county to county, nearly always including EMA, EMS, hospitals, coroner, funeral directors, county officials, law enforcement, hospitals and pharmacies. However, levels of stakeholder support for LHD planning efforts varied greatly, and at times were a significant barrier to further planning development. Reasons for lack of support included skepticism or apathy about local planning efforts, sole reliance on state directives, limited resources and other pressing priorities, and/or interpersonal conflicts between agencies.

LHDs reported a lack of sufficient leverage to negotiate with resistant stakeholders; in the case of large pharmacy chains like CVS or Walgreens, local stores were unable to commit resources and/or volunteers without corporate approval. There is great opportunity to assist local-level planning on a large scale by negotiating with stakeholders at the state and Federal level. These opportunities include:

- Development of a state-level task force composed of ISDH, IDHS, state law enforcement and state coroner association to integrate planning and communication among agencies. This should include specific feedback to LPHCs responsible for planning at the local level.
- State-level communication with Purdue Extension Administration. This integral community component is not an active stakeholder in many counties. ISDH may explore partnership with Purdue Extension for education out to local level for support in local education, volunteers, and overall community planning efforts.
- Development of local, district and state contingency plans for public works.
- Partnership with Indiana Medical Society to provide additional support in recruitment and surveillance of local healthcare providers.
- State-level partnerships with Area on Aging and other state agencies for identification of homebound and special needs in declared emergency; explore HIPAA guidelines in relationship to declared emergency situations.
- Negotiations with corporate pharmacy stakeholders at national level to secure some degree of support for local pandemic response.

Assistance and guidance from the State is also needed in the following areas:

- Development of recommended written policies and procedures as template for LHDs.
- Stronger network of connections between LHDs and districts, particularly to share best practices and solutions to common challenges.
- State website resources, including rationale for infection control practices, references and additional resources for LHDs.
- Development of local level reporting mechanism to capture hospital surge and activity, morgue surge, EMS surge, pharmacy activity and other significant occurrences during pandemic; to be reported to the State for accurate assessment of state-wide activity.
- Clarification of necessity and legal implications of MOUs in Indiana.

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PANDEMIC INFLUENZA GAP ANALYSIS AND RECOMMENDATIONS

FOR INDIANA LOCAL HEALTH DEPARTMENTS

Prepared for Indiana State Department of Health (ISDH)
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HEALTHCARE TECHNICAL ASSISTANCE PROGRAM

Purdue Homeland
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1. EXECUTIVE SUMMARY

Purdue University's Technical Assistance Program was contracted by the Indiana State Department of Health (ISDH) to perform pandemic flu planning gap analyses for all local health departments (LHD) in the State of Indiana. By April 2006, each LHD had completed a self-assessment provided to ISDH by the Centers for Disease Control and Prevention. In May 2006, Purdue received these self-assessments as a starting point for the gap analysis procedure, which was designed by the Purdue team. This procedure consisted of two steps: (1) an auditing call or site visit with each LHD, and (2) development of a final gap report for each LHD.

Audits revealed that self-assessments were typically out-of-date or only marginally accurate. Inaccuracies were caused by unclear wording in self-assessment questions as well as insufficient resolution in allowable numerical responses. Thus, self-assessment analyses only roughly represent the state of LHD pandemic planning as of April 2006. Even with these shortcomings, self-assessment analyses did capture state-wide and district patterns, as illustrated in Figure 1 of this report and Figures 18-29 of Appendix G.

Audits revealed more accurate information, which is included in the final gap reports for each LHD in Appendix M. Each report has ten sections, corresponding to the sections in the CDC self-assessment form. Each section summarizes key points discussed during the audit, areas for improvement, and strategies to complete planning. Strengths identified across LHDs include: 1) a clear understanding of the roles of the LHD, LHO, and EMA in pandemic planning and response, 2) identification of local healthcare resources and psychosocial services for pandemic response, 3) memos of understanding (MOU) in place for points of distribution (POD), mutual aid and support of supplies and volunteers, and 4) on-going work to complete written plans and ensure flexibility.

Significant gaps include 1) alternate care site planning, 2) volunteer management, 3) mass fatality planning, 4) public and business education and involvement in LHD planning, 5) identification of homebound or special needs populations, 6) integration of key stakeholders and delineation of roles in LHD plans, 7) identification of priority groups for vaccination and anti-viral, 8) routine surveillance for seasonal influenza at the local level, 9) PPE management, 10) planning or consensus on isolation/quarantine implementation, and 11) depth in plans for continuing operation, particularly with regard to the local health officer. Each of these are discussed in this report and recommendations to ISDH are proposed to address six priority areas: 1) alternate care site planning, 2) volunteer management, 3) mass fatality planning, 4) public education, 5) isolation/quarantine, and 6) state-level coordination.

2. Process Overview

In May 2006, Purdue Healthcare Technical Assistance Program (HTAP) was contracted by the Indiana State Department of Health (ISDH) to complete gap analyses of pandemic influenza plans at each of the 94 local health departments (LHD) in the state (Appendix A). The stated goal of the four-month project was to increase the capability of state and local public health/medical entities to respond to an influenza pandemic, catalyzing community-wide preparedness efforts through development, coordination and testing of state and local pandemic influenza plans.

As the contracted agency, Purdue HTAP agreed to complete the following project tasks:

a) Review CDC Pandemic Influenza Planning Self-Assessment (Appendix B) and written Gap Audit Template (Appendix C).
b) Analyze individual self-assessments completed and submitted by LHDs (Appendix D).
c) Engage in meetings with LHD staff through site visits and telephone interviews, and otherwise obtain additional information supporting local self-assessments as necessary and appropriate to understand the nature and scope of the self-assessment.
d) Prepare a written gap analysis report for each LHD based on that agency's self-assessment and other information. Gap analysis should identify key gaps under each category of the self-assessment tool, and set forth ongoing and/or recommended approaches to close those key gaps (Appendix E).
e) Provide ISDH with hard and electronic copies of an individualized written gap analysis for each LHD.

To accomplish these tasks, ISDH provided Purdue HTAP with a variety of materials, including completed copies of the CDC self-assessment from each of the 94 LHDs. Purdue requested, and ISDH provided, a list of self-assessment items that ISDH deemed "not applicable" (N/A) for LHDs. A discussion of N/A items can be found on page 11 of this report.

Purdue HTAP assembled a team of faculty, staff and students (Appendix F) from the following areas:

a) Purdue Homeland Security Institute (PHSI)
b) Regenstrief Center for Healthcare Engineering at Purdue University (RCHE)
c) Purdue Technical Assistance Program (TAP)
d) College of Engineering
e) School of Nursing

f) Department of Statistics

g) Department of Computer Graphics Technology

The project was completed in two phases; first, LHD self-assessment results were statistically analyzed to present and summarize individual and statewide data. In the second phase, audits were conducted by phone or site visit with each of the 94 LHDs.

2.1 Analysis of Self-Assessment Tool

A questionnaire, *Pandemic Influenza Planning Self-Assessment – Local Public Health, Public Health Roles and Responsibilities* (referred to as the "self-assessment") was completed by each of the 94 LHDs in April 2006 (Appendix B).

Format of collected data

The self-assessment consisted of 72 questions (items) grouped into ten sections:

Table 1. Self-Assessment Sections

Index	Section	Number of Items
1	Community Preparedness Leadership and Networking	18
2	Surveillance	5
3	Public Health and Clinical Laboratories	5
4	Healthcare and Public Health Partners	15
5	Infection Control and Clinical Guidelines	3
6	Vaccine Distribution and Use	4
7	Antiviral Drug Distribution and Use	2
8	Community Disease Control and Prevention	7
9	Public Health Communications	11
10	Workforce Support	2

Respondents were asked to select the choice that best described their preparedness status for each element by placing a mark in the appropriate box as follows:

Table 2. Sample Item Response

	COMPLETED
X	IN-PROGRESS
	NOT STARTED
	N/A – **NOT** LOCAL PH REPONSIBILITY

Coding of responses

Responses were numerically coded in the following way in order to compute averages:

Table 3. Numerical Codes for Responses

2	COMPLETED
1	IN-PROGRESS
0	NOT STARTED
-1	N/A – **NOT** LOCAL PH REPONSIBILITY

A missing value code of 99 was given to items for which there was no response or more than one response. Responses coded as -1 or 99 were not included in statistical computations. Data analysis was completed using SAS and SPSS (statistical software packages), and Microsoft Excel and Access.

2.2 Description of Self-Assessment Summary Report

A summary report, describing responses to the self-assessment, was prepared for each LHD (Appendix D). This report compares LHD responses to a) average responses of the district, b) LHDs of a similar size, and c) all LHDs in the state. Graphs and charts are used to visualize these comparisons and identify gaps.

The Self-Assessment Summary Report had two purposes: a) to summarize progress of each LHD and identify sections needing the most work, and b) to help audit teams prepare by identifying gaps and providing comparisons.

2.3 Audit Procedures

Based upon preliminary statistical analyses, audit procedures were developed by Purdue HTAP to ensure consistent data collection and reporting across audit teams (Appendix H). Audits were completed by conference call or site visit with each of the 94 LHDs in Indiana. Calls or site visits included the local public health coordinator (LPHC) and/or other key individuals as determined by the LHD.

Audit scheduling

Audits were scheduled by Purdue Healthcare TAP; selection of individual counties for phone conference or site visit was determined using stratified random sampling. The order of audits was determined by LHD and audit team availability.

Audit team structure and responsibilities

Audit teams consisted of at least two members: a lead auditor and a recorder (see Appendix F for audit team members). The lead auditor was responsible to ensure that each of the ten sections of the self-assessment was addressed and answers documented. All members of the audit team present during an audit interview recorded findings and observations, and these notes were forwarded to the lead auditor and compiled into the final audit report for each LHD.

Audit description

The goal of each audit was to clarify, update and document progress made by each LHD in the area of pandemic influenza planning. An audit interview guide was used for all audits to ensure consistency among lead auditors (Appendix I).

Prior to each audit, the audit team reviewed pertinent county statistics and self-assessment results for the individual LHD. Based upon this information, the lead auditor selected questions from the Gap Audit Template to address each of the ten sections. Responses were recorded by all audit team members and forwarded to the audit leader.

2.4 Final Audit Reports and Records

The lead auditor and other team members utilized the Self-Assessment Summary Report, audit interview guide and team notes to draft a final audit report for each LHD. Each report summarizes key points for each of the ten sections, identifies areas for improvement, and suggests strategies to advance planning efforts (Appendix E). Audit reports were forwarded to the project leader and lead auditors to create this final summary report, identifying statewide trends, gaps and opportunities.

A file has been created for each LHD, containing the following records and retained at the Purdue Healthcare TAP office:

a) A copy of the completed self-assessment tool;
b) Self-Assessment Summary Report;
c) Audit interview guide;
d) Team notes;
e) Other objective evidence requested of the local LHD; and
f) Final audit report summarizing main points, gaps and recommendations.

3. Gap Findings

Quantitative and qualitative analyses were performed on the self-assessment data and information collected in the audit interviews. A discussion of each and a comparison of the quantitative and qualitative findings follow here.

3.1 Self-Assessment Findings

Analyses of LHD self-assessments were conducted early in the project to provide audit teams with baseline information regarding pandemic planning in individual LHDs. This information was used to guide audit interviews.

Overall averages

Statewide averages were computed for the self-assessment as a whole, and for each individual assessment section. Scores range from 0 (item not started) to 2 (item completed). The statewide average of 0.76 indicates that, on average, a quarter of items have not been started and the remaining are in progress. The map demonstrates that the lower half of the state reported a lower level of completion than the upper half (more dark and medium shades).

Figure 1. Overall Average for each LHD

Dark shade = 0 – 0.2
(least items "in progress" or "completed")

Medium shade = 0.21 – 0.99

Lightest shade = 1.0 – 2.0
(most items "in progress" or "completed")

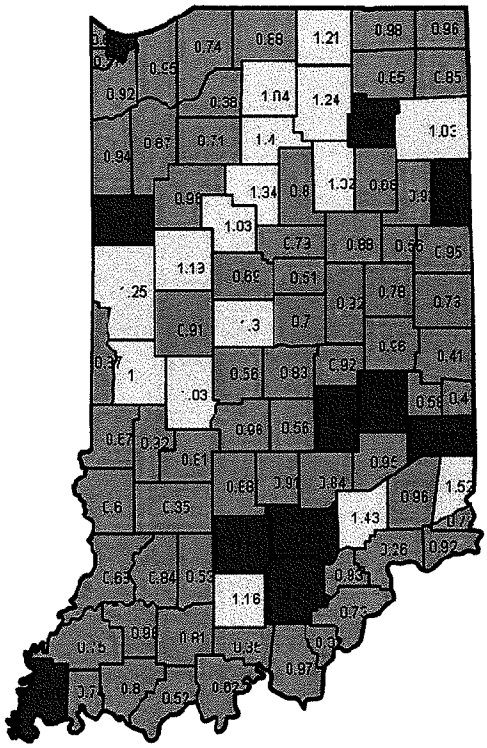
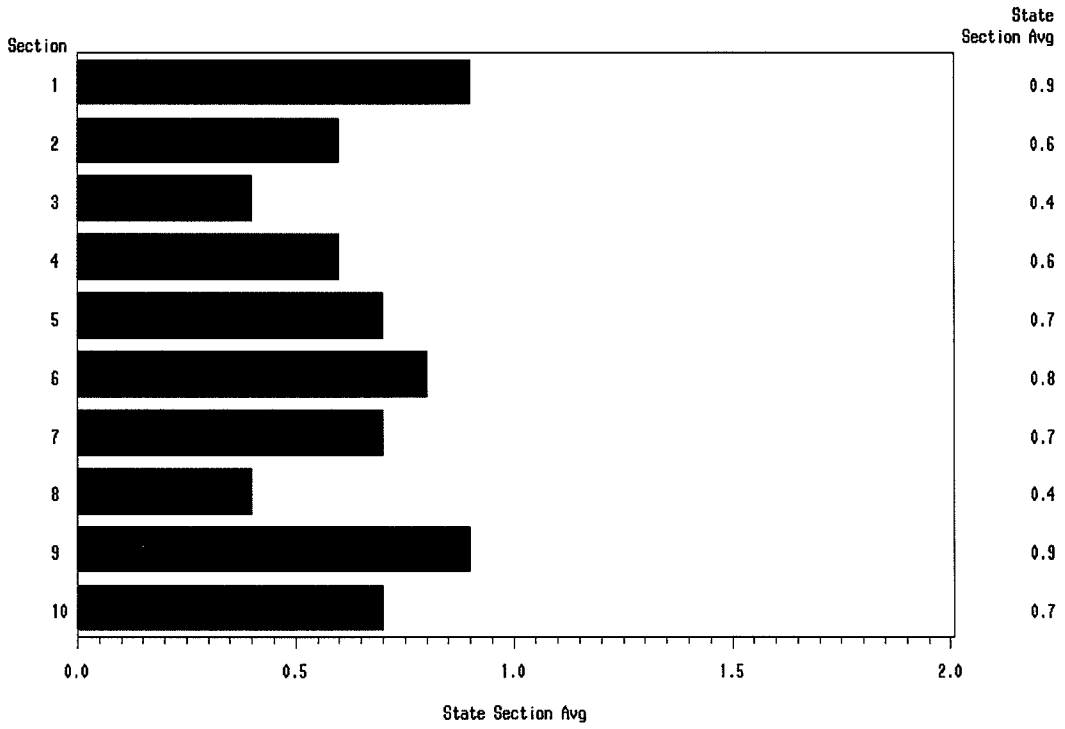


Figure 2 further summarizes statewide averages for each section of the self-assessment. Section 3 (Public Health and Clinical Labs) and Section 8 (Community Disease Control and Prevention) have the lowest averages, indicating that many LHDs reported little or no work in these areas.

Figure 2. Bar Chart of State Section Averages

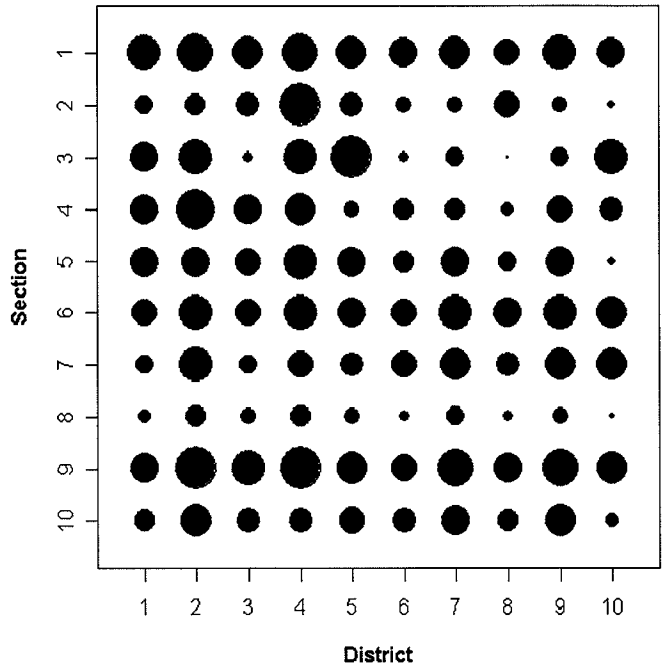


District and size trends

In addition to statewide analysis, self-assessment responses were analyzed by comparing LHDs of similar size; no significant trends emerged from this analysis (see Appendix G for details of this comparison).

Responses were also analyzed by grouping districts. In Figure 3, the size of the "bubble" represents the magnitude of the response (i.e., larger "bubbles" indicate a higher preparedness level). Districts 8 and 10 reported the lowest level of preparedness, and Districts 2 and 4 have relatively high section averages.

Figure 3. Bubble Plot of Section Averages for Districts



Discussion of N/A responses

ISDH specified that 20 of the 72 self-assessment questions were not the responsibility of individual LHDs; thus, an N/A response was expected from the 94 LHDs for these (and only these) items. In Table 4, questions are organized by section number (1-10) and question number. The column labeled 'Actual N/A' shows the number of LHDs that marked the item as N/A.

Note that Section 1 (Community Preparedness Leadership and Networking) and Section 2 (Surveillance) have large differences; few LHDs indicated that these items were not their responsibility. Shaded rows are items that ISDH indicated were local responsibilities, but many LHDs indicated the items were "not applicable" to them. These data suggest much confusion about local and state-level responsibilities.

Table 4. Expected vs. Actual N/A Responses

	Expected N/A	Actual N/A
Section 1		
Q14 Determined "law enforcement' emergency	94	7
Q18 Address animal health –disease	94	18
Section 2		
Q01 Traditional surveillance seasonal flu	94	34
Q02 Improved capacity-ID of new flu	94	67
Q03 Implement enhanced surveillance	94	27
Q04 Animal and human systems linked	94	46
Q05 Obtain and track information daily	94	6
Section 3		
Q01 Surveillance of lab personnel	94	79
Q02 Augment capacity of public health	94	81
Q03 This plan has been exercised	94	80
Q04 Diagnostic testing assessed	94	83
Q05 Frontline personnel aware of protocols	94	67
Section 4		
S04Q01 State defined role clear	0	15
S04Q04 Developed operational plan - 7 items	94	49
S04Q05 Plan for isolating patients	94	44
S04Q06 Quarantine of exposed personnel	94	45
S04Q07 Components of delivery network	0	33
S04Q08 Real-time situational awareness	94	55
S04Q09 Plan developed for mortuary	94	47
S04Q10 Plan tested for mortuary	94	54
S04Q12 Medical staffing emergency defined	0	13
S04Q14 Health facilities plan for isolating	94	49
S04Q15 Health facilities plan for quarantine	94	54

Conclusions

The self-assessment response scale does not allow a LHD to report its progress with much detail. The "in-progress" category covers a wide range of activity; thus, it is difficult to accurately assess progress of any one LHD using only self-assessment data.

3.2 Audit Findings

Gap audit findings are discussed by section below. For each section, the discussion provides an overall assessment of the activities occurring and the gaps that exist throughout the state. These observations are distilled from hundreds of hours of interviews and discussions with people from public health and related areas. Words and phrases such as "typically" and "almost all" are used to indicate that there are LHDs who are exceptions to the observations being made.

Community preparedness and leadership networking

Most Indiana LHDs have established community-based pandemic planning committees that include local hospitals, emergency management agency (EMA), emergency medical services (EMS), law enforcement, local health officers (LHO), coroners, funeral directors, district public health coordinators (DPHC), and local government officials. Stakeholder cooperation in LHD planning is not uniformly good and integration of stakeholders into LHD pandemic plans is limited, although the majority of LHDs are working hard to achieve this. Many LPHCs have received little cooperation from local industries and public response is often skepticism or apathy. Most counties that have completed Town Hall meetings or summits report mediocre attendance by the public. Continuing efforts on the part of LHDs will be required to build effective stakeholder relationships based on trust and mutual need.

During the final eight weeks of the study, a more integrated partnership between LHDs and law enforcement seemed to be emerging as requirements for security in mass prophylaxis (MP) planning were addressed. Although many LHDs have identified the law enforcement personnel who will provide support in an emergency response, many express concern that these officers might not be available for point of distribution (POD) security in an actual pandemic event.

Strengths in this section include defining the role of the LHD within the community for purposes of pandemic planning, acknowledging the LHO as the authority to activate plans and authorize isolation and quarantine, and recognizing the EMA as the lead agency in response. Memos of understanding (MOU) are in place among counties of a given district for mutual aid and support of supplies and volunteers. LPHCs are working to complete written plans and to ensure flexibility to apply effectively to multiple emergency situations. Most LHDs have identified local psychosocial services to be activated in response to a pandemic.

Areas for improvement include written delineation of stakeholder roles and responsibilities in response planning, completion of training to meet updated NIMS requirements, clarity in the process for requesting resources from state and federal agencies, completion and regular exercising of the LHD incident command structure (ICS), and public education.

Further, there is little direction, organization, and support among key stakeholders to address mass fatality planning, and no strategy to guide planning efforts. Most counties have not started in mass fatality planning with the exception of contacting the coroner as a key stakeholder. School and business planning are in the beginning stages, with LPHCs

consistently inviting these audiences to educational presentations. Again, the response to the LHD invitation is often tepid.

Surveillance

Indiana LHDs do not conduct routine surveillance for seasonal influenza at the local level. In most cases, LHDs have no plans for enhanced local surveillance level once a pandemic is detected. There is a general consensus that flu test samples will be forwarded directly from hospitals to the ISDH lab. There are no standard mechanisms through which hospitals notify LHDs that samples are sent, nor by which the ISDH lab notifies LHDs that samples have been received and tested. LHDs express concern regarding their lack of integration into this process, since they feel a breakdown in communication could impede disease containment efforts.

Surveillance mechanisms used on a regular basis include school absenteeism reporting, Indiana Health Alert Network (IHAN), and State Webmail. Epidemic Information Exchange (EPI-X) is not uniformly used. LHDs are often unaware of Sentinel physicians in their county and typically have not considered how these individuals might be used for enhanced surveillance. In addition, most counties are not represented by a Sentinel healthcare provider.

LHDs tend not to be aware of whether their local hospital is participating in Public Health Emergency Syndromic Surveillance (PHESS) and how they might obtain or use information from this system at the local level. Informal reporting exists in many counties between hospital infection control nurses and public health nurses (PHN) or LPHCs. In a select few counties, a formal reporting system has been established to provide for weekly reporting of communicable diseases and seasonal influenza from all healthcare providers and entities directly to the LHD.

Public health and clinical labs

Aside from Marion County, laboratories do not exist within LHDs at the local level. Pandemic planning in relation to local hospital clinical labs is being addressed by hospital facility planning. Indiana LPHCs tend not to be aware of local capability for performing rapid flu testing by hospitals; likewise, they are unaware of the potential and capability of rapid flu testing by healthcare providers at the local level.

Healthcare and public health providers

Nearly all LHDs have identified and/or contacted healthcare entities at the county level. These include hospitals, long-term care facilities, and home health nursing agencies. MOUs are being developed to use these agencies in a cooperative fashion or as a resource in response. Areas

for improvement include identification of homebound or special needs populations, mass fatality planning, clarification of cooperative role in alternate care site (ACS) planning, volunteer acquisition and management, credentialing and daily tracking of pandemic activity.

While some consideration has been given to identification of special populations, this planning remains very loose. Specific lists of these populations and how they will be contacted are not documented in most counties. The Health Information Privacy and Accountability Act (HIPAA) can pose an obstacle to identifying individuals who are homebound.

Mass fatality planning is in very early stages at best and is lacking direction. There is some disagreement regarding the role and responsibility of the county coroner in emergency planning. This is a barrier to planning in a number of counties and is documented as such in the individual reports.

Responsibility for ACS requires clarification. LHDs are unsure about their role in this area, and often cite their lack of resources and inability to staff such facilities. Many hospitals have not actively embraced ACS planning, and those developing ACS plans typically have not integrated the LHD into their plans. In addition, counties without hospitals are working to determine how such issues may be addressed and, with local populations traveling out of county for medical care, how tracking of pandemic activity is best accomplished.

Volunteer acquisition, credentialing and management are an area of concern for most LHDs. Those along the southern border of Indiana are unsure about regulations for nurses who live in Indiana but are licensed to practice in Kentucky. Many other counties are seeking information to address skill sets and liability of retired physicians and nurses. A few LHDs have been prohibited by county government from creating volunteer lists because the county has failed to address liability or worker's compensation issues. These are documented in individual county reports.

While working with local healthcare entities, LHDs have not identified means of tracking daily pandemic activity at the county level. This information is recognized to be a summation of hospital surge, mortuary surge, local physician practice surge and pharmacy status. LPHCs express the need for reporting guidelines to develop this aspect of emergency response and management during a pandemic.

Infection control and clinical guidelines

Almost all LPHCs recognize the importance of planning for infection control. However, many do not feel qualified to craft messages and infection control guidelines for healthcare providers, or to develop plans to regularly update these providers. LHDs often responded "not applicable" or

"not started" for this area of public health practice. In addition, many LPHCs felt that local hospitals should be responsible for keeping their staff updated on infection control guidelines.

LHDs lack clarity as to their role in developing infection control practices and educating staff, key stakeholders, and volunteers. Little PPE has been stockpiled because of a lack of specific recommendations. Likewise, little PPE has been stockpiled for enlisted volunteers.

Vaccination distribution and use & Antiviral distribution and use

LHDs have completed and submitted drafts of MP plans over the past six months. These operational plans address storage, cold chain requirements, and location of vaccines, as indicated in the operational plan of the self-assessment tool. Plans are in various stages of approval with some LPHCs awaiting guidance for revision of initial plans. Security issues are also being addressed. MP plans are being revised to reflect changes necessary to secure received Strategic National Stockpile (SNS), per recent directives.

Areas for improvement in MP planning include clarity about identifying priority groups and writing plans to vaccinate these groups. Current plans reflect CDC guidelines for seasonal influenza vaccination, a unique local list that usually includes first responders, volunteers and families, or no list at this time. This element of planning is not consistent across LHDs.

Volunteer recruitment and management is an additional area of concern. Most do not have an adequate number of volunteers to set-up and run a POD per their written plan. Credentialing of volunteers also lacks clarity and uniformity at the local level. Progress in volunteer management is documented for all counties in individual audit reports.

As counties work to identify supplies and resources to support implementation of their MP plan, challenges occur in rural counties where the Red Cross is available only at a regional level. In addition, LHDs are not able to establish MOUs with "chain" pharmacies and have been directed to corporate offices. Many LHDs have added local pharmacists and pharmacy technicians to volunteer lists, however, crucial MP supplies have not been secured through MOUs, unless through a locally-owned business.

Community disease control and prevention

Most LHDs have done little with respect to community disease control and prevention. LHDs do not feel they have the necessary guidelines to develop operational plans to investigate and contain potential cases or outbreaks of influenza. No LHD has exercised an operational plan to investigate and contain cases. Most LHDs have not established criteria for isolation and quarantine or developed procedures with legal authorities to implement these measures. Nor

have they exercised plans for mitigation of public activity. Further, pre-scripted messages for publicizing disease control and prevention measures have not been written into pandemic plans. LHDs understand that the LHO has authority to activate such measures; however, LHDs are uncertain and doubtful about actual implementation. Legal representatives (local attorneys and judges) have not been integrated into planning, and local law enforcement is skeptical regarding their ability to provide adequate support for enforcement. Public education and communication with local healthcare providers regarding shelter-in-place, isolation and quarantine remain a priority for LPHCs.

Public health communications

LHDs address public health communications by designating a PIO and establishing and exercising crisis communications within the LHD and with the EMA. Although LPHCs can access and use IHAN, other stakeholders cannot, and they could benefit from access. A primary focus has been updating stakeholders by phone tree or blast fax, although this has not been exercised in most counties.

LPHCs are working to identify the most effective media to reach the public. These include local radio, public service announcements (PSA) via cable television, and newspaper. An area for improvement in communications is access to alternative modes of communication such as website display. LHDs do not uniformly have websites and those that do often lack funding to update and maintain current information for public access and reference. Small health departments are not able to provide a dedicated phone line and staffing to service a hotline. While reverse 911 and/or 211 are available in some counties, these are most often cost-prohibitive for smaller counties. Some counties have received radios from ISDH but lack towers or training for their use. This has been documented in LHD audit reports.

Workforce support

LHDs are working to identify essential services, potential strategies for cross-training, and other elements of continuity of operations planning (COOP). Many small health departments lack the depth necessary to accomplish this effectively. In the majority of LHDs, there is minimal to no documentation of COOP plans. Psychosocial support services have not focused on support of LHD staff. This may also include volunteers who are trained to provide LHD support. Additional educational and training materials addressing psychosocial aspects are needed for staff and volunteers who participate in or provide support in a public health emergency response.

3.3 Comparison of Self-Assessment and Audit Results

Written pandemic plans at the county level did not exist at the initiation of this project; thus, qualitative data for analysis was gathered through extensive site visits and phone conference calls. This is in contrast to the self-assessment tool completed by each of the counties where results are reflected in a quantitative manner.

A general lack of clarity existed among LPHCs in completing the self-assessment using the response options provided: "completed," "in progress," "not started" or "not applicable." Specifically, many LPHCs considered pandemic planning documents to be perpetually "in progress," and never scored an objective using the "completed" response. The definition of "in progress" varied widely among LPHCs; to some, it constituted reading one piece of literature on a given area of planning, while to others it was a representation of a significant amount of work toward "completed". In some counties, the "not applicable" response was directed by DPHCs in cooperation with LPHCs, and in other counties it was used when the purpose or intent of a specific item was not understood. This inconsistency of responses brings the reliability of the self-assessment as a solitary tool into question.

It is important to note that self-assessments were completed two to four months prior to audit interviews. Planning is an on-going process, and each report reflects two different points in time and planning. Self-assessments indicated very early stages of planning among most LHDs in April 2006. Initial audit interviews found similar results, but as time progressed, audit interviews revealed greater understanding on the part of LPHCs and more indications that overall planning is "in progress." This may have translated into a statewide average of greater than 1.0.

Audit interviews confirmed that local planning is minimal in Sections 3 (Public Health and Clinical Labs) and 8 (Community Disease Prevention and Control), as indicated in initial self-assessment analysis. LHDs do not have responsibility for clinical labs; thus, little planning has been completed. Most LHDs are awaiting guidelines on disease prevention and control, and planning will likely not progress until these guidelines are received.

No statistically significant trends were noted when comparing counties of comparable size, but qualitative analysis did reveal important gaps unique to small, rural counties, particularly those without hospitals. These counties do not have the same resources as larger counties and rely on collaboration with neighboring counties to address certain aspects of planning. These collaborations are reflected in individual county reports.

4. Recommendations

This section provides recommendations for the most significant gaps identified in the audit procedure. Areas addressed are alternative care sites, volunteer management, mortuary planning, public education, isolation/quarantine, and state-level coordination. For those areas that ISDH is already addressing, these recommendations will provide additional motivation and perhaps new ideas. For those areas not currently being addressed, the recommendations can help ISDH prioritize and understand how best to approach these problem areas. Any of these recommendations can be further developed and expanded at ISDH request.

4.1 Alternative Care Sites

With 45 million Americans currently uninsured, an ongoing nursing shortage expected to worsen, and the fact that nearly 50% of hospitals have been on a 'divert' status sometime during in the past year, the need for effective ACS planning, exercise, and deployment in Indiana is a certainty. The process of ACS planning, practice, and execution requires coordination between hospitals, public health departments, and emergency services at the local, district, and state levels. Although many Indiana hospitals are developing pandemic response plans, it is not reasonable to expect hospitals to carry the burden for ACS planning alone. Indeed, a significant number of Indiana counties have no local hospitals to assess their ACS needs.

Efforts should be made to develop a process for coordinated ACS planning for the State of Indiana. Such a process should specify how state, district, and local health and emergency services can work together to plan for the care of surges of ill patients during a pandemic. Further, ACS needs should be assessed, the required number of sites per county estimated, sizes and locations specified, staffing and resource needs developed, and planning, exercise, and deployment responsibilities delineated.

Once site designs and locations have been determined, an implementation plan should be developed. This requires specification of the likely set of public health scenarios that will require ACS response, the 'trigger' events in each scenario that will initiate site activation, the set of sites that will be activated in response to each trigger, and the order in which those sites will be activated, if multiple sites are involved. The implementation plan should also specify the process of opening a specific ACS.

4.2 Volunteer Management

Sufficient volunteer resources are vital to successful pandemic response at the local level, particularly among counties with limited LHD, law enforcement, healthcare and other

professional personnel. Most counties reported insufficient volunteer resources to operate PODs and ensure back-up for vital records and other essential services. Once volunteers are secured, counties face the challenges of credentialing, training, addressing liability and maintaining communication with the volunteer base.

Volunteer management research is needed to determine the most effective way to recruit, credential, train and maintain active and integrated volunteers. Volunteer management for pandemic influenza is a process by which individuals from outside public health are integrated in a systematic manner into the public health and emergency response infrastructure. Volunteer management should be an on-going, multi-step process that includes the following functions:

- Identifying the work that volunteers will be asked to do in case of emergency and assessing the skill sets necessary to do that work.
- Projecting how many volunteers with each skill set are necessary. This step must take into account the estimated time-span of an emergency, the projected influx of patients from the public, working hours, and volunteer availability and attrition. For example, volunteer requirements for setting up and staffing a POD for 48 hours might be much different than volunteer requirements for an ACS in operation for several weeks.
- Assessing the risk that volunteers will assume during the performance of their duties. During a flu pandemic, many volunteers will be exposed to critically ill patients with a highly contagious infection. Assuring that each volunteer has the appropriate, properly fitted PPE will be absolutely essential. Further, volunteers and their families must have priority for vaccine and anti-viral distribution.
- Recruiting volunteers by identifying those members of the community and district that have the required skills, contacting and persuading candidates, providing incentives, establishing expectations, and answering questions. Recruited candidates should be assessed for leadership skills so that those most able can be assigned backup leadership roles.
- Training volunteers so they understand the work they will be asked to do and how to keep themselves and their families' safe during a pandemic. It must also assure that volunteers are familiar with district and county pandemic plans, the events that will trigger those plans, and how to assume their role in those plans.
- Reinforcing and refining training through exercises. These provide volunteers the opportunity to meet, work together, practice procedures, test PPE, and so forth. Selected

volunteers can work with public health and emergency personnel to plan, staff, execute, and assess these exercise experiences.

- Considering volunteer turnover and retention. A well-managed, up-to-date volunteer group will constantly be adding new people and allowing others to retire. A management program that integrates recruitment, retention, and retirement incentives will serve best.
- Assuring that volunteers have the appropriate credential and are keeping them up-to-date before an emergency occurs.

4.3 Mass Fatality Planning

Lack of mortuary planning emerged as a significant gap across counties. This aspect of planning was often viewed as solely the coroner's responsibility; in many cases, coroners expressed a reliance on state directives for any local planning. Few counties had integrated mortuary planning into pandemic response plans. Advances in this area of planning will require a community-wide effort of coroners, funeral directors and other integral stakeholders to develop independent local plans. Research is needed toward the development of guidelines for local level implementation and coordination of mortuary planning efforts; this should include clarification of roles and responsibilities.

Alternatives for handling mass fatalities in a coordinated manner should be developed at the district and local levels. This should involve identifying the required steps that must occur, the resources required, the most critical potential shortages, and opportunities for mass storage, stockpiling supplies, and cost-sharing among counties. Important religious, cultural, and/or psychological aspects should be taken into account. Factors that should be considered include

- Estimated number of fatalities;
- Individuals with authority to pronounce death and sign death certificate;
- Number and shelf life of body bags;
- Quantity and shelf life of embalming fluid; amount needed per body;
- Where and how families transport bodies resulting from death occurring at home;
- Resources to transport bodies from hospital or homes;
- Morgue location and capacity;
- Location and capacity of alternate morgue sites;
- Location and capacity of funeral homes;
- Location and capacity of alternate funeral home sites;
- Length of time embalmed and un-embalmed bodies can be stored;
- Number of individuals trained to embalm and speed of embalming;

- Speed and capacity of crematoriums;
- Casket availability and barriers to acquisition;
- Resources for grave preparation;
- Temporary caskets alternatives;
- Potential locations for temporary mass burial sites;
- Legal procedures for acquisition of land for mass burial;
- Capacity and time necessary for funeral home memorial service; and
- Social, cultural, and psychological aspects of mass fatality and burial.

4.4 Public Education

Many counties reported community-wide skepticism and apathy regarding pandemic influenza planning, even among key stakeholders. The limited attendance at Town Hall meetings throughout the state appears to confirm this observation. It is difficult to balance a sense of gravity and urgency in communication and education, while avoiding panic and other extreme responses. It is also difficult to sustain long-term public interest and action.

Accurate and consistent communication is needed from the local and state level regarding community planning efforts, individual responsibility and concepts of shelter-in-place, neighborhood networking, and volunteering. A variety of media should be explored to transmit these messages, including:

- PSAs on cable networks and radio stations;
- Regular columns in local newspaper;
- Presentations to community groups and employers;
- Distribution of educational packets at public locations (e.g., library, Chamber of Commerce, grocery stores, and health fairs);
- Flyers in paychecks, utility bills and/or church bulletins; and
- Promotion of LHD, county and district websites.

Using a variety of local, district and state media outlets ensures greater community coverage and consistent reinforcement of messages, and it also conditions the public to access these outlets for crucial information during a pandemic.

Educational efforts on disease prevention should also be targeted to school-age children. This can be accomplished in a number of ways, including:

- State-level collaboration between ISDH and Indiana State Department of Education and Insight Indiana Youth Corps to launch school programs in hand washing, covering mouth with cough, staying home when sick, etc.

- Collaboration between LPHCs, local school nurses and Red Cross to launch educational programs at the local level.

4.5 Isolation/Quarantine

Although awareness of isolation/quarantine legal issues is evolving in Indiana, there is considerable confusion over the current status of quarantine laws. Many LHDs need legal clarification of House Bill 1235 in terms of responsibility and liability, and there is a need to strengthen and assure collaboration and planning between LHDs, hospitals, and law enforcement at the local level. Although many LHDs have some understanding of the legal steps that must be taken in isolation/quarantine, they are uniformly skeptical that isolation/quarantine measures can be implemented. Predominant reasons for this include lack of cooperation from local law enforcement, interference by local judges and politicians, and resistance from the public. Further, many LHDs express concern that isolation/quarantine will not be an effective strategy in a flu pandemic, even if well-implemented.

To address this, the ISDH should work with state associations for health and law enforcement to draft policies and procedures for isolation/quarantine that clarify local roles and responsibilities and ensure standard approaches to care. Further, educational efforts must address skepticism and apathy among key stakeholders, and the effectiveness of well-implemented isolation/quarantine measures in a pandemic scenario should be investigated to ensure standard approaches to care.

4.6 State-Level Coordination

Lists of stakeholders were fairly consistent from county to county, nearly always including EMA, EMS, hospitals, coroner, funeral directors, county officials, law enforcement, hospitals and pharmacies. However, levels of stakeholder support for LHD planning efforts varied greatly, and at times were a significant barrier to further planning development. Reasons for lack of support included skepticism or apathy about local planning efforts, sole reliance on state directives, limited resources and other pressing priorities, and/or interpersonal conflicts between agencies.

LHDs reported a lack of sufficient leverage to negotiate with resistant stakeholders; in the case of large pharmacy chains like CVS or Walgreens, local stores were unable to commit resources and/or volunteers without corporate approval. There is great opportunity to assist local-level planning on a large scale by negotiating with stakeholders at the state and Federal level. These opportunities include:

- Development of a state-level task force composed of ISDH, IDHS, state law enforcement and state coroner association to integrate planning and communication among agencies. This should include specific feedback to LPHCs responsible for planning at the local level.
- State-level communication with Purdue Extension Administration. This integral community component is not an active stakeholder in many counties. ISDH may explore partnership with Purdue Extension for education out to local level for support in local education, volunteers, and overall community planning efforts.
- Development of local, district and state contingency plans for public works.
- Partnership with Indiana Medical Society to provide additional support in recruitment and surveillance of local healthcare providers.
- State-level partnerships with Area on Aging and other state agencies for identification of homebound and special needs in declared emergency; explore HIPAA guidelines in relationship to declared emergency situations.
- Negotiations with corporate pharmacy stakeholders at national level to secure some degree of support for local pandemic response.

Assistance and guidance from the State is also needed in the following areas:

- Development of recommended written policies and procedures as template for LHDs.
- Stronger network of connections between LHDs and districts, particularly to share best practices and solutions to common challenges.
- State website resources, including rationale for infection control practices, references and additional resources for LHDs.
- Development of local level reporting mechanism to capture hospital surge and activity, morgue surge, EMS surge, pharmacy activity and other significant occurrences during pandemic; to be reported to the State for accurate assessment of state-wide activity.
- Clarification of necessity and legal implications of MOUs in Indiana.

APPENDIX H.1 – Local Health Department Gap Analysis Reports: Indiana Homeland Security District 1 - Newton County

PURDUE
UNIVERSITY

FINAL PANDEMIC INFLUENZA GAP REPORT
Newton County, District #1
Population: 14,500

■ Audit Information

Audit Date: July 14, 2006 Visit X Call

County Representative: Marshall Robb, LPHC; Dianne Hopkins, RN, Administrative Assistant

Audit Team Members: Deborah Koester, MSN, RN; Feng Lin, MS

■ Section 1: Community Preparedness, Leadership and Networking

Summary of Key Points:

- Small LHD with 5 full-time and 2 part-time employees.
- EMA director key to planning efforts for LPHC; planning efforts more successful with joint approach; EMA has CEMP.
- LPHC has EMA background; EMA is lead agency; LHD is partner with EMA.
- Two Town Hall Meetings: one intended for public had attendance of 52; one intended for govt officials and other authorities had attendance of 12, including LHO, 3 fire chiefs, Director of Health Board. Folders prepared with informational material (included in GAP file).
- County commissioners and town marshall did not attend Town Hall Meeting; LPHC may present to town and county board meetings.
- LHO lives in Illinois; back-up LHO lives in Lake County; no LHO in Newton County.
- Local city/county officials not integrated into pan flu planning.
- County extension officer supportive and involved in Town Hall meeting - prepared all materials, paid for advertising and was a visible presence at meeting. Serves as link to volunteers, disseminates information through newsletter, sent letter to 70 businesses and school with LPHD, has list of recommended supplies for shelter in place.
- Law enforcement identified as stakeholder; supportive with EMA involved.
- Working with stakeholders is best accomplished in one on one effort with EMA/LPHD approach - has not established task force/work group in County; difficult to get everyone together.
- EMS identified by LPHC as stakeholder; MOU signed but EMS not supportive of participating in exercises.
- No morgue in County.
- Two Funeral homes identified as stakeholders; no contact by LPHC at this time.
- No hospital in County; County residents travel to Jasper, Lake or Tippecanoe County, depending on geographical location of residence.
- One MD in County; three health clinics exist - two are nurse practitioner managed; no healthcare providers reside in County.

- Media stakeholders include newspaper, Jasper County radio station (no local) and County Extension office. County Extension has fax numbers for every county office.
- One local pharmacy is involved and supportive; limited resources.
- No local ARC; MOU in place with Lake County ARC via EMA.
- Schools are supportive in planning efforts. Will explore use of school food and kitchen for volunteers.
- Local vet is involved in State BOAH; has attended Board of Health meetings.
- One large industry in County; even during gas leak in past has refused to close production; LPHC expressed concern re: isolation/shelter in place with employment policies.
- NIMS certification; all staff certified to level 700; updating to 100 with new guidelines. EMS NIMS compliant; law enforcement and volunteer fire dept given online source for NIMS training.
- ICS needs to integrate into CEMP.
- LPHC has encountered difficulty recruiting others for exercising components of plan. They plan to focus on exercising next grant year.
- Wabash Mental Health planning to utilize LPHD for future group counseling opportunities - LPHC will coordinate for pan flu planning. Ministerial support identified as possibility.
- PHO is responsible to activate PHO; understood by stakeholders.
- Sheriff's department identified for law enforcement support.
- LPHC feels plan can not be very flexible due to size of community, lack of support and resources available to LPHD; best option is coordinating with EMA.
- LPHC states 95% nurses that reside in County work outside County.
- Pan flu preparedness information to be distributed at 4-H fair.

Areas for Improvement:

- Limited resources for County are limited due to size and lack of healthcare facilities and providers.
- Identification of individuals and resources integral to planning process.
- Integration of stakeholders, including local government into planning process.
- Education of public, school, businesses and churches.
- Lack of support from County and Town govt. officials.

Strategies to Complete Planning:

- Integrate remaining stakeholders: regional ARC, pastoral care and churches, funeral directors, additional pharmacies.
- Schedule additional Town Hall Meetings or identify local groups and clubs to approach for educational opportunities; also consider School PTAs for education.
- Clarify that LHO or back up will be available; coordinate IHAN access with LHO - discuss with district coordinator.
- Meet with funeral directors/coroner to discuss delegation of mass fatality planning roles and responsibilities; consider referring to Dept. Of Homeland Security G386 Mass Fatalities Incident Management course. Contact is: www.in.gov/dhs/training.
- Contact Lake County ARC to ensure availability and opportunity for resources.
- Work with EMA director toward exercising ICS.
- Attend exercises in other counties within district.
- Arrange to make presentations at County and Town Board meetings.

- Clarify with district coordinator the agency responsible for ACS.

■ Section 2: Surveillance

Summary of Key Points:

- School surveillance reports absenteeism at 20%; good relationship with LHD.
- No routine surveillance/communication with nurse practitioner clinics.
- LHD receives State webmail.
- District epidemiologist provides information from State; responsible for investigations.
- Infection Control Nurses from nearby healthcare facility identified as possible resource.

Areas for Improvement:

- No healthcare providers registered on IHAN.
- No Sentinel physicians and no hospital for surveillance.

Strategies to Complete Planning:

- Contact district coordinator to register stakeholders on IHAN communication system.
- Contact district epidemiologist for information to access EPI-X program and registration of local physicians as Sentinel participants. Explore whether nurse practitioners can be Sentinel participants.
- Explore with local pharmacies potential of University of Pittsburgh, RODS program (Real-time Outbreak and Disease Surveillance System). Contact info is: (412) 647-3555 or (800) 533-8762.
- Contact Infection Disease Nurse at Jasper, Lake County and Lafayette hospitals to explore possibility of MOU re: IFI surveillance information as additional resource.
- Establish means of local reporting system with physician/nurse practitioners; create document for reporting to LHD to reflect community activity.
- Consider MOU with school nurses to report absenteeism <20%.

■ Section 3: PH & Clinical Labs

Summary of Key Points:

- No lab facilities located in County.
- Local healthcare providers send lab samples to various private labs.

Areas for Improvement:

Strategies to Complete Planning:

- Ensure safe handling of samples by local healthcare provider staff.

■ Section 4: Healthcare and Public Health Partners

Summary of Key Points:

- Two long term care facilities located in County. One supportive to planning efforts and serving as alternative distribution site, one not supportive.
- No MOUs with healthcare facilities or hospitals outside County.
- District MAA signed with all other Counties.
- Mortuary planning falls under CEMP. EMA Director has established good relationship with coroner and funeral directors. Coroner has not taken active response to planning; LPHC and EMA currently evaluating other plans as a resource to planning efforts.
- Vital records clerk has good relationship with funeral directors; will work to further this relationship.
- 170 volunteers needed for two POD sites (due to length of County.) Fifty percent of necessary volunteers identified. EMS has list of volunteers with credentialing done, but has not brought disk to LHD. Fire, police and nurse practitioners will be integral volunteers.
- Limited pharmaceutical supplies in County due to presence of only 4 pharmacies and no hospital.

Areas for Improvement:

- Completion of mortuary plan.
- No MOUs with healthcare facilities or healthcare providers.
- Limited volunteer resources.
- Limited public education for preparedness and shelter-in-place.
- Completion of mortuary plan.
- Limited availability of pharmaceuticals.
- Inability to locate homebound/special needs population.

Strategies to Complete Planning:

- Schedule additional Town Hall Meetings and launch public education campaign.
- Provide volunteer sign-ups at Town Hall Meetings and educational offerings; focus on non-medical volunteers.
- Identify additional groups in County for educational presentations (e.g., school PTA).
- Schedule meeting with coroner to learn about mortuary planning in progress.
- Integrate funeral home directors into mortuary planning with EMA.
- Schedule meeting with local healthcare providers re: providing outpatient healthcare in event of Pandemic.
- Contact local fire department to explore existing resource of homebound.
- Consider nurse and nurse practitioner volunteers to assist with public education campaign.
- Consider placing educational packets at each of the three healthcare provider clinics (due to length of county).

■ Section 5: Infection Control

Summary of Key Points:

- LHD up to date with Universal Precautions; completes annual inservices.
- Limited supply of PPE (masks, gloves, isolation gowns).

Areas for Improvement:

- Limited resources will prohibit purchase of additional PPE/improvements.

Strategies to Complete Planning:

- Update guidelines and practices as additional information becomes available.

■ Section 6: Vaccine Distribution & Use

Summary of Key Points:

- MP submitted 4/30/06. Awaiting approval and/or additional guidelines for revisions from State.
- Primary POD sites identified.
- Logistics of security, administration, and organization addressed in written plan.
- Will not exercise plan until submitted and approved and pan flu plan is completed.
- Plans to participate in District exercise scheduled in July.
- Few supplies stockpiled at this time.
- EMA will assist is setting up POD sites.

Areas for Improvement:

- Approval and revisions to MP plan.
- Acquisition of adequate volunteer resources to implement plan.
- Lack of resources to improve stockpile of supplies.

Strategies to Complete Planning:

- Complete written MP plan when revisions and updates are received.
- Submit updated MP plan to ISDH.
- Attend exercises/drills in other counties.
- Conduct volunteer recruitment with education campaign.
- Establish written list of medical and non-medical volunteers.
- Consider use of nurse practitioners in MP plan as back-up to PHO if no physician available.

■ Section 7: Antiviral Drug Distribution & Use

Summary of Key Points:

- Unaware new drugs may have additional documentation requirements.
- Awaiting MP revisions and pan flu template.
- Administration of antiviral will be appendices to MP plan.

Areas for Improvement:

- Completion of revisions/updates to MP plan.

Strategies to Complete Planning:

- Complete and submit revised MP plan to ISDH when appropriate.
- Update pan flu and MP plans to reflect additional reporting mechanisms re: new drugs.

■ Section 8: Community Disease Control/Prevention

Summary of Key Points:

- No plans in place for early investigation, containment, isolation, quarantine.
- No public education completed re: preparedness and self isolation/shelter in place.

Areas for Improvement:

- No written plans for establishing isolation/quarantine.
- Lack of public education re: preparedness, containment and shelter in place.

Strategies to Complete Planning:

- Schedule Town Hall Meetings and educational opportunities to discuss Shelter In Place and isolation/quarantine.
- Meet with local healthcare providers and other stakeholders to discuss isolation/quarantine policy/issues.

■ Section 9: Communication

Summary of Key Points:

- Limited access to IHAN by stakeholders and healthcare providers.
- No recent meetings with District PIO to review and update communication plan.
- LPHC has no pre-scripted material and templates from ISDH for Pandemic Flu.
- Emergency communication and redundant communication established via EMA.
- Stakeholders will be contacted via telephone/fax in event of Pandemic.

- PHN plan includes use of radio station in adjacent County and local newspaper for communication with public.
- No website for LHD.
- Questionable if majority of population in County has cable access.
- No funding for reverse 911; 211 not available.

Areas for Improvement:

- Lack of IHAN access.
- No plans in place for pre-scripted communication material.
- Limited communication in County via 'non local' radio and local newspaper.
- Communication plans have not been exercised.

Strategies to Complete Planning:

- Explore use of County government website to display pre-pandemic and real-time pandemic information.
- Contact District Coordinator to provide IHAN access to all stakeholders/first responders.
- Develop pre-scripted messages for pre-pandemic and pandemic.
- Consider use of Ham Radios and Scanners to disseminate information across County.
- Exercise communication plan with EMA and other key stakeholders.
- Consider use of electronic Bank and High School signs for disseminating information.
- Establish routine utilization of IHAN, CDC and ISDH websites by LHD staff.
- Establish recorded message for dedicated phone line through LHD.

■ Section 10: Workforce Support

Summary of Key Points:

- No LHO residing in County.
- No resources for COOP planning.

Areas for Improvement:

- Limited resources for LHO and LHD staff for continuity of operations during pandemic event.

Strategies to Complete Planning:

- Utilize educational opportunities to acquire volunteers for vital records.
- Contact county school corporation to explore support for vital records, phones and other non-medical support.

APPENDIX H.2 – Local Health Department Gap Analysis Reports: Indiana Homeland Security District 2 - Marshall County

PURDUE
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FINAL PANDEMIC INFLUENZA GAP REPORT
Marshall County, District #2
Population: 46,732

■ Audit Information

Audit Date: June 13, 2006 Visit Call X

County Representative: Wesley Curden, REHS

Audit Team Members: Deborah Koester, MSN, RN; Pamela Aaltonen, MSN, RN; Patty Gunning, MS, RN CCRN; Feng Lin,MS

■ Section 1: Community Preparedness, Leadership and Networking

Summary of Key Points:

- Stakeholders include EMA director, ARC, Animal Board of Health, sheriff, funeral directors, businesses, schools, hospitals, mental health, veterinarian and district epidemiologist.
- MOUs with POD sites.
- Schools providing full support, have set-up radio communication; working to complete preparedness checklists for LPHC.
- ARC as volunteer resource; has 30-35 volunteers.
- Three Town Hall meetings with poor to fair response; last meeting attendance was 35. Culver Military Academy expressed interest in presentation - could have attendance of 1400; other invitations from clubs and schools for educational programs; public more responsive.
- Funeral directors estimating projected numbers from Spanish flu; planning for alternative burial sites; everyone trained; concerns include three-day wait for cremation and developing standards for infection control.
- Seven staff members are NIMS trained to level 700; worked with EMA and police; EMA director has NIMS 100 and 200 certification.
- Decision Team formed to identify trigger points for declaring emergency response; working with law enforcement; nearing completion.
- MOUs in place with other counties in district.
- LHO supportive; communicates with LPHC via internet; stays updated.
- Plans for psychosocial support in County include mobile site.
- MOUs in place with businesses for medication.
- MOU in place with ARC for food and shelter.
- MOU in place with EMA for emergency services.
- LPHC works closely with county extension officer.
- LHO has authority for isolation/quarantine and mitigation of activity.

Areas for Improvement:

- Integration of mortuary planning into written pan flu plan.
- Identification of additional stakeholders and resources integral to planning process.
- Education of public, school, businesses and churches.

Strategies to Complete Planning:

- Continue to establish working relationships with key stakeholders on Pan Flu Planning Committee; may consider establishing smaller working groups to target specific components of planning (i.e., mortuary, volunteers and psycho-social services) and review written plan.
- Exercise internal ICS system.
- Identify additional small groups for education presentations (e.g., community health fairs, presentation to local clubs).
- Attend exercises in other districts to evaluate own plan.
- Consider how school nurses may contribute to education and infection control planning.
- Update NIMS certifications to meet new guidelines.

■ Section 2: Surveillance

Summary of Key Points:

- School surveillance reports absenteeism at 20%.
- LHD receives information from local hospital; established relationship with infectious disease nurse.
- LHD receives information via State webmail and IHAN.
- LPHC feels district epidemiologist will be good resource.
- PHN responsible for surveillance in schools and clinics.
- No surveillance in place with pharmacies, but will be in future.
- No Sentinel physicians in County.
- Enhanced surveillance would occur through infectious disease nurse, IHAN, PHN; also use death certificates for death due to infectious disease.
- No access to EPI-X.

Areas for Improvement:

- IHAN access for all key stakeholders for surveillance.
- Pharmacy surveillance opportunities.
- No Sentinel physicians in private practice or hospital for surveillance.

Strategies to Complete Planning:

- Contact district coordinator to register surveillance stakeholders on IHAN.

- Contact district epidemiologist for information to access EPI-X program, registration of local physicians as Sentinel participants and information re: participation of local hospital in PHESS.
- Explore with local pharmacies potential of University of Pittsburgh, RODS program (Real-time Outbreak and Disease Surveillance System). Contact info is: (412) 647-3555 or (800) 533-8762.
- Contact Infection Disease Nurse at local hospital to create written plan for enhanced surveillance.
- Establish means of local reporting system with physicians; create report template to record community activity during seasonal flu outbreak or daily during pandemic for LHD.
- Consider MOU with school nurses to report absenteeism <20%.

■ Section 3: PH & Clinical Labs

Summary of Key Points:

- Local healthcare providers send lab samples to various private labs.

Areas for Improvement:

Strategies to Complete Planning:

- Ensure safe handling of samples by local healthcare provider staff.

■ Section 4: Healthcare and Public Health Partners

Summary of Key Points:

- Two hospitals in County: Breeman and St. Joseph Regional Medical.
- Reverse 911, IHAN, newspaper and radio are primary means of communication with healthcare stakeholders and public.
- MOU in place with ARC for resources.
- Volunteer list includes 93 nurses (need 180); 20 doctors, dentists, pharmacists, senior citizens for "triage," law enforcement for security and public works employees for heavy equipment.
- ARC assisting with credentialing and working with hospital to complete ACS planning.
- Area Agency on Aging to identify location of homebound and special needs; a mobile team will address individual calls.
- Faith-based organizations identified as additional stakeholder for support and psycho-social services; not contacted yet.

Areas for Improvement:

- Volunteer resources.
- Public education for preparedness.
- Mortuary plan.

Strategies to Complete Planning:

- Launch public education campaign and provide education packets to library, school offices, doctor offices, county extension office, etc.
- Offer volunteer sign-ups at Town Hall meetings and educational offerings.
- Schedule meeting with coroner/funeral directors to learn about mortuary planning for written pan flu plan.
- Distribute office planning checklists to local healthcare providers.
- Consider nurse volunteers to assist with public education campaign.
- Contact local ministerial association to integrate faith-based organizations into planning.

■ Section 5: Infection Control

Summary of Key Points:

- LHD up-to-date with Universal Precautions; completes annual in-services.

Areas for Improvement:

- Education outreach to school age children re: infection control and disease spread.

Strategies to Complete Planning:

- Update guidelines and practices as additional information becomes available.
- Contact school nurses to develop educational campaign for school age children.
- Explore educational websites with children's curriculum development, including www.glogerm.com and http://www.healthychild.net/articles/mc52handwash.html.

■ Section 6: Vaccine Distribution & Use

Summary of Key Points:

- MP plan completed.
- Two primary POD sites identified.
- Written plan addresses logistics of security, administration, and organization.
- Plans to have full MP exercise on 7/6/06; looking for 120 volunteers.

Areas for Improvement:

- Completion of MP exercise.
- Adequate volunteer resources to implement exercise.

Strategies to Complete Planning:

- Conduct MP exercise as scheduled; modify plan as necessary.
- Attend exercises/drills in other counties to cont to evaluate own plan.
- Conduct volunteer recruitment with education campaign.
- Complete written list of necessary medical and non-medical volunteers.

- Credential volunteers as necessary.

■ Section 7: Antiviral Drug Distribution & Use

Summary of Key Points:

- LPHC unaware new drugs may have additional documentation requirements.
- Administration of antiviral will be appendices to MP plan.
- Priority list for administration includes first responders, EMTs, law enforcement, volunteers and their families.
- Hospitals have own plan for administration of antiviral and vaccine to employees.

Areas for Improvement:

Strategies to Complete Planning:

- Update pan flu and MP plans to reflect additional reporting mechanisms re: new drugs.

■ Section 8: Community Disease Control/Prevention

Summary of Key Points:

- Identification of first cases will involve PHN and district epidemiologist; LHO will implement self-isolation.
- Limited public education completed re: self isolation/shelter-in-place; to be include at future Town Hall meetings and small group meetings.

Areas for Improvement:

- Limited public education re: containment and shelter-in-place.

Strategies to Complete Planning:

- Complete Town Hall meetings and educational opportunities to discuss shelter-in-place and isolation/quarantine.
- Meet with local healthcare providers and other stakeholders to discuss isolation/quarantine policy/issues.
- Consult district epidemiologist updated guidelines.

■ Section 9: Communication

Summary of Key Points:

- LHD website includes family preparedness links and FEMA children's site: http://www.co.marshall.in.us/Departments/Health%20Dept/Public%20Disaster%20Preparedness.htm.
- Code Red Reverse 911 in place through sheriff; can call thousands of numbers in 60 seconds; can also repeat IHAN alert.
- Utilizing District PIO for PR; designating one additional LHD staff for PIO.
- Emergency communication and redundant communication established via EMA.
- PHN communication plan includes use of website, hotline, radio, newspaper, local radio stations, television station, cable company.
- LPHC creating family and children response plan.
- ICS in place.

Areas for Improvement:

- Limited public education re: preparedness for pandemic.

Strategies to Complete Planning:

- Develop pre-scripted messages for pre-pandemic and pandemic and include in written pan flu plan.
- Exercise communication plan with EMA and other key stakeholders.
- Consider use of electronic Bank and High School signs for disseminating information.
- Establish routine utilization of IHAN, CDC and DPH websites by LPHD staff.
- Link to preparedness page from County webpage for additional communication at: www.plychamber.org.
- Consider including preparedness as a topic for a Community Outreach Education Program as noted on County website schedule.
- Contact Chamber of Commerce to explore possibility of including article in the online NewsMonth webpage (linked to County website).

■ Section 10: Workforce Support

Summary of Key Points:

- Five additional volunteers are available as back-up if staff become ill.

Areas for Improvement:

- PHO-backup.

Strategies to Complete Planning:

- Work with Board of Health to ensure back up resources for LHO.
- Continue to review and update existing COOP plan.

Indiana State Department of Health
Public Health Preparedness & Emergency Response –
Pandemic Influenza Supplemental Funding
08/31/06 through 08/30/07

APPENDIX H.3 – Local Health Department Gap Analysis Reports: Indiana Homeland Security District 3 - Noble County

PURDUE
UNIVERSITY

FINAL PANDEMIC INFLUENZA GAP REPORT
Noble County, District #3
Population: 46,732

■ Audit Information

Audit Date: June 15, 2006 Visit Call X

County Representative: Mick Newton, LPHC

Audit Team Members: Mark Lawley, PhD; Deborah Koester, MSN, RN; Feng Lin, MS; Patty Gunning, MS, RN, CCRN

■ Section 1: Community Preparedness, Leadership and Networking

Summary of Key Points:

- LPHC is retired police officer.
- Stakeholders in pan flu planning include: EMA director, safety officer and infection control nurse from hospital, elected officials (two mayors), town manager, judge, fire chief, schools and businesses, sheriff, police, churches.
- LPHC/LHD received $5000 grant from Community Foundation for local planning efforts and purchase of PPE.
- Town Hall Meeting held with poor response; newspaper utilized for PR; many first responders attended, few general public; LPHC attributes poor response to apathy and skepticism of public.
- NIMS compliant; updating to meet new guidelines.
- LPHC concerned that County has 2nd largest population in district, but LHD only has seven employees.
- ICS command structure in place.
- Utilized ISDH toolkit; checklists sent to schools and businesses for planning.
- EMA director is 83 years old, in poor health.
- District coordinator supportive; good resource.
- Working with school superintendent to help in school planning.
- LHO is part-time, not NIMS trained, functions as medical advisor.
- No MOUs as they are included in State statute.
- Only four volunteers at this time; will plan to provide just in time training for additional volunteers when POD set up.
- Latino community is 9% of total population; cultural barriers; planning separate POD staffed by the medical staff most often in contact with Latino population.
- Coroner and funeral directors to be included in planning; currently do not work together.
- No local ARC; regional ARC available from Fort Wayne.

Areas for Improvement:

- Integration of mortuary planning into written pan flu plan.

- Identification of additional individuals and resources integral to planning process: psychosocial services and support.
- Integration of remaining stakeholders into planning process.
- Education of public, school, businesses and churches.
- EMA involvement in planning (not currently NIMS compliant).
- Volunteer resources.

Strategies to Complete Planning:

- Continue to establish working relationships with key stakeholders on Pan Flu Planning Committee; may consider establishing smaller working groups to target specific components of planning, i.e. mortuary, volunteers and psychosocial services and review of written plan.
- Exercise internal ICS system.
- Identify additional small groups for education presentations (e.g., community health fairs, presentation to local clubs).
- Attend exercises in other districts to evaluate own plan.
- Consider how school nurses may contribute to planning with education and infection control.
- Update NIMS certifications to meet new guidelines.
- Prepare pandemic flu planning educational packets to distribute to library, physician offices, and schools.
- Establish back up for EMA and LHO; include in written pan flu plan.
- Identify additional sources of volunteers; provide opportunity to register as volunteer at all educational presentations.
- Ensure that interpreters are available at POD and educational presentations. Recruit and train Latino volunteers to help with POD activities.

■ Section 2: Surveillance

Summary of Key Points:

- Schools report absenteeism at 20%; school nurses good resource.
- LHD receives information from Parkview Hospital System.
- LHD receives information via State web mail and IHAN.
- District epidemiologist good resource.

Areas for Improvement:

- IHAN access for all key stakeholders for surveillance.
- Pharmacy surveillance opportunities.
- No Sentinel physicians in private practice.

Strategies to Complete Planning:

- Contact district coordinator to register surveillance stakeholders on IHAN.

- LPHC explore with local pharmacies the potential of University of Pittsburgh, RODS program (Real-time Outbreak and Disease Surveillance System). Contact info is: (412) 647-3555 or (800) 533-8762.
- Contact infection disease nurse at local hospital to create written plan for enhanced surveillance.
- Establish means of local reporting system with physicians; create report template to capture community activity during seasonal flu outbreak or daily during pandemic for LHD.

■ Section 3: PH & Clinical Labs

Summary of Key Points:

- Local healthcare providers send lab samples to various private labs.

Areas for Improvement:

Strategies to Complete Planning:

- Ensure safe handling of samples by local healthcare provider staff.

■ Section 4: Healthcare and Public Health Partners

Summary of Key Points:

- Jails and nursing homes identified as special populations.
- Churches and parish nurses are important resource.
- LPHC planning to coordinate county mortuary plan.
- No mechanism for daily tracking during pandemic.
- Faith-based organizations identified as stakeholder for support and psychosocial services; not yet contacted.

Areas for Improvement:

- Volunteer resources.
- Public education for preparedness.
- Mortuary plan.

Key Strategies to Complete Planning:

- Launch public education campaign and provide education packets to library, school offices, doctor offices, county extension office, etc.
- Offer volunteer sign-ups at Town Hall meetings and educational offerings.
- Schedule meeting with coroner/funeral directors for awareness and direction of mortuary planning for written pan flu plan.
- Consider nurse volunteers to assist with public education campaign.

- Contact local ministerial association to integrate faith-based organizations and parish nurses in planning, volunteering and education.

■ Section 5: Infection Control

Summary of Key Points:

- LHD up-to-date with Universal Precautions; in-services completed annually.
- LPHC has $5000 grant award for purchase of PPE.
- Hospital stocks PPE for employees and their families.

Areas for Improvement:

- Education outreach to school age children re: infection control and disease spread.

Strategies to Complete Planning:

- Update guidelines and practices as additional information becomes available.
- Contact school nurses to develop educational campaign for school age children.
- Explore educational websites for curriculum development regarding infection control for children (i.e., www.glogerm.com and http://www.healthychild.net/articles/mc52handwash.html).

■ Section 6: Vaccine Distribution & Use

Summary of Key Points:

- MP plan completed.
- Has not exercised MP at this time.
- Written plan addresses logistics of security, administration, and organization.
- Volunteer newsletter planned.

Key Areas of Concern:

- Completion of MP exercise.
- Adequate volunteer resources to implement exercise.

Key Strategies to Complete Planning:

- Conduct MP exercise.
- Attend exercises/drills in other counties to cont to evaluate own plan.
- Conduct volunteer recruitment with education campaign.
- Complete written list of necessary medical and non-medical volunteers.
- Credential volunteers as necessary.

■ Section 7: Antiviral Drug Distribution & Use

Summary of Key Points:

- LPHC unaware new drugs may have additional documentation requirements; unsure if anti-viral will come from SNS.
- Administration of anti-viral will be appendices to MP plan.
- Priority list for administration includes first responders, EMTs, law enforcement, volunteers and their families.

Areas of Improvement:

Strategies to Complete Planning:

- Update pan flu and MP plans to reflect additional reporting mechanisms re: new drugs as additional guidelines available.

■ Section 8: Community Disease Control/Prevention

Summary of Key Points:

- First cases to be identified by Decision Making Team: PHN, District Epi, LHO and County Commissioner. Team will gather at hospital, assess data, make decision and provide written response to declare county emergency.
- Limited public education has been completed re: self-isolation/shelter-in-place; to be included at additional Town Hall Meeting and future small group meetings.

Key Areas of Concern:

- Limited public education re: containment and shelter in place.

Key Strategies to Complete Planning:

- Complete Town Hall Meetings and educational opportunities to discuss shelter-in-place and isolation/quarantine.
- Meet with local healthcare providers and other stakeholders to discuss isolation/quarantine policy/issues.
- Consult District epidemiologist for updated guidelines.

■ Section 9: Communication

Summary of Key Points

- Primary means of communication with public include newspaper; radio, cable television emergency announcements, 211, website.
- No funding for Reverse 911.
- IHAN is planned to set up group, send message (will work like reverse 911).
- Emergency communication and redundant communication established via EMA.

- ICS in place, unsure of activation procedure.

Key Areas of Concern:

- Limited public education re: preparedness for pandemic.

Strategies to Complete Planning:

- Develop pre-scripted messages for pre-pandemic and pandemic; include in written pan flu plan.
- Exercise communication plan with EMA and other key stakeholders.
- Consider use of electronic Bank and High School signs for disseminating information.
- Establish routine utilization of IHAN, CDC and DPH websites by LHD staff.
- Consider link to preparedness page from County webpage.

■ Section 10: Workforce Support

Summary of Key Points:

- Continuity of operations includes cross training.

Key Areas of Concern:

- Adequate LHO and staff back-up.

Strategies to Complete Planning:

- Work with Board of Health to ensure back up resources for LHO.
- Continue to review and update existing COOP plan.
- Identify non-medical volunteers to provide back up for essential LHD functions.

APPENDIX H.4 – Local Health Department Gap Analysis Reports: Indiana Homeland Security District 4 – Fountain/Warren combined County Health Department

PURDUE
UNIVERSITY

FINAL PANDEMIC INFLUENZA GAP REPORT
Fountain-Warren County, District #4
Population: 26,341

■ Audit Information

Audit Date: June 15, 2006 Visit X Call

County Representative: Duane Warner, DVM, LPHC

Audit Team Members: Deborah Koester, MSN, RN; Patricia Gunning, MS, RN; Feng Lin, MS

■ Section 1: Community Preparedness, Leadership and Networking

Summary of Key Points:

- VX chemical stockpile located here; additional support for County provided by U.S. Army.
- Pandemic Influenza Planning Committee includes LPHC, EMA director, two County commissioners, two PIO, sheriff, hospital (St. Vincent Infection Control), local health board (nurse, physician and public representative).
- LPHC, EMA and chief environmental officer work well together to integrate and implement emergency planning.
- Schools difficult to integrate into planning efforts.
- Coroner addressing mass fatality planning; has specific plan that includes refrigeration trucks, three burial sites for mass graves and electronic generation of death certificates.
- No Red Cross in County; MOU in place with Montgomery County Red Cross for shelter; working to establish Red Cross within County.
- Town Hall Meeting held; included schools, faith-based groups, businesses, physicians on Board of Health and families. Attendance approximately 70; presented PowerPoint, DVD and additional education.
- LHD had booth at local 4H Fair for public education.
- Law enforcement supportive but lack of staffing during pandemic is a concern.
- LPHC views LHD role as education for preparedness and prevention for shelter-in-place and self-isolation.
- LHO/LHA will activate plan.
- Two pharmacies located in County; private-owned more supportive than CVS.
- All LHD employees are NIMS compliant; updating to new guidelines.
- Stakeholders understand LHO is legal authority for activating plan and making decisions related to isolation, quarantine and movement restriction.
- ICS in place; has exercised communication twice in TTX.
- Has exercised mortuary TTX, real-time incident.

Areas for Improvement:

Strategies to Complete Planning:

- Continue to conduct media campaign and educational efforts with public for pandemic preparedness.
- Collaborate with coroner and funeral directors toward incorporating written mortuary plan.
- Consider attendance of key stakeholders at Dept. Of Homeland Security G386 Mass Fatalities Incident Management course. Contact is: www.in.gov/dhs/training.

■ Section 2: Surveillance

Summary of Key Points:

- District epidemiologist very supportive; in contact with LHD daily for updates.
- Animal surveillance: phone conversation three times a week with veterinarian, use FDA reports and internet resources.
- All physicians and St. Vincent Infection Disease Control report to LHD weekly.
- Regional/state surveillance established utilizing State Webmail and IHAN.
- Two Sentinel physicians located in County.
- School absenteeism rate reported at 20%.

Areas for Improvement:

- Written plan to track daily activity during pandemic for coordinating agencies.

Strategies to Complete Planning:

- Collaborate with healthcare sector to report unusual flu activity.
- Collaborate with healthcare sector to develop means of daily tracking of activity during pandemic.

■ Section 3: PH & Clinical Labs

Summary of Key Points:

- No clinical lab at LHD.

Areas for Improvement:

Strategies to Complete Planning:

- Secure communications with ISDH for influenza testing.
- Collaborate with district epidemiologist to assure LHD receives results of State lab testing.

■ Section 4: Healthcare and Public Health Partners

Summary of Key Points:

- Six physicians practice in County, four reside there.
- No hospital located in County.
- Volunteer list includes physician, RNs, school nurses, LPNs and first responders.
- LPHC has communicated with coroner; mortuary planning in place.
- Closest hospital has only 15 beds.
- MOU in place with Montgomery County Red Cross for shelter.

Areas for Improvement:

Strategies to Complete Planning:

- Maintain communication with nearest hospital to verify plan and assure necessary collaboration, including isolation, quarantine and surge plans.
- Complete volunteer credentialing as necessary.
- Maintain communication with coroner and mortuary services to finalize mortuary planning.

■ Section 5: Infection Control

Summary of Key Points:

- LHD has identified supplier for PPE, but no supply available at this time.
- Annual staff updates re: Universal Precautions.
- Education has been exercised with LHD staff.

Areas for Improvement:

Strategies to Complete Planning:

- Update as new guidelines are available.

■ Section 6: Vaccine Distribution & Use

Summary of Key Points:

- Food for local PODs to be provided by local businesses.
- Volunteer list in place; credentialing in progress; two portable computerized badge machines available.
- Primary POD site identified.

- LPHC continues to consider feasibility of drive-through POD.
- Public to be informed about MP by means of radio and newspaper.
- Pan flu vaccine incorporated into MP plan.

Areas for Improvement:

Strategies to Complete Planning:

- Continue to exercise components of plan; revise as necessary.
- Update guidelines for priority of administration as available.
- Continue public education and communication efforts regarding implementation of MP plan.

■ Section 7: Antiviral Drug Distribution & Use

Summary of Key Points:

- Incorporated into MP plan.
- First responders will be priority of administration.

Areas for Improvement:

- Distribution of anti-viral.
- Priority list reflects updated guidelines.

Strategies to Complete Planning:

- Complete written plan for distribution of anti-viral with anticipated shortages.
- Exercise distribution of anti-viral under anticipated shortages.
- Review priority list as guidelines are updated.

■ Section 8: Community Disease Control/Prevention

Summary of Key Points:

- LPHC feels isolation/quarantine can be established easily due to small size and rural geography of County.
- Plan for early containment established by early self-isolation.

Areas for Improvement:

- Public education of importance of early self isolation and containment.

Strategies to Complete Planning:

- Collaborate with local healthcare sector to exercise plan for early containment.

- Continue public education efforts on importance of self-isolation.
- Collaborate with district epidemiologist for early isolation/quarantine/containment.
- Collaborate with school nurses and daycare centers to provide educational opportunities for students to reduce spread of infection.

■ Section 9: Communication

Summary of Key Points:

- Emergency communication plan includes activating EOC; notifying all pertinent stakeholders.
- PIO and backup identified at LHD.
- LHD will use radio, Emergency Alert Network and two local newspapers to inform the public.
- Attempting to secure funding to implement reverse 911.
- LHD has access to EPI-X.
- Redundant communications systems established via EMA.

Areas for Improvement:

Strategies to Complete Planning:

- Explore use of County website to display pan flu preparedness information.
- Develop pre-scripted messages for pre-pandemic and pandemic.
- Continue to exercise emergency communication plans internally and with EMA and other key stakeholders of EOC.
- Consider use of electronic bank and high school signs for dissemination of information.

■ Section 10: Workforce Support

Summary of Key Points:

- LHO back-up includes physicians on local Health Board.
- Resource list available for volunteers to provide back-up.

Areas for Improvement:

Strategies to Complete Planning:

Indiana State Department of Health
Public Health Preparedness & Emergency Response –
Pandemic Influenza Supplemental Funding
08/31/06 through 08/30/07

APPENDIX H.5 – Local Health Department Gap Analysis Reports: Indiana Homeland Security District 5 – Hamilton County

PURDUE
UNIVERSITY

FINAL PANDEMIC INFLUENZA GAP REPORT
Hamilton County, District #5
Population: 231,760

■ Audit Information

Audit Date: June 27, 2006 Visit Call X

County Representative: Nicole Anderson, LPHC

Audit Team Members: Deborah Koester, MSN, RN; Feng Lin, MS

■ Section 1: Community Preparedness, Leadership and Networking

Summary of Key Points:

- Stakeholders in pan flu planning include: EMA director, EMS director, city and county government officials (mayor and commissioners), hospital, law enforcement, local media, pharmacies, LHO, schools and churches.
- Pan Flu Summit held in May; attendance = 144.
- ARC not responsive to planning efforts, new director in place; LPHC working to build this relationship.
- LPHC has clear understanding of planning activities occurring at state, local and coordinated levels.
- LHD and LPHC roles include education, coordination and integration of planning efforts and serving as a resource to other agencies.
- All but two LHD staff have completed NIMS 700 course; working to complete additional courses to meet updated guidelines by 9/30/06; LPHC states most hospitals in County are NIMS trained.
- LPHC planning to have MOUs in place with local printing company for supplies, department stores for water and food, ARC for food and shelter, EMA to delineate roles and responsibilities. MOUs in place with District 5 for mutual aid, schools for MP plan, law enforcement for security.
- Stakeholders understand LHO is legal authority for isolation, quarantine and mitigation of activity; Decision Making Team also integrated into process, including LHD administrator.
- Local Decision Making Team initiates request for state and Federal resources; worksheet developed for necessity and direction of request(s).
- ICS in place; TTX scheduled for September 2006.
- Psychosocial planning includes Behavioral Corp. and Indiana Mental Health Association; assisting LPHC with constructing messages for public and establishing plans for a hot line.
- Mortuary planning: good relationship with funeral directors and coroner, will work in this area in future.
- Churches invited to summit; have not worked with this group on an individual basis.
- Businesses and industry: identified for future area of planning.
- Identifying triggers to activate plan; key area of planning for LPHC.
- June district-wide TTX with attendance of 35; EMS, hospital, pharmacy and schools absent.

Areas for Improvement:

- Integration of mortuary planning, faith-based organizations, businesses and industry into written pan flu plan.
- Identification of additional stakeholders and resources integral to planning process.
- Education of public, school, businesses and churches.

Strategies to Complete Planning:

- Continue to establish working relationships with key stakeholders Pan Flu Planning Committee; consider establishing smaller working groups to target specific components of planning, (i.e., mortuary, volunteers and psycho-social services) and review written plan.
- Continue to exercise internal ICS system.
- Identify additional small groups for education presentations (e.g., community health fairs, presentation to local clubs).
- Attend exercises in other districts to evaluate own plan.
- Consider how school nurses may contribute education and infection control plans.
- Update NIMS certifications to meet new guidelines.
- Provide educational presentation to local ministerial group and explore opportunities to integrate faith-based organizations as resources and possible volunteers.

■ Section 2: Surveillance

Summary of Key Points:

- School surveillance reports absenteeism at 20%.
- LHD receives information from local hospital; relationship established with infectious disease nurse.
- LHD receives information via weekly reports from State webmail.
- LPHC feels district epidemiologist will be good resource; receives info from this source.
- PHIN responsible for surveillance in schools and clinics.
- LHD planning local electronic surveillance with Medtronic (as a part of Citi-Readiness Initiative).
- No or few Sentinel physicians in County.
- Plan for enhanced surveillance and daily tracking during pandemic to be determined.
- Possible access to EPI-X by PHNs.

Areas for Improvement:

- IHAN access for all key stakeholders.
- Pharmacy surveillance opportunities.
- Lack of Sentinel physicians in private practice or hospital for surveillance.

Strategies to Complete Planning:

- Contact district coordinator to register surveillance stakeholders on IHAN.

- Identify means of enhanced surveillance for written pan flu plan. Also contact district epidemiologist and PHN to ensure access to EPI-X program and registration of local physicians as Sentinel participants.
- Explore with local pharmacies potential of University of Pittsburgh, RODS program (Real-time Outbreak and Disease Surveillance System). Contact info is: (412) 647-3555 or (800) 533-8762.
- Contact Infection Disease Nurse at local hospitals to create written plan for enhanced surveillance.
- Establish means of local reporting system with physicians, healthcare entities and coroner; create report template to capture community activity during seasonal flu outbreak or daily during pandemic for LHD.

■ Section 3: PH & Clinical Labs

Summary of Key Points:

- Local healthcare providers send lab samples to various private labs.

Areas for Improvement:

Strategies to Complete Planning:

- Ensure safe handling of samples by local healthcare provider staff.

■ Section 4: Healthcare and Public Health Partners

Summary of Key Points:

- Hamilton County Medical Reserve Corp initiated. All physicians notified by letter that they are included unless they opt out; no physicians have opted out at this time.
- ARC not responsive to planning efforts; LPHC working to build this relationship.
- Volunteer list includes physicians, nurses, pharmacists, dentists; working to establish coordinated effort in County for volunteers; would like to integrate with hospitals.
- Credentialing accomplished with license verification, establishing database, assigning badges with bar codes, will scan volunteers in and out of POD; will have wireless capability for on-site credentialing.
- LPHC working with the following County healthcare entities (i.e., hospitals, home-healthcare agencies, long-term care facilities, and urgent (immediate) care centers.
- LPHC to address ACS in planning; need to discuss medical care responsibilities, ventilators, staffing, access to medications. Responsibilities (hospital?) need to be clarified.

Areas for Improvement:

- Volunteer resources.
- Public education for preparedness.
- Mortuary plan, including adequate number of body bags, refrig truck, integration of coroner and funeral directors.

Strategies to Complete Planning:

- Launch public education campaign and provide education packets to library, school offices, doctor offices, county extension office, etc.
- Provide volunteer sign-up opportunities at Town Hall Meetings and educational offerings.
- Schedule meeting with coroner/funeral directors to develop mortuary planning for written pan flu plan. May consider attending Mass Fatality Training Course through Indiana Department of Homeland Security. Information available at www.in.gov/dhs/training.
- Contact/visit local healthcare provider offices to distribute office planning checklists.
- Consider nurse volunteers to assist with public education campaign.
- Contact local ministerial association to integrate faith-based organizations into planning.
- Continue to build Medical Reserve Corp.
- Continue to strengthen relationship with ARC and obtain MOU.
- Clarify plan and responsibility for ACS with local healthcare facilities.
- Consider attending September 21st Pan Flu Summit sponsored by Indiana Public Health Foundation.

■ Section 5: Infection Control

Summary of Key Points:

- LHD up to date with Universal Precautions; completes annual inservices.
- Infection Control training included in MP plan for Just In Time training for all volunteers; can be trained for POD in 20 minutes.
- LHD supplies include 4000 N95 masks, gloves and booties.

Areas for Improvement:

- Education outreach to school age children re: infection control and disease spread.

Strategies to Complete Planning:

- Update guidelines and practices as additional information becomes available.
- Contact school nurses to develop educational campaign for school age children.
- Explore educational websites for children curriculum development, including www.glogerm.com and http://www.healthychild.net/articles/mc52handwash.html.
- Continue stockpiling supplies as determined necessary.

■ Section 6: Vaccine Distribution & Use

Summary of Key Points:

- MP plan completed.
- Full-scale exercise of MP scheduled for Nov. 2006; includes all integrated agencies, high school drama students, triage, mental health. Using students allows population of 2000 to work toward 800/hr; will work to create flexibility in execution.

- Four primary POD sites identified for MP; exercise planned.
- Written plan addresses logistics of security, administration, and organization.
- Planning includes on site credentialing and utilization of different colored dots or colored badges for different types of volunteers (Med Reserve Corp, medical and non-medical).
- Priority list established according to CDC and WHO.
- School television monitors will be used for education and information while waiting in line.

Areas for Improvement:

- Completion of MP exercise.
- Adequate volunteer resources to implement exercise.

Strategies to Complete Planning:

- Conduct MP exercise as scheduled; modify plan as necessary.
- Attend exercises/drills in other counties to evaluate own plan.
- Conduct volunteer recruitment with education campaign.
- Continue to update written list of necessary medical and non-medical volunteers.
- Credential volunteers as necessary.

■ Section 7: Antiviral Drug Distribution & Use

Summary of Key Points:

- Unaware new drugs may have additional documentation requirements.
- Administration of antiviral will be appendices to MP plan.
- Priority list for administration includes first responders, EMTs, law enforcement, volunteers and their families.
- Hospitals have own plan for administration of antiviral and vaccine to employees.

Areas for Improvement:

Strategies to Complete Planning:

- Update pan flu and MP plans to reflect additional reporting mechanisms re: new drugs as additional guidelines available.

■ Section 8: Community Disease Control/Prevention

Summary of Key Points:

- Decision Making Team (LHO, LPHC, sheriff, commissioner, PHN) to identify first cases and activate plan.
- Limited public education at this time completed re: self isolation/shelter in place.

- LPHC plans to include above at time of additional educational presentations and small group meetings in future.
- Self-isolation planned with first case; Decision Team has exercised with TTX.
- Communication with public will include local media, newspaper, radio, local TV, reverse 911 and 211.

Areas for Improvement:

- Limited public education re: containment and shelter-in-place.

Strategies to Complete Planning:

- Continue to schedule educational opportunities to discuss shelter-in-place and isolation/quarantine.
- Discuss isolation/quarantine policy/issues with local healthcare providers and other stakeholders.
- Consult district epidemiologist for updated guidelines.

■ Section 9: Communication

Summary of Key Points:

- Goal is to send consistent message, not cause panic.
- LHD uses District PIO; does not have LHD PIO; will test with full-scale exercise.
- LHD website includes links to ISDH and CDC for additional preparedness info.
- Reverse 911 in place.
- Redundant emergency communication established via EMA.
- LPHC stakeholder communication plan includes use of blast fax; also website, hotline, radio, newspaper, local radio stations, television station, cable company.
- ICS in place.

Areas for Improvement:

- Limited public education re: preparedness for pandemic.

Strategies to Complete Planning:

- Develop pre-scripted messages for pre-pandemic and pandemic; include in written pan flu plan.
- Exercise communication plan with EMA and other key stakeholders.
- Consider use of electronic Bank and High School signs for disseminating information.
- Ensure routine utilization of IHAN, CDC and DPH websites by LHD staff.
- Consider link to preparedness page from County webpage.
- Consider including preparedness as a topic for a Community Outreach Education Program at hospital educational offerings.
- Contact Chamber of Commerce (COC) to explore including an article and/or correspondence in mailings and/or at upcoming COC meetings.

■ Section 10: Workforce Support

Summary of Key Points:

- Continuity of operations includes suspending non-critical positions and cross-training individuals to emergency response; continuing only vital functions and encouraging self isolation.

Areas for Improvement:

- LHO backup.

Strategies to Complete Planning:

- Work with Board of Health to ensure back up resources for LHO.
- Continue to review and update existing COOP plan.

Indiana State Department of Health
Public Health Preparedness & Emergency Response –
Pandemic Influenza Supplemental Funding
08/31/06 through 08/30/07

APPENDIX H.6 – Local Health Department Gap Analysis Reports: Indiana Homeland Security District 6 – Tipton County

PURDUE
UNIVERSITY

FINAL PANDEMIC INFLUENZA GAP REPORT
Tipton County, District #6
Population: 16,605

■ Audit Information

Audit Date: June 27, 2006 Visit X Call

County Representative: Leslie Meye, LPHC; Debra Bennington, RN, Health Educator, Immunization Specialist

Audit Team Members: Deborah Koester, MSN, RN; Feng Lin, MS

■ Section 1: Community Preparedness, Leadership and Networking

Summary of Key Points:

- Small LHD with 5 employees.
- LPHC does not reside in County; is integral in coordinating County planning efforts.
- Small hospital with less than 40 beds.
- No LEPC or All-Hazards plan.
- LPHC re-initiated EMA Council with weekly meetings; emergency and first responder agencies currently function independently with weak integration of services.
- EMA recently received template for pan flu planning from Homeland Security; LPHC to provide integration and efficiency of community planning.
- Psychosocial services addressed through local ministerial support and strong parish nurse network; faith-based organizations would be very active in pandemic response.
- EMA director supportive; not NIMS trained but working to complete NIMS 700.
- EMS services provided through Howard County; EMS Director has no plans for provision during pandemic.
- Mayor, county commissioners and three town marshals supportive of planning efforts; commissioner working to complete NIMS 700.
- Coroner has been identified as a stakeholder; very supportive; however resources limited.
- No local ARC; County is served by Howard County ARC; will provide food. Invitation extended for ARC representative to attend meeting, but no attendance at this time.
- District coordinator and district epidemiologist good resources in planning and providing consistent information between state, district and local levels.
- Purdue county extension officer involved in planning; MOU in place to utilize 4-H Building (County Fairgrounds) for MP plan.
- Law enforcement support includes city police and sheriff departments; LPHC views primary role to be crowd control and security of SNS and POD; very limited resources for pandemic response; currently addressing internal integration issues.
- Eight physicians practicing in County.

- Four pharmacies in County.
- LHO supportive in planning; has authority to make decisions re: mitigation of activity, isolation/quarantine, and activation of plan.
- Two large and four small Town Hall meetings planned; utilizing ISDH Tool Kit.
- LHD NIMS compliant to 700; updating to new guidelines.
- MOUs in place with pharmacies, long-term care facilities and retirement facilities, jail, grocery store, extension office, fire department, school corporations, churches, all doctor offices and home-health care.
- LPHC views role in community as education, communication, coordination and integration of resources.
- One retired veterinarian on Board of Health; one active veterinarian not involved in planning.
- ICS in place; planning to exercise in TTX.

Areas for Improvement:

- Integration of emergency response agencies.
- Emergency transportation and community resources.
- Education of public, school, businesses and churches.
- Mortuary planning.

Strategies to Complete Planning:

- Continue working with emergency response and local agencies/healthcare entities to integrate planning and response.
- Establish smaller working group for Mass Fatality Planning; include coroner, funeral directors, EMA, and all potential stakeholders. Consider following up with Indiana Homeland Security G386 Mass Fatalities Incident Management Course; information at (317) 234-4286.
- Ensure back-up for LHO.
- Hold Town Hall meetings; offer volunteer sign-ups at all educational presentations; involve City and County government officials in presentations.
- Contact ARC in Howard County and Regional ARC office to meet re: MOU with County for planning resources. May also consider involving district coordinator.
- Prepare educational packets focusing on family preparedness and neighborhood networking; distribute to local library, schools, physician offices, day care centers, Chamber of Commerce and churches.
- Attend 9/21 Pan Flu Summit in Indianapolis, sponsored by Indiana Public Health Foundation.
- Work with EMA Director to meet with all key stakeholders and present HSI template for additional required planning.

■ Section 2: Surveillance

Summary of Key Points:

- School surveillance reports absenteeism at 20%; schools routinely report if there is unusual absenteeism <20%.
- No Sentinel physicians practicing in County.
- LHD receives information via State web mail and IHAN.
- Hospitals in surveillance system program; LHD not aware or involved in program; little or no communication between hospital ED, lab and LHD re: results and trends.
- Good working relationship with local pharmacies; LHD unaware of surveillance systems with local pharmacies.
- No formal reporting system between physician offices and LHD; communicable diseases reported to LHD.
- No organized reporting system track daily pandemic cases, deaths, etc at healthcare facilities and throughout County.

Areas for Improvement:

- Daily tracking for pan flu activity during pandemic outbreak (ED, MD offices, coroner, funeral homes, etc.).
- LHD involvement in formal surveillance programs in local hospital and pharmacies.

Strategies to Complete Planning:

- Contact district epidemiologist for information to access EPI-X program through ISDH, how to register local physicians as participants in Sentinel and information re: hospital syndromic surveillance system.
- Explore with local pharmacies potential of University of Pittsburgh, RODS program (Real-time Outbreak and Disease Surveillance System). Contact info is: (412) 647-3555 or (800) 533-8762.
- Establish formal local reporting system for all healthcare entities; create report template for recording community activity for EOC and LHD.
- Distribute information re: 9/21 Pan Flu Summit in Indianapolis to PHNs and school nurses. Additional information can be found by contacting (317) 244-2145.

■ Section 3: PH & Clinical Labs

Summary of Key Points:

- Local healthcare providers send lab samples to hospital and various private labs.

Areas for Improvement:

Strategies to Complete Planning:

- Ensure safe handling of samples by local healthcare provider staff.

■ Section 4: Healthcare and Public Health Partners

Summary of Key Points:

- Hospital has started planning process; setting up ICS structure; considering closing hospital and implementing ACS for triage and possibly care; LPHC unaware if hospital has exercised plans or components therein.
- Hospital has two ventilators, LHD has purchased ten portable and ten pediatric ventilators as part of stockpiled resources.
- MOU in place between LHD and hospital.
- EMA will be Lead Agency in response; working with LHD to determine trigger to activate components of plan.
- Coroner coordinating mortuary planning; no MOUs in place, funeral director confident he can access refrigerated trucks when needed; has stockpile of body bags.
- Volunteer list includes nurses, doctors, pharmacists and non-medical volunteers; credentialing as necessary; resources very limited; list not complete to meet needs.
- Focus of public education is family preparedness and neighborhood networking.
- LPHC unaware of effective means to identify location of homebound and special needs individuals.

Areas for Improvement:

- Limited volunteer resources.
- Public education for family preparedness and shelter in place.
- Mortuary planning.
- Locating homebound and special needs population.
- Integration of LHD and hospital in planning efforts.

Strategies to Complete Planning:

- Offer volunteer sign-ups at all Town Hall meetings and educational presentations.
- Create small working group for mortuary planning.
- Contact local Area on Aging agency, fire department, sheriff department, retirement center and senior groups to locate homebound and special needs individuals.
- Consider nurse volunteers from Parish Nurse group and hospital to assist with public education campaign.
- Attend hospital planning meetings or acquire minutes from meetings, if possible.

■ Section 5: Infection Control

Summary of Key Points:

- LHD fitted for N95 masks; storage space for stockpiled supplies is limited.
- Standards for immunization clinics include utilization of Universal Precautions.

Areas for Improvement:

Strategies to Complete Planning:

- Update guidelines and practices as additional information available.
- Stockpile as per ISDH recommendations.

■ Section 6: Vaccine Distribution & Use

Summary of Key Points:

- MP plan submitted to State; awaiting response and possible revisions.
- POD sites identified.
- Written plan addresses logistics of security, administration, and organization.
- Unable to exercise MP plan until revisions are received and adequate volunteer base is established.
- Priority of administration - follow CDC guidelines.

Areas for Improvement:

Strategies to Complete Planning:

- Continue to conduct volunteer recruitment.
- Amend MP plan as per ISDH guidance.
- Attend exercise in other counties, especially of similar size to evaluate County plan.
- Exercise components of MP plan with 'back to school' immunizations and seasonal flu immunizations; work with LHO, hospital and local healthcare providers to implement.

■ Section 7: Antiviral Drug Distribution & Use

Summary of Key Points:

- Unaware new drugs may have additional documentation requirements.
- MP plan submitted; awaiting revisions.
- Administration of antiviral will be appendices to MP plan.

Areas for Improvement:

Strategies to Complete Planning:

- Complete updates to MP, as appropriate.
- Update pan flu and MP plans to reflect additional reporting mechanisms re: new drugs.

■ Section 8: Community Disease Control/Prevention

Summary of Key Points:

- Plan not established for early investigation, containment, isolation/quarantine.
- Self-isolation/shelter-in-place to be included in public education efforts.
- Hospital is working to coordinate a Decision Making Team to activate plan based on identified triggers; communicating with LPHC in this aspect of planning.

Areas for Improvement:

- No plan in place for isolation/quarantine.

Strategies to Complete Planning:

- Schedule and include additional educational opportunities to discuss shelter-in-place and isolation/quarantine.
- Meet with all local healthcare provider and other stakeholders to discuss isolation/quarantine policy/issues and identify triggers to activate plans.

■ Section 9: Communication

Summary of Key Points:

- Primary means of communication with public include: cable public service announcements, website updates for 24-hour access, newspaper; high school computer calling system and LHD hotline. Exploring use of high school ability to send out mass e-mails.
- No local radio stations, no access to reverse 911 or 211.
- PIO has no back-up.
- Phone tree developed to update stakeholders.
- Emergency communication and redundant communication established via EMA.
- Two staff in LHD with access to IHAN.
- Utilizing bank and school tickers (electronic signs) as additional means of communication with public.

Areas for Improvement:

- Means of providing timely communication to public.
- Back-up for PIO.
- IHAN access.

Strategies to Complete Planning:

- Contact LHD to establish access to IHAN for stakeholders/first responders.
- Develop pre-scripted messages for pre-pandemic and pandemic.
- Consider use of Hamm radios and scanners to disseminate information across County.

- Exercise communication component of plan with EMA and other key stakeholders; exercise opening EOC.
- Continue routine utilization of IHAN, CDC and DPH websites by LHD staff.
- Establish recorded message and dedicated phone line through LHD.
- Establish back-up for PIO.
- Contact area/regional radio stations and obtain MOU for additional means of communication.

■ Section 10: Workforce Support

Summary of Key Points:

- Vital records identified as essential service.
- Working to consider most effective and practical means of planning.

Areas for Improvement:

- Limited resources for LHD staff for continuity of operations during pandemic event.

Strategies to Complete Planning:

- Continue cross training and identify back-up for all essential services; may access parish nurse network.
- Utilize educational opportunities to acquire volunteers for vital records.
- Contact local school corporation to explore support for vital records, phones and other non-medical support.
- Consider vital records working out of hospital(s).

APPENDIX H.7 – Local Health Department Gap Analysis Reports: Indiana Homeland Security District 7 – Vigo County

PURDUE
UNIVERSITY

FINAL PANDEMIC INFLUENZA GAP REPORT
Vigo County, District #7
Population: 103,195

■ Audit Information

Audit Date: June 22, 2006 Visit Call X

County Representative: Joanie Foulkes, Director of Operations; Doreen Hojaicki, PHC

Audit Team Members: Deborah Koester, MSN, RN; Feng Lin,MS

■ Section 1: Community Preparedness, Leadership and Networking

Summary of Key Points:

- LHD with 45 employees; LPHC feels LHD is Lead Agency for community preparedness effort for the County; has formed All Hazards Task Force locally, includes pan flu planning.
- Pan Flu Self Assessment completed by LPHC and Dir. Of Operations at LHD.
- Two hospitals; LPHC working with each hospital separately (difficult to work with both at same time).
- LPHC has working relationship with local government officials, City and County.
- LPHC works with City, County and State levels of law enforcement; views their role as securing the hospitals and clinics during pandemic; has considered preparing for and care of their families.
- Difficult relationship with EMA director; EMA has not integrated into planning with LHD. Director stepping down July 2006; LPHC will work to establish relationship with new director.
- EMS: most calls are made by volunteer fire fighters; working relationship established with EMS Director.
- LPHC is member of Task Force 7 - All Emergency Response Team that represents all of District 7.
- Coroner has been identified as a stakeholder; slow to respond to information provided by LPHC; LHD vital records staff have established working relationship with funeral directors.
- Area schools very supportive of LHD pan flu planning efforts; they are included in MP and pan flu plans.
- Red Cross is available resource.
- Area veterinarians recently became involved in planning; representative from BOAH attended Task Force meeting; discussed where animal surveillance fits into planning and what they have to offer local County.
- Purdue county extension officer involved in planning.
- LPHC has list of all local pharmacies and available drugs.

- Several large industries identified in area: two hospitals, three universities and Ivy Tech, Sony, Pfizer and Columbia House; LPHC trying to work more closely with industries. Universities beginning to write pan flu plans.
- Need for body bags, burials and refrigeration; have MOU with Great Dane refrigerated trucks; will continue to work in this area of planning.
- Two mental health providers identified and written into plan; mental health personnel are making a DVD and will distribute at health fairs; strong focus on education.
- One Town Hall Meeting held; attendance over 100 participants; worked with Chamber of Commerce to send invitations, used all forms of media to advertise, made phone calls to follow up on invitations.
- LHO is authority for public health decisions; has four back-up deputy health officers.
- LHD NIMS compliant to 700; updating to new guidelines; would like all volunteers to be NIMS compliant.
- LPHC views role in community as education, communication, coordination and resources.
- Assessment of volunteer needs underway identified need for interpreters. Adequate volunteers will make plan flexible.
- LHD holds mini-medical school for the public; free to anyone who would like to attend; offer various topics; each session has had attendance of 150-200 people; have discussed historical influenza outbreaks.
- ICS in place; exercised it during internal call-out and district-wide callout; LPHC believes must use it to stay current.
- Decision Making Team formed: includes LHO, PIO, communicable disease RN, Vector, LPHC. Three levels of callout standby, come-together and activation.

Areas for Improvement:

- Planning with hospitals.
- Relationship with EMA director.
- Continued education of public, school, businesses and churches.
- Mortuary planning.

Strategies to Complete Planning:

- Integrate remaining stakeholders.
- Continue working with hospitals to integrate hospital plans with LHD plan.
- Establish working relationship with new EMA Director; integrate into All Hazards Task Force.
- Establish smaller working group for Mass Fatality Planning; include coroner, funeral directors, new EMA, and all potential stakeholders. Consider Indiana Homeland Security G386 Mass Fatalities Incident Management Course. For additional information contact (317) 234-4286.
- Contact retired physicians as additional backup resource.

■ Section 2: Surveillance

Summary of Key Points:

- School surveillance reports absenteeism at 20%; LPHC would like 5-10% reported if anticipating pandemic; schools routinely report unusual absenteeism <20%.
- Sentinel physicians practicing in County; include ISU Health Center and Family Practice Center.
- LHD receives information via State web mail and IHAN.
- Hospital lab/Infection Control Nurse identified as resources.
- Hospitals on PHESS.
- Good working relationship with local pharmacies.
- No formal reporting system between physician offices and LHD.
- When human-to-human contact is reported, Decision Making Team will discuss necessary implementation of plan and how it relates to businesses, schools, etc.
- LPHC currently addressing need for formal reporting system to implement during pandemic to track daily the cases, deaths, etc at healthcare facilities and agencies.
- Emergency Departments at both hospitals report unusual rise in seasonal influenza to LHD when observed.

Areas for Improvement:

- Daily tracking for pan flu activity during pandemic outbreak (ED, MD offices, coroner, funeral homes, etc.).
- Formal surveillance in local pharmacies.

Strategies to Complete Planning:

- Contact district epidemiologist for information to access EPI-X program through ISDH.
- LPHC explore with local pharmacies potential of University of Pittsburgh, RODS program (Real-time Outbreak and Disease Surveillance System). Contact info is: (412) 647-3555 or (800) 533-8762.
- Establish formal means of local reporting system for all healthcare entities and create report template recording community activity for LHD.
- Distribute information to PHNs and school nurses re: Pan Flu Summit on September 21. Additional information at (317) 244-2145.

■ Section 3: PH & Clinical Labs

Summary of Key Points:

- No lab facilities located in County.
- Local healthcare providers send lab samples to various labs.

Areas for Improvement:

Strategies to Complete Planning:

- Ensure safe handling of samples by local healthcare provider staff.

■ Section 4: Healthcare and Public Health Partners

Summary of Key Points:

- LPHC working with healthcare entities to evaluate use of Cooperative Call Center, Strike Teams, ACS - senses just-in-time mindset when attempting to accomplish planning areas. Call Center will serve to identify when resources are needed and what is available.
- Hospitals, home-healthcare entities, long term care facilities included in plan.
- One urgent care in County with minimal involvement in planning.
- LPHC working on local syndromic surveillance plan.
- Exercised MP plan in January. Successfully screened 300/hour.
- Exercised communications in TTX with law enforcement and EMS.
- Currently evaluating facilities to address the quarantine of exposed healthcare personnel.
- Neighborhood networking is focus of public education.
- Some special needs and homebound individuals to be identified by volunteer fire department.
- LPHC has established Medical Reserve Corp, includes medical and non-medical volunteers. Volunteer roster includes sign language and foreign language interpreters - assessment revealed 10% college population is international.
- LHD has had to address legal issues with volunteers; liability biggest issue.

Areas for Improvement:

- Volunteer resources.
- Public education for preparedness/shelter in place.
- Mass fatality planning.
- Locating homebound/special needs population.
- Integration of urgent care in planning.
- Quarantine/housing of exposed healthcare personnel.

Strategies to Complete Planning:

- Offer volunteer sign-ups all mini-medical schools and public speaking opportunities.
- Consider creating small working group for mass fatality planning (i.e. coroner, funeral directors, EMA). Integrate funeral directors into planning process.
- Contact local sheriff department to explore additional resources for locating homebound.

- Consider nurse volunteers to assist with public education campaign.
- Continue integrate urgent care into planning process.

■ Section 5: Infection Control

Summary of Key Points:

- LHD up-to-date with Universal Precautions; completes annual in-services.

Areas for Improvement:

Strategies to Complete Planning:

- Update guidelines and practices as additional information becomes available.

■ Section 6: Vaccine Distribution & Use

Summary of Key Points:

- MP plan submitted to State.
- Four to five primary POD sites identified; four to five secondary sites identified.
- Written plan addresses logistics of security, administration, and organization.
- MP plan exercised in 01/06; successful screening 300/hr.
- Small local extended-care facilities/long-term care facilities as POD for residents, staff and their families.
- Security of PODS and MP distribution re-evaluated.

Areas for Improvement:

Strategies to Complete Planning:

- Continue to conduct volunteer recruitment for Reserve Corp with education campaign.
- Continue to build written list of medical and non-medical volunteers; credential as appropriate.

■ Section 7: Antiviral Drug Distribution & Use

Summary of Key Points:

- Unaware new drugs may have additional documentation requirements.
- MP plan submitted.
- Administration of antiviral will be appendices to MP plan.

Areas for Improvement:

Strategies to Complete Planning:

- Complete updates to MP as appropriate.
- Update pan flu and MP plans to reflect additional reporting mechanisms re: new drugs.

■ Section 8: Community Disease Control/Prevention

Summary of Key Points:

- Decision Making Team to plan for early investigation, containment, isolation/quarantine; addressed through public education efforts.
- Educating businesses re: plans and preparedness.

Areas for Improvement:

Strategies to Complete Planning:

- Schedule additional educational opportunities to discuss shelter-in-place and isolation/quarantine.
- Continue to meet with local healthcare providers and other stakeholders to discuss isolation/quarantine policy/issues.

■ Section 9: Communication

Summary of Key Points:

- Primary means of communication with public include cable public service announcements, website updates for 24 hour access, radio and newspaper. Considering reverse 911. Established combined dispatch center.
- PIO is LHO; created Crisis Communication Team.
- General public not dependent upon computer for updates; very rural county. Large percentage of population is over 55.
- Emergency communication and redundant communication established via EMA.
- Five staff in LHD with access to IHAN.
- Establishing call center is unique approach.

Areas for Improvement:

- Communication to majority of public who are rural and/or elderly.

Strategies to Complete Planning:

- Contact DPHC to provide access to IHAN for stakeholders/first responders in County.
- Develop pre-scripted messages for pre-pandemic and pandemic.
- Consider use of Hamm radios and scanners to disseminate information across County.
- Continue to exercise communication plan with EMA and other key stakeholders.
- Consider use of electronic bank and high school signs for disseminating information.
- Continue routine utilization of IHAN, CDC and DPH websites by LHD staff.
- Establish recorded message and dedicated phone line through LHD.

■ Section 10: Workforce Support

Summary of Key Points:

- Back-up for LHO is four-deep.
- Vital records identified as essential service.
- Considering staffing in staggered shifts.

Areas for Improvement:

- Resources for LHD staff for continuity of operations during pandemic event.

Strategies to Complete Planning:

- Continue cross-training and work to identify back-up, even from another county or include subsequent authority in written pan flu plan.
- Utilize educational opportunities to acquire volunteers for vital records.
- Contact local school corporation to explore support for vital records, phones and other non-medical support.
- Consider vital records working out of hospital(s).

Indiana State Department of Health
Public Health Preparedness & Emergency Response –
Pandemic Influenza Supplemental Funding
08/31/06 through 08/30/07

APPENDIX H.8 – Local Health Department Gap Analysis Reports: Indiana Homeland Security District 8 – Bartholomew County

PURDUE
UNIVERSITY

FINAL PANDEMIC INFLUENZA GAP REPORT
Bartholomew County, District #8
Population: 72,987

■ Audit Information

Audit Date: July 20, 2006 Visit X Call

County Representative: Hollis Mayfield, Administrator

Audit Team Members: Deborah Koester, MSN, RN; Feng Lin, MS

■ Section 1: Community Preparedness, Leadership and Networking

Summary of Key Points:

- LPHC with PH background.
- Planning organized by two key working groups.
- Internal LHD healthcare task force includes nursing division, environmental health, vital records.
- Community task force occurs through LEPC; includes EMA, LHD and all other agencies on LEPC.
- LPHC has worked one-on-one with stakeholders until recently. LHD, EMA, hospital, police and fire departments brought together for first time; currently delineating roles and responsibilities.
- Good working relationship with EMA director, law enforcement and fire department.
- Good working relationship with surrounding counties.
- County government officials not actively involved, but supportive.
- Initial pan flu meeting held for city and county government officials including mayors, council members and commissioners; good relationship established.
- ARC represented on LEPC; has volunteer list; willing to share resources.
- LPHC meeting with local churches; 20-30 attend each presentation.
- Psychosocial resources: LPHC using Quinn Co., potential hospital resources and one ministerial volunteer; building this area of planning.
- Participated in district-wide drill on 7/18; 15-16 attendees from all key agencies. 20-30 minute discussion following exercise; felt it met the objectives and generated necessary discussion to further their planning at local level.
- One hospital in County; good relationship.
- Hospital morgue capacity of approximately 20; LPHC contacted refrigerated trucking company. Good relationship with coroner, but has not attended meetings. Good relationship with funeral directors.
- Interested in any educational opportunities re: pan flu planning that allows staff to network, meet colleagues for planning resources, share ideas.
- MOUs signed with POD sites.

- One Town Hall meeting (attendance 70-80) and several other community meetings held.
- LHO supportive but not actively involved; attended Town Hall meeting and provided introductions; LHO updated regularly by LPHC; back-up identified and in place for LHO.
- Local Board of Health updated regularly re: pan flu planning.
- Decision Making Team to include LHD administrator, LHO, director of nursing and LPHC.
- LHD administrator is PIO, working with director of nursing and PHN.
- NIMS compliant; written ICS structure completed.
- LHO understood by stakeholders; work with EMA under CEMP to activate plan.
- State and Federal resources requested via EMA.
- EMA director contacts State and Federal authorities in emergency response.
- LHD administrator views primary role in pan flu planning and response to be education, coordination and agency support.

Areas for Improvement:

- Integration of mortuary planning.
- Identification of additional stakeholders, individuals and resources integral to planning.
- Education of public, school, businesses and churches.

Strategies to Complete Planning:

- Continue to establish working relationships with key stakeholders on Pan Flu Planning committee; consider establishing smaller working groups to target specific components of planning (i.e., mortuary and psychosocial services) and review written plan.
- Integrate remaining stakeholders: psychosocial resources, coroner, funeral directors, churches, ministerial resources.
- Continue to exercise internal ICS system.
- Identify additional means of increasing public awareness (i.e., small group presentations, community health fairs, presentation to local clubs); continue to utilize these as opportunities for new volunteers.
- Attend exercises in other counties/districts to evaluate own plan.
- Consider distribution of educational packets at libraries, schools, physician offices, etc.
- Meet with County extension officer to explore opportunities for resource sharing, including volunteers.
- Meet with local ministerial association for additional volunteers for psychosocial support.
- May consider contacting Indiana Public Health Foundation re: Pan Flu Summit on September 21 in Indianapolis.
- May consider contacting Indiana Homeland Security Institute re: Mass Fatality Management Course; share information with coroner and funeral directors.

■ Section 2: Surveillance

Summary of Key Points:

- School surveillance reports absenteeism at 20%.
- Hospital may be on PHESS; administrator not aware of this surveillance system.
- LHD receives information via State web mail and IHAN.
- District epidemiologist good resource.
- Hospital infection control nurse identified as resource.
- Unaware of surveillance mechanism through local pharmacies.

Areas for Improvement:

- Hospital, pharmacy and local physician surveillance.

Strategies to Complete Planning:

- Contact district epidemiologist to register local physicians as Sentinel participants; check on progress of local hospital participation in PHESS.
- Explore with local pharmacies potential of University of Pittsburgh, RODS program (Real-time Outbreak and Disease Surveillance System). Contact info is: (412) 647-3555 or (800) 533-8762.
- Contact Infection Disease Nurse at hospital to explore possibility of MOU re: IFI surveillance information.
- Establish means of local reporting system with physicians; create report template to record community activity during pandemic for LHD.

■ Section 3: PH & Clinical Labs

Summary of Key Points:

- Local healthcare providers send lab samples to various private labs.

Areas for Improvement:

Strategies to Complete Planning:

- Ensure safe handling of samples by local healthcare provider staff.

■ Section 4: Healthcare and Public Health Partners

Summary of Key Points:

- LPHC continuing public education re: shelter-in-place and preparedness planning.
- Home healthcare agencies may provide future support.
- Coroner not active in mortuary planning; unaware of funeral director involvement.
- Identification of homebound/special needs individuals not confirmed.

- Working to improve volunteer resources.
- LPHC attends hospital planning meetings.
- LHD has good working relationship with hospital and EMS.

Areas for Improvement:

- Volunteer resources.
- Public education for preparedness.
- Mortuary planning.

Strategies to Complete Planning:

- Continue to launch public education efforts; distribute education packets to library, school offices, doctor offices, county extension office, etc.
- Offer volunteer sign-ups at Town Hall meetings and educational offerings.
- Schedule meeting with funeral directors for awareness and direction of mortuary planning.
- Contact/visit local healthcare provider offices to distribute office planning checklists and establish relationship with LHD.
- Consider nurse volunteers to assist with public education campaign.

■ Section 5: Infection Control

Summary of Key Points:

- LPHD up-to-date with Universal Precautions; completes annual in-services.

Areas for Improvement:

- Education outreach to school-age children re: infection control and disease spread.

Strategies to Complete Planning:

- Update guidelines and practices as additional information becomes available.
- Contact school nurses to develop educational campaign for school-age children.
- Explore educational websites for children's curriculum development, including www.glogerm.com and http://www.healthychild.net/articles/mc52handwash.html.

■ Section 6: Vaccine Distribution & Use

Summary of Key Points:

- MP plan completed.
- MOUs with POD sites.

- School nurses identified as resource in POD site and vaccine administration.
- Logistics of security, administration, and organization addressed in planning.
- ARC will be integral resource to PODs as support.

Areas for Improvement:

- Acquisition of adequate volunteer resources to implement plan.

Strategies to Complete Planning:

- Attend exercises/drills in other counties to continue to evaluate own plan.
- Conduct volunteer recruitment with education campaign.
- Establish written list of minimum needed medical and non-medical volunteers.

■ Section 7: Antiviral Drug Distribution & Use

Summary of Key Points:

- Unaware new drugs may have additional documentation requirements.
- Administration of antiviral will be appendices to MP plan.

Areas for Improvement:

Strategies to Complete Planning:

- Update pan flu and MP plans to reflect additional reporting mechanisms re: new drugs.

■ Section 8: Community Disease Control/Prevention

Summary of Key Points:

- Decision Making Team established for purposes of isolation/quarantine and mitigation of activity.
- Limited public education re: self isolation/shelter-in-place; to be included in future small group meetings.

Areas for Improvement:

- Limited public education re: containment and shelter-in-place.

Strategies to Complete Planning:

- Schedule Town Hall meeting and small group educational opportunities to discuss shelter-in-place and isolation/quarantine.
- Meet with local healthcare providers and other stakeholders to discuss isolation/quarantine policy/issues.
- Consult district epidemiologist for updated guidelines.

■ Section 9: Communication

Summary of Key Points:

- Administrator is PIO.
- Bumper stickers created to enhance public awareness of LHD.
- Emergency communication and redundant communication established via EMA.
- LPHC communication plan includes use of local radio stations, television station, cable company, website and newspapers; all notified by blast fax.
- LHD website has capability to allow public to send in questions; access materials; have added web address to all letterhead and envelopes.
- LHD purchased own 800 MHZ radios for internal communication purposes with all key LHD staff; use two channels - one for internal LHD and one for other emergency agencies.
- Individuals to meet at central location for internal plan activation.
- LHD internal phone tree established; exercised twice; very useful in evaluation.
- LHD to use Emergency Warning System through EMA/911 as if tornado warning to reach mass public.

Areas for Improvement:

Strategies to Complete Planning:

- Explore use of LHD website to display pre-pandemic information and real-time information during pandemic.
- Develop and update pre-scripted messages for pre-pandemic and pandemic.
- Consider use of electronic bank and high school signs for disseminating information.
- Include LHD educational materials with mailed birth certificates.

■ Section 10: Workforce Support

Summary of Key Points:

- COOP plan in place.

Areas for Improvement:

Strategies to Complete Planning:

- Continue to review and update existing COOP plan.

Indiana State Department of Health
Public Health Preparedness & Emergency Response –
Pandemic Influenza Supplemental Funding
08/31/06 through 08/30/07

APPENDIX H.9 – Local Health Department Gap Analysis Reports: Indiana Homeland Security District 9 – Ripley County

PURDUE
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FINAL PANDEMIC INFLUENZA GAP REPORT
Ripley, District #9
Population: 27,549

■ Audit Information

Audit Date: June 27, 2006 Visit X Call

County Representative: Patricia Thomas, LPHC

Audit Team Members: Pamela M. Aaltonen, MSN, RN; Narayanan Varadarajan, BS

■ Section 1: Community Preparedness, Leadership and Networking

Summary of Key Points:

- LPHC worked for LHD for 21 years as public health specialist/environmental health. Active links to many local resources. Involved with LEPC.
- LHD staff includes LHO, three personnel in environmental health, two PHNs, two persons in vital records, clerk and office manager. One EH staff recently became County's EMA.
- One hospital in County; licensed for 79 beds, more likely have 20-25 beds in use.
- Major people influx June and September for National Muzzle Loading Rifle Association in Friendship, IN (10,000-20,000 persons from all over the world).
- Stakeholders include city and county officials, EMA director, EMS director, hospital, law enforcement (state police, sheriff, local police), Red Cross, school nurses, churches. One pharmacy interested; Kroger and CVS chain pharmacies involvement limited. One large employer to work with employees and families.
- Recent meeting with coroner (also a firefighter) and funeral directors; to begin mortuary planning.
- Pandemic planning Chamber of Commerce to-do list. Large industries that have begun planning will serve as example; LPHC interested to establish working relationship.
- Physicians asked to participate at Town Hall meeting at hospital on July 28.
- Many stakeholders NIMS educated; LHD staff 100,200,700 completed; 2 need to complete 800. School nurses, county commissioners, and others to NIMS 700.
- A number of Town Hall meetings have been held. Community leaders targeted; LPHC using county council and city council meetings for education. Teachers to be educated at school's teacher orientation sessions.
- LPHC role is that of coordination and education.
- ESF-8 in development with EMA. Close working relationship with EMA – employee is joint employee of LHD and EMA. All plans well integrated.
- District epidemiologist involved in activities; key resource.
- Stakeholders aware of legal authority of PHO and LHD.
- Preparedness brochure developed for general distribution; colorful, succinct. Another brochure drafted for use once pandemic arrives.

- Numerous MOUs within County and with other counties in district. Identifying others as plan is refined. Used ISDH template; volunteers to sign MOU forms at meetings.
- EMA has self-sufficient, mobile RV command center, set up for communications. LEPDC has annual exercise; recent TTX uncovered need for jacks.
- EMA director and LPHC part of ICS; LPHC has assigned incident commander for each of 5 clinic sites. Hillenbrand would be own site. Two back-ups for every position in ICS. EMA director would activate ICS. Fire chief has also served as incident commander. Have developed SOPs.
- Plans flexible, meet PHIN requirements.
- Regular flu clinics used as exercise - 40 volunteers, 160 clients.
- Newly formed Critical Incident Stress Management Team (5 counties, operates out of County); currently training. Community mental health director helped to look at issues in broader geographical area.
- Good coordination in district.
- Health department monitors birds, mosquitoes (have sent in for West Nile testing).
- EMA tracks avian influenza international activities daily.

Areas for Improvements:

Strategies to Complete Planning:

- Continue to complete tasks outlined with coroner, physicians, churches, and Chamber of Commerce.

■ Section 2: Surveillance

Summary of Key Points:

- Routine surveillance with local healthcare providers stopped; return of former PHN to re-activate surveillance system, including school absenteeism reporting.
- Rely on ISDH for surveillance; district epidemiologist very involved.
- Hospital infection control nurse reports diseases to LHD.
- On State web mail.
- On IHAN: Hillenbrand OHN, 4 LHD staff, PHO, health board president, hospital (need to add infection control nurse).
- Questioned if CHIRP system (immunization program software) could be used in tracking activities.
- LPHC expects to gain information in surveillance at summer session in Atlanta.

Areas for Improvements:

- Local surveillance activities.

Strategies to Complete Planning:

- Inquire of ISDH if CHIPR system could be used to track influenza cases, deaths, etc (system already known to LHDs).
- Collaborate with school nurses on school absenteeism reporting.

- Re-establish routine reporting system to be used prior to outbreak/epidemic.
- Collaborate with district epidemiologist regarding routine surveillance activities that are successful in other counties/jurisdictions around the country.

■ Section 3: PH & Clinical Labs

Summary of Key Points:

- Hospital has a basic lab, unsure if it does POC or PCR influenza testing.
- Specimens sent to ISDH; rely on state to do laboratory work.

Areas for Improvements:

- Clarity regarding what testing done at local level.

Strategies to Complete Planning:

- Review hospital plan laboratory section to assure coordination with LHD.

■ Section 4: Healthcare and Public Health Partners

Summary of Key Points:

- Hospital plan draft form; not yet shared with LPHC.
- One exercise at hospital; participated in district exercise.
- LPHC using *What Does This Mean to Me?* ISDH flyer to discuss expectations with healthcare providers.
- EMS submitted grant for tent and 75 beds.
- Addressing surge capacity, supply, and isolation with healthcare entities.
- Some supplies of PPE (e.g., ISDH kit, EMA-issued kit, decontamination equipment).
- Hospital discussed isolation/quarantine; has isolation ward. Self-isolation most likely scenario.
- Coroner is mortician; not very engaged. LPHC working to increase participation and buy-in.
- Improvements needed to better simulate real-time conditions; last exercise provided flu vaccine to 160 persons with 40 volunteers – needed more volunteers.
- Working to expand volunteer ranks among healthcare providers.
- Local pharmacist suggested participation of all pharmacies to facilitate rotation of stockpiled drugs.
- ID equipment available for volunteers; laminated cards have person's picture, Ripley County Health Department hologram, and bar with name (background color to indicate classification). License information on back of card when applicable.
- Language teachers from area schools used for translation (~ 200 Hispanics in county).
- Home care (part of Margaret Mary Hospital) personnel identify approximate number of isolated, vulnerable populations. No MOU with Home Care at this stage but would like to set this up.
- Residents of group homes are expected to join general population; will be speaking with persons running the group homes.

- Six nursing homes in County; each will administer drugs/vaccine in-house.
- Jail to receive supplies and take care of themselves.

Areas for Improvements:

- Mortuary planning.
- MOU with home care.

Strategies to Complete Planning:

- Share LHD credentialing system as best practice - well designed and in process.
- Share creative use of language teachers at area schools for translation as best practice.
- Review hospital plan for integration/compatibility with LHD and EMA plans.
- Continue to facilitate work of coroner and funeral home directors re: mass casualty plans.
- Formalize arrangement with Mary Margaret Community Hospital Home Care.

■ Section 5: Infection Control

Summary of Key Points:

- Considerable dialogue with healthcare providers to establish consistent guidelines for all healthcare providers.
- Provider email and fax communication available.
- N-95 masks and other forms of PPE are on LPHC agenda.

Areas for Improvements:

- PPE supplies.

Strategies to Complete Planning:

- Complete this aspect of plan and modify as additional information becomes available re: specifics of an organism.
- Monitor federal/state recommendations re: PPE and stockpile as able.

■ Section 6: Vaccine Distribution & Use

Summary of Key Points:

- Indiana SNS security survey helpful; revealed 11 persons are needed for SNS security.
- Verbal feedback received form ISDH on MP plan.
- MP drive-through for handicapped being considered.
- Exercise plan using October routine flu vaccination program.
- CDC site accessed for information on vaccine tracking and dispensing/allocation. Looking forward to opportunity to do "full-fledged" practice.

- Planning on pre-training volunteers.
- MOUs in place and key personnel assigned to PODs.
- Public informed cable TV, tobacco hotline (?), website, 3 fax phones, 2 toll-free lines, and radio. No reverse 911.
- Brochure encourages citizens to visit local websites at www.ripley_co_in_health.org or www.ripleylepc.com.

Areas for Improvements:

- Exercise modified plan.

Strategies to Complete Planning:

- Share brochure and website as best practices.

■ Section 7: Antiviral Drug Distribution & Use

Summary of Key Points:

- Antiviral to be written addendum to MP plan; head-of-household plan.
- Clinics (Osgood, Versailles, Milan and Batesville) set up by township; outlined on LHD brochure *Pandemic Influenza: What Can You Do?*
- Understand need for informed consent with investigational drugs.

Areas for Improvements:

Strategies to Complete Planning:

- Share township clinic structure with other LHDs (particularly rural counties).

■ Section 8: Community Disease Control/Prevention

Summary of Key Points:

- Written plan for investigating and containing early potential cases, but not as well defined as would like.
- Assisting public understanding of self-limiting movement using "snow days" analogy.
- Attended July MAPHTC workshop on isolation and quarantine; considering how to incorporate available strategies.
- LEPC has a two-page flow chart with two-level hot zones.

Areas for Improvements:

- Refinement of plan for investigation and containment.

Strategies to Complete Planning:

- Complete containment plan, incorporate in planned exercise to evaluate workability.

■ Section 9: Communication

Summary of Key Points:

- Phone tree developed; cell phones for all but one staff person.
- Have 800 Megahertz radio, EMA van has radio, EMA director has requested 4 additional radios.
- Have 20 walkie-talkies for use at clinics; Ham radio capabilities.
- County has a PIO; LHD PIO will be PHO ultimately, LPHC will be next in line and positioned to provide PHO with information.
- 5 LHD staff well versed in risk communication.
- LPHC has collected email addresses and fax numbers for stakeholder updates.
- County does not have Reverse 911 nor 211.
- LPHC, PHO, 4 LHD staff, and hospital on IHAN. School nurses are interested in being on IHAN.
- Not on EPI-X, but interested.

Areas for Improvements:

- Information regarding EPI-X.

Strategies to Complete Planning:

- Clarify breadth of persons on IHAN.
- Acquire additional information on EPI-X.

■ Section 10: Workforce Support

Summary of Key Points:

- Plans to have each position three-deep.
- Contingency planning continues. LPHC has strong emphasis on cross training.
- Working on psychosocial support.
- School counselors as potential resource; currently no MOU.

Areas for Improvements:

- Psychosocial support for workforce.

Strategies to Complete Planning:

- Complete written plan; other counties might consider use of school counselors as volunteers for psychosocial support to supplement mental health system workers.

■ Overall

- LHD offers a number of creative approaches to planning that would be of value to others who are at a less developed point on the planning continuum.
- LHD has purchased mobile hand washing sink - used for hand washing education at variety of locations & county
events.
- Working on cross-training all employees; takes time.
- A comprehensive plan for all hazards with addendum for specific threats could decrease frustration with individual plan development. Challenging to stay up with all the changes through various levels of government.

APPENDIX H.10 – Local Health Department Gap Analysis Reports: Indiana Homeland Security District 10 – Warrick County

PURDUE
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FINAL PANDEMIC INFLUENZA GAP REPORT
Warrick County, District #10
Population: 55,465

■ Audit Information

Audit Date: July 25, 2006 Visit Call X

County Representative: Faye Bass, LPHC; Linda Bass, PHN, RN

Audit Team Members: Deborah Koester, MSN, RN; Narayanan Varadarajan, BS

■ Section 1: Community Preparedness, Leadership and Networking

Summary of Key Points:

- LHD with nine full-time and two part-time employees; LPHC has been in position two years; background is education and human resources in industrial safety.
- County commissioners: some are very supportive and involved, while others are not involved in pan flu planning process; those who are supportive attend and participate in exercises.
- LPHC has developed Pan Flu Task Force: includes LHD staff, hospital, EMA, EMS, schools, ARC, industry, fire department, law enforcement, city and county govt. officials and Purdue extension; integrated group; works well together.
- EMA director supportive; works closely with LPHC.
- EMS director is new to position; this is a developing relationship.
- Coroner recently added as a member of the LEPC; responsible for developing mortuary plans.
- LHD has MOU with funeral homes for transportation of deceased victims.
- Three hospitals located in County; good relationship with all facilities.
- Law enforcement support identified as sheriff and city police.
- LHO is elderly, retired physician in poor health; does not participate in planning process; LHD has MOUs with two ED physicians and one family practice physician to serve as back up to LHO.
- LHD has MOUs with all pharmacies in the County for supplies and staff.
- LHD has MOU with ARC for provision of food for workers at POD and for shelter as necessary.
- Good relationship with schools; representative from schools sits on LEPC; LHD has MOU to provide transportation to POD for individuals without access to own transportation.
- Veterinarian is president of local Board of Health; acts as resource for animal human link issues related to pan flu planning.
- Two public health fairs in April; information provided for all LHD services, highlighted pan flu preparedness; Sponsored by local bank, radio station provided live coverage.

- ALCOA is largest industry in County; have own medical staff and fire department; fire chief is writing their pan flu plan; will sit on Task Force.
- Purdue County Extension officer is involved and supportive in planning; set up display for food safety at health fair.
- Response agencies exercise plans cooperatively through LEPC.
- County exercised emergency plans and administration of tetanus after tornado last year.
- LHD NIMS compliant; updating to new guidelines; all but three Health Board members NIMS compliant; LPHC plans for all Task Force members to be NIMS compliant.
- District-wide MOUs in place.
- Written ICS structure completed; emergency communication through EOC.
- Exercised ICS following recent tornado; have also exercised communication during table top.
- LPHC plans to coordinate educational presentations with schools, churches and scout troops this fall.
- LPHC views primary role in pan flu planning and response to be education, coordination and agency support.
- Law enforcement families are planning for supplies, including food, medication and water for one week.
- Stakeholders understand legal authority for making decisions is LHO, working with LPHC.

Areas for Improvement:

- Integration of mortuary planning.
- Identification of additional stakeholders, individuals and resources integral to planning process.
- Education of public, school, businesses and churches.

Strategies to Complete Planning:

- Continue to establish working relationships with key stakeholders on Pan Flu Task Force; consider establishing smaller working groups to target specific components of planning (i.e., mortuary, psychosocial services) and review written plan.
- Integrate remaining stakeholders: psychosocial resources.
- Continue to address additional means of increasing public awareness (i.e., small group presentations, community health fairs, presentation to local clubs; educational flyers included with pay stubs for county employees, ALCOA employees; flyer included in a distribution of newspaper, educational packets at healthcare provider offices, library).
- Continue to attend exercises in other districts to evaluate own plan.

■ Section 2: Surveillance

Summary of Key Points:

- School surveillance reports absenteeism at 20%.

- Schools forward weekly report to LHD, including incidence of whooping cough, Fifth's disease, impetigo, infectious mono, lice, pneumonia, scabes, strep, scarlet fever, ring worm, diarrhea, pink eye, and other. Now has data for 1 year to compile annual report.
- Deaconess and St. Mary's Hospitals may be on PHESS; LPHC unsure.
- LPHC receives information via State web mail and IHAN.
- District epidemiologist good resource.
- Hospital labs send weekly communicable disease report, including influenza testing results.
- No Sentinel physician.
- LPHC unaware of surveillance in place through local pharmacies.
- Task Force will evaluate means of effective local surveillance this fall.

Areas for Improvement:

- Explore surveillance opportunities that exist at hospital and pharmacies.
- No Sentinel physicians for surveillance.

Strategies to Complete Planning:

- Contact district epidemiologist to register local physicians as Sentinel participants; determine participation of local hospital in PHESS.
- Explore with local pharmacies potential of University of Pittsburgh, RODS program (Real-time Outbreak and Disease Surveillance System). Contact info is: (412) 647-3555 or (800) 533-8762.
- Consider utilizing local reporting system with physicians, coroner and hospital to collect real-time data for pan flu to reflect community activity.

■ Section 3: PH & Clinical Labs

Summary of Key Points:

- Local healthcare providers send lab samples to various private labs.

Areas for Improvement:

Strategies to Complete Planning:

- Ensure safe handling of samples by local healthcare provider staff.

■ Section 4: Healthcare and Public Health Partners

Summary of Key Points:

- LHD has home healthcare services who that can identify homebound, special needs population and deliver supplies.
- Volunteer list near 50; additional non-medical volunteers include CERT teams and ARC.

- Pan flu funding utilized to create volunteer database for tracking and credentialing.
- Hospitals not considering ACS at this time.
- Nursing homes will administer own vaccine/antiviral.
- Local Agency on Aging may have additional resources for identifying special needs population.
- Hospitals are working to write plans; have not exercised plans at this time.

Areas for Improvement:

- Volunteer resources.
- Public education for preparedness.
- Mortuary plan.

Strategies to Complete Planning:

- Launch additional public education campaign by providing education packets to library, school offices, doctor offices, county extension office, etc.
- Offer volunteer sign-ups at educational presentations.
- Contact/visit local healthcare provider offices to distribute office planning checklists or follow up on previous contacts.
- Consider nurse volunteers to assist with public education campaign.
- Complete credentialing of medical volunteers.
- Follow up with Area Agency on Aging to ensure homebound population identified.

■ Section 5: Infection Control

Summary of Key Points:

- LHD up-to-date with Universal Precautions; completes annual in-services.
- Currently stocking PPE; plans to purchase additional supplies.
- LPHC plans to meet with local teachers for educational presentation at beginning of school year.

Areas for Improvement:

- Education outreach to school age children re: infection control and disease spread.

Strategies to Complete Planning:

- Update guidelines and practices as additional information available.
- Contact school nurses to develop educational campaign for school age children.
- Explore educational websites for children's curriculum development, including http://www.glogerm.com and http://www.healthychild.net/articles/mc52handwash.html.

■ Section 6: Vaccine Distribution & Use

Summary of Key Points:

- MP plan completed; awaiting revisions; completing updated guidelines.
- Two primary POD sites identified.
- Logistics of security, administration, and organization addressed in planning.
- October 2005, exercised essential personnel portion of plan, using volunteers as victims; showed video on SNS and used M&Ms as medication.
- August 23, 2006 will have table top exercise; September 9, 2006 will hold full-scale exercise.

Areas for Improvement:

- Submission and final approval of MP plan with revisions/updates.
- Acquisition of adequate volunteer resources to implement plan.

Strategies to Complete Planning:

- Complete updates and revisions to MP plan.
- Resubmit MP plan to ISDH.
- Carry out exercises/drills as scheduled.
- Conduct volunteer recruitment with education campaign.
- Establish completed written list of medical and non-medical volunteers.

■ Section 7: Antiviral Drug Distribution & Use

Summary of Key Points:

- Unaware new drugs may have additional documentation requirements.
- Writing MP and pan flu plans.
- Administration of antiviral will be appendices to MP plan.

Areas for Improvement:

- Completion of written MP plan.

Strategies to Complete Planning:

- Complete and submit revised/update MP plan to ISDH.
- Update pan flu and MP plans to reflect additional reporting mechanisms re: new drugs.

■ Section 8: Community Disease Control/Prevention

Summary of Key Points:

- Upon identification of first case in Indiana, County will screen non-essential traffic entering the County. After first case in County, they will stop non-essential traffic entering the County.
- Upon activation of plan and first case, LPHC will contact LHO, district epidemiologist and ISDH.
- LPHC plans include education for shelter in place at time of all educational presentation.

Areas for Improvement:

- Public education re: containment and shelter-in-place.

Strategies to Complete Planning:

- Complete educational presentations to discuss shelter-in-place and isolation/quarantine.
- Meet with local healthcare providers and other stakeholders to discuss isolation/quarantine policy/issues.
- Consult district epidemiologist for updated guidelines.

■ Section 9: Communication

Summary of Key Points:

- LHD and EMA depended heavily on cell phones during tornado; landlines and 400 MHZ radios did not work.
- PIO is LHO; backup is president of Board of Health and LPHC.
- Emergency communication and redundant communication established via EMA.
- LPHC communication plan includes use of local radio stations, television station, cable co, newspaper.
- LHD has website; not updated frequently.
- Reverse 911 and 211 not available.
- LPHC and PHN registered on IHAN; not currently receiving updates; plans to register LEPC members on IHAN.

Areas for Improvement:

- Lack of key stakeholders with IHAN access.
- 400 MHZ radios do not function properly due to terrain.

Strategies to Complete Planning:

- Explore use of County/LHD website to display pre-pandemic information and real-time information during pandemic; consider utilizing local high school or community college students to update website.
- Contact District Coordinator for information to establish access to IHAN for additional stakeholders.
- Develop pre-scripted messages for pre-pandemic and pandemic.
- Exercise communication plan with EMA and other key stakeholders.
- Consider use of electronic bank and high school signs for disseminating information.

■ Section 10: Workforce Support

Summary of Key Points:

- COOP plan includes nursing staff to provide information to public; back-up for vital records and off-site capability.

Areas for Improvement:

- Back-up for nursing and vital records.

Strategies to Complete Planning:

- Review and update existing COOP plan to ensure adequate back-up. Consider non-medical and medical volunteers as back-up if necessary.

APPENDIX I – Attachment 4c Self Assessment Local TOTALS

PANDEMIC INFLUENZA PLANNING

SELF-ASSESSMENT – LOCALS PUBLIC HEALTH TOTALS

PUBLIC HEALTH ROLES AND RESPONSIBILITIES

This self-assessment contains activities that are conducted at the state level, local level, or both. Because the level at which they take place may vary across states, states are asked to determine for each whether the responsibility lies at the state or local level (or both), thus creating a state and a local version of the checklist. States are responsible for returning both the completed state self-assessment, and aggregated results for the local assessment.

Note: You should include the results of the assessments by direct-funded metropolitan areas (i.e., the District of Columbia, New York City, Los Angeles County, and Chicago) on this form.

State:	**Indiana**
Total Population in State:	**6,237,569**
Assessment Completed By:	**Carolyn M. Dawson**
Title:	**Business Manager, PHPER Program**
Telephone:	**(317) 233-7396**
Email Address:	**cdawson@isdh.in.gov**
Date:	**8/2/2006**

Community Preparedness Leadership and Networking ***[Pandemic Influenza Preparedness Goal 1 - Increase the use and development of interventions known to prevent influenza.]***

Elements	Completed		In Process		Not Started		N/A-State PH Responsibility	
	#	% of Population	#	% of Population	#	% of Population	#	% of Population
The proportion of a State's population that is served by a Local Public Health Agency that has developed a Pandemic Preparedness Coordinating Committee representing all relevant stakeholders in the jurisdiction and accountable for articulating strategic priorities and overseeing the development and execution of the jurisdiction's operational pandemic plan.	1,149,255	18.42%	4,240,793	67.99%	847,521	13.59%	0	0.00%
The proportion of a State's population that is served by a Local Public Health Agency that has developed plans delineating the accountability and responsibility for key stakeholders engaged in planning and executing specific components of the operational plan and includes timelines, deliverables, and performance measures.	191,777	3.07%	4,770,228	76.48%	1,275,564	20.45%	0	0.00%

The proportion of a State's population that is served by a Local Public Health Agency that has clearly defined which activities will occur at state, local, or coordinated level.	507,115	8.13%	4,220,800	67.67%	498,055	7.98%	1,011,599	16.22%
The proportion of a State's population that is served by a Local Public Health Agency that has defined the Local Public Health Agency 's role in providing guidance and assistance to local/regional level.	834,868	13.38%	4,910,382	78.72%	492,319	7.89%	0	0.00%
The proportion of a State's population that is served by a Local Public Health Agency that has an operational plan for pandemic influenza response that is an integral element of the overall state and local emergency response plan established under Federal Emergency Support Function 8 (ESF-8) and compliant with NIMS.	973,840	15.61%	4,584,333	73.50%	651,514	10.44%	27,882	0.45%
The proportion of a State's population that is served by a Local Public Health Agency that has an operational plan addressing integration of state, local, tribal, territorial, and regional plans across jurisdictional boundaries.	675,814	10.83%	3,992,993	64.02%	1,508,527	24.18%	60,235	0.97%
The proportion of a State's population that is served by a Local Public Health Agency that has formalized agreements with neighboring jurisdictions that address communication, mutual aid, and other cross-jurisdictional needs.	1,071,561	17.18%	4,705,141	75.43%	413,570	6.63%	47,297	0.76%
The proportion of a State's population that is subject to legal authorities for executing a Local Public Health Agency 's operational pandemic influenza plan. Relevant legal authorities address case identification, isolation, quarantine, movement restriction, healthcare services, emergency care, and mutual aid, and are transparent to all stakeholders.	192,135	3.08%	4,637,251	74.34%	1,408,183	22.58%	0	0.00%
The proportion of a State's population that is served by the Local Public Health Agency that has made the process for requesting, coordinating, and approving requests for resources to state and federal agencies clear to all stakeholders.	340,489	5.46%	3,922,337	62.88%	1,974,743	31.66%	0	0.00%
The proportion of a State's population that is served by a Local Public Health Agency that has created an Incident Command System for the pandemic plan that is based on the National Incident Management System.	1,748,230	28.03%	3,942,565	63.21%	546,774	8.77%	0	0.00%
The proportion of a State's population that is served by a Local Public Health Agency that has exercised its Incident Command System along with other operational elements of the plan.	1,290,244	20.69%	1,597,461	25.61%	3,349,864	53.70%	0	0.00%

The proportion of a State's population served by a Local Public Health Agency that has identified the authority responsible for declaring a public health emergency at the Local Public Health Agency level and for officially activating the pandemic influenza response plan.	3,708,187	59.45%	2,240,447	35.92%	288,935	4.63%	0	0.00%
The proportion of a State's population that is served by a Local Public Health Agency that has identified the local law enforcement personnel who will maintain public order and help implement control measures and has confirmed that law enforcement leadership is supportive of their role.	1,437,651	23.05%	4,284,749	68.69%	440,662	7.06%	74,507	1.19%
The proportion of a State's population served by a Local Public Health Agency that has determined what constitutes a “law enforcement” emergency and has educated law enforcement officials so they can pre-plan for their families to sustain themselves during the emergency.	363,598	5.83%	2,536,823	40.67%	1,953,712	31.32%	1,383,436	22.18%
The proportion of a State's population that is served by a Local Public Health Agency with plans that are flexible enough to be adapted to the magnitude and severity of the pandemic and to available resources.	932,947	14.96%	4,780,629	76.64%	523,993	8.40%	0	0.00%
The proportion of a State's population that is served by a Local Public Health Agency's plans which include having or having access to information systems that can exchange data, adhere to vocabulary and technical standards, and employ best practices to support the detection of and response to pandemic flu. The plans meet the requirements of the PHIN Functional Areas, Early Event Detection, Connecting Laboratory Systems, Outbreak Management System, Countermeasure and Response Administration, and Partner Communication and Alerting as specified in the 2005/2006 cooperative agreement.	266,531	4.27%	2,742,442	43.97%	1,566,189	25.11%	1,662,407	26.65%
The proportion if a State's population that is served by a Local Public Health Agency's plan to address the provision of psychosocial support services for the community, including parents and their families, and those affected by community containment procedures.	770,748	12.36%	3,419,305	54.82%	1,183,920	18.98%	863,596	13.85%

The proportion of a State's population that is served by a Local Public Health Agency with animal health sectors in its jurisdiction (including but not limited to industry, veterinary diagnostic laboratories, state departments of agriculture) that has developed an operational plan to prevent, detect and respond to reports of disease in animals as a early warning of threat to human health including: o education of and risk communication to the poultry owning public, especially small operations o a plan for surveillance in birds o disease reporting and data sharing o triggers for action to contain disease within the animal sector o triggers to perform heightened surveillance to detect human illness	77,278	1.24%	1,463,766	23.47%	3,236,503	51.89%	1,460,022	23.41%

Surveillance ***[HHS Pandemic Influenza Supplement 1. Pandemic Influenza Preparedness Goal 3 - Decrease the time needed to detect and report an influenza outbreak with pandemic potential. Pandemic Influenza Preparedness Goal 5 Decrease the time to classify causes, risk factors, and appropriate interventions for those affected by the threat of pandemic influenza.***

	Completed		In Process		Not Started		N/A-State PH Responsibility	
Elements	**#**	**% of Population**	**#**	**% of Population**	**#**	**% of Population**	**#**	**% of Population**
The proportion of a State's population served by a Local Public Health Agency that conducts traditional surveillance for seasonal influenza (e.g., virologic, outpatient visits, hospitalization, and mortality) including electronic reporting, year round.	481,528	7.72%	2,903,324	46.55%	623,439	9.99%	2,229,278	35.74%
The proportion of a State's population that is served by a Local Public Health Agency that has improved capacity for rapid identification of unusual influenza strains by working with federal partners to enhance laboratory-based monitoring of seasonal influenza subtypes.	74,556	1.20%	445,848	7.15%	453,858	7.28%	5,263,307	84.38%
The proportion of a State's population that is served by a Local Public Health Agency that has developed procedures to implement enhanced surveillance once a pandemic is detected, to ensure recognition of the first cases of pandemic virus infection in time to initiate appropriate containment protocols.	126,351	2.03%	2,031,032	32.56%	2,282,594	36.59%	1,797,592	28.82%
The proportion of a State's population that is served by a Local Public Health Agency where animal and human health surveillance systems are linked and routinely share information.	500,079	8.02%	561,493	9.00%	1,788,497	28.67%	3,387,500	54.31%

The proportion of a State's population that is served by a Local Public Health Agency that has developed systems to obtain and track information daily during a pandemic on the following items: o the numbers of newly hospitalized cases, o newly quarantined persons, and o hospitals with pandemic influenza cases o number of deaths o number of discharged patients	409,427	6.56%	1,576,418	25.27%	4,090,753	65.58%	160,971	2.58%

Public Health and Clinical Laboratories ***[HHS Pandemic Influenza Supplement 2. Pandemic Influenza Preparedness Goal 3 - Decrease the time needed to detect and report an influenza outbreak with pandemic potential.]***

Elements	Completed		In Process		Not Started		N/A-State PH Responsibility	
	#	% of Population	#	% of Population	#	% of Population	#	% of Population
The proportion of a State's population that is served by a Local Public Health Agency that has instituted surveillance for influenza-like illnesses (ILI) among laboratory personnel working with novel influenza viruses.	48,583	0.78%	187,832	3.01%	297,282	4.77%	5,703,872	91.44%
The proportion of a State's population that is served by a Local Public Health Agency that has an operational plan to augment the capacity of public health and clinical laboratories to meet the needs of the jurisdiction during a pandemic should include rapid testing (PCR, rapid POC tests), having or having access to information systems that electronically send and receive test orders and results, support influenza laboratory activities for sample management, laboratory workflow, and results reporting, and integrates with national aggregation and reporting.	0	0.00%	136,065	2.18%	387,620	6.21%	5,713,884	91.60%
The proportion of a State's population that is served by a Local Public Health Agency that has exercised its operational plan.	0	0.00%	47,809	0.77%	475,379	7.62%	5,714,381	91.61%
The proportion of a State's population that is served by a Local Public Health Agency that assesses influenza diagnostic testing proficiency and adherence to biosafety containment and biomonitoring protocols and is assessed in all public health and clinical laboratories at least annually.	0	0.00%	967,350	15.51%	225,323	3.61%	5,044,896	80.88%
The proportion of a State's population that is served by a Local Public Health Agency that has frontline clinicians and laboratory personnel who are aware of protocols for safe specimen collection and testing, know how and to whom they should report a potential case of novel influenza, and know the indications and mechanism for submitting specimens to referral laboratories.	1,116,702	17.90%	693,934	11.13%	338,652	5.43%	4,088,281	65.54%

Healthcare and Public Health Partners ***[HHS Pandemic Influenza Supplement 3. Pandemic Influenza Preparedness Goal 6 - Decrease the time needed to provide countermeasures and health guidance to those affected by the threat of pandemic influenza.]***

Elements	Completed		In Process		Not Started		N/A-State PH Responsibility	
	#	% of Population	#	% of Population	#	% of Population	#	% of Population
The proportion of a State's population that is served by a Local Public Health Agency where the State-defined role of public health in coordinating with the healthcare sector in delivery of care during a pandemic has been made clear to the local public health and healthcare sectors.	575,798	9.23%	3,034,617	48.65%	887,601	14.23%	1,739,553	27.89%
The proportion of a State's population that is served by a Local Public Health Agency where public health knows what the healthcare sector needs or expects of it before and during a pandemic.	264,033	4.23%	4,770,005	76.47%	1,130,368	18.12%	73,163	1.17%
The proportion of a State's population that is served by a Local Public Health Agency that has in place the necessary memoranda of agreement/understanding between public health and the healthcare sector .	461,169	7.39%	3,375,472	54.12%	2,244,351	35.98%	156,577	2.51%
The proportion of a State's population that is served by a Local Public Health Agency that has developed an operational plan for the healthcare sector that addresses the following elements: o healthcare of persons with influenza during a pandemic, o legal issues that can affect staffing and patient care o continuity of services for other patients, o medical supply contingency plans o surge capacity o plans for isolating compliant and noncompliant patients o plans for the protection of the healthcare workforce: ensuring continuity of operations; personal protective equipment; isolation; and necessities: food, water, generators.	89,000	1.43%	1,386,713	22.23%	911,284	14.61%	3,850,572	61.73%
The proportion of a State's population that is served by healthcare facilities in a Local Public Health Agency jurisdiction in which the facilities have exercised plans for isolating and/or cohorting patients with known or suspected influenza, training clinicians, and supporting the needs for personal protective equipment.	48,583	0.78%	1,217,591	19.52%	1,274,519	20.43%	3,696,876	59.27%
The proportion of a State's population that is served by the healthcare facilities in a Local Public Health Agency jurisdiction in which the facilities have exercised operational plans to initiate, support, and enforce quarantine of potentially exposed healthcare personnel.	26,431	0.42%	1,032,090	16.55%	1,391,756	22.31%	3,787,292	60.72%

The proportion of a State's population that is served by all components of the healthcare delivery network (e.g., hospitals, long-term care, home care, emergency care) in a Local Public Health Agency Jurisdiction which are included in the operational plan, and the special needs of vulnerable and hard-to-reach patients are addressed.	175,225	2.81%	2,215,268	35.51%	844,781	13.54%	3,002,295	48.13%
The proportion of a State's population that is served by a Local Public Health Agency that has developed a plan for ensuring real-time situational awareness of patient visits, hospital bed and intensive care needs, medical supply needs, and medical staffing needs during a pandemic.	14,421	0.23%	1,418,283	22.74%	1,054,937	16.91%	3,749,928	60.12%
The proportion of a State's population that is served by a Local Public Health Agency that has an operational plan for provision of mortuary services during a pandemic.	62,570	1.00%	957,098	15.34%	1,888,436	30.28%	3,329,465	53.38%
The proportion of a State's population that is served by a Local Public Health Agency that has tested its plan for mortuary services.	0	0.00%	177,351	2.84%	2,206,708	35.38%	3,853,510	61.78%
The proportion of a State's population served by a Local Public Health Agency that maintains a current roster of all active and formerly active healthcare personnel available for emergency healthcare services.	1,079,407	17.30%	3,732,218	59.83%	1,298,434	20.82%	127,510	2.04%
The proportion of a State's population that is served by a Local Public Health Agency that has defined what will constitute a medical staffing emergency.	477,282	7.65%	3,140,481	50.35%	1,590,191	25.49%	1,029,615	16.51%
The proportion of a State's population that is served by a Local Public Health Agency that has exercised an operational plan to initiate appropriate credentialing of volunteer healthcare personnel (including in-state, out-of-state, international, returning retired, and non-medical volunteers) to meet staffing needs during a pandemic.	173,157	2.78%	2,674,822	42.88%	2,376,834	38.11%	1,012,756	16.24%
The proportion of a State's population that is served by healthcare facilities in a Local Public Health Agency jurisdiction where the facilities have exercised plans for isolating and/or cohorting patients with known or suspected influenza, training clinicians, and supporting the needs for personal protective equipment.	0	0.00%	1,947,300	31.22%	1,128,637	18.09%	3,161,632	50.69%
The proportion of a State's population that is served by healthcare facilities in a Local Public Health Agency jurisdiction where the facilities have exercised operational plans to initiate, support, and enforce quarantine of potentially exposed healthcare personnel.	75,014	1.20%	1,701,415	27.28%	1,217,655	19.52%	3,243,485	52.00%

Continued on Sheet 2

PANDEMIC INFLUENZA PLANNING
SELF-ASSESSMENT – LOCAL PUBLIC HEALTH TOTALS

PUBLIC HEALTH ROLES AND RESPONSIBILITIES

This self-assessment contains activities that are conducted at the state level, local level, or both. Because the level at which they take place may vary across states, states are asked to determine for each whether the responsibility lies at the state or local level (or both), thus creating a state and a local version of the checklist. States are responsible for returning both the completed state self-assessment, and aggregated results for the local assessment.

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Infection Control and Clinical Guidelines ***[HHS Pandemic Influenza Supplements 4 & 5. Pandemic Influenza Preparedness Goal 6 - Decrease the time needed to provide countermeasures and health guidance to those affected by the threat of pandemic influenza.]***

Elements	Completed		In Process		Not Started		N/A-State PH Responsibility	
	#	% of Total	#	% of Total	#	% of Total	#	% of Total
The proportion of a State's population served by a Local Public Health Agency that has crafted messages to help educate healthcare providers about novel and pandemic influenza, and infection control guidelines.	833,954	13.37%	4,449,681	71.34%	948,085	15.20%	5,849	0.09%
The proportion of a State's population served by a Local Public Health Agency that has developed an operational plan to regularly update providers as the influenza pandemic unfolds.	998,364	16.01%	3,660,376	58.68%	1,578,829	25.31%	0	0.00%
The proportion of a State's population served by a Local Public Health Agency that has tested its operational plan to regularly update providers as the influenza pandemic unfolds.	401,644	6.44%	2,543,078	40.77%	3,292,847	52.79%	0	0.00%

Vaccine Distribution and Use ***[HHS Pandemic Influenza Supplement 6. Pandemic Influenza Preparedness Goal 6 - Decrease the time needed to provide countermeasures and health guidance to those affected by the threat of pandemic influenza.]***

Elements	Completed		In Process		Not Started		N/A-State PH Responsibility	
	#	% of Total	#	% of Total	#	% of Total	#	% of Total

The proportion of a State's population served by a Local Public Health Agency that has developed an operational plan for vaccine distribution, use, and monitoring which covers the following elements: o Plan for vaccinating occupationally-defined and other priority groups o Storage o Security during transport, storage, and administration o Cold chain requirements o Location of vaccination o Personnel who will vaccinate o Availability of necessary equipment and supplies o Training requirements for involved personnel. o Tracking number and priority of vaccine recipients o Vaccine safety monitoring o Contingency plan for administration under IND or EUA (Investigational o New Drug or Emergency Use Authorization) o Address needs of vulnerable populations o Having or having access to information systems to support tracking and allocation of vaccine distribution, use and monitoring	789,513	12.66%	5,119,158	82.07%	328,898	5.27%	0	0.00%
The proportion of a State's population served by a Local Public Health Agency that has tested its operational plan for vaccine distribution, use, and monitoring.	577,959	9.27%	2,538,615	40.70%	3,120,995	50.04%	0	0.00%
The proportion of a State's population served by a Local Public Health Agency that has written agreements that document the commitments of participating personnel and organizations in the Local Public Health Agency's vaccination operational plan.	520,709	8.35%	4,148,051	66.50%	520,709	8.35%	520,709	8.35%
The proportion of a State's population served by a Local Public Health Agency that has plans to inform the public--including businesses, education and faith-based communities— about preparedness plans and activities they can undertake to mitigate the effects of pandemic influenza (including information about vaccination as it becomes available).	20,331	0.33%	5,445,046	87.29%	772,192	12.38%	0	0.00%

Antiviral Drug Distribution and Use ***[HHS Pandemic Influenza Supplement 7. Pandemic Influenza Preparedness Goal 6 - Decrease the time needed to provide countermeasures and health guidance to those affected by the threat of pandemic influenza.]***

	Completed		In Process		Not Started		N/A-State PH Responsibility	
Elements	**#**	**% of Population**	**#**	**% of Population**	**#**	**% of Population**	**#**	**% of Population**

The proportion of a State's population served by a Local Public Health Agency that has developed plans for distribution and use of antiviral drugs during a pandemic via the Strategic National Stockpile (SNS), as appropriate, to healthcare facilities that will administer them to priority groups. These plans cover: o Storage o Security o Security o Distribution o Tracking o Adverse events monitoring o Contingency plan for administration under IND or EUA (Investigational New Drug or Emergency Use Authorization)	527,640	8.46%	5,302,276	85.01%	396,486	6.36%	11,167	0.18%
The proportion of a State's population served by a Local Public Health Agency that has tested its plans for distribution and use of antiviral drugs during a pandemic.	651,853	10.45%	2,781,920	44.60%	2,792,629	44.77%	11,167	0.18%

Community Disease Control and Prevention (including managing travel-related risk of disease transmission) ***[HHS Pandemic Influenza Supplements 8 & 9. Pandemic Influenza Preparedness Goal 6 - Decrease the time needed to provide countermeasures and health guidance to those affected by the threat of pandemic influenza.]***

Elements	Completed		In Process		Not Started		N/A-State PH Responsibility	
	#	% of Population	#	% of Population	#	% of Population	#	% of Population
The proportion of a State's population served by Local Public Health Agency that has developed an operational plan to investigate and contain potential cases or local outbreaks of influenza potentially caused by a novel or pandemic strain.	146,336	2.35%	3,942,240	63.20%	1,963,958	31.49%	185,035	2.97%
The proportion of a State's population served by Local Public Health Agency that has exercised its operational plan to investigate and contain potential cases or local outbreaks of influenza potentially caused by a novel or pandemic strain.	0	0.00%	1,349,401	21.63%	4,676,436	74.97%	211,732	3.39%

The proportion of a State's population served by a Local Public Health Agency that has developed a containment operational plan that delineates the following items: o the criteria for isolation and quarantine, o the procedures and legal authorities for implementing and enforcing these containment measures, o the methods that will be used to provide psychosocial support, continuity of essential services, and appropriate monitoring of those affected by these containment measures in healthcare facilities, other residential facilities, homes, community facilities, and other settings, and o having or having access to information systems that support the reporting, investigation, control, and prevention of influenza cases.	40,417	0.65%	3,998,821	64.11%	2,198,331	35.24%	0	0.00%
The proportion of a State's population served by a Local Public Health Agency has exercised its containment operational plan.	0	0.00%	617,514	9.90%	5,620,055	90.10%	0	0.00%
The number of population served by a Local Public Health Agency that has an operational plan to implement various levels of movement restrictions within, to, and from the jurisdiction.	0	0.00%	2,122,932	34.03%	4,107,411	65.85%	7,226	0.12%
The proportion of a State's population served by a Local Public Health Agency that has exercised its plan to implement various levels of movement restrictions within, to, and from the jurisdiction.	0	0.00%	594,336	9.53%	5,636,007	90.36%	7,226	0.12%
The proportion of a State's population served by a Local Public Health Agency that has informed the public in advance what containment procedures may be used in the community.	40,417	0.65%	3,134,534	50.25%	3,062,618	49.10%	0	0.00%

Public Health Communications ***[HHS Pandemic Influenza Supplement 10. Pandemic Influenza Preparedness Goal 4 - Improve the timeliness and accuracy of communications regarding the threat posed by an influenza outbreak with pandemic potential.]***

Elements	Completed		In Process		Not Started		N/A-State PH Responsibility	
	#	% of Population	#	% of Population	#	% of Population	#	% of Population
The proportion of a State's population served by a Local Public Health Agency that has assessed readiness to meet communications needs in preparation for an influenza pandemic, including regular review and updating of communications plans.	963,024	15.44%	4,755,200	76.23%	519,345	8.33%	0	0.00%
The proportion of a State's population served by a Local Public Health Agency that has developed plans for coordinating emergency communication activities with private industry, education, and non-profit partners (e.g., local Red Cross chapters).	497,528	7.98%	4,781,578	76.66%	958,463	15.37%	0	0.00%

The proportion of a State's population served by a Local Public Health Agency that has identified and trained lead subject-specific spokespersons.	1,412,072	22.64%	3,699,125	59.30%	1,126,372	18.06%	0	0.00%
The proportion of a State's population served by a Local Public Health Agency that has provided public health communications staff with training on risk communications for use during an influenza pandemic.	1,663,933	26.68%	3,102,797	49.74%	1,470,839	23.58%	0	0.00%
The proportion of a State's population served by a Local Public Health Agency that maintains up-to-date communications contacts of key stakeholders.	2,364,224	37.90%	3,784,723	60.68%	88,622	1.42%	0	0.00%
The proportion of a State's population served by the Local Public Health Agency that has developed a plan for providing regular updates to key stakeholders as the pandemic unfolds.	859,144	13.77%	4,452,684	71.38%	925,741	14.84%	0	0.00%
The proportion of a State's population served by a Local Public Health Agency that has exercised its plan for providing regular updates to key stakeholders as the pandemic unfolds.	455,386	7.30%	2,801,645	44.92%	2,980,538	47.78%	0	0.00%
The proportion of a State's population served by a Local Public Health Agency that has developed and maintains community resources, such as hotlines and websites to respond to local questions from the public and professional groups.	812,394	13.02%	3,583,748	57.45%	1,841,427	29.52%	0	0.00%
The proportion of a State's population served by the Health Alert Network in The Local Public Health Agency jurisdiction that reaches at least 80% of all practicing licensed frontline healthcare personnel and links via the communications network to other pandemic responders.	367,217	5.89%	2,333,611	37.41%	1,702,253	27.29%	1,834,488	29.41%
The proportion of a State's population served by a Local Public Health Agency that has the appropriate number of local health authorities with access to EPI-X who are also trained in its use.	1,890,709	30.31%	2,556,425	40.98%	1,096,518	17.58%	693,917	11.12%
The proportion of a State's population served by a Local Public Health Agency that has established redundant communications systems/channels that allow for expedited transmission and receipt of information.	1,985,864	31.84%	3,727,791	59.76%	470,465	7.54%	53,449	0.86%

Workforce Support: Psychosocial Considerations and Information Needs ***[HHS Pandemic Influenza Supplement 11. Pandemic Influenza Preparedness Goal 6 - Decrease the time needed to provide countermeasures and health guidance to those affected by the threat of pandemic influenza.]***

	Completed		In Process		Not Started		N/A-State PH Responsibility	
Elements	**#**	**% of Population**	**#**	**% of Population**	**#**	**% of Population**	**#**	**% of Population**

The proportion of a State's population served by a Local Public Health Agency that has developed a continuity of operations plan for essential department services, including contingency planning for increasing public health workforce in response to absenteeism among health department staff and stakeholder groups that have key responsibilities under a community's response plan.	88,536	1.42%	4,092,102	65.60%	2,056,931	32.98%	0	0.00%
The proportion of a State's population served by a Local Public Health Agency that has developed a plan for ensuring availability of psychosocial support services (including educational and training materials) for employees who participate in or provide support for the response to public health emergencies such as influenza pandemics.	423,924	6.80%	4,340,957	69.59%	1,472,688	23.61%	0	0.00%
THE END								

Local Health Department Self-Assessment Totals Worksheet

			INDIANA HOMELAND SECURITY DISTRICT		3	3	8	4	6	5	8	4	4	9	7	4	10
	Question	Local Health Department Name	Population Represented	94	Adams County Health Department	Allen County Health Department	Bartholomew County Health Department	Benton County Health Department	Blackford County Health Department	Boone County Health Department	Brown County Health Department	Carroll County Health Department	Cass County Health Department	Clark County Health Department	Clay County Health Department	Clinton County Health Department	Crawford County Health Department
		Population Of Each Local Unit	100.00%	6,237,569	33,815	342,168	72,987	9,139	13,841	50,847	15,228	20,331	40,417	100,706	27,210	34,148	11,167
			BALANCED	94	72	72	72	72	72	72	72	72	72	72	72	72	72
TOTALS BY PERCENTAGE			Completed	9.90%	0.00%	15.28%	12.50%	1.39%	4.17%	40.28%	20.83%	20.83%	27.78%	8.33%	18.06%	2.78%	2.78%
			In-Progress	43.11%	0.00%	63.89%	43.06%	13.89%	43.06%	33.33%	38.89%	51.39%	55.56%	40.28%	43.06%	54.17%	19.44%
			Not Started	29.99%	81.94%	12.50%	25.00%	68.06%	44.44%	13.89%	29.17%	18.06%	0.00%	29.17%	25.00%	26.39%	48.61%
			N/A-NOT Local PH Respons.	16.99%	18.06%	8.33%	19.44%	16.67%	8.33%	12.50%	11.11%	9.72%	16.67%	22.22%	13.89%	16.67%	29.17%
COMMUNITY PREPAREDNESS LEADERSHIP & NETWORKING	1	Completed	1,149,255	9		C									C		
		In-Progress	4,240,793	61					IP	IP		IP	IP	IP		IP	
		Not Started	847,521	24	NS		NS	NS			NS						NS
		N/A-NOT Local PH Responsibility	0	0													
	2	Completed	191,777	4													
		In-Progress	4,770,228	63		IP	IP		IP	IP		IP	IP		IP	IP	
		Not Started	1,275,564	27	NS			NS			NS			NS			NS
		N/A-NOT Local PH Responsibility	0	0													
	3	Completed	507,115	15						C	C	C			C		
		In-Progress	4,220,800	59		IP	IP		IP				IP			IP	
		Not Started	498,055	17	NS			NS									NS
		N/A-NOT Local PH Responsibility	1,011,599	3										X			
	4	Completed	834,868	18			C			C		C				C	
		In-Progress	4,910,382	61		IP			IP		IP		IP		IP		
		Not Started	492,319	15	NS			NS						NS			NS
		N/A-NOT Local PH Responsibility	0	0													
	5	Completed	973,840	13			C			C		C					
		In-Progress	4,584,333	64		IP					IP		IP		IP	IP	
		Not Started	651,514	16	NS			NS	NS					NS			NS
		N/A-NOT Local PH Responsibility	27,882	1													
	6	Completed	675,814	12						C	C						
		In-Progress	3,992,993	58		IP	IP					IP	IP		IP	IP	
		Not Started	1,508,527	22	NS			NS	NS					NS			NS
		N/A-NOT Local PH Responsibility	60,235	2													
	7	Completed	1,071,561	18								C					
		In-Progress	4,705,141	60		IP	IP			IP			IP	IP	IP		IP
		Not Started	413,570	15	NS			NS	NS		NS					NS	
		N/A-NOT Local PH Responsibility	47,297	1													
	8	Completed	192,135	4			C			C							
		In-Progress	4,637,251	60		IP					IP	IP	IP	IP	IP	IP	
		Not Started	1,408,183	30	NS			NS	NS								NS
		N/A-NOT Local PH Responsibility	0	0													
	9	Completed	340,489	7						C							
		In-Progress	3,922,337	60		IP	IP				IP	IP	IP	IP	IP	IP	
		Not Started	1,974,743	27	NS			NS	NS								NS
		N/A-NOT Local PH Responsibility	0	0													
	10	Completed	1,748,230	32						C	C	C	C	C	C	C	
		In-Progress	3,942,565	48		IP	IP		IP								IP
		Not Started	546,774	14	NS			NS									
		N/A-NOT Local PH Responsibility	0	0													
	11	Completed	1,290,244	16						C	C						
		In-Progress	1,597,461	36			IP					IP	IP	IP		IP	IP
		Not Started	3,349,864	42	NS	NS		NS	NS						NS		
		N/A-NOT Local PH Responsibility	0	0													

Local Health Department Self-Assessment Totals Worksheet

	Question	Local Health Department Name	Daviess County Health Department	Dearborn County Health Department	Decatur County Health Department	Dekalb County Health Department	Delaware County Health Department	Dubois County Health Department	East Chicago City Health Department	Elkhart County Health Department	Fayette County Health Department	Floyd County Health Department	Fountain-Warren County Combined Health Department	Franklin County Health Department	Fulton County Health Department	Gary City Health Department	Gibson County Health Department
		INDIANA H	10	9	9	3	6	10	1	2	6	9	4	9	1	1	10
		Population Of Each Local Unit	30,245	48,583	24,970	41,524	117,774	40,771	31,366	191,768	24,934	71,543	26,431	22,852	20,581	99,961	33,286
			72	72	72	72	72	72	72	72	72	72	72	72	72	72	72
TOTALS BY PERCENTAGE			1.39%	55.56%	20.83%	2.78%	5.56%	18.06%	11.11%	19.44%	4.17%	0.00%	25.00%	0.00%	30.56%	0.00%	6.94%
			68.06%	27.78%	40.28%	79.17%	56.94%	29.17%	45.83%	50.00%	40.28%	31.94%	66.67%	8.33%	45.83%	18.06%	44.44%
			15.28%	8.33%	25.00%	18.06%	22.22%	33.33%	22.22%	4.17%	38.89%	68.06%	1.39%	81.94%	0.00%	75.00%	26.39%
		N/A-NOT	15.28%	8.33%	13.89%	0.00%	15.28%	19.44%	20.83%	26.39%	16.67%	0.00%	6.94%	9.72%	23.61%	6.94%	22.22%
COMMUNITY PREPAREDNESS LEADERSHIP & NETWORKING	1	Completed					C								C		
		In-Progress	IP		IP	IP		IP	IP	IP		IP	IP	IP			IP
		Not Started		NS							NS					NS	
		N/A-NOT Local PH Responsibility															
	2	Completed		C													
		In-Progress	IP		IP	IP	IP	IP	IP	IP		IP	IP		IP		IP
		Not Started									NS			NS		NS	
		N/A-NOT Local PH Responsibility															
	3	Completed		C													
		In-Progress	IP		IP	IP	IP	IP	IP	IP		IP	IP		IP	IP	IP
		Not Started									NS			NS			
		N/A-NOT Local PH Responsibility															
	4	Completed		C	C												
		In-Progress	IP			IP	IP	IP	IP	IP	IP	IP	IP		IP	IP	IP
		Not Started												NS			
		N/A-NOT Local PH Responsibility															
	5	Completed		C						C							
		In-Progress	IP		IP	IP	IP				IP	IP	IP		IP	IP	IP
		Not Started						NS	NS					NS			
		N/A-NOT Local PH Responsibility															
	6	Completed		C													
		In-Progress	IP		IP	IP	IP	IP	IP	IP		IP	IP		IP	IP	IP
		Not Started									NS			NS			
		N/A-NOT Local PH Responsibility															
	7	Completed				C	C			C			C		C		
		In-Progress	IP	IP	IP			IP	IP		IP	IP				IP	IP
		Not Started												NS			
		N/A-NOT Local PH Responsibility															
	8	Completed		C													
		In-Progress	IP		IP	IP	IP	IP	IP	IP	IP		IP		IP		
		Not Started										NS		NS		NS	NS
		N/A-NOT Local PH Responsibility															
	9	Completed			C										C		
		In-Progress	IP	IP		IP	IP	IP	IP	IP			IP				IP
		Not Started									NS	NS		NS		NS	
		N/A-NOT Local PH Responsibility															
	10	Completed		C				C		C			C				
		In-Progress	IP		IP	IP	IP				IP	IP			IP	IP	IP
		Not Started							NS					NS			
		N/A-NOT Local PH Responsibility															
	11	Completed						C		C			C				
		In-Progress		IP		IP					IP				IP		
		Not Started	NS		NS		NS		NS			NS		NS		NS	NS
		N/A-NOT Local PH Responsibility															

Local Health Department Self-Assessment Totals Worksheet

		INDIANA H	6	7	5	1	5	9	5	6	6	3	8	1	6	9	9
	Question	Local Health Department Name	Grant County Health Department	Greene County Health Department	Hamilton County Health Department	Hammond City Health Department	Hancock County Health Department	Harrison County Health Department	Hendricks County Health Department	Henry County Health Department	Howard County Health Department	Huntington County Health Department	Jackson County Health Department	Jasper County Health Department	Jay County Health Department	Jefferson County Health Department	Jennings County Health Department
		Population Of Each Local Unit	71,543	33,500	231,760	80,547	60,915	36,376	123,476	47,809	84,615	38,124	41,959	31,624	21,654	32,110	28,401
			72	72	72	72	72	72	72	72	72	72	72	72	72	72	72
TOTALS BY PERCENTAGE			2.78%	6.94%	8.33%	0.00%	2.78%	22.22%	0.00%	23.61%	0.00%	1.39%	0.00%	18.06%	8.33%	2.78%	40.28%
			77.78%	18.06%	43.06%	43.06%	75.00%	43.06%	44.44%	48.61%	68.06%	44.44%	8.33%	37.50%	68.06%	16.67%	25.00%
			13.89%	66.67%	34.72%	31.94%	9.72%	25.00%	34.72%	27.78%	18.06%	23.61%	65.28%	29.17%	12.50%	65.28%	8.33%
		N/A-NOT	5.56%	8.33%	13.89%	25.00%	12.50%	9.72%	20.83%	0.00%	13.89%	30.56%	26.39%	15.28%	11.11%	15.28%	26.39%
COMMUNITY PREPAREDNESS LEADERSHIP & NETWORKING	1	Completed								C							
		In-Progress	IP	IP	IP	IP	IP	IP			IP	IP		IP	IP	IP	IP
		Not Started							NS				NS				
		N/A-NOT Local PH Responsibility															
	2	Completed								C							
		In-Progress	IP			IP	IP	IP			IP	IP		IP	IP		IP
		Not Started		NS	NS				NS				NS			NS	
		N/A-NOT Local PH Responsibility															
	3	Completed								C				C			C
		In-Progress	IP		IP	IP	IP	IP	IP		IP	IP			IP		
		Not Started		NS									NS			NS	
		N/A-NOT Local PH Responsibility															
	4	Completed						C		C				C	C		C
		In-Progress	IP		IP	IP	IP		IP		IP	IP					
		Not Started		NS									NS			NS	
		N/A-NOT Local PH Responsibility															
	5	Completed					C	C						C			C
		In-Progress	IP		IP	IP			IP	IP	IP	IP			IP		
		Not Started		NS									NS			NS	
		N/A-NOT Local PH Responsibility															
	6	Completed						C		C							C
		In-Progress	IP		IP	IP	IP		IP		IP	IP		IP	IP		
		Not Started		NS									NS			NS	
		N/A-NOT Local PH Responsibility															
	7	Completed	C							C					C		
		In-Progress		IP	IP	IP	IP	IP	IP		IP		IP	IP			IP
		Not Started										NS				NS	
		N/A-NOT Local PH Responsibility															
	8	Completed															
		In-Progress	IP		IP		IP	IP		IP	IP	IP		IP	IP		IP
		Not Started		NS		NS			NS				NS			NS	
		N/A-NOT Local PH Responsibility															
	9	Completed						C									
		In-Progress	IP		IP		IP			IP	IP	IP		IP	IP		IP
		Not Started		NS		NS			NS				NS			NS	
		N/A-NOT Local PH Responsibility															
	10	Completed						C		C				C			C
		In-Progress	IP		IP	IP	IP		IP		IP	IP			IP		
		Not Started		NS									NS			NS	
		N/A-NOT Local PH Responsibility															
	11	Completed			C					C				C			C
		In-Progress	IP				IP				IP	IP			IP		
		Not Started		NS		NS		NS	NS				NS			NS	
		N/A-NOT Local PH Responsibility															

Local Health Department Self-Assessment Totals Worksheet

		INDIANA H	5	10	2	3	1	1	8	6	5	2	10	3	8	4	5
	Question	Local Health Department Name	Johnson County Health Department	Knox County Health Department	Kosciusko County Health Department	LaGrange County Health Department	Lake County Health Department	LaPorte County Health Department	Lawrence County Health Department	Madison County Health Department	Marion County Health Department	Marshall County Health Department	Martin County Health Department	Miami County Health Department	Monroe County Health Department	Montgomery County Health Department	Morgan County Health Department
		Population Of Each Local Unit	125,864	38,442	75,667	36,515	278,970	109,755	46,398	130,602	863,596	46,732	10,467	35,955	121,013	37,937	69,424
			72	72	72	72	72	72	72	72	72	72	72	72	72	72	72
TOTALS BY PERCENTAGE			1.39%	8.33%	31.94%	11.11%	0.00%	9.72%	0.00%	11.11%	5.56%	5.56%	9.72%	11.11%	23.61%	5.56%	6.94%
			47.22%	38.89%	30.56%	47.22%	55.56%	47.22%	8.33%	61.11%	48.61%	65.28%	19.44%	45.83%	26.39%	61.11%	62.50%
			40.28%	34.72%	13.89%	12.50%	19.44%	15.28%	58.33%	18.06%	18.06%	2.78%	44.44%	27.78%	33.33%	12.50%	9.72%
		N/A-NOT	11.11%	18.06%	23.61%	29.17%	25.00%	27.78%	33.33%	9.72%	27.78%	26.39%	26.39%	15.28%	16.67%	20.83%	20.83%
COMMUNITY PREPAREDNESS LEADERSHIP & NETWORKING	1	Completed			C					C					C		
		In-Progress	IP			IP	IP	IP			IP	IP		IP		IP	IP
		Not Started		NS					NS				NS				
		N/A-NOT Local PH Responsibility															
	2	Completed			C												
		In-Progress		IP		IP	IP	IP		IP	IP	IP	IP	IP	IP		IP
		Not Started	NS						NS							NS	
		N/A-NOT Local PH Responsibility															
	3	Completed											C		C		
		In-Progress	IP	IP	IP	IP	IP	IP		IP		IP		IP		IP	IP
		Not Started							NS								
		N/A-NOT Local PH Responsibility									X						
	4	Completed													C		
		In-Progress	IP	IP	IP	IP	IP	IP		IP	IP	IP	IP	IP		IP	IP
		Not Started							NS								
		N/A-NOT Local PH Responsibility															
	5	Completed													C		
		In-Progress	IP	IP	IP	IP	IP	IP		IP	IP	IP	IP	IP		IP	IP
		Not Started							NS								
		N/A-NOT Local PH Responsibility															
	6	Completed			C										C		
		In-Progress	IP	IP		IP	IP	IP		IP		IP		IP		IP	IP
		Not Started							NS		NS		NS				
		N/A-NOT Local PH Responsibility															
	7	Completed											C				C
		In-Progress	IP	IP	IP		IP	IP	IP	IP	IP	IP			IP	IP	
		Not Started				NS								NS			
		N/A-NOT Local PH Responsibility															
	8	Completed															
		In-Progress			IP	IP	IP	IP		IP	IP	IP	IP		IP	IP	IP
		Not Started	NS	NS					NS					NS			
		N/A-NOT Local PH Responsibility															
	9	Completed												C			
		In-Progress	IP		IP	IP	IP			IP		IP				IP	IP
		Not Started		NS				NS	NS		NS		NS		NS		
		N/A-NOT Local PH Responsibility															
	10	Completed		C	C			C		C		C	C		C	C	
		In-Progress	IP			IP	IP				IP			IP			IP
		Not Started							NS								
		N/A-NOT Local PH Responsibility															
	11	Completed		C						C					C		
		In-Progress	IP		IP	IP						IP				IP	IP
		Not Started					NS	NS	NS		NS		NS	NS			
		N/A-NOT Local PH Responsibility															

Local Health Department Self-Assessment Totals Worksheet

	Question	INDIANA H	1	3	9	8	7	7	10	10	1	10	2	7	6	9	6
		Local Health Department Name	Newton County Health Department	Noble County Health Department	Ohio County Health Department	Orange County Health Department	Owen County Health Department	Parke County Health Department	Perry County Health Department	Pike County Health Department	Porter County Health Department	Posey County Health Department	Pulaski County Health Department	Putnam County Health Department	Randolph County Health Department	Ripley County Health Department	Rush County Health Department
		Population Of Each Local Unit	14,421	47,297	5,849	19,718	23,074	17,254	18,999	12,938	154,961	26,990	13,825	36,786	26,697	27,549	18,028
			72	72	72	72	72	72	72	72	72	72	72	72	72	72	72
TOTALS BY PERCENTAGE			20.83%	0.00%	8.33%	33.33%	2.78%	0.00%	0.00%	22.22%	0.00%	1.39%	4.17%	5.56%	0.00%	6.94%	1.39%
			44.44%	55.56%	47.22%	26.39%	66.67%	94.44%	50.00%	29.17%	76.39%	5.56%	45.83%	86.11%	65.28%	61.11%	15.28%
			26.39%	9.72%	31.94%	20.83%	19.44%	0.00%	30.56%	25.00%	4.17%	93.06%	26.39%	2.78%	23.61%	9.72%	83.33%
		N/A-NOT	8.33%	34.72%	12.50%	19.44%	11.11%	5.56%	19.44%	23.61%	19.44%	0.00%	23.61%	5.56%	11.11%	22.22%	0.00%
COMMUNITY PREPAREDNESS LEADERSHIP & NETWORKING	1	Completed															
		In-Progress	IP	IP			IP	IP	IP	IP	IP			IP	IP	IP	
		Not Started			NS	NS						NS	NS				NS
		N/A-NOT Local PH Responsibility															
	2	Completed				C											
		In-Progress	IP	IP			IP	IP	IP	IP	IP			IP	IP	IP	
		Not Started			NS							NS	NS				NS
		N/A-NOT Local PH Responsibility															
	3	Completed	C			C										C	
		In-Progress			IP		IP	IP	IP	IP	IP		IP	IP	IP		
		Not Started										NS					NS
		N/A-NOT Local PH Responsibility		X													
	4	Completed	C			C											
		In-Progress		IP	IP		IP	IP	IP	IP	IP		IP	IP	IP	IP	IP
		Not Started										NS					
		N/A-NOT Local PH Responsibility															
	5	Completed				C											
		In-Progress	IP	IP	IP		IP	IP	IP	IP	IP		IP	IP	IP	IP	IP
		Not Started										NS					
		N/A-NOT Local PH Responsibility															
	6	Completed				C											
		In-Progress	IP		IP		IP	IP	IP		IP		IP	IP	IP	IP	
		Not Started										NS					NS
		N/A-NOT Local PH Responsibility		X						X							
	7	Completed										C	C				
		In-Progress			IP	IP	IP	IP	IP	IP	IP			IP	IP	IP	
		Not Started	NS														NS
		N/A-NOT Local PH Responsibility		X													
	8	Completed				C											
		In-Progress		IP	IP		IP	IP	IP	IP	IP			IP	IP	IP	
		Not Started	NS									NS	NS				NS
		N/A-NOT Local PH Responsibility															
	9	Completed				C											
		In-Progress	IP	IP	IP		IP	IP	IP	IP	IP			IP	IP	IP	
		Not Started										NS	NS				NS
		N/A-NOT Local PH Responsibility															
	10	Completed			C	C				C				C		C	
		In-Progress	IP	IP			IP	IP	IP		IP		IP		IP		
		Not Started										NS					NS
		N/A-NOT Local PH Responsibility															
	11	Completed															
		In-Progress		IP			IP	IP	IP		IP		IP	IP		IP	
		Not Started	NS		NS	NS				NS		NS			NS		NS
		N/A-NOT Local PH Responsibility															

Local Health Department Self-Assessment Totals Worksheet

	Question	Local Health Department Name	St. Joseph County Health Department	Scott County Health Department	Shelby County Health Department	Spencer County Health Department	Starke County Health Department	Steuben County Health Department	Sullivan County Health Department	Switzerland County Health Department	Tippecanoe County Health Department	Tipton County Health Department	Union County Health Department	Vanderburgh County Health Department	Vermillion County Health Department	Vigo County Health Department	Wabash County Health Department
		INDIANA H	2	9	5	10	2	3	7	9	4	6	6	10	7	7	3
		Population Of Each Local Unit	266,431	23,604	43,717	20,310	22,903	33,722	21,862	9,508	152,042	16,605	7,226	173,157	16,500	103,195	34,169
			72	72	72	72	72	72	72	72	72	72	72	72	72	72	72
TOTALS BY PERCENTAGE			4.17%	5.56%	0.00%	5.56%	1.39%	12.50%	0.00%	0.00%	36.11%	1.39%	2.78%	12.50%	0.00%	8.33%	31.94%
			59.72%	58.33%	6.94%	27.78%	26.39%	43.06%	59.72%	81.94%	13.89%	36.11%	25.00%	34.72%	75.00%	41.67%	45.83%
			13.89%	11.11%	77.78%	41.67%	48.61%	15.28%	40.28%	6.94%	22.22%	38.89%	47.22%	33.33%	11.11%	37.50%	5.56%
		N/A-NOT	22.22%	25.00%	15.28%	25.00%	23.61%	29.17%	0.00%	11.11%	27.78%	23.61%	25.00%	19.44%	13.89%	12.50%	16.67%
COMMUNITY PREPAREDNESS LEADERSHIP & NETWORKING	1	Completed	C														
		In-Progress		IP			IP	IP	IP	IP	IP	IP		IP	IP	IP	IP
		Not Started			NS	NS							NS				
		N/A-NOT Local PH Responsibility															
	2	Completed															
		In-Progress	IP	IP		IP		IP	IP	IP	IP			IP	IP	IP	IP
		Not Started			NS		NS					NS	NS				
		N/A-NOT Local PH Responsibility															
	3	Completed		C		C											
		In-Progress	IP				IP	IP	IP	IP	IP			IP	IP	IP	IP
		Not Started			NS							NS	NS				
		N/A-NOT Local PH Responsibility															
	4	Completed				C					C						C
		In-Progress	IP	IP				IP	IP	IP		IP		IP	IP	IP	
		Not Started			NS		NS						NS				
		N/A-NOT Local PH Responsibility															
	5	Completed	C														
		In-Progress		IP	IP	IP		IP	IP	IP		IP	IP	IP	IP	IP	IP
		Not Started					NS				NS						
		N/A-NOT Local PH Responsibility															
	6	Completed												C			C
		In-Progress	IP	IP		IP	IP	IP		IP	IP				IP	IP	
		Not Started			NS				NS			NS	NS				
		N/A-NOT Local PH Responsibility															
	7	Completed									C		C	C			C
		In-Progress	IP	IP		IP	IP		IP	IP		IP			IP	IP	
		Not Started			NS			NS									
		N/A-NOT Local PH Responsibility															
	8	Completed															
		In-Progress	IP	IP		IP	IP	IP		IP	IP				IP		IP
		Not Started			NS				NS			NS	NS	NS		NS	
		N/A-NOT Local PH Responsibility															
	9	Completed									C						
		In-Progress	IP	IP		IP	IP	IP	IP	IP				IP	IP	IP	IP
		Not Started			NS							NS	NS				
		N/A-NOT Local PH Responsibility															
	10	Completed		C										C		C	C
		In-Progress	IP			IP		IP	IP	IP		IP	IP		IP		
		Not Started			NS		NS				NS						
		N/A-NOT Local PH Responsibility															
	11	Completed									C					C	
		In-Progress		IP				IP		IP					IP		IP
		Not Started	NS		NS	NS	NS		NS			NS	NS	NS			
		N/A-NOT Local PH Responsibility															

Local Health Department Self-Assessment Totals Worksheet

		INDIANA H	10	8	6	3	4	3
	Question	Local Health Department Name	Warrick County Health Department	Washington County Health Department	Wayne County Health Department	Wells County Health Department	White County Health Department	Whitley County Health Department
		Population Of Each Local Unit	55,465	27,882	69,778	27,963	24,846	31,955
			72	72	72	72	72	72
TOTALS BY PERCENTAGE			16.67%	0.00%	0.00%	8.33%	16.67%	4.17%
			29.17%	16.67%	34.72%	45.83%	41.67%	0.00%
			31.94%	70.83%	50.00%	13.89%	19.44%	84.72%
		N/A-NOT	22.22%	12.50%	15.28%	31.94%	22.22%	11.11%
COMMUNITY PREPAREDNESS LEADERSHIP & NETWORKING	1	Completed						
		In-Progress			IP	IP	IP	
		Not Started	NS	NS				NS
		N/A-NOT Local PH Responsibility						
	2	Completed						
		In-Progress	IP			IP	IP	
		Not Started		NS	NS			NS
		N/A-NOT Local PH Responsibility						
	3	Completed						
		In-Progress	IP			IP	IP	
		Not Started		NS	NS			NS
		N/A-NOT Local PH Responsibility						
	4	Completed	C					
		In-Progress			IP	IP	IP	
		Not Started		NS				NS
		N/A-NOT Local PH Responsibility						
	5	Completed					C	
		In-Progress	IP		IP	IP		
		Not Started						NS
		N/A-NOT Local PH Responsibility		X				
	6	Completed					C	
		In-Progress	IP			IP		
		Not Started		NS	NS			NS
		N/A-NOT Local PH Responsibility						
	7	Completed					C	
		In-Progress	IP	IP	IP	IP		
		Not Started						NS
		N/A-NOT Local PH Responsibility						
	8	Completed						
		In-Progress			IP	IP	IP	
		Not Started	NS	NS				NS
		N/A-NOT Local PH Responsibility						
	9	Completed						
		In-Progress	IP		IP	IP	IP	
		Not Started		NS				NS
		N/A-NOT Local PH Responsibility						
	10	Completed						
		In-Progress	IP	IP	IP	IP	IP	
		Not Started						NS
		N/A-NOT Local PH Responsibility						
	11	Completed	C				C	
		In-Progress		IP		IP		
		Not Started			NS			NS
		N/A-NOT Local PH Responsibility						

Local Health Department Self-Assessment Totals Worksheet

				INDIANA HOMELAND SECURITY DISTRICT	3	3	8	4	6	5	8	4	4	9	7	4	10
	Question	Local Health Department Name	Population Represented	94	Adams County Health Department	Allen County Health Department	Bartholomew County Health Department	Benton County Health Department	Blackford County Health Department	Boone County Health Department	Brown County Health Department	Carroll County Health Department	Cass County Health Department	Clark County Health Department	Clay County Health Department	Clinton County Health Department	Crawford County Health Department
		Population Of Each Local Unit	100.00%	6,237,569	33,815	342,168	72,987	9,139	13,841	50,847	15,228	20,331	40,417	100,706	27,210	34,148	11,167
			BALANCED	94	72	72	72	72	72	72	72	72	72	72	72	72	72
COMMUNITY PREPAREDNESS LEADERSHIP & NETWORKING	12	Completed	3,708,187	54		C	C			C	C		C	C	C		
		In-Progress	2,240,447	31					IP			IP				IP	IP
		Not Started	288,935	9	NS			NS									
		N/A-NOT Local PH Responsibility	0	0													
	13	Completed	1,437,651	26						C		C					
		In-Progress	4,284,749	54		IP	IP		IP		IP		IP	IP		IP	IP
		Not Started	440,662	12	NS			NS									
		N/A-NOT Local PH Responsibility	74,507	2											X		
	14	Completed	363,598	10						C		C					
		In-Progress	2,536,823	37		IP	IP						IP			IP	
		Not Started	1,953,712	40	NS			NS	NS		NS			NS			NS
		N/A-NOT Local PH Responsibility	1,383,436	7											X		
	15	Completed	932,947	18						C		C			C		
		In-Progress	4,780,629	62		IP	IP		IP		IP		IP	IP		IP	
		Not Started	523,993	14	NS			NS									NS
		N/A-NOT Local PH Responsibility	0	0													
	16	Completed	266,531	4								C					
		In-Progress	2,742,442	48				IP		IP			IP		IP		
		Not Started	1,566,189	28	NS	NS	NS		NS		NS						NS
		N/A-NOT Local PH Responsibility	1,662,407	14										X		X	
	17	Completed	770,748	11		C				C			C				
		In-Progress	3,419,305	51			IP		IP			IP		IP	IP	IP	
		Not Started	1,183,920	31	NS			NS			NS						NS
		N/A-NOT Local PH Responsibility	863,596	1													
	18	Completed	77,278	2						C							
		In-Progress	1,463,766	24		IP		IP				IP	IP	IP			
		Not Started	3,236,503	50	NS				NS		NS					NS	
		N/A-NOT Local PH Responsibility	1,460,022	18			X								X		X
SURVEILLANCE	19	Completed	481,528	10				C			C		C				
		In-Progress	2,903,324	26		IP						IP					
		Not Started	623,439	23	NS				NS							NS	NS
		N/A-NOT Local PH Responsibility	2,229,278	35			X			X				X	X		
	20	Completed	74,556	3									C				
		In-Progress	445,848	13				IP	IP		IP					IP	
		Not Started	453,858	11	NS												
		N/A-NOT Local PH Responsibility	5,263,307	67		X	X			X		X		X	X		X
	21	Completed	126,351	5							C						
		In-Progress	2,031,032	25					IP			IP				IP	
		Not Started	2,282,594	37	NS	NS	NS							NS	NS		NS
		N/A-NOT Local PH Responsibility	1,797,592	27				X		X			X				
	22	Completed	500,079	5		C				C							
		In-Progress	561,493	14			IP		IP		IP	IP					
		Not Started	1,788,497	30	NS									NS	NS		
		N/A-NOT Local PH Responsibility	3,387,500	45				X					X			X	X
	23	Completed	409,427	7						C							
		In-Progress	1,576,418	29		IP	IP	IP			IP		IP				
		Not Started	4,090,753	51	NS				NS					NS	NS	NS	NS
		N/A-NOT Local PH Responsibility	160,971	7								X					
PUBLIC HEALTH & CLINICAL LABORATORIES	24	Completed	48,583	1													
		In-Progress	187,832	6													
		Not Started	297,282	8	NS												
		N/A-NOT Local PH Responsibility	5,703,872	79		X	X	X	X	X	X	X	X	X	X	X	X
	25	Completed	0	0													
		In-Progress	136,065	3													
		Not Started	387,620	10							NS						
		N/A-NOT Local PH Responsibility	5,713,884	81	X	X	X	X	X	X		X	X	X	X	X	X
	26	Completed	0	0													
		In-Progress	47,809	1													
		Not Started	475,379	13							NS						

Local Health Department Self-Assessment Totals Worksheet

	Question	Local Health Department Name	Daviess County Health Department	Dearborn County Health Department	Decatur County Health Department	Dekalb County Health Department	Delaware County Health Department	Dubois County Health Department	East Chicago City Health Department	Elkhart County Health Department	Fayette County Health Department	Floyd County Health Department	Fountain-Warren County Combined Health Department	Franklin County Health Department	Fulton County Health Department	Gary City Health Department	Gibson County Health Department
		INDIANA H	10	9	9	3	6	10	1	2	6	9	4	9	1	1	10
		Population Of Each Local Unit	30,245	48,583	24,970	41,524	117,774	40,771	31,366	191,768	24,934	71,543	26,431	22,852	20,581	99,961	33,286
			72	72	72	72	72	72	72	72	72	72	72	72	72	72	72
COMMUNITY PREPAREDNESS LEADERSHIP & NETWORKING	12	Completed		C	C	C	C	C	C	C	C		C		C		
		In-Progress	IP									IP				IP	IP
		Not Started												NS			
		N/A-NOT Local PH Responsibility															
	13	Completed		C	C		C	C	C	C			C		C		
		In-Progress	IP			IP					IP	IP				IP	IP
		Not Started												NS			
		N/A-NOT Local PH Responsibility															
	14	Completed		C	C												
		In-Progress	IP			IP			IP	IP	IP		IP		IP		
		Not Started					NS	NS				NS		NS		NS	NS
		N/A-NOT Local PH Responsibility															
	15	Completed		C									C				
		In-Progress	IP		IP	IP	IP	IP	IP	IP	IP	IP			IP	IP	IP
		Not Started												NS			
		N/A-NOT Local PH Responsibility															
	16	Completed		C						C							
		In-Progress	IP		IP	IP	IP	IP					IP		IP	IP	IP
		Not Started									NS	NS		NS			
		N/A-NOT Local PH Responsibility							X								
	17	Completed													C		
		In-Progress	IP	IP	IP		IP		IP	IP	IP		IP				
		Not Started				NS		NS				NS		NS		NS	NS
		N/A-NOT Local PH Responsibility															
	18	Completed											C				
		In-Progress	IP	IP	IP	IP		IP	IP	IP					IP		
		Not Started					NS				NS	NS		NS		NS	NS
		N/A-NOT Local PH Responsibility															
SURVEILLANCE	19	Completed		C									C				
		In-Progress				IP	IP										
		Not Started			NS			NS			NS	NS					NS
		N/A-NOT Local PH Responsibility	X						X	X				X	X	X	
	20	Completed															
		In-Progress				IP	IP						IP				
		Not Started										NS					
		N/A-NOT Local PH Responsibility	X	X	X			X	X	X	X			X	X	X	X
	21	Completed		C													
		In-Progress				IP	IP			IP			IP		IP		
		Not Started			NS			NS			NS	NS		NS		NS	NS
		N/A-NOT Local PH Responsibility	X						X								
	22	Completed											C				
		In-Progress			IP												
		Not Started		NS		NS	NS					NS				NS	
		N/A-NOT Local PH Responsibility	X					X	X	X	X			X	X		X
	23	Completed		C													
		In-Progress			IP	IP	IP		IP				IP		IP		
		Not Started						NS		NS	NS	NS		NS		NS	NS
		N/A-NOT Local PH Responsibility	X														
PUBLIC HEALTH & CLINICAL LABORATORIES	24	Completed		C													
		In-Progress				IP							IP				
		Not Started										NS					
		N/A-NOT Local PH Responsibility	X		X		X	X	X	X	X			X	X	X	X
	25	Completed															
		In-Progress				IP											
		Not Started			NS							NS				NS	
		N/A-NOT Local PH Responsibility	X	X			X	X	X	X	X		X	X	X		X
	26	Completed															
		In-Progress															
		Not Started			NS	NS						NS		NS		NS	

Local Health Department Self-Assessment Totals Worksheet

		INDIANA H	6	7	5	1	5	9	5	6	6	3	8	1	6	9	9
	Question	Local Health Department Name	Grant County Health Department	Greene County Health Department	Hamilton County Health Department	Hammond City Health Department	Hancock County Health Department	Harrison County Health Department	Hendricks County Health Department	Henry County Health Department	Howard County Health Department	Huntington County Health Department	Jackson County Health Department	Jasper County Health Department	Jay County Health Department	Jefferson County Health Department	Jennings County Health Department
		Population Of Each Local Unit	71,543	33,500	231,760	80,547	60,915	36,376	123,476	47,809	84,615	38,124	41,959	31,624	21,654	32,110	28,401
			72	72	72	72	72	72	72	72	72	72	72	72	72	72	72
COMMUNITY PREPAREDNESS LEADERSHIP & NETWORKING	12	Completed	C	C	C			C		C		C		C	C		C
		In-Progress				IP	IP		IP		IP						
		Not Started											NS			NS	
		N/A-NOT Local PH Responsibility															
	13	Completed			C					C				C			C
		In-Progress	IP			IP	IP	IP	IP		IP	IP			IP		
		Not Started		NS									NS			NS	
		N/A-NOT Local PH Responsibility															
	14	Completed												C			C
		In-Progress	IP		IP		IP	IP	IP						IP		
		Not Started		NS		NS				NS	NS		NS			NS	
		N/A-NOT Local PH Responsibility										X					
	15	Completed						C		C				C			C
		In-Progress	IP		IP	IP	IP		IP		IP	IP			IP		
		Not Started		NS									NS			NS	
		N/A-NOT Local PH Responsibility															
	16	Completed															
		In-Progress	IP				IP		IP	IP	IP	IP			IP		IP
		Not Started		NS	NS	NS		NS								NS	
		N/A-NOT Local PH Responsibility											X	X			
	17	Completed						C									C
		In-Progress	IP		IP	IP	IP		IP		IP	IP		IP			
		Not Started		NS						NS			NS		NS	NS	
		N/A-NOT Local PH Responsibility															
	18	Completed															
		In-Progress	IP				IP								IP		
		Not Started		NS	NS	NS			NS	NS	NS	NS		NS		NS	NS
		N/A-NOT Local PH Responsibility						X					X				
SURVEILLANCE	19	Completed															
		In-Progress						IP		IP	IP				IP		
		Not Started	NS	NS													NS
		N/A-NOT Local PH Responsibility			X	X	X		X			X	X	X		X	
	20	Completed															
		In-Progress															
		Not Started	NS							NS	NS						
		N/A-NOT Local PH Responsibility		X	X	X	X	X	X			X	X	X	X	X	X
	21	Completed															C
		In-Progress						IP		IP	IP				IP		
		Not Started	NS	NS													
		N/A-NOT Local PH Responsibility			X	X	X		X			X	X	X		X	
	22	Completed					C										
		In-Progress								IP					IP		
		Not Started	NS	NS				NS									
		N/A-NOT Local PH Responsibility			X	X			X		X	X	X	X		X	X
	23	Completed															C
		In-Progress				IP	IP	IP		IP	IP				IP		
		Not Started	NS	NS	NS				NS			NS	NS	NS		NS	
		N/A-NOT Local PH Responsibility															
PUBLIC HEALTH & CLINICAL LABORATORIES	24	Completed															
		In-Progress								IP							
		Not Started	NS														
		N/A-NOT Local PH Responsibility		X	X	X	X	X	X		X	X	X	X	X	X	X
	25	Completed															
		In-Progress								IP							
		Not Started	NS														
		N/A-NOT Local PH Responsibility		X	X	X	X	X	X		X	X	X	X	X	X	X
	26	Completed															
		In-Progress								IP							
		Not Started	NS														

Local Health Department Self-Assessment Totals Worksheet

	Question	INDIANA H	5	10	2	3	1	1	8	6	5	2	10	3	8	4	5
		Local Health Department Name	Johnson County Health Department	Knox County Health Department	Kosciusko County Health Department	LaGrange County Health Department	Lake County Health Department	LaPorte County Health Department	Lawrence County Health Department	Madison County Health Department	Marion County Health Department	Marshall County Health Department	Martin County Health Department	Miami County Health Department	Monroe County Health Department	Montgomery County Health Department	Morgan County Health Department
		Population Of Each Local Unit	125,864	38,442	75,667	36,515	278,970	109,755	46,398	130,602	863,596	46,732	10,467	35,955	121,013	37,937	69,424
			72	72	72	72	72	72	72	72	72	72	72	72	72	72	72
COMMUNITY PREPAREDNESS LEADERSHIP & NETWORKING	12	Completed		C	C	C		C		C	C	C	C	C		C	C
		In-Progress	IP				IP								IP		
		Not Started							NS								
		N/A-NOT Local PH Responsibility															
	13	Completed			C			C					C	C			
		In-Progress	IP	IP		IP	IP			IP	IP	IP				IP	IP
		Not Started							NS						NS		
		N/A-NOT Local PH Responsibility															
	14	Completed			C	C											
		In-Progress						IP		IP		IP		IP			IP
		Not Started	NS	NS					NS				NS			NS	
		N/A-NOT Local PH Responsibility					X				X				X		
	15	Completed	C		C										C		
		In-Progress		IP		IP	IP	IP		IP	IP	IP		IP		IP	IP
		Not Started							NS				NS				
		N/A-NOT Local PH Responsibility															
	16	Completed															
		In-Progress	IP		IP	IP	IP					IP		IP		IP	IP
		Not Started											NS		NS		
		N/A-NOT Local PH Responsibility		X				X	X	X	X						
	17	Completed															
		In-Progress		IP	IP	IP	IP	IP		IP		IP		IP		IP	IP
		Not Started	NS						NS				NS		NS		
		N/A-NOT Local PH Responsibility									X						
	18	Completed															
		In-Progress												IP			IP
		Not Started	NS	NS	NS	NS	NS			NS					NS	NS	
		N/A-NOT Local PH Responsibility						X	X		X	X	X				
SURVEILLANCE	19	Completed		C						C					C		
		In-Progress	IP								IP					IP	
		Not Started											NS				
		N/A-NOT Local PH Responsibility			X	X	X	X	X			X		X			X
	20	Completed															
		In-Progress														IP	
		Not Started															
		N/A-NOT Local PH Responsibility	X	X	X	X	X	X	X	X	X	X	X	X	X		X
	21	Completed															
		In-Progress			IP						IP	IP			IP		IP
		Not Started		NS						NS			NS	NS			
		N/A-NOT Local PH Responsibility	X			X	X	X	X							X	
	22	Completed															
		In-Progress										IP					IP
		Not Started	NS	NS						NS				NS	NS		
		N/A-NOT Local PH Responsibility			X	X	X	X	X		X		X			X	
	23	Completed			C												
		In-Progress		IP		IP						IP					IP
		Not Started	NS				NS	NS	NS	NS	NS		NS	NS	NS	NS	
		N/A-NOT Local PH Responsibility															
PUBLIC HEALTH & CLINICAL LABORATORIES	24	Completed															
		In-Progress															
		Not Started															
		N/A-NOT Local PH Responsibility	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	25	Completed															
		In-Progress										IP					
		Not Started															
		N/A-NOT Local PH Responsibility	X	X	X	X	X	X	X	X	X		X	X	X	X	X
	26	Completed															
		In-Progress															
		Not Started															

Local Health Department Self-Assessment Totals Worksheet

		INDIANA H	1	3	9	8	7	7	10	10	1	10	2	7	6	9	6
	Question	Local Health Department Name	Newton County Health Department	Noble County Health Department	Ohio County Health Department	Orange County Health Department	Owen County Health Department	Parke County Health Department	Perry County Health Department	Pike County Health Department	Porter County Health Department	Posey County Health Department	Pulaski County Health Department	Putnam County Health Department	Randolph County Health Department	Ripley County Health Department	Rush County Health Department
		Population Of Each Local Unit	14,421	47,297	5,849	19,718	23,074	17,254	18,999	12,938	154,961	26,990	13,825	36,786	26,697	27,549	18,028
			72	72	72	72	72	72	72	72	72	72	72	72	72	72	72
COMMUNITY PREPAREDNESS LEADERSHIP & NETWORKING	12	Completed	C		C	C	C			C			C	C		C	
		In-Progress		IP				IP	IP		IP				IP		IP
		Not Started										NS					
		N/A-NOT Local PH Responsibility															
	13	Completed	C		C	C	C			C				C			
		In-Progress						IP	IP		IP		IP		IP	IP	
		Not Started										NS					NS
		N/A-NOT Local PH Responsibility		X													
	14	Completed								C							
		In-Progress	IP		IP		IP	IP			IP		IP	IP	IP		
		Not Started				NS			NS			NS				NS	NS
		N/A-NOT Local PH Responsibility		X													
	15	Completed				C				C							
		In-Progress	IP	IP	IP		IP	IP	IP		IP		IP	IP	IP	IP	IP
		Not Started										NS					
		N/A-NOT Local PH Responsibility															
	16	Completed			C												
		In-Progress	IP	IP			IP	IP	IP	IP	IP			IP		IP	IP
		Not Started										NS	NS		NS		
		N/A-NOT Local PH Responsibility				X											
	17	Completed								C							
		In-Progress		IP	IP	IP		IP			IP		IP	IP	IP	IP	IP
		Not Started	NS				NS		NS			NS					
		N/A-NOT Local PH Responsibility															
	18	Completed															
		In-Progress						IP			IP			IP	IP		
		Not Started	NS				NS		NS	NS		NS	NS				NS
		N/A-NOT Local PH Responsibility		X	X	X										X	
SURVEILLANCE	19	Completed				C											
		In-Progress	IP	IP				IP	IP		IP			IP			
		Not Started			NS					NS		NS			NS	NS	NS
		N/A-NOT Local PH Responsibility					X						X				
	20	Completed	C			C											
		In-Progress						IP						IP			
		Not Started					NS					NS			NS		NS
		N/A-NOT Local PH Responsibility		X	X				X	X	X		X			X	
	21	Completed	C			C											
		In-Progress			IP		IP	IP	IP					IP			
		Not Started								NS	NS	NS	NS		NS	NS	NS
		N/A-NOT Local PH Responsibility		X													
	22	Completed				C											
		In-Progress	IP		IP						IP			IP			
		Not Started		NS			NS					NS			NS	NS	NS
		N/A-NOT Local PH Responsibility						X	X	X			X				
	23	Completed				C											
		In-Progress					IP	IP	IP		IP			IP			
		Not Started			NS					NS		NS	NS		NS	NS	NS
		N/A-NOT Local PH Responsibility	X	X													
PUBLIC HEALTH & CLINICAL LABORATORIES	24	Completed															
		In-Progress						IP						IP			IP
		Not Started					NS					NS					
		N/A-NOT Local PH Responsibility	X	X	X	X			X	X	X		X		X	X	
	25	Completed															
		In-Progress															
		Not Started	NS				NS					NS					NS
		N/A-NOT Local PH Responsibility		X	X	X		X	X	X	X		X	X	X	X	
	26	Completed															
		In-Progress															
		Not Started			NS		NS					NS					NS

Local Health Department Self-Assessment Totals Worksheet

		INDIANA H	2	9	5	10	2	3	7	9	4	6	6	10	7	7	3
	Question	Local Health Department Name	St. Joseph County Health Department	Scott County Health Department	Shelby County Health Department	Spencer County Health Department	Starke County Health Department	Steuben County Health Department	Sullivan County Health Department	Switzerland County Health Department	Tippecanoe County Health Department	Tipton County Health Department	Union County Health Department	Vanderburgh County Health Department	Vermillion County Health Department	Vigo County Health Department	Wabash County Health Department
		Population Of Each Local Unit	266,431	23,604	43,717	20,310	22,903	33,722	21,862	9,508	152,042	16,605	7,226	173,157	16,500	103,195	34,169
			72	72	72	72	72	72	72	72	72	72	72	72	72	72	72
COMMUNITY PREPAREDNESS LEADERSHIP & NETWORKING	12	Completed		C		C		C				C				C	C
		In-Progress	IP				IP		IP	IP	IP		IP	IP	IP		
		Not Started			NS												
		N/A-NOT Local PH Responsibility															
	13	Completed									C						
		In-Progress	IP	IP	IP	IP		IP	IP	IP		IP	IP	IP	IP	IP	IP
		Not Started					NS										
		N/A-NOT Local PH Responsibility															
	14	Completed						C									
		In-Progress	IP							IP					IP		IP
		Not Started		NS	NS	NS	NS		NS		NS	NS		NS		NS	
		N/A-NOT Local PH Responsibility											X				
	15	Completed												C			C
		In-Progress	IP	IP		IP	IP	IP	IP	IP		IP	IP		IP	IP	
		Not Started			NS						NS						
		N/A-NOT Local PH Responsibility															
	16	Completed															
		In-Progress	IP	IP		IP		IP					IP	IP	IP		
		Not Started			NS		NS		NS	NS		NS				NS	
		N/A-NOT Local PH Responsibility									X						X
	17	Completed									C						C
		In-Progress	IP	IP				IP	IP	IP				IP	IP	IP	
		Not Started			NS	NS	NS					NS	NS				
		N/A-NOT Local PH Responsibility															
	18	Completed															
		In-Progress								IP					IP		
		Not Started	NS		NS	NS	NS	NS	NS		NS	NS		NS		NS	
		N/A-NOT Local PH Responsibility		X									X				X
SURVEILLANCE	19	Completed															
		In-Progress	IP							IP	IP			IP	IP	IP	
		Not Started		NS		NS			NS				NS				
		N/A-NOT Local PH Responsibility			X		X	X				X					X
	20	Completed															
		In-Progress								IP					IP		
		Not Started							NS								
		N/A-NOT Local PH Responsibility	X	X	X	X	X	X			X	X	X	X		X	X
	21	Completed															
		In-Progress								IP					IP		
		Not Started	NS	NS		NS	NS		NS					NS		NS	
		N/A-NOT Local PH Responsibility			X			X			X	X	X				X
	22	Completed															
		In-Progress													IP		
		Not Started		NS					NS	NS				NS		NS	
		N/A-NOT Local PH Responsibility	X		X	X	X	X			X	X	X				X
	23	Completed									C						C
		In-Progress						IP		IP					IP		
		Not Started	NS	NS	NS	NS	NS		NS					NS		NS	
		N/A-NOT Local PH Responsibility										X	X				
PUBLIC HEALTH & CLINICAL LABORATORIES	24	Completed															
		In-Progress															
		Not Started							NS						NS		
		N/A-NOT Local PH Responsibility	X	X	X	X	X	X		X	X	X	X	X		X	X
	25	Completed															
		In-Progress															
		Not Started							NS								
		N/A-NOT Local PH Responsibility	X	X	X	X	X	X		X	X	X	X	X	X	X	X
	26	Completed															
		In-Progress															
		Not Started							NS								

Local Health Department Self-Assessment Totals Worksheet

		INDIANA H	10	8	6	3	4	3
	Question	Local Health Department Name	Warrick County Health Department	Washington County Health Department	Wayne County Health Department	Wells County Health Department	White County Health Department	Whitley County Health Department
		Population Of Each Local Unit	55,465	27,882	69,778	27,963	24,846	31,955
			72	72	72	72	72	72
COMMUNITY PREPAREDNESS LEADERSHIP & NETWORKING	12	Completed	C			C	C	
		In-Progress		IP	IP			
		Not Started						NS
		N/A-NOT Local PH Responsibility						
	13	Completed				C		
		In-Progress	IP	IP	IP		IP	
		Not Started						NS
		N/A-NOT Local PH Responsibility						
	14	Completed						
		In-Progress			IP	IP	IP	
		Not Started	NS	NS				NS
		N/A-NOT Local PH Responsibility						
	15	Completed				C	C	
		In-Progress	IP		IP			
		Not Started		NS				NS
		N/A-NOT Local PH Responsibility						
	16	Completed						
		In-Progress	IP			IP		
		Not Started			NS		NS	NS
		N/A-NOT Local PH Responsibility		X				
	17	Completed				C	C	
		In-Progress	IP					
		Not Started		NS	NS			NS
		N/A-NOT Local PH Responsibility						
	18	Completed						
		In-Progress						
		Not Started	NS	NS	NS		NS	NS
		N/A-NOT Local PH Responsibility				X		
SURVEILLANCE	19	Completed						C
		In-Progress	IP	IP	IP			
		Not Started						
		N/A-NOT Local PH Responsibility				X	X	
	20	Completed						
		In-Progress			IP			
		Not Started		NS				
		N/A-NOT Local PH Responsibility	X			X	X	X
	21	Completed						
		In-Progress			IP			
		Not Started	NS	NS		NS		NS
		N/A-NOT Local PH Responsibility					X	
	22	Completed						
		In-Progress						
		Not Started	NS	NS	NS			
		N/A-NOT Local PH Responsibility				X	X	X
	23	Completed						
		In-Progress						
		Not Started	NS	NS	NS	NS		NS
		N/A-NOT Local PH Responsibility					X	
PUBLIC HEALTH & CLINICAL LABORATORIES	24	Completed						
		In-Progress						
		Not Started						NS
		N/A-NOT Local PH Responsibility	X	X	X	X	X	
	25	Completed						
		In-Progress						
		Not Started						
		N/A-NOT Local PH Responsibility	X	X	X	X	X	X
	26	Completed						
		In-Progress						
		Not Started						NS

Local Health Department Self-Assessment Totals Worksheet

				INDIANA HOMELAND SECURITY DISTRICT	3	3	8	4	6	5	8	4	4	9	7	4	10
	Question	Local Health Department Name	Population Represented	94	Adams County Health Department	Allen County Health Department	Bartholomew County Health Department	Benton County Health Department	Blackford County Health Department	Boone County Health Department	Brown County Health Department	Carroll County Health Department	Cass County Health Department	Clark County Health Department	Clay County Health Department	Clinton County Health Department	Crawford County Health Department
		Population Of Each Local Unit	100.00%	6,237,569	33,815	342,168	72,987	9,139	13,841	50,847	15,228	20,331	40,417	100,706	27,210	34,148	11,167
			BALANCED	94	72	72	72	72	72	72	72	72	72	72	72	72	72
		N/A-NOT Local PH Responsibility	5,714,381	80	X	X	X	X	X	X		X	X	X	X	X	X

Local Health Department Self-Assessment Totals Worksheet

		INDIANA H	**10**	**9**	**9**	**3**	**6**	**10**	**1**	**2**	**6**	**9**	**4**	**9**	**1**	**1**	**10**
	Question	**Local Health Department Name**	Daviess County Health Department	Dearborn County Health Department	Decatur County Health Department	Dekalb County Health Department	Delaware County Health Department	Dubois County Health Department	East Chicago City Health Department	Elkhart County Health Department	Fayette County Health Department	Floyd County Health Department	Fountain-Warren County Combined Health Department	Franklin County Health Department	Fulton County Health Department	Gary City Health Department	Gibson County Health Department
		Population Of Each Local Unit	**30,245**	**48,583**	**24,970**	**41,524**	**117,774**	**40,771**	**31,366**	**191,768**	**24,934**	**71,543**	**26,431**	**22,852**	**20,581**	**99,961**	**33,286**
			72	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**
		N/A-NOT Local PH Responsibility	X	X			X	X	X	X	X		X		X		X

Local Health Department Self-Assessment Totals Worksheet

		INDIANA H	**6**	**7**	**5**	**1**	**5**	**9**	**5**	**6**	**6**	**3**	**8**	**1**	**6**	**9**	**9**
	Question	**Local Health Department Name**	Grant County Health Department	Greene County Health Department	Hamilton County Health Department	Hammond City Health Department	Hancock County Health Department	Harrison County Health Department	Hendricks County Health Department	Henry County Health Department	Howard County Health Department	Huntington County Health Department	Jackson County Health Department	Jasper County Health Department	Jay County Health Department	Jefferson County Health Department	Jennings County Health Department
		Population Of Each Local Unit	**71,543**	**33,500**	**231,760**	**80,547**	**60,915**	**36,376**	**123,476**	**47,809**	**84,615**	**38,124**	**41,959**	**31,624**	**21,654**	**32,110**	**28,401**
			72	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**
		N/A-NOT Local PH Responsibility		X	X	X	X	X	X		X	X	X	X	X	X	X

Local Health Department Self-Assessment Totals Worksheet

		INDIANA H	**5**	**10**	**2**	**3**	**1**	**1**	**8**	**6**	**5**	**2**	**10**	**3**	**8**	**4**	**5**
	Question	**Local Health Department Name**	Johnson County Health Department	Knox County Health Department	Kosciusko County Health Department	LaGrange County Health Department	Lake County Health Department	LaPorte County Health Department	Lawrence County Health Department	Madison County Health Department	Marion County Health Department	Marshall County Health Department	Martin County Health Department	Miami County Health Department	Monroe County Health Department	Montgomery County Health Department	Morgan County Health Department
		Population Of Each Local Unit	**125,864**	**38,442**	**75,667**	**36,515**	**278,970**	**109,755**	**46,398**	**130,602**	**863,596**	**46,732**	**10,467**	**35,955**	**121,013**	**37,937**	**69,424**
			72	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**
		N/A-NOT Local PH Responsibility	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X

Local Health Department Self-Assessment Totals Worksheet

		INDIANA H	1	3	9	8	7	7	10	10	1	10	2	7	6	9	6
	Question	**Local Health Department Name**	Newton County Health Department	Noble County Health Department	Ohio County Health Department	Orange County Health Department	Owen County Health Department	Parke County Health Department	Perry County Health Department	Pike County Health Department	Porter County Health Department	Posey County Health Department	Pulaski County Health Department	Putnam County Health Department	Randolph County Health Department	Ripley County Health Department	Rush County Health Department
		Population Of Each Local Unit	**14,421**	**47,297**	**5,849**	**19,718**	**23,074**	**17,254**	**18,999**	**12,938**	**154,961**	**26,990**	**13,825**	**36,786**	**26,697**	**27,549**	**18,028**
			72	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**
		N/A-NOT Local PH Responsibility	X	X		X		X	X	X	X		X	X	X	X	

Local Health Department Self-Assessment Totals Worksheet

		INDIANA H	**2**	**9**	**5**	**10**	**2**	**3**	**7**	**9**	**4**	**6**	**6**	**10**	**7**	**7**	**3**
	Question	**Local Health Department Name**	St. Joseph County Health Department	Scott County Health Department	Shelby County Health Department	Spencer County Health Department	Starke County Health Department	Steuben County Health Department	Sullivan County Health Department	Switzerland County Health Department	Tippecanoe County Health Department	Tipton County Health Department	Union County Health Department	Vanderburgh County Health Department	Vermillion County Health Department	Vigo County Health Department	Wabash County Health Department
		Population Of Each Local Unit	**266,431**	**23,604**	**43,717**	**20,310**	**22,903**	**33,722**	**21,862**	**9,508**	**152,042**	**16,605**	**7,226**	**173,157**	**16,500**	**103,195**	**34,169**
			72	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**
		N/A-NOT Local PH Responsibility	X	X	X	X	X	X		X	X	X	X	X	X	X	X

Local Health Department Self-Assessment Totals Worksheet

		INDIANA H	10	8	6	3	4	3
	Question	**Local Health Department Name**	Warrick County Health Department	Washington County Health Department	Wayne County Health Department	Wells County Health Department	White County Health Department	Whitley County Health Department
		Population Of Each Local Unit	**55,465**	**27,882**	**69,778**	**27,963**	**24,846**	**31,955**
			72	**72**	**72**	**72**	**72**	**72**
		N/A-NOT Local PH Responsibility	X	X	X	X	X	

Local Health Department Self-Assessment Totals Worksheet

				INDIANA HOMELAND SECURITY DISTRICT	3	3	8	4	6	5	8	4	4	9	7	4	10
	Question	Local Health Department Name	Population Represented	94	Adams County Health Department	Allen County Health Department	Bartholomew County Health Department	Benton County Health Department	Blackford County Health Department	Boone County Health Department	Brown County Health Department	Carroll County Health Department	Cass County Health Department	Clark County Health Department	Clay County Health Department	Clinton County Health Department	Crawford County Health Department
		Population Of Each Local Unit	100.00%	6,237,569	33,815	342,168	72,987	9,139	13,841	50,847	15,228	20,331	40,417	100,706	27,210	34,148	11,167
			BALANCED	94	72	72	72	72	72	72	72	72	72	72	72	72	72
PUBLIC HEALTH & CLINICAL LABORATORIES	27	Completed	0	0													
		In-Progress	967,350	4													
		Not Started	225,323	7													
		N/A-NOT Local PH Responsibility	5,044,896	83	X	X	X	X	X	X	X	X	X	X	X	X	X
	28	Completed	1,116,702	4													
		In-Progress	693,934	14							IP						
		Not Started	338,652	9			NS	NS	NS								
		N/A-NOT Local PH Responsibility	4,088,281	67	X	X				X		X	X	X	X	X	X
HEALTHCARE & PUBLIC HEALTH PARTNERS	29	Completed	575,798	7									C				
		In-Progress	3,034,617	54		IP			IP		IP	IP			IP	IP	
		Not Started	887,601	18			NS	NS		NS				NS			NS
		N/A-NOT Local PH Responsibility	1,739,553	15	X												
	30	Completed	264,033	6									C				
		In-Progress	4,770,005	65		IP		IP	IP		IP	IP			IP	IP	
		Not Started	1,130,368	21	NS		NS			NS				NS			NS
		N/A-NOT Local PH Responsibility	73,163	2													
	31	Completed	461,169	9								C					
		In-Progress	3,375,472	52		IP			IP		IP		IP				
		Not Started	2,244,351	30	NS		NS			NS					NS	NS	NS
		N/A-NOT Local PH Responsibility	156,577	3				X						X			
	32	Completed	89,000	2									C				
		In-Progress	1,386,713	23		IP						IP			IP		
		Not Started	911,284	20				NS	NS							NS	
		N/A-NOT Local PH Responsibility	3,850,572	49	X		X			X	X			X			X
	33	Completed	48,583	1													
		In-Progress	1,217,591	22		IP			IP				IP				
		Not Started	1,274,519	27				NS		NS		NS			NS	NS	
		N/A-NOT Local PH Responsibility	3,696,876	44	X		X				X			X			X
	34	Completed	26,431	1													
		In-Progress	1,032,090	15		IP							IP				
		Not Started	1,391,756	33				NS	NS	NS	NS	NS			NS	NS	
		N/A-NOT Local PH Responsibility	3,787,292	45	X		X							X			X
	35	Completed	175,225	5									C		C		
		In-Progress	2,215,268	37		IP				IP		IP		IP		IP	
		Not Started	844,781	19			NS	NS	NS								
		N/A-NOT Local PH Responsibility	3,002,295	33	X						X						X
	36	Completed	14,421	1													
		In-Progress	1,418,283	20		IP				IP					IP		
		Not Started	1,054,937	17			NS		NS			NS		NS			
		N/A-NOT Local PH Responsibility	3,749,928	56	X			X			X		X			X	X
	37	Completed	62,570	2													
		In-Progress	957,098	19						IP				IP	IP		
		Not Started	1,888,436	26		NS						NS					
		N/A-NOT Local PH Responsibility	3,329,465	47	X		X	X	X		X		X			X	X
	38	Completed	0	0													
		In-Progress	177,351	5													
		Not Started	2,206,708	34		NS				NS		NS		NS	NS		
		N/A-NOT Local PH Responsibility	3,853,510	55	X		X	X	X		X		X			X	X
	39	Completed	1,079,407	15		C			C	C							
		In-Progress	3,732,218	62			IP				IP	IP	IP	IP	IP	IP	IP
		Not Started	1,298,434	14				NS									
		N/A-NOT Local PH Responsibility	127,510	3	X												
	40	Completed	477,282	13							C		C		C		
		In-Progress	3,140,481	37		IP			IP			IP				IP	
		Not Started	1,590,191	31	NS		NS	NS		NS							
		N/A-NOT Local PH Responsibility	1,029,615	13										X			X
	41	Completed	173,157	1													
		In-Progress	2,674,822	42		IP			IP		IP	IP	IP				
		Not Started	2,376,834	47	NS		NS	NS		NS				NS	NS	NS	NS

Local Health Department Self-Assessment Totals Worksheet

	Question	Local Health Department Name	Daviess County Health Department	Dearborn County Health Department	Decatur County Health Department	Dekalb County Health Department	Delaware County Health Department	Dubois County Health Department	East Chicago City Health Department	Elkhart County Health Department	Fayette County Health Department	Floyd County Health Department	Fountain-Warren County Combined Health Department	Franklin County Health Department	Fulton County Health Department	Gary City Health Department	Gibson County Health Department
		INDIANA H	10	9	9	3	6	10	1	2	6	9	4	9	1	1	10
		Population Of Each Local Unit	30,245	48,583	24,970	41,524	117,774	40,771	31,366	191,768	24,934	71,543	26,431	22,852	20,581	99,961	33,286
			72	72	72	72	72	72	72	72	72	72	72	72	72	72	72
PUBLIC HEALTH & CLINICAL LABORATORIES	27	Completed															
		In-Progress				IP											
		Not Started										NS					
		N/A-NOT Local PH Responsibility	X	X	X		X	X	X	X	X		X	X	X	X	X
	28	Completed		C					C								
		In-Progress				IP							IP				
		Not Started										NS					
		N/A-NOT Local PH Responsibility	X		X		X	X		X	X			X	X	X	X
HEALTHCARE & PUBLIC HEALTH PARTNERS	29	Completed		C					C	C							
		In-Progress	IP		IP	IP	IP	IP			IP			IP	IP		IP
		Not Started										NS				NS	
		N/A-NOT Local PH Responsibility											X				
	30	Completed		C					C								
		In-Progress	IP		IP	IP		IP		IP	IP			IP	IP		IP
		Not Started					NS					NS				NS	
		N/A-NOT Local PH Responsibility											X				
	31	Completed		C					C								
		In-Progress	IP		IP	IP	IP			IP		IP	IP		IP		IP
		Not Started						NS			NS			NS		NS	
		N/A-NOT Local PH Responsibility															
	32	Completed		C													
		In-Progress	IP			IP	IP					IP	IP				
		Not Started									NS			NS		NS	
		N/A-NOT Local PH Responsibility			X			X	X	X					X		X
	33	Completed		C													
		In-Progress				IP						IP	IP	IP			
		Not Started	NS								NS					NS	
		N/A-NOT Local PH Responsibility			X		X	X	X	X					X		X
	34	Completed											C				
		In-Progress		IP		IP						IP		IP			
		Not Started	NS		NS						NS					NS	
		N/A-NOT Local PH Responsibility					X	X	X	X					X		X
	35	Completed		C													
		In-Progress	IP			IP	IP		IP		IP		IP				
		Not Started										NS		NS		NS	
		N/A-NOT Local PH Responsibility			X			X		X					X		X
	36	Completed															
		In-Progress				IP			IP				IP				
		Not Started										NS		NS		NS	
		N/A-NOT Local PH Responsibility	X	X	X		X	X		X	X				X		X
	37	Completed															
		In-Progress	IP			IP					IP		IP				
		Not Started		NS			NS	NS				NS		NS		NS	
		N/A-NOT Local PH Responsibility			X				X	X					X		X
	38	Completed															
		In-Progress															
		Not Started	NS	NS		NS	NS	NS				NS	NS	NS		NS	
		N/A-NOT Local PH Responsibility			X				X	X	X				X		X
	39	Completed		C											C		
		In-Progress	IP		IP	IP	IP	IP		IP		IP	IP				IP
		Not Started							NS		NS			NS		NS	
		N/A-NOT Local PH Responsibility															
	40	Completed		C					C				C				
		In-Progress	IP		IP	IP	IP			IP					IP		IP
		Not Started						NS			NS	NS		NS		NS	
		N/A-NOT Local PH Responsibility															
	41	Completed															
		In-Progress	IP	IP						IP	IP		IP		IP		IP
		Not Started			NS	NS	NS	NS	NS			NS		NS		NS	

Local Health Department Self-Assessment Totals Worksheet

	Question	Local Health Department Name	Grant County Health Department	Greene County Health Department	Hamilton County Health Department	Hammond City Health Department	Hancock County Health Department	Harrison County Health Department	Hendricks County Health Department	Henry County Health Department	Howard County Health Department	Huntington County Health Department	Jackson County Health Department	Jasper County Health Department	Jay County Health Department	Jefferson County Health Department	Jennings County Health Department
		INDIANA H	6	7	5	1	5	9	5	6	6	3	8	1	6	9	9
		Population Of Each Local Unit	71,543	33,500	231,760	80,547	60,915	36,376	123,476	47,809	84,615	38,124	41,959	31,624	21,654	32,110	28,401
			72	72	72	72	72	72	72	72	72	72	72	72	72	72	72
PUBLIC HEALTH & CLINICAL LABORATORIES	27	Completed															
		In-Progress								IP							
		Not Started	NS														
		N/A-NOT Local PH Responsibility		X	X	X	X	X	X		X	X	X	X	X	X	X
	28	Completed															
		In-Progress	IP		IP					IP							
		Not Started															
		N/A-NOT Local PH Responsibility		X		X	X	X	X		X	X	X	X	X	X	X
HEALTHCARE & PUBLIC HEALTH PARTNERS	29	Completed															
		In-Progress	IP			IP	IP	IP	IP	IP	IP			IP	IP		
		Not Started		NS									NS				
		N/A-NOT Local PH Responsibility			X							X				X	X
	30	Completed						C						C			
		In-Progress	IP		IP	IP	IP			IP	IP	IP			IP		IP
		Not Started		NS					NS				NS			NS	
		N/A-NOT Local PH Responsibility															
	31	Completed						C									C
		In-Progress	IP			IP				IP				IP	IP		
		Not Started		NS	NS		NS		NS		NS	NS	NS			NS	
		N/A-NOT Local PH Responsibility															
	32	Completed															
		In-Progress	IP					IP		IP	IP			IP	IP		
		Not Started		NS	NS								NS			NS	
		N/A-NOT Local PH Responsibility				X	X		X			X					X
	33	Completed															
		In-Progress	IP					IP		IP	IP	IP			IP		
		Not Started		NS	NS		NS							NS		NS	
		N/A-NOT Local PH Responsibility				X			X				X				X
	34	Completed															
		In-Progress	IP					IP		IP	IP						
		Not Started		NS	NS		NS							NS	NS	NS	
		N/A-NOT Local PH Responsibility				X			X			X	X				X
	35	Completed															
		In-Progress	IP		IP		IP	IP	IP	IP	IP			IP	IP		
		Not Started		NS									NS			NS	
		N/A-NOT Local PH Responsibility				X						X					X
	36	Completed															
		In-Progress	IP				IP			IP				IP	IP		
		Not Started		NS	NS			NS								NS	
		N/A-NOT Local PH Responsibility				X			X		X	X	X				X
	37	Completed															C
		In-Progress					IP	IP						IP			
		Not Started		NS	NS				NS	NS	NS				NS	NS	
		N/A-NOT Local PH Responsibility	X			X						X	X				
	38	Completed															
		In-Progress															
		Not Started		NS	NS		NS	NS	NS	NS				NS	NS	NS	NS
		N/A-NOT Local PH Responsibility	X			X					X	X	X				
	39	Completed															C
		In-Progress	IP	IP	IP	IP	IP	IP	IP	IP	IP	IP			IP	IP	
		Not Started											NS	NS			
		N/A-NOT Local PH Responsibility															
	40	Completed												C			C
		In-Progress	IP			IP	IP		IP	IP	IP	IP			IP		
		Not Started		NS				NS					NS			NS	
		N/A-NOT Local PH Responsibility			X												
	41	Completed															
		In-Progress	IP		IP	IP				IP	IP	IP		IP	IP		
		Not Started		NS			NS	NS	NS				NS			NS	NS

Local Health Department Self-Assessment Totals Worksheet

		INDIANA H	5	10	2	3	1	1	8	6	5	2	10	3	8	4	5
	Question	Local Health Department Name	Johnson County Health Department	Knox County Health Department	Kosciusko County Health Department	LaGrange County Health Department	Lake County Health Department	LaPorte County Health Department	Lawrence County Health Department	Madison County Health Department	Marion County Health Department	Marshall County Health Department	Martin County Health Department	Miami County Health Department	Monroe County Health Department	Montgomery County Health Department	Morgan County Health Department
		Population Of Each Local Unit	125,864	38,442	75,667	36,515	278,970	109,755	46,398	130,602	863,596	46,732	10,467	35,955	121,013	37,937	69,424
			72	72	72	72	72	72	72	72	72	72	72	72	72	72	72
PUBLIC HEALTH & CLINICAL LABORATORIES	27	Completed															
		In-Progress									IP						
		Not Started															
		N/A-NOT Local PH Responsibility	X	X	X	X	X	X	X	X		X	X	X	X	X	X
	28	Completed									C						
		In-Progress	IP														
		Not Started															
		N/A-NOT Local PH Responsibility		X	X	X	X	X	X	X		X	X	X	X	X	X
HEALTHCARE & PUBLIC HEALTH PARTNERS	29	Completed			C									C			
		In-Progress	IP	IP			IP	IP		IP						IP	IP
		Not Started											NS				
		N/A-NOT Local PH Responsibility				X			X		X	X			X		
	30	Completed			C												
		In-Progress	IP	IP		IP	IP	IP		IP	IP		IP	IP	IP	IP	IP
		Not Started							NS								
		N/A-NOT Local PH Responsibility										X					
	31	Completed			C												
		In-Progress	IP	IP		IP	IP	IP		IP			IP	IP	IP	IP	IP
		Not Started							NS		NS						
		N/A-NOT Local PH Responsibility										X					
	32	Completed															
		In-Progress								IP						IP	
		Not Started	NS														
		N/A-NOT Local PH Responsibility		X	X	X	X	X	X		X	X	X	X	X		X
	33	Completed															
		In-Progress				IP				IP							
		Not Started	NS											NS			
		N/A-NOT Local PH Responsibility		X	X		X	X	X		X	X	X		X	X	X
	34	Completed															
		In-Progress								IP							
		Not Started	NS											NS	NS		
		N/A-NOT Local PH Responsibility		X	X	X	X	X	X		X	X	X			X	X
	35	Completed															
		In-Progress	IP	IP						IP				IP		IP	
		Not Started							NS						NS		
		N/A-NOT Local PH Responsibility			X	X	X	X			X	X	X				X
	36	Completed															
		In-Progress	IP							IP				IP			
		Not Started													NS		
		N/A-NOT Local PH Responsibility		X	X	X	X	X	X		X	X	X			X	X
	37	Completed															
		In-Progress					IP										IP
		Not Started								NS					NS		
		N/A-NOT Local PH Responsibility	X	X	X	X		X	X		X	X	X	X		X	
	38	Completed															
		In-Progress															IP
		Not Started								NS					NS		
		N/A-NOT Local PH Responsibility	X	X	X	X	X	X	X		X	X	X	X		X	
	39	Completed			C							C					
		In-Progress	IP			IP	IP	IP		IP			IP	IP	IP	IP	IP
		Not Started		NS							NS						
		N/A-NOT Local PH Responsibility							X								
	40	Completed						C						C			
		In-Progress			IP	IP	IP				IP	IP	IP			IP	
		Not Started	NS	NS						NS					NS		
		N/A-NOT Local PH Responsibility							X								X
	41	Completed															
		In-Progress	IP		IP	IP				IP		IP			IP	IP	IP
		Not Started		NS			NS	NS					NS	NS			

Local Health Department Self-Assessment Totals Worksheet

		INDIANA H	1	3	9	8	7	7	10	10	1	10	2	7	6	9	6
	Question	Local Health Department Name	Newton County Health Department	Noble County Health Department	Ohio County Health Department	Orange County Health Department	Owen County Health Department	Parke County Health Department	Perry County Health Department	Pike County Health Department	Porter County Health Department	Posey County Health Department	Pulaski County Health Department	Putnam County Health Department	Randolph County Health Department	Ripley County Health Department	Rush County Health Department
		Population Of Each Local Unit	14,421	47,297	5,849	19,718	23,074	17,254	18,999	12,938	154,961	26,990	13,825	36,786	26,697	27,549	18,028
			72	72	72	72	72	72	72	72	72	72	72	72	72	72	72
PUBLIC HEALTH & CLINICAL LABORATORIES	27	Completed															
		In-Progress	IP														
		Not Started			NS							NS					NS
		N/A-NOT Local PH Responsibility		X		X	X	X	X	X	X		X	X	X	X	
	28	Completed															
		In-Progress					IP	IP								IP	IP
		Not Started			NS							NS					
		N/A-NOT Local PH Responsibility	X	X		X			X	X	X		X	X	X		
HEALTHCARE & PUBLIC HEALTH PARTNERS	29	Completed															
		In-Progress	IP	IP		IP	IP	IP	IP	IP	IP		IP	IP	IP	IP	IP
		Not Started			NS							NS					
		N/A-NOT Local PH Responsibility															
	30	Completed															
		In-Progress	IP	IP	IP	IP	IP	IP	IP	IP	IP		IP	IP	IP	IP	
		Not Started										NS					NS
		N/A-NOT Local PH Responsibility															
	31	Completed								C							
		In-Progress	IP	IP		IP	IP	IP			IP		IP	IP	IP	IP	IP
		Not Started			NS				NS			NS					
		N/A-NOT Local PH Responsibility															
	32	Completed															
		In-Progress				IP		IP						IP	IP		
		Not Started	NS				NS					NS					NS
		N/A-NOT Local PH Responsibility		X	X				X	X	X		X			X	
	33	Completed															
		In-Progress		IP	IP			IP						IP			
		Not Started	NS									NS			NS		NS
		N/A-NOT Local PH Responsibility				X	X		X	X	X		X			X	
	34	Completed															
		In-Progress			IP			IP						IP			
		Not Started	NS									NS			NS		NS
		N/A-NOT Local PH Responsibility		X		X	X		X	X	X		X			X	
	35	Completed															
		In-Progress	IP	IP		IP	IP	IP						IP	IP		
		Not Started			NS							NS					NS
		N/A-NOT Local PH Responsibility							X	X	X		X			X	
	36	Completed	C														
		In-Progress				IP	IP	IP						IP			
		Not Started										NS					NS
		N/A-NOT Local PH Responsibility		X	X				X	X	X		X		X	X	
	37	Completed															
		In-Progress			IP	IP		IP	IP					IP			
		Not Started								NS		NS			NS		NS
		N/A-NOT Local PH Responsibility	X	X			X				X		X			X	
	38	Completed															
		In-Progress				IP		IP						IP			
		Not Started			NS				NS			NS					NS
		N/A-NOT Local PH Responsibility	X	X			X			X	X		X		X	X	
	39	Completed	C			C				C							
		In-Progress			IP		IP	IP			IP	IP	IP	IP	IP	IP	
		Not Started							NS								NS
		N/A-NOT Local PH Responsibility		X													
	40	Completed	C														
		In-Progress			IP		IP	IP			IP		IP	IP	IP	IP	
		Not Started							NS	NS		NS					NS
		N/A-NOT Local PH Responsibility		X		X											
	41	Completed															
		In-Progress	IP		IP		IP	IP		IP				IP	IP	IP	
		Not Started				NS			NS		NS	NS	NS				NS

Local Health Department Self-Assessment Totals Worksheet

		INDIANA H	2	9	5	10	2	3	7	9	4	6	6	10	7	7	3
	Question	Local Health Department Name	St. Joseph County Health Department	Scott County Health Department	Shelby County Health Department	Spencer County Health Department	Starke County Health Department	Steuben County Health Department	Sullivan County Health Department	Switzerland County Health Department	Tippecanoe County Health Department	Tipton County Health Department	Union County Health Department	Vanderburgh County Health Department	Vermillion County Health Department	Vigo County Health Department	Wabash County Health Department
		Population Of Each Local Unit	266,431	23,604	43,717	20,310	22,903	33,722	21,862	9,508	152,042	16,605	7,226	173,157	16,500	103,195	34,169
			72	72	72	72	72	72	72	72	72	72	72	72	72	72	72
PUBLIC HEALTH & CLINICAL LABORATORIES	27	Completed															
		In-Progress															
		Not Started							NS	NS							
		N/A-NOT Local PH Responsibility	X	X	X	X	X	X			X	X	X	X	X	X	X
	28	Completed												C			
		In-Progress							IP	IP					IP		
		Not Started											NS			NS	
		N/A-NOT Local PH Responsibility	X	X	X	X	X	X			X	X					X
HEALTHCARE & PUBLIC HEALTH PARTNERS	29	Completed									C						
		In-Progress	IP	IP			IP		IP	IP		IP	IP		IP		IP
		Not Started			NS	NS								NS			
		N/A-NOT Local PH Responsibility						X								X	
	30	Completed															
		In-Progress	IP	IP			IP	IP	IP	IP	IP	IP	IP	IP	IP	IP	IP
		Not Started			NS	NS											
		N/A-NOT Local PH Responsibility															
	31	Completed									C						
		In-Progress	IP	IP			IP	IP	IP	IP		IP		IP		IP	IP
		Not Started			NS	NS							NS		NS		
		N/A-NOT Local PH Responsibility															
	32	Completed															
		In-Progress								IP						IP	IP
		Not Started							NS				NS				
		N/A-NOT Local PH Responsibility	X	X	X	X	X	X			X	X		X	X		
	33	Completed															
		In-Progress						IP							IP		IP
		Not Started			NS				NS			NS				NS	
		N/A-NOT Local PH Responsibility	X	X		X	X			X	X		X	X			
	34	Completed															
		In-Progress															IP
		Not Started			NS				NS			NS	NS		NS		
		N/A-NOT Local PH Responsibility	X	X		X	X	X		X	X			X		X	
	35	Completed															C
		In-Progress								IP			IP		IP		
		Not Started			NS				NS							NS	
		N/A-NOT Local PH Responsibility	X	X		X	X	X			X	X		X			
	36	Completed															
		In-Progress	IP							IP							
		Not Started							NS							NS	
		N/A-NOT Local PH Responsibility		X	X	X	X	X			X	X	X	X	X		X
	37	Completed															C
		In-Progress								IP							
		Not Started			NS				NS			NS				NS	
		N/A-NOT Local PH Responsibility	X	X		X	X	X			X		X	X	X		
	38	Completed															
		In-Progress															IP
		Not Started			NS				NS							NS	
		N/A-NOT Local PH Responsibility	X	X		X	X	X		X	X	X	X	X	X		
	39	Completed									C			C			
		In-Progress	IP	IP		IP	IP	IP		IP		IP	IP		IP	IP	IP
		Not Started			NS				NS								
		N/A-NOT Local PH Responsibility															
	40	Completed						C									C
		In-Progress				IP				IP							
		Not Started			NS		NS		NS				NS	NS		NS	
		N/A-NOT Local PH Responsibility	X	X							X	X			X		
	41	Completed												C			
		In-Progress	IP	IP		IP				IP						IP	
		Not Started			NS		NS	NS	NS		NS	NS	NS		NS		NS

Local Health Department Self-Assessment Totals Worksheet

		INDIANA H	10	8	6	3	4	3
	Question	Local Health Department Name	Warrick County Health Department	Washington County Health Department	Wayne County Health Department	Wells County Health Department	White County Health Department	Whitley County Health Department
		Population Of Each Local Unit	55,465	27,882	69,778	27,963	24,846	31,955
			72	72	72	72	72	72
PUBLIC HEALTH & CLINICAL LABORATORIES	27	Completed						
		In-Progress						
		Not Started						
		N/A-NOT Local PH Responsibility	X	X	X	X	X	X
	28	Completed						
		In-Progress						
		Not Started		NS				
		N/A-NOT Local PH Responsibility	X		X	X	X	X
HEALTHCARE & PUBLIC HEALTH PARTNERS	29	Completed						
		In-Progress					IP	
		Not Started	NS	NS				NS
		N/A-NOT Local PH Responsibility			X	X		
	30	Completed						
		In-Progress				IP	IP	
		Not Started	NS	NS	NS			NS
		N/A-NOT Local PH Responsibility						
	31	Completed	C					
		In-Progress				IP	IP	
		Not Started		NS	NS			NS
		N/A-NOT Local PH Responsibility						
	32	Completed						
		In-Progress						
		Not Started		NS	NS			NS
		N/A-NOT Local PH Responsibility	X			X	X	
	33	Completed						
		In-Progress						
		Not Started		NS	NS		NS	NS
		N/A-NOT Local PH Responsibility	X			X		
	34	Completed						
		In-Progress						
		Not Started		NS	NS		NS	NS
		N/A-NOT Local PH Responsibility	X			X		
	35	Completed					C	
		In-Progress			IP	IP		
		Not Started		NS				NS
		N/A-NOT Local PH Responsibility	X					
	36	Completed						
		In-Progress						
		Not Started		NS				
		N/A-NOT Local PH Responsibility	X		X	X	X	X
	37	Completed						
		In-Progress			IP			
		Not Started		NS				
		N/A-NOT Local PH Responsibility	X			X	X	X
	38	Completed						
		In-Progress						
		Not Started		NS				
		N/A-NOT Local PH Responsibility	X		X	X	X	X
	39	Completed	C				C	
		In-Progress		IP	IP	IP		
		Not Started						NS
		N/A-NOT Local PH Responsibility						
	40	Completed						
		In-Progress	IP					
		Not Started		NS	NS		NS	NS
		N/A-NOT Local PH Responsibility				X		
	41	Completed						
		In-Progress				IP		
		Not Started		NS	NS		NS	NS

Local Health Department Self-Assessment Totals Worksheet

				INDIANA HOMELAND SECURITY DISTRICT	3	3	8	4	6	5	8	4	4	9	7	4	10
	Question	Local Health Department Name	Population Represented	94	Adams County Health Department	Allen County Health Department	Bartholomew County Health Department	Benton County Health Department	Blackford County Health Department	Boone County Health Department	Brown County Health Department	Carroll County Health Department	Cass County Health Department	Clark County Health Department	Clay County Health Department	Clinton County Health Department	Crawford County Health Department
		Population Of Each Local Unit	100.00%	6,237,569	33,815	342,168	72,987	9,139	13,841	50,847	15,228	20,331	40,417	100,706	27,210	34,148	11,167
			BALANCED	94	72	72	72	72	72	72	72	72	72	72	72	72	72
		N/A-NOT Local PH Responsibility	1,012,756	4													

Local Health Department Self-Assessment Totals Worksheet

		INDIANA H	**10**	**9**	**9**	**3**	**6**	**10**	**1**	**2**	**6**	**9**	**4**	**9**	**1**	**1**	**10**
	Question	**Local Health Department Name**	Daviess County Health Department	Dearborn County Health Department	Decatur County Health Department	Dekalb County Health Department	Delaware County Health Department	Dubois County Health Department	East Chicago City Health Department	Elkhart County Health Department	Fayette County Health Department	Floyd County Health Department	Fountain-Warren County Combined Health Department	Franklin County Health Department	Fulton County Health Department	Gary City Health Department	Gibson County Health Department
		Population Of Each Local Unit	**30,245**	**48,583**	**24,970**	**41,524**	**117,774**	**40,771**	**31,366**	**191,768**	**24,934**	**71,543**	**26,431**	**22,852**	**20,581**	**99,961**	**33,286**
			72	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**
		N/A-NOT Local PH Responsibility															

Local Health Department Self-Assessment Totals Worksheet

		INDIANA H	**6**	**7**	**5**	**1**	**5**	**9**	**5**	**6**	**6**	**3**	**8**	**1**	**6**	**9**	**9**
	Question	**Local Health Department Name**	Grant County Health Department	Greene County Health Department	Hamilton County Health Department	Hammond City Health Department	Hancock County Health Department	Harrison County Health Department	Hendricks County Health Department	Henry County Health Department	Howard County Health Department	Huntington County Health Department	Jackson County Health Department	Jasper County Health Department	Jay County Health Department	Jefferson County Health Department	Jennings County Health Department
		Population Of Each Local Unit	**71,543**	**33,500**	**231,760**	**80,547**	**60,915**	**36,376**	**123,476**	**47,809**	**84,615**	**38,124**	**41,959**	**31,624**	**21,654**	**32,110**	**28,401**
			72	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**
		N/A-NOT Local PH Responsibility															

Local Health Department Self-Assessment Totals Worksheet

		INDIANA H	**5**	**10**	**2**	**3**	**1**	**1**	**8**	**6**	**5**	**2**	**10**	**3**	**8**	**4**	**5**
	Question	**Local Health Department Name**	Johnson County Health Department	Knox County Health Department	Kosciusko County Health Department	LaGrange County Health Department	Lake County Health Department	LaPorte County Health Department	Lawrence County Health Department	Madison County Health Department	Marion County Health Department	Marshall County Health Department	Martin County Health Department	Miami County Health Department	Monroe County Health Department	Montgomery County Health Department	Morgan County Health Department
		Population Of Each Local Unit	**125,864**	**38,442**	**75,667**	**36,515**	**278,970**	**109,755**	**46,398**	**130,602**	**863,596**	**46,732**	**10,467**	**35,955**	**121,013**	**37,937**	**69,424**
			72	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**
		N/A-NOT Local PH Responsibility							X		X						

Local Health Department Self-Assessment Totals Worksheet

		INDIANA H	1	3	9	8	7	7	10	10	1	10	2	7	6	9	6
	Question	**Local Health Department Name**	Newton County Health Department	Noble County Health Department	Ohio County Health Department	Orange County Health Department	Owen County Health Department	Parke County Health Department	Perry County Health Department	Pike County Health Department	Porter County Health Department	Posey County Health Department	Pulaski County Health Department	Putnam County Health Department	Randolph County Health Department	Ripley County Health Department	Rush County Health Department
		Population Of Each Local Unit	**14,421**	**47,297**	**5,849**	**19,718**	**23,074**	**17,254**	**18,999**	**12,938**	**154,961**	**26,990**	**13,825**	**36,786**	**26,697**	**27,549**	**18,028**
			72	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**
		N/A-NOT Local PH Responsibility		X													

Local Health Department Self-Assessment Totals Worksheet

		INDIANA H	**2**	**9**	**5**	**10**	**2**	**3**	**7**	**9**	**4**	**6**	**6**	**10**	**7**	**7**	**3**
	Question	**Local Health Department Name**	St. Joseph County Health Department	Scott County Health Department	Shelby County Health Department	Spencer County Health Department	Starke County Health Department	Steuben County Health Department	Sullivan County Health Department	Switzerland County Health Department	Tippecanoe County Health Department	Tipton County Health Department	Union County Health Department	Vanderburgh County Health Department	Vermillion County Health Department	Vigo County Health Department	Wabash County Health Department
		Population Of Each Local Unit	**266,431**	**23,604**	**43,717**	**20,310**	**22,903**	**33,722**	**21,862**	**9,508**	**152,042**	**16,605**	**7,226**	**173,157**	**16,500**	**103,195**	**34,169**
			72	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**
		N/A-NOT Local PH Responsibility															

Local Health Department Self-Assessment Totals Worksheet

		INDIANA H	10	8	6	3	4	3
	Question	**Local Health Department Name**	Warrick County Health Department	Washington County Health Department	Wayne County Health Department	Wells County Health Department	White County Health Department	Whitley County Health Department
		Population Of Each Local Unit	**55,465**	**27,882**	**69,778**	**27,963**	**24,846**	**31,955**
			72	**72**	**72**	**72**	**72**	**72**
		N/A-NOT Local PH Responsibility	X					

Local Health Department Self-Assessment Totals Worksheet

				INDIANA HOMELAND SECURITY DISTRICT	3	3	8	4	6	5	8	4	4	9	7	4	10
	Question	Local Health Department Name	Population Represented	94	Adams County Health Department	Allen County Health Department	Bartholomew County Health Department	Benton County Health Department	Blackford County Health Department	Boone County Health Department	Brown County Health Department	Carroll County Health Department	Cass County Health Department	Clark County Health Department	Clay County Health Department	Clinton County Health Department	Crawford County Health Department
		Population Of Each Local Unit	100.00%	6,237,569	33,815	342,168	72,987	9,139	13,841	50,847	15,228	20,331	40,417	100,706	27,210	34,148	11,167
			BALANCED	94	72	72	72	72	72	72	72	72	72	72	72	72	72
HEALTHCARE & PUBLIC HEALTH PARTNERS	42	Completed	0	0													
		In-Progress	1,947,300	21		IP						IP					
		Not Started	1,128,637	24	NS				NS	NS	NS				NS		
		N/A-NOT Local PH Responsibility	3,161,632	49			X	X					X	X		X	X
	43	Completed	75,014	2													
		In-Progress	1,701,415	11		IP											
		Not Started	1,217,655	27	NS				NS	NS	NS	NS			NS		
		N/A-NOT Local PH Responsibility	3,243,485	54			X	X					X	X		X	X
INFECTION CONTROL & CLINICAL GUIDELINES	44	Completed	833,954	12		C			C	C		C	C				
		In-Progress	4,449,681	57			IP				IP			IP	IP	IP	
		Not Started	948,085	24	NS			NS									NS
		N/A-NOT Local PH Responsibility	5,849	1													
	45	Completed	998,364	14		C				C	C	C	C				
		In-Progress	3,660,376	46			IP		IP					IP	IP	IP	
		Not Started	1,578,829	34	NS			NS									NS
		N/A-NOT Local PH Responsibility	0	0													
	46	Completed	401,644	5						C			C				
		In-Progress	2,543,078	28		IP								IP		IP	
		Not Started	3,292,847	61	NS		NS	NS	NS		NS	NS			NS		NS
		N/A-NOT Local PH Responsibility	0	0													
VACCINE DISTRIBUTION & USE	47	Completed	789,513	11						C							
		In-Progress	5,119,158	73		IP	IP		IP		IP	IP	IP	IP	IP	IP	IP
		Not Started	328,898	10	NS			NS									
		N/A-NOT Local PH Responsibility	0	0													
	48	Completed	577,959	10			C			C	C						
		In-Progress	2,538,615	34		IP			IP				IP	IP			IP
		Not Started	3,120,995	50	NS			NS				NS			NS	NS	
		N/A-NOT Local PH Responsibility	0	0													
	49	Completed	520,709	10										C			
		In-Progress	4,148,051	67		IP	IP		IP	IP	IP	IP	IP		IP	IP	IP
		Not Started	1,568,809	17	NS			NS									
		N/A-NOT Local PH Responsibility	0	0													
	50	Completed	20,331	1								C					
		In-Progress	5,445,046	76		IP	IP		IP	IP	IP		IP	IP	IP	IP	IP
		Not Started	772,192	17	NS			NS									
		N/A-NOT Local PH Responsibility	0	0													
ANTIVIRAL DRUG DISTRIBUTION & USE	51	Completed	527,640	9													
		In-Progress	5,302,276	75		IP	IP		IP	IP	IP	IP	IP	IP	IP	IP	
		Not Started	396,486	9	NS			NS									
		N/A-NOT Local PH Responsibility	11,167	1													X
	52	Completed	651,853	9			C										
		In-Progress	2,781,920	28		IP				IP	IP		IP				
		Not Started	2,792,629	56	NS			NS	NS			NS		NS	NS	NS	
		N/A-NOT Local PH Responsibility	11,167	1													X
COMMUNITY DISEASE CONTROL AND PREVENTION	53	Completed	146,336	5							C						
		In-Progress	3,942,240	45		IP	IP			IP		IP	IP		IP	IP	
		Not Started	1,963,958	38	NS			NS	NS					NS			NS
		N/A-NOT Local PH Responsibility	185,035	6													
	54	Completed	0	0													
		In-Progress	1,349,401	22						IP			IP				
		Not Started	4,676,436	65	NS	NS	NS	NS	NS		NS	NS		NS	NS	NS	NS
		N/A-NOT Local PH Responsibility	211,732	7													

Local Health Department Self-Assessment Totals Worksheet

	Question	INDIANA H	10	9	9	3	6	10	1	2	6	9	4	9	1	1	10
		Local Health Department Name	Daviess County Health Department	Dearborn County Health Department	Decatur County Health Department	Dekalb County Health Department	Delaware County Health Department	Dubois County Health Department	East Chicago City Health Department	Elkhart County Health Department	Fayette County Health Department	Floyd County Health Department	Fountain-Warren County Combined Health Department	Franklin County Health Department	Fulton County Health Department	Gary City Health Department	Gibson County Health Department
		Population Of Each Local Unit	30,245	48,583	24,970	41,524	117,774	40,771	31,366	191,768	24,934	71,543	26,431	22,852	20,581	99,961	33,286
			72	72	72	72	72	72	72	72	72	72	72	72	72	72	72
HEALTH CARE & PUBLIC HEALTH PARTNERS	42	Completed															
		In-Progress	IP	IP		IP							IP				
		Not Started			NS				NS			NS		NS		NS	
		N/A-NOT Local PH Responsibility					X	X		X	X				X		X
	43	Completed		C									C				
		In-Progress				IP											
		Not Started	NS		NS				NS			NS		NS		NS	
		N/A-NOT Local PH Responsibility					X	X		X	X				X		X
INFECTION CONTROL & CLINICAL GUIDELINES	44	Completed		C													
		In-Progress	IP		IP	IP	IP		IP	IP			IP		IP		
		Not Started						NS			NS	NS		NS		NS	NS
		N/A-NOT Local PH Responsibility															
	45	Completed		C	C												
		In-Progress	IP			IP	IP		IP	IP			IP		IP		
		Not Started						NS			NS	NS		NS		NS	NS
		N/A-NOT Local PH Responsibility															
	46	Completed		C													
		In-Progress							IP	IP			IP		IP		
		Not Started	NS		NS	NS	NS	NS			NS	NS		NS		NS	NS
		N/A-NOT Local PH Responsibility															
VACCINE DISTRIBUTION & USE	47	Completed		C	C			C							C		
		In-Progress	IP			IP	IP		IP	IP	IP	IP	IP				IP
		Not Started												NS		NS	
		N/A-NOT Local PH Responsibility															
	48	Completed						C							C		
		In-Progress		IP						IP	IP		IP				IP
		Not Started	NS		NS	NS	NS		NS			NS		NS		NS	
		N/A-NOT Local PH Responsibility															
	49	Completed		C				C							C		
		In-Progress	IP		IP	IP	IP		IP	IP	IP	IP	IP				IP
		Not Started												NS		NS	
		N/A-NOT Local PH Responsibility															
	50	Completed															
		In-Progress	IP	IP	IP	IP	IP	IP		IP	IP		IP		IP		IP
		Not Started							NS			NS		NS		NS	
		N/A-NOT Local PH Responsibility															
ANTIVIRAL DRUG DISTRIBUTION & USE	51	Completed		C	C			C							C		C
		In-Progress	IP			IP	IP		IP	IP	IP	IP	IP				
		Not Started												NS		NS	
		N/A-NOT Local PH Responsibility															
	52	Completed						C							C		
		In-Progress		IP							IP		IP				IP
		Not Started	NS		NS	NS	NS		NS	NS		NS		NS		NS	
		N/A-NOT Local PH Responsibility															
COMMUNITY DISEASE CONTROL AND PREVENTION	53	Completed		C									C				
		In-Progress	IP			IP	IP		IP	IP					IP		IP
		Not Started			NS			NS			NS	NS		NS		NS	
		N/A-NOT Local PH Responsibility															
	54	Completed															
		In-Progress		IP						IP			IP		IP		
		Not Started	NS		NS	NS	NS	NS	NS		NS	NS		NS		NS	NS
		N/A-NOT Local PH Responsibility															

Local Health Department Self-Assessment Totals Worksheet

	Question	INDIANA H	6	7	5	1	5	9	5	6	6	3	8	1	6	9	9
		Local Health Department Name	Grant County Health Department	Greene County Health Department	Hamilton County Health Department	Hammond City Health Department	Hancock County Health Department	Harrison County Health Department	Hendricks County Health Department	Henry County Health Department	Howard County Health Department	Huntington County Health Department	Jackson County Health Department	Jasper County Health Department	Jay County Health Department	Jefferson County Health Department	Jennings County Health Department
		Population Of Each Local Unit	71,543	33,500	231,760	80,547	60,915	36,376	123,476	47,809	84,615	38,124	41,959	31,624	21,654	32,110	28,401
			72	72	72	72	72	72	72	72	72	72	72	72	72	72	72
HEALTH CARE & PUBLIC HEALTH PARTNERS	42	Completed															
		In-Progress								IP		IP					
		Not Started		NS	NS		NS	NS						NS		NS	
		N/A-NOT Local PH Responsibility	X			X			X		X		X		X		X
	43	Completed															
		In-Progress								IP							
		Not Started		NS	NS		NS	NS						NS		NS	
		N/A-NOT Local PH Responsibility	X			X			X		X	X	X		X		X
INFECTION CONTROL & CLINICAL GUIDELINES	44	Completed															C
		In-Progress	IP		IP	IP	IP	IP	IP	IP	IP	IP		IP	IP		
		Not Started		NS									NS			NS	
		N/A-NOT Local PH Responsibility															
	45	Completed															C
		In-Progress	IP			IP	IP	IP			IP	IP			IP		
		Not Started		NS	NS				NS	NS			NS	NS		NS	
		N/A-NOT Local PH Responsibility															
	46	Completed															
		In-Progress	IP			IP	IP	IP									IP
		Not Started		NS	NS				NS	NS	NS	NS	NS	NS	NS	NS	
		N/A-NOT Local PH Responsibility															
VACCINE DISTRIBUTION & USE	47	Completed			C			C									C
		In-Progress	IP	IP		IP	IP		IP		IP	IP	IP	IP	IP	IP	
		Not Started								NS							
		N/A-NOT Local PH Responsibility															
	48	Completed															C
		In-Progress	IP		IP	IP	IP								IP		
		Not Started		NS				NS	NS	NS	NS	NS	NS	NS		NS	
		N/A-NOT Local PH Responsibility															
	49	Completed						C									C
		In-Progress	IP	IP	IP		IP		IP		IP		IP	IP	IP	IP	
		Not Started				NS				NS		NS					
		N/A-NOT Local PH Responsibility															
	50	Completed															
		In-Progress	IP	IP	IP	IP	IP	IP	IP	IP	IP	IP		IP	IP	IP	IP
		Not Started											NS				
		N/A-NOT Local PH Responsibility															
ANTIVIRAL DRUG DISTRIBUTION & USE	51	Completed															C
		In-Progress	IP	IP	IP	IP	IP	IP	IP	IP	IP	IP	IP	IP	IP	IP	
		Not Started															
		N/A-NOT Local PH Responsibility															
	52	Completed								C							C
		In-Progress	IP		IP		IP								IP		
		Not Started		NS		NS		NS	NS		NS	NS	NS	NS		NS	
		N/A-NOT Local PH Responsibility															
COMMUNITY DISEASE CONTROL AND PREVENTION	53	Completed						C									
		In-Progress	IP			IP	IP			IP	IP			IP			
		Not Started		NS	NS				NS				NS		NS	NS	
		N/A-NOT Local PH Responsibility										X					X
	54	Completed															
		In-Progress	IP				IP										
		Not Started		NS	NS	NS		NS	NS	NS	NS		NS	NS	NS	NS	
		N/A-NOT Local PH Responsibility										X					X

Local Health Department Self-Assessment Totals Worksheet

		INDIANA H	5	10	2	3	1	1	8	6	5	2	10	3	8	4	5
	Question	Local Health Department Name	Johnson County Health Department	Knox County Health Department	Kosciusko County Health Department	LaGrange County Health Department	Lake County Health Department	LaPorte County Health Department	Lawrence County Health Department	Madison County Health Department	Marion County Health Department	Marshall County Health Department	Martin County Health Department	Miami County Health Department	Monroe County Health Department	Montgomery County Health Department	Morgan County Health Department
		Population Of Each Local Unit	125,864	38,442	75,667	36,515	278,970	109,755	46,398	130,602	863,596	46,732	10,467	35,955	121,013	37,937	69,424
			72	72	72	72	72	72	72	72	72	72	72	72	72	72	72
HEALTHCARE & PUBLIC HEALTH PARTNERS	42	Completed															
		In-Progress		IP		IP				IP	IP			IP			IP
		Not Started	NS														
		N/A-NOT Local PH Responsibility			X		X	X	X			X	X		X	X	
	43	Completed															
		In-Progress								IP	IP						
		Not Started	NS	NS													
		N/A-NOT Local PH Responsibility			X	X	X	X	X			X	X	X	X	X	X
INFECTION CONTROL & CLINICAL GUIDELINES	44	Completed										C			C		C
		In-Progress	IP		IP	IP	IP	IP		IP	IP		IP	IP		IP	
		Not Started		NS					NS								
		N/A-NOT Local PH Responsibility															
	45	Completed			C	C		C									
		In-Progress	IP				IP			IP	IP	IP			IP	IP	IP
		Not Started		NS					NS				NS	NS			
		N/A-NOT Local PH Responsibility															
	46	Completed						C									
		In-Progress								IP	IP	IP				IP	
		Not Started	NS	NS	NS	NS	NS		NS				NS	NS	NS		NS
		N/A-NOT Local PH Responsibility															
VACCINE DISTRIBUTION & USE	47	Completed													C		
		In-Progress	IP	IP	IP	IP	IP	IP	IP	IP	IP	IP		IP		IP	IP
		Not Started											NS				
		N/A-NOT Local PH Responsibility															
	48	Completed		C													
		In-Progress						IP		IP						IP	
		Not Started	NS		NS	NS	NS		NS		NS	NS	NS	NS	NS		NS
		N/A-NOT Local PH Responsibility															
	49	Completed															
		In-Progress		IP	IP	IP	IP	IP	IP	IP		IP	IP	IP	IP	IP	IP
		Not Started	NS								NS						
		N/A-NOT Local PH Responsibility															
	50	Completed															
		In-Progress		IP	IP	IP	IP	IP			IP	IP		IP	IP	IP	IP
		Not Started	NS						NS	NS			NS				
		N/A-NOT Local PH Responsibility															
ANTIVIRAL DRUG DISTRIBUTION & USE	51	Completed															
		In-Progress		IP	IP	IP	IP	IP	IP	IP	IP	IP	IP	IP	IP	IP	IP
		Not Started	NS														
		N/A-NOT Local PH Responsibility															
	52	Completed								C							
		In-Progress		IP							IP	IP					
		Not Started	NS		NS	NS	NS	NS	NS				NS	NS	NS	NS	NS
		N/A-NOT Local PH Responsibility															
COMMUNITY DISEASE CONTROL AND PREVENTION	53	Completed															
		In-Progress			IP		IP	IP		IP	IP	IP		IP	IP	IP	IP
		Not Started	NS	NS					NS				NS				
		N/A-NOT Local PH Responsibility				X											
	54	Completed															
		In-Progress								IP		IP				IP	
		Not Started	NS	NS	NS		NS	NS	NS		NS		NS	NS	NS		NS
		N/A-NOT Local PH Responsibility				X											

Local Health Department Self-Assessment Totals Worksheet

	Question	INDIANA H	1	3	9	8	7	7	10	10	1	10	2	7	6	9	6
		Local Health Department Name	Newton County Health Department	Noble County Health Department	Ohio County Health Department	Orange County Health Department	Owen County Health Department	Parke County Health Department	Perry County Health Department	Pike County Health Department	Porter County Health Department	Posey County Health Department	Pulaski County Health Department	Putnam County Health Department	Randolph County Health Department	Ripley County Health Department	Rush County Health Department
		Population Of Each Local Unit	14,421	47,297	5,849	19,718	23,074	17,254	18,999	12,938	154,961	26,990	13,825	36,786	26,697	27,549	18,028
			72	72	72	72	72	72	72	72	72	72	72	72	72	72	72
HEALTHCARE & PUBLIC HEALTH PARTNERS	42	Completed															
		In-Progress			IP		IP	IP						IP	IP		
		Not Started	NS									NS					NS
		N/A-NOT Local PH Responsibility		X		X			X	X	X		X			X	
	43	Completed															
		In-Progress			IP			IP			IP			IP	IP		
		Not Started	NS									NS					NS
		N/A-NOT Local PH Responsibility		X		X	X		X	X			X			X	
INFECTION CONTROL & CLINICAL GUIDELINES	44	Completed															C
		In-Progress	IP	IP			IP	IP	IP	IP	IP		IP	IP	IP	IP	
		Not Started				NS						NS					
		N/A-NOT Local PH Responsibility			X												
	45	Completed				C											
		In-Progress	IP	IP	IP		IP	IP		IP	IP		IP	IP	IP	IP	
		Not Started							NS			NS					NS
		N/A-NOT Local PH Responsibility															
	46	Completed															
		In-Progress		IP			IP	IP			IP			IP	IP	IP	
		Not Started	NS		NS	NS			NS	NS		NS	NS				NS
		N/A-NOT Local PH Responsibility															
VACCINE DISTRIBUTION & USE	47	Completed															
		In-Progress	IP	IP	IP	IP	IP	IP	IP	IP	IP		IP	IP	IP	IP	
		Not Started										NS					NS
		N/A-NOT Local PH Responsibility															
	48	Completed															
		In-Progress		IP			IP	IP			IP		IP	IP		IP	
		Not Started	NS		NS	NS			NS	NS		NS			NS		NS
		N/A-NOT Local PH Responsibility															
	49	Completed								C							
		In-Progress	IP	IP		IP	IP	IP	IP		IP		IP	IP	IP	IP	
		Not Started			NS							NS					NS
		N/A-NOT Local PH Responsibility															
	50	Completed															
		In-Progress	IP	IP	IP	IP	IP	IP	IP	IP	IP		IP	IP	IP	IP	
		Not Started										NS					NS
		N/A-NOT Local PH Responsibility															
ANTIVIRAL DRUG DISTRIBUTION & USE	51	Completed			C												
		In-Progress	IP	IP		IP	IP	IP	IP	IP	IP		IP	IP	IP	IP	
		Not Started										NS					NS
		N/A-NOT Local PH Responsibility															
	52	Completed															
		In-Progress						IP			IP		IP	IP		IP	
		Not Started	NS	NS	NS	NS	NS		NS	NS		NS			NS		NS
		N/A-NOT Local PH Responsibility															
COMMUNITY DISEASE CONTROL AND PREVENTION	53	Completed				C											
		In-Progress	IP	IP				IP	IP		IP			IP	IP	IP	
		Not Started			NS		NS			NS		NS	NS				NS
		N/A-NOT Local PH Responsibility															
	54	Completed															
		In-Progress	IP					IP			IP			IP		IP	
		Not Started		NS	NS	NS	NS		NS	NS		NS	NS				NS
		N/A-NOT Local PH Responsibility													X		

Local Health Department Self-Assessment Totals Worksheet

	Question	INDIANA H	2	9	5	10	2	3	7	9	4	6	6	10	7	7	3
		Local Health Department Name	St. Joseph County Health Department	Scott County Health Department	Shelby County Health Department	Spencer County Health Department	Starke County Health Department	Steuben County Health Department	Sullivan County Health Department	Switzerland County Health Department	Tippecanoe County Health Department	Tipton County Health Department	Union County Health Department	Vanderburgh County Health Department	Vermillion County Health Department	Vigo County Health Department	Wabash County Health Department
		Population Of Each Local Unit	266,431	23,604	43,717	20,310	22,903	33,722	21,862	9,508	152,042	16,605	7,226	173,157	16,500	103,195	34,169
			72	72	72	72	72	72	72	72	72	72	72	72	72	72	72
HEALTHCARE & PUBLIC HEALTH PARTNERS	42	Completed															
		In-Progress						IP									IP
		Not Started			NS				NS								
		N/A-NOT Local PH Responsibility	X	X		X	X			X	X	X	X	X	X	X	
	43	Completed															
		In-Progress															IP
		Not Started			NS				NS								
		N/A-NOT Local PH Responsibility	X	X		X	X	X		X	X	X	X	X	X	X	
INFECTION CONTROL & CLINICAL GUIDELINES	44	Completed															C
		In-Progress	IP	IP				IP	IP	IP		IP		IP	IP	IP	
		Not Started			NS	NS	NS				NS		NS				
		N/A-NOT Local PH Responsibility															
	45	Completed						C			C						
		In-Progress	IP	IP					IP	IP					IP	IP	IP
		Not Started			NS	NS	NS					NS	NS	NS			
		N/A-NOT Local PH Responsibility															
	46	Completed									C						
		In-Progress		IP					IP	IP					IP		IP
		Not Started	NS		NS	NS	NS	NS				NS	NS	NS		NS	
		N/A-NOT Local PH Responsibility															
VACCINE DISTRIBUTION & USE	47	Completed									C						C
		In-Progress	IP	IP	IP	IP	IP	IP	IP	IP		IP	IP	IP	IP	IP	
		Not Started															
		N/A-NOT Local PH Responsibility															
	48	Completed									C					C	
		In-Progress	IP	IP					IP	IP				IP	IP		IP
		Not Started			NS	NS	NS	NS				NS	NS				
		N/A-NOT Local PH Responsibility															
	49	Completed									C						
		In-Progress	IP	IP		IP		IP	IP	IP		IP	IP	IP	IP	IP	IP
		Not Started			NS		NS										
		N/A-NOT Local PH Responsibility															
	50	Completed															
		In-Progress	IP	IP			IP	IP	IP	IP	IP	IP		IP	IP	IP	IP
		Not Started			NS	NS							NS				
		N/A-NOT Local PH Responsibility															
ANTIVIRAL DRUG DISTRIBUTION & USE	51	Completed									C			C			
		In-Progress	IP	IP	IP	IP	IP	IP	IP	IP		IP	IP		IP	IP	IP
		Not Started															
		N/A-NOT Local PH Responsibility															
	52	Completed									C					C	
		In-Progress	IP	IP					IP	IP				IP	IP		IP
		Not Started			NS	NS	NS	NS				NS	NS				
		N/A-NOT Local PH Responsibility															
COMMUNITY DISEASE CONTROL AND PREVENTION	53	Completed															
		In-Progress	IP	IP					IP	IP					IP		IP
		Not Started			NS		NS				NS	NS	NS	NS		NS	
		N/A-NOT Local PH Responsibility				X		X									
	54	Completed															
		In-Progress	IP	IP					IP	IP					IP		IP
		Not Started			NS		NS				NS	NS	NS	NS		NS	
		N/A-NOT Local PH Responsibility				X		X									

Local Health Department Self-Assessment Totals Worksheet

		INDIANA H	10	8	6	3	4	3
	Question	Local Health Department Name	Warrick County Health Department	Washington County Health Department	Wayne County Health Department	Wells County Health Department	White County Health Department	Whitley County Health Department
		Population Of Each Local Unit	55,465	27,882	69,778	27,963	24,846	31,955
			72	72	72	72	72	72
HEALTH CARE & PUBLIC HEALTH PARTNERS	42	Completed						
		In-Progress						
		Not Started		NS				NS
		N/A-NOT Local PH Responsibility	X		X	X	X	
	43	Completed						
		In-Progress						
		Not Started		NS				NS
		N/A-NOT Local PH Responsibility	X		X	X	X	
INFECTION CONTROL & CLINICAL GUIDELINES	44	Completed						
		In-Progress			IP	IP	IP	
		Not Started	NS	NS				NS
		N/A-NOT Local PH Responsibility						
	45	Completed						
		In-Progress				IP		
		Not Started	NS	NS	NS		NS	NS
		N/A-NOT Local PH Responsibility						
	46	Completed						
		In-Progress						
		Not Started	NS	NS	NS	NS	NS	NS
		N/A-NOT Local PH Responsibility						
VACCINE DISTRIBUTION & USE	47	Completed						
		In-Progress	IP		IP	IP	IP	
		Not Started		NS				NS
		N/A-NOT Local PH Responsibility						
	48	Completed	C					
		In-Progress			IP		IP	
		Not Started		NS		NS		NS
		N/A-NOT Local PH Responsibility						
	49	Completed	C				C	
		In-Progress				IP		
		Not Started		NS	NS			NS
		N/A-NOT Local PH Responsibility						
	50	Completed						
		In-Progress	IP	IP	IP	IP	IP	
		Not Started						NS
		N/A-NOT Local PH Responsibility						
ANTIVIRAL DRUG DISTRIBUTION & USE	51	Completed						
		In-Progress	IP		IP	IP	IP	
		Not Started		NS				NS
		N/A-NOT Local PH Responsibility						
	52	Completed	C					
		In-Progress			IP			
		Not Started		NS		NS	NS	NS
		N/A-NOT Local PH Responsibility						
COMMUNITY DISEASE CONTROL AND PREVENTION	53	Completed						
		In-Progress					IP	
		Not Started	NS	NS	NS			NS
		N/A-NOT Local PH Responsibility				X		
	54	Completed						
		In-Progress						
		Not Started	NS	NS	NS		NS	NS
		N/A-NOT Local PH Responsibility				X		

Local Health Department Self-Assessment Totals Worksheet

				INDIANA HOMELAND SECURITY DISTRICT	3	3	8	4	6	5	8	4	4	9	7	4	10
	Question	Local Health Department Name	Population Represented	94	Adams County Health Department	Allen County Health Department	Bartholomew County Health Department	Benton County Health Department	Blackford County Health Department	Boone County Health Department	Brown County Health Department	Carroll County Health Department	Cass County Health Department	Clark County Health Department	Clay County Health Department	Clinton County Health Department	Crawford County Health Department
		Population Of Each Local Unit	100.00%	6,237,569	33,815	342,168	72,987	9,139	13,841	50,847	15,228	20,331	40,417	100,706	27,210	34,148	11,167
			BALANCED	94	72	72	72	72	72	72	72	72	72	72	72	72	72
COMMUNITY DISEASE CONTROL AND PREVENTION	55	Completed	40,417	1									C				
		In-Progress	3,998,821	51		IP	IP			IP	IP	IP				IP	
		Not Started	2,198,331	42	NS			NS	NS					NS	NS		NS
		N/A-NOT Local PH Responsibility	0	0													
	56	Completed	0	0													
		In-Progress	617,514	14						IP		IP	IP				
		Not Started	5,620,055	80	NS	NS	NS	NS	NS		NS			NS	NS	NS	NS
		N/A-NOT Local PH Responsibility	0	0													
	57	Completed	0	0													
		In-Progress	2,122,932	39			IP			IP		IP	IP		IP		
		Not Started	4,107,411	54	NS	NS		NS	NS		NS			NS		NS	NS
		N/A-NOT Local PH Responsibility	7,226	1													
	58	Completed	0	0													
		In-Progress	594,336	10						IP			IP				
		Not Started	5,636,007	83	NS	NS	NS	NS	NS		NS	NS		NS	NS	NS	NS
		N/A-NOT Local PH Responsibility	7,226	1													
	59	Completed	40,417	1									C				
		In-Progress	3,134,534	49		IP	IP			IP		IP		IP	IP	IP	
		Not Started	3,062,618	44	NS			NS	NS		NS						NS
		N/A-NOT Local PH Responsibility	0	0													
PUBLIC HEALTH COMMUNICATIONS	60	Completed	963,024	15			C										
		In-Progress	4,755,200	65		IP			IP	IP	IP	IP	IP	IP	IP	IP	IP
		Not Started	519,345	14	NS			NS									
		N/A-NOT Local PH Responsibility	0	0													
	61	Completed	497,528	8							C						
		In-Progress	4,781,578	65		IP	IP		IP	IP		IP	IP	IP	IP	IP	
		Not Started	958,463	21	NS			NS									NS
		N/A-NOT Local PH Responsibility	0	0													
	62	Completed	1,412,072	24					C	C					C		
		In-Progress	3,699,125	51		IP	IP	IP			IP	IP	IP	IP		IP	IP
		Not Started	1,126,372	19	NS												
		N/A-NOT Local PH Responsibility	0	0													
	63	Completed	1,663,933	20						C				C	C		C
		In-Progress	3,102,797	53		IP	IP				IP	IP	IP			IP	
		Not Started	1,470,839	21	NS			NS	NS								
		N/A-NOT Local PH Responsibility	0	0													
	64	Completed	2,364,224	40		C	C			C	C		C		C		C
		In-Progress	3,784,723	51				IP	IP			IP		IP		IP	
		Not Started	88,622	3	NS												
		N/A-NOT Local PH Responsibility	0	0													
	65	Completed	859,144	18						C	C		C				
		In-Progress	4,452,684	57		IP	IP		IP			IP		IP	IP	IP	
		Not Started	925,741	19	NS			NS									NS
		N/A-NOT Local PH Responsibility	0	0													
	66	Completed	455,386	6						C					C		
		In-Progress	2,801,645	33		IP							IP	IP			
		Not Started	2,980,538	55	NS		NS	NS	NS		NS	NS				NS	NS
		N/A-NOT Local PH Responsibility	0	0													
	67	Completed	812,394	10		C	C			C		C					
		In-Progress	3,583,748	40									IP	IP	IP	IP	
		Not Started	1,841,427	44	NS			NS	NS		NS						NS
		N/A-NOT Local PH Responsibility	0	0													
	68	Completed	367,217	10								C			C		
		In-Progress	2,333,611	36		IP		IP		IP			IP			IP	
		Not Started	1,702,253	24	NS		NS		NS		NS			NS			
		N/A-NOT Local PH Responsibility	1,834,488	24													X
	69	Completed	1,890,709	19									C	C			
		In-Progress	2,556,425	35		IP		IP		IP	IP				IP		IP
		Not Started	1,096,518	27	NS		NS		NS			NS				NS	
		N/A-NOT Local PH Responsibility	693,917	13													

Local Health Department Self-Assessment Totals Worksheet

		INDIANA H	10	9	9	3	6	10	1	2	6	9	4	9	1	1	10
	Question	Local Health Department Name	Daviess County Health Department	Dearborn County Health Department	Decatur County Health Department	Dekalb County Health Department	Delaware County Health Department	Dubois County Health Department	East Chicago City Health Department	Elkhart County Health Department	Fayette County Health Department	Floyd County Health Department	Fountain-Warren County Combined Health Department	Franklin County Health Department	Fulton County Health Department	Gary City Health Department	Gibson County Health Department
		Population Of Each Local Unit	30,245	48,583	24,970	41,524	117,774	40,771	31,366	191,768	24,934	71,543	26,431	22,852	20,581	99,961	33,286
			72	72	72	72	72	72	72	72	72	72	72	72	72	72	72
COMMUNITY DISEASE CONTROL AND PREVENTION	55	Completed															
		In-Progress	IP	IP	IP	IP	IP			IP			IP		IP		
		Not Started						NS	NS		NS	NS		NS		NS	NS
		N/A-NOT Local PH Responsibility															
	56	Completed															
		In-Progress		IP									IP		IP		
		Not Started	NS		NS	NS	NS	NS	NS	NS	NS	NS		NS		NS	NS
		N/A-NOT Local PH Responsibility															
	57	Completed															
		In-Progress	IP	IP	IP	IP			IP	IP			IP		IP		
		Not Started					NS	NS			NS	NS		NS		NS	NS
		N/A-NOT Local PH Responsibility															
	58	Completed															
		In-Progress								IP			IP		IP		
		Not Started	NS	NS	NS	NS	NS	NS	NS		NS	NS		NS		NS	NS
		N/A-NOT Local PH Responsibility															
	59	Completed															
		In-Progress	IP	IP	IP		IP	IP		IP			IP		IP		IP
		Not Started				NS			NS		NS	NS		NS		NS	
		N/A-NOT Local PH Responsibility															
PUBLIC HEALTH COMMUNICATIONS	60	Completed		C	C					C					C		
		In-Progress	IP			IP	IP	IP	IP		IP	IP	IP				IP
		Not Started												NS		NS	
		N/A-NOT Local PH Responsibility															
	61	Completed	C	C											C		
		In-Progress			IP	IP	IP	IP	IP	IP	IP		IP				IP
		Not Started										NS		NS		NS	
		N/A-NOT Local PH Responsibility															
	62	Completed			C					C	C		C		C		C
		In-Progress	IP	IP		IP	IP	IP	IP							IP	
		Not Started										NS		NS			
		N/A-NOT Local PH Responsibility															
	63	Completed		C	C								C		C		
		In-Progress	IP			IP	IP		IP	IP	IP	IP					IP
		Not Started						NS						NS		NS	
		N/A-NOT Local PH Responsibility															
	64	Completed		C	C			C		C	C		C		C		C
		In-Progress	IP			IP	IP		IP			IP				IP	
		Not Started												NS			
		N/A-NOT Local PH Responsibility															
	65	Completed		C	C					C			C		C		
		In-Progress	IP			IP	IP	IP	IP		IP	IP					IP
		Not Started												NS		NS	
		N/A-NOT Local PH Responsibility															
	66	Completed								C					C		
		In-Progress	IP	IP				IP			IP		IP				IP
		Not Started			NS	NS	NS		NS			NS		NS		NS	
		N/A-NOT Local PH Responsibility															
	67	Completed													C		
		In-Progress	IP			IP	IP		IP	IP			IP				
		Not Started		NS	NS			NS			NS	NS		NS		NS	NS
		N/A-NOT Local PH Responsibility															
	68	Completed		C	C			C									C
		In-Progress	IP			IP							IP		IP		
		Not Started										NS		NS		NS	
		N/A-NOT Local PH Responsibility					X		X	X	X						
	69	Completed						C	C						C		C
		In-Progress	IP		IP	IP	IP						IP	IP			
		Not Started									NS	NS				NS	
		N/A-NOT Local PH Responsibility		X						X							

Local Health Department Self-Assessment Totals Worksheet

		INDIANA H	6	7	5	1	5	9	5	6	6	3	8	1	6	9	9
	Question	Local Health Department Name	Grant County Health Department	Greene County Health Department	Hamilton County Health Department	Hammond City Health Department	Hancock County Health Department	Harrison County Health Department	Hendricks County Health Department	Henry County Health Department	Howard County Health Department	Huntington County Health Department	Jackson County Health Department	Jasper County Health Department	Jay County Health Department	Jefferson County Health Department	Jennings County Health Department
		Population Of Each Local Unit	71,543	33,500	231,760	80,547	60,915	36,376	123,476	47,809	84,615	38,124	41,959	31,624	21,654	32,110	28,401
			72	72	72	72	72	72	72	72	72	72	72	72	72	72	72
COMMUNITY DISEASE CONTROL AND PREVENTION	55	Completed															
		In-Progress	IP			IP	IP	IP	IP		IP	IP			IP		IP
		Not Started		NS	NS					NS			NS	NS		NS	
		N/A-NOT Local PH Responsibility															
	56	Completed															
		In-Progress	IP				IP										
		Not Started		NS	NS	NS		NS	NS	NS	NS	NS	NS	NS	NS	NS	NS
		N/A-NOT Local PH Responsibility															
	57	Completed															
		In-Progress	IP				IP				IP	IP			IP		IP
		Not Started		NS	NS	NS		NS	NS	NS			NS	NS		NS	
		N/A-NOT Local PH Responsibility															
	58	Completed															
		In-Progress					IP								IP		
		Not Started	NS	NS	NS	NS		NS	NS	NS	NS	NS	NS	NS		NS	NS
		N/A-NOT Local PH Responsibility															
	59	Completed															
		In-Progress	IP	IP			IP				IP				IP		IP
		Not Started			NS	NS		NS	NS	NS		NS	NS	NS		NS	
		N/A-NOT Local PH Responsibility															
PUBLIC HEALTH COMMUNICATIONS	60	Completed												C			
		In-Progress	IP	IP	IP	IP	IP	IP	IP		IP	IP			IP	IP	IP
		Not Started								NS			NS				
		N/A-NOT Local PH Responsibility															
	61	Completed															
		In-Progress	IP	IP	IP		IP	IP		IP	IP	IP		IP	IP	IP	IP
		Not Started				NS			NS				NS				
		N/A-NOT Local PH Responsibility															
	62	Completed		C	C										C		
		In-Progress	IP				IP		IP		IP			IP		IP	IP
		Not Started				NS		NS		NS		NS	NS				
		N/A-NOT Local PH Responsibility															
	63	Completed								C							
		In-Progress	IP	IP			IP	IP	IP		IP			IP	IP	IP	IP
		Not Started			NS	NS						NS	NS				
		N/A-NOT Local PH Responsibility															
	64	Completed		C	C			C		C					C	C	C
		In-Progress	IP			IP	IP		IP		IP	IP	IP	IP			
		Not Started															
		N/A-NOT Local PH Responsibility															
	65	Completed		C						C					C		C
		In-Progress	IP		IP	IP	IP	IP			IP	IP		IP		IP	
		Not Started							NS				NS				
		N/A-NOT Local PH Responsibility															
	66	Completed															
		In-Progress	IP				IP			IP					IP		IP
		Not Started		NS	NS	NS		NS	NS		NS	NS	NS	NS		NS	
		N/A-NOT Local PH Responsibility															
	67	Completed						C									
		In-Progress	IP		IP		IP		IP	IP				IP	IP		IP
		Not Started		NS		NS					NS	NS	NS			NS	
		N/A-NOT Local PH Responsibility															
	68	Completed								C							
		In-Progress	IP	IP	IP		IP	IP	IP		IP				IP		
		Not Started				NS											
		N/A-NOT Local PH Responsibility										X	X	X		X	X
	69	Completed		C						C				C			
		In-Progress	IP		IP		IP	IP	IP		IP				IP		
		Not Started				NS							NS			NS	
		N/A-NOT Local PH Responsibility										X					X

Local Health Department Self-Assessment Totals Worksheet

		INDIANA H	5	10	2	3	1	1	8	6	5	2	10	3	8	4	5
	Question	Local Health Department Name	Johnson County Health Department	Knox County Health Department	Kosciusko County Health Department	LaGrange County Health Department	Lake County Health Department	LaPorte County Health Department	Lawrence County Health Department	Madison County Health Department	Marion County Health Department	Marshall County Health Department	Martin County Health Department	Miami County Health Department	Monroe County Health Department	Montgomery County Health Department	Morgan County Health Department
		Population Of Each Local Unit	125,864	38,442	75,667	36,515	278,970	109,755	46,398	130,602	863,596	46,732	10,467	35,955	121,013	37,937	69,424
			72	72	72	72	72	72	72	72	72	72	72	72	72	72	72
COMMUNITY DISEASE CONTROL AND PREVENTION	55	Completed															
		In-Progress			IP	IP	IP			IP	IP	IP		IP		IP	IP
		Not Started	NS	NS				NS	NS				NS		NS		
		N/A-NOT Local PH Responsibility															
	56	Completed															
		In-Progress										IP					
		Not Started	NS	NS	NS	NS	NS	NS	NS	NS	NS		NS	NS	NS	NS	NS
		N/A-NOT Local PH Responsibility															
	57	Completed															
		In-Progress	IP			IP	IP			IP		IP					IP
		Not Started		NS	NS			NS	NS		NS		NS	NS	NS	NS	
		N/A-NOT Local PH Responsibility															
	58	Completed															
		In-Progress															
		Not Started	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS
		N/A-NOT Local PH Responsibility															
	59	Completed															
		In-Progress	IP		IP	IP		IP		IP		IP		IP	IP		IP
		Not Started		NS			NS		NS		NS		NS			NS	
		N/A-NOT Local PH Responsibility															
PUBLIC HEALTH COMMUNICATIONS	60	Completed			C	C								C	C		
		In-Progress	IP	IP			IP	IP		IP	IP	IP	IP			IP	IP
		Not Started							NS								
		N/A-NOT Local PH Responsibility															
	61	Completed			C										C		
		In-Progress	IP	IP		IP	IP	IP		IP	IP	IP		IP		IP	IP
		Not Started							NS				NS				
		N/A-NOT Local PH Responsibility															
	62	Completed			C	C				C			C		C		C
		In-Progress	IP	IP				IP			IP	IP		IP		IP	
		Not Started					NS		NS								
		N/A-NOT Local PH Responsibility															
	63	Completed				C					C		C				
		In-Progress		IP	IP			IP		IP		IP		IP	IP	IP	IP
		Not Started	NS				NS		NS								
		N/A-NOT Local PH Responsibility															
	64	Completed			C	C								C	C	C	C
		In-Progress	IP	IP			IP	IP	IP	IP	IP	IP	IP				
		Not Started															
		N/A-NOT Local PH Responsibility															
	65	Completed			C												
		In-Progress		IP		IP	IP	IP		IP	IP	IP		IP	IP	IP	IP
		Not Started	NS						NS				NS				
		N/A-NOT Local PH Responsibility															
	66	Completed															
		In-Progress					IP	IP		IP	IP	IP				IP	
		Not Started	NS	NS	NS	NS			NS				NS	NS	NS		NS
		N/A-NOT Local PH Responsibility															
	67	Completed			C												
		In-Progress	IP	IP				IP			IP	IP			IP	IP	IP
		Not Started				NS	NS		NS	NS			NS	NS			
		N/A-NOT Local PH Responsibility															
	68	Completed			C												
		In-Progress					IP	IP				IP		IP			
		Not Started	NS	NS						NS					NS		
		N/A-NOT Local PH Responsibility				X			X		X		X			X	X
	69	Completed			C						C				C		
		In-Progress	IP				IP	IP		IP		IP				IP	IP
		Not Started		NS					NS					NS			
		N/A-NOT Local PH Responsibility				X							X				

Local Health Department Self-Assessment Totals Worksheet

		INDIANA H	1	3	9	8	7	7	10	10	1	10	2	7	6	9	6
	Question	Local Health Department Name	Newton County Health Department	Noble County Health Department	Ohio County Health Department	Orange County Health Department	Owen County Health Department	Parke County Health Department	Perry County Health Department	Pike County Health Department	Porter County Health Department	Posey County Health Department	Pulaski County Health Department	Putnam County Health Department	Randolph County Health Department	Ripley County Health Department	Rush County Health Department
		Population Of Each Local Unit	14,421	47,297	5,849	19,718	23,074	17,254	18,999	12,938	154,961	26,990	13,825	36,786	26,697	27,549	18,028
			72	72	72	72	72	72	72	72	72	72	72	72	72	72	72
COMMUNITY DISEASE CONTROL AND PREVENTION	55	Completed															
		In-Progress	IP	IP		IP	IP	IP			IP		IP	IP	IP	IP	
		Not Started			NS				NS	NS		NS					NS
		N/A-NOT Local PH Responsibility															
	56	Completed															
		In-Progress						IP			IP					IP	
		Not Started	NS	NS	NS	NS	NS		NS	NS		NS	NS	NS	NS		NS
		N/A-NOT Local PH Responsibility															
	57	Completed															
		In-Progress		IP		IP	IP	IP			IP			IP		IP	
		Not Started	NS		NS				NS	NS		NS	NS		NS		NS
		N/A-NOT Local PH Responsibility															
	58	Completed															
		In-Progress						IP			IP						
		Not Started	NS	NS	NS	NS	NS		NS	NS		NS	NS	NS	NS	NS	NS
		N/A-NOT Local PH Responsibility															
	59	Completed															
		In-Progress	IP	IP	IP		IP	IP	IP		IP			IP	IP		
		Not Started				NS				NS		NS	NS			NS	NS
		N/A-NOT Local PH Responsibility															
PUBLIC HEALTH COMMUNICATIONS	60	Completed															
		In-Progress	IP	IP	IP		IP	IP	IP	IP	IP		IP	IP	IP	IP	
		Not Started				NS						NS					NS
		N/A-NOT Local PH Responsibility															
	61	Completed															
		In-Progress	IP	IP	IP	IP	IP	IP	IP	IP	IP		IP	IP	IP	IP	
		Not Started										NS					NS
		N/A-NOT Local PH Responsibility															
	62	Completed	C							C							
		In-Progress		IP	IP	IP	IP	IP	IP		IP		IP	IP	IP	IP	
		Not Started										NS					NS
		N/A-NOT Local PH Responsibility															
	63	Completed	C			C				C							
		In-Progress		IP	IP		IP	IP	IP		IP		IP	IP	IP	IP	
		Not Started										NS					NS
		N/A-NOT Local PH Responsibility															
	64	Completed	C			C				C			C			C	
		In-Progress		IP	IP		IP	IP	IP		IP	IP		IP	IP		IP
		Not Started															
		N/A-NOT Local PH Responsibility															
	65	Completed	C			C				C							
		In-Progress		IP	IP		IP	IP	IP		IP	IP	IP	IP	IP	IP	
		Not Started															NS
		N/A-NOT Local PH Responsibility															
	66	Completed								C							
		In-Progress			IP			IP			IP			IP	IP	IP	
		Not Started	NS	NS		NS	NS		NS			NS	NS				NS
		N/A-NOT Local PH Responsibility															
	67	Completed															
		In-Progress		IP			IP	IP		IP	IP	IP		IP		IP	
		Not Started	NS		NS	NS			NS				NS		NS		NS
		N/A-NOT Local PH Responsibility															
	68	Completed	C														
		In-Progress		IP				IP			IP		IP	IP	IP	IP	
		Not Started							NS			NS					NS
		N/A-NOT Local PH Responsibility			X	X	X			X							
	69	Completed			C	C								C			
		In-Progress	IP				IP	IP		IP							
		Not Started							NS		NS	NS	NS		NS		NS
		N/A-NOT Local PH Responsibility		X												X	

Local Health Department Self-Assessment Totals Worksheet

	Question	INDIANA H	2	9	5	10	2	3	7	9	4	6	6	10	7	7	3
		Local Health Department Name	St. Joseph County Health Department	Scott County Health Department	Shelby County Health Department	Spencer County Health Department	Starke County Health Department	Steuben County Health Department	Sullivan County Health Department	Switzerland County Health Department	Tippecanoe County Health Department	Tipton County Health Department	Union County Health Department	Vanderburgh County Health Department	Vermillion County Health Department	Vigo County Health Department	Wabash County Health Department
		Population Of Each Local Unit	266,431	23,604	43,717	20,310	22,903	33,722	21,862	9,508	152,042	16,605	7,226	173,157	16,500	103,195	34,169
			72	72	72	72	72	72	72	72	72	72	72	72	72	72	72
COMMUNITY DISEASE CONTROL AND PREVENTION	55	Completed															
		In-Progress	IP	IP				IP	IP	IP					IP		IP
		Not Started			NS	NS	NS				NS	NS	NS	NS		NS	
		N/A-NOT Local PH Responsibility															
	56	Completed															
		In-Progress							IP	IP							
		Not Started	NS	NS	NS	NS	NS	NS			NS	NS	NS	NS	NS	NS	NS
		N/A-NOT Local PH Responsibility															
	57	Completed															
		In-Progress		IP				IP	IP	IP							IP
		Not Started	NS		NS	NS	NS				NS	NS		NS	NS	NS	
		N/A-NOT Local PH Responsibility											X				
	58	Completed															
		In-Progress								IP							
		Not Started	NS	NS	NS	NS	NS	NS	NS		NS	NS		NS	NS	NS	NS
		N/A-NOT Local PH Responsibility											X				
	59	Completed															
		In-Progress	IP					IP		IP		IP			IP	IP	
		Not Started		NS	NS	NS	NS		NS		NS		NS	NS			NS
		N/A-NOT Local PH Responsibility															
PUBLIC HEALTH COMMUNICATIONS	60	Completed						C			C						C
		In-Progress	IP	IP		IP	IP		IP	IP		IP		IP	IP	IP	
		Not Started			NS								NS				
		N/A-NOT Local PH Responsibility															
	61	Completed									C						C
		In-Progress	IP	IP		IP		IP	IP	IP		IP		IP	IP		
		Not Started			NS		NS						NS			NS	
		N/A-NOT Local PH Responsibility															
	62	Completed				C		C			C						C
		In-Progress	IP	IP					IP	IP			IP		IP	IP	
		Not Started			NS		NS					NS		NS			
		N/A-NOT Local PH Responsibility															
	63	Completed						C			C					C	C
		In-Progress	IP	IP					IP	IP		IP	IP		IP		
		Not Started			NS	NS	NS							NS			
		N/A-NOT Local PH Responsibility															
	64	Completed					C	C			C			C			C
		In-Progress	IP	IP	IP	IP			IP	IP		IP	IP		IP	IP	
		Not Started															
		N/A-NOT Local PH Responsibility															
	65	Completed									C						C
		In-Progress	IP	IP				IP	IP	IP		IP			IP	IP	
		Not Started			NS	NS	NS						NS	NS			
		N/A-NOT Local PH Responsibility															
	66	Completed									C						
		In-Progress		IP					IP	IP		IP			IP		IP
		Not Started	NS		NS	NS	NS	NS					NS	NS		NS	
		N/A-NOT Local PH Responsibility															
	67	Completed									C		C				C
		In-Progress	IP	IP					IP					IP			
		Not Started			NS	NS	NS	NS		NS		NS			NS	NS	
		N/A-NOT Local PH Responsibility															
	68	Completed															C
		In-Progress		IP			IP		IP	IP	IP		IP		IP		
		Not Started	NS		NS	NS						NS		NS		NS	
		N/A-NOT Local PH Responsibility						X									
	69	Completed	C														C
		In-Progress							IP					IP	IP	IP	
		Not Started			NS	NS	NS			NS		NS	NS				
		N/A-NOT Local PH Responsibility		X				X			X						

Local Health Department Self-Assessment Totals Worksheet

		INDIANA H	10	8	6	3	4	3
	Question	Local Health Department Name	Warrick County Health Department	Washington County Health Department	Wayne County Health Department	Wells County Health Department	White County Health Department	Whitley County Health Department
		Population Of Each Local Unit	55,465	27,882	69,778	27,963	24,846	31,955
			72	72	72	72	72	72
COMMUNITY DISEASE CONTROL AND PREVENTION	55	Completed						
		In-Progress				IP	IP	
		Not Started	NS	NS	NS			NS
		N/A-NOT Local PH Responsibility						
	56	Completed						
		In-Progress						
		Not Started	NS	NS	NS	NS	NS	NS
		N/A-NOT Local PH Responsibility						
	57	Completed						
		In-Progress				IP	IP	
		Not Started	NS	NS	NS			NS
		N/A-NOT Local PH Responsibility						
	58	Completed						
		In-Progress						
		Not Started	NS	NS	NS	NS	NS	NS
		N/A-NOT Local PH Responsibility						
	59	Completed						
		In-Progress	IP			IP	IP	
		Not Started		NS	NS			NS
		N/A-NOT Local PH Responsibility						
PUBLIC HEALTH COMMUNICATIONS	60	Completed	C			C		
		In-Progress		IP			IP	
		Not Started			NS			NS
		N/A-NOT Local PH Responsibility						
	61	Completed						
		In-Progress				IP	IP	
		Not Started	NS	NS	NS			NS
		N/A-NOT Local PH Responsibility						
	62	Completed						
		In-Progress	IP	IP		IP		
		Not Started			NS		NS	NS
		N/A-NOT Local PH Responsibility						
	63	Completed					C	
		In-Progress	IP	IP		IP		
		Not Started			NS			NS
		N/A-NOT Local PH Responsibility						
	64	Completed	C				C	
		In-Progress		IP	IP	IP		
		Not Started						NS
		N/A-NOT Local PH Responsibility						
	65	Completed						
		In-Progress			IP	IP	IP	
		Not Started	NS	NS				NS
		N/A-NOT Local PH Responsibility						
	66	Completed						
		In-Progress					IP	
		Not Started	NS	NS	NS	NS		NS
		N/A-NOT Local PH Responsibility						
	67	Completed						
		In-Progress	IP				IP	
		Not Started		NS	NS	NS		NS
		N/A-NOT Local PH Responsibility						
	68	Completed						
		In-Progress					IP	
		Not Started	NS					NS
		N/A-NOT Local PH Responsibility		X	X	X		
	69	Completed	C					C
		In-Progress					IP	
		Not Started			NS			
		N/A-NOT Local PH Responsibility		X		X		

Local Health Department Self-Assessment Totals Worksheet

				INDIANA HOMELAND SECURITY DISTRICT	3	3	8	4	6	5	8	4	4	9	7	4	10
	Question	Local Health Department Name	Population Represented	94	Adams County Health Department	Allen County Health Department	Bartholomew County Health Department	Benton County Health Department	Blackford County Health Department	Boone County Health Department	Brown County Health Department	Carroll County Health Department	Cass County Health Department	Clark County Health Department	Clay County Health Department	Clinton County Health Department	Crawford County Health Department
		Population Of Each Local Unit	100.00%	6,237,569	33,815	342,168	72,987	9,139	13,841	50,847	15,228	20,331	40,417	100,706	27,210	34,148	11,167
			BALANCED	94	72	72	72	72	72	72	72	72	72	72	72	72	72
	70	Completed	1,985,864	32		C				C	C			C	C		
		In-Progress	3,727,791	50			IP	IP	IP			IP	IP			IP	IP
		Not Started	470,465	9	NS												
		N/A-NOT Local PH Responsibility	53,449	3													
WORKFORCE SUPPORT: PSYCHO-SOCIAL CONSIDERATIONS	71	Completed	88,536	3									C				
		In-Progress	4,092,102	53		IP	IP		IP	IP	IP	IP		IP	IP		
		Not Started	2,056,931	38	NS			NS								NS	NS
		N/A-NOT Local PH Responsibility	0	0													
	72	Completed	423,924	4		C							C				
		In-Progress	4,340,957	58			IP		IP	IP	IP	IP		IP	IP		
		Not Started	1,472,688	32	NS			NS								NS	NS
		N/A-NOT Local PH Responsibility	0	0													

Local Health Department Self-Assessment Totals Worksheet

		INDIANA H	**10**	**9**	**9**	**3**	**6**	**10**	**1**	**2**	**6**	**9**	**4**	**9**	**1**	**1**	**10**
	Question	**Local Health Department Name**	Daviess County Health Department	Dearborn County Health Department	Decatur County Health Department	Dekalb County Health Department	Delaware County Health Department	Dubois County Health Department	East Chicago City Health Department	Elkhart County Health Department	Fayette County Health Department	Floyd County Health Department	Fountain-Warren County Combined Health Department	Franklin County Health Department	Fulton County Health Department	Gary City Health Department	Gibson County Health Department
		Population Of Each Local Unit	**30,245**	**48,583**	**24,970**	**41,524**	**117,774**	**40,771**	**31,366**	**191,768**	**24,934**	**71,543**	**26,431**	**22,852**	**20,581**	**99,961**	**33,286**
			72	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**
	70	Completed		C	C			C		C			C		C		
		In-Progress	IP			IP	IP		IP		IP					IP	IP
		Not Started										NS		NS			
		N/A-NOT Local PH Responsibility															
WORKFORCE SUPPORT: PSYCHO-SOCIAL CONSIDERATIONS	**71**	Completed															
		In-Progress	IP	IP	IP	IP	IP		IP	IP	IP		IP		IP		
		Not Started						NS				NS		NS		NS	NS
		N/A-NOT Local PH Responsibility															
	72	Completed															
		In-Progress	IP	IP	IP	IP	IP		IP	IP	IP		IP		IP		
		Not Started						NS				NS		NS		NS	NS
		N/A-NOT Local PH Responsibility															

Local Health Department Self-Assessment Totals Worksheet

		INDIANA H	6	7	5	1	5	9	5	6	6	3	8	1	6	9	9
	Question	Local Health Department Name	Grant County Health Department	Greene County Health Department	Hamilton County Health Department	Hammond City Health Department	Hancock County Health Department	Harrison County Health Department	Hendricks County Health Department	Henry County Health Department	Howard County Health Department	Huntington County Health Department	Jackson County Health Department	Jasper County Health Department	Jay County Health Department	Jefferson County Health Department	Jennings County Health Department
		Population Of Each Local Unit	71,543	33,500	231,760	80,547	60,915	36,376	123,476	47,809	84,615	38,124	41,959	31,624	21,654	32,110	28,401
			72	72	72	72	72	72	72	72	72	72	72	72	72	72	72
	70	Completed						C								C	C
		In-Progress	IP	IP	IP		IP		IP	IP	IP	IP	IP	IP	IP		
		Not Started				NS											
		N/A-NOT Local PH Responsibility															
WORKFORCE SUPPORT: PSYCHO-SOCIAL CONSIDERATIONS	71	Completed															C
		In-Progress	IP				IP	IP	IP		IP				IP	IP	
		Not Started		NS	NS	NS				NS		NS	NS	NS			
		N/A-NOT Local PH Responsibility															
	72	Completed															C
		In-Progress	IP		IP		IP	IP	IP	IP	IP						
		Not Started		NS		NS						NS	NS	NS	NS	NS	
		N/A-NOT Local PH Responsibility															

Local Health Department Self-Assessment Totals Worksheet

		INDIANA H	5	10	2	3	1	1	8	6	5	2	10	3	8	4	5
	Question	Local Health Department Name	Johnson County Health Department	Knox County Health Department	Kosciusko County Health Department	LaGrange County Health Department	Lake County Health Department	LaPorte County Health Department	Lawrence County Health Department	Madison County Health Department	Marion County Health Department	Marshall County Health Department	Martin County Health Department	Miami County Health Department	Monroe County Health Department	Montgomery County Health Department	Morgan County Health Department
		Population Of Each Local Unit	125,864	38,442	75,667	36,515	278,970	109,755	46,398	130,602	863,596	46,732	10,467	35,955	121,013	37,937	69,424
			72	72	72	72	72	72	72	72	72	72	72	72	72	72	72
	70	Completed		C	C	C		C		C				C	C	C	
		In-Progress	IP				IP		IP		IP	IP	IP				IP
		Not Started															
		N/A-NOT Local PH Responsibility															
WORKFORCE SUPPORT: PSYCHO-SOCIAL CONSIDERATIONS	71	Completed															
		In-Progress			IP	IP	IP	IP			IP	IP		IP	IP	IP	IP
		Not Started	NS	NS					NS	NS			NS				
		N/A-NOT Local PH Responsibility															
	72	Completed															
		In-Progress	IP	IP		IP	IP			IP	IP	IP		IP		IP	IP
		Not Started			NS			NS	NS				NS		NS		
		N/A-NOT Local PH Responsibility															

Local Health Department Self-Assessment Totals Worksheet

		INDIANA H	1	3	9	8	7	7	10	10	1	10	2	7	6	9	6
	Question	Local Health Department Name	Newton County Health Department	Noble County Health Department	Ohio County Health Department	Orange County Health Department	Owen County Health Department	Parke County Health Department	Perry County Health Department	Pike County Health Department	Porter County Health Department	Posey County Health Department	Pulaski County Health Department	Putnam County Health Department	Randolph County Health Department	Ripley County Health Department	Rush County Health Department
		Population Of Each Local Unit	14,421	47,297	5,849	19,718	23,074	17,254	18,999	12,938	154,961	26,990	13,825	36,786	26,697	27,549	18,028
			72	72	72	72	72	72	72	72	72	72	72	72	72	72	72
	70	Completed	C							C						C	
		In-Progress		IP			IP	IP	IP		IP		IP	IP	IP		
		Not Started										NS					NS
		N/A-NOT Local PH Responsibility			X	X											
WORKFORCE SUPPORT: PSYCHO-SOCIAL CONSIDERATIONS	71	Completed				C											
		In-Progress	IP	IP	IP		IP	IP			IP		IP	IP	IP	IP	
		Not Started							NS	NS		NS					NS
		N/A-NOT Local PH Responsibility															
	72	Completed								C							
		In-Progress	IP		IP	IP	IP	IP	IP		IP		IP	IP	IP	IP	
		Not Started		NS								NS					NS
		N/A-NOT Local PH Responsibility															

Local Health Department Self-Assessment Totals Worksheet

		INDIANA H	**2**	**9**	**5**	**10**	**2**	**3**	**7**	**9**	**4**	**6**	**6**	**10**	**7**	**7**	**3**
	Question	**Local Health Department Name**	St. Joseph County Health Department	Scott County Health Department	Shelby County Health Department	Spencer County Health Department	Starke County Health Department	Steuben County Health Department	Sullivan County Health Department	Switzerland County Health Department	Tippecanoe County Health Department	Tipton County Health Department	Union County Health Department	Vanderburgh County Health Department	Vermillion County Health Department	Vigo County Health Department	Wabash County Health Department
		Population Of Each Local Unit	**266,431**	**23,604**	**43,717**	**20,310**	**22,903**	**33,722**	**21,862**	**9,508**	**152,042**	**16,605**	**7,226**	**173,157**	**16,500**	**103,195**	**34,169**
			72	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**
	70	Completed		C				C			C						C
		In-Progress	IP			IP	IP		IP	IP		IP	IP	IP	IP		
		Not Started			NS											NS	
		N/A-NOT Local PH Responsibility															
WORKFORCE SUPPORT: PSYCHO-SOCIAL CONSIDERATIONS	**71**	Completed															
		In-Progress	IP	IP					IP	IP		IP			IP		IP
		Not Started			NS	NS	NS	NS			NS		NS	NS		NS	
		N/A-NOT Local PH Responsibility															
	72	Completed															
		In-Progress	IP	IP			IP	IP	IP	IP		IP		IP	IP	IP	IP
		Not Started			NS	NS					NS		NS				
		N/A-NOT Local PH Responsibility															

Local Health Department Self-Assessment Totals Worksheet

		INDIANA H	10	8	6	3	4	3
	Question	Local Health Department Name	Warrick County Health Department	Washington County Health Department	Wayne County Health Department	Wells County Health Department	White County Health Department	Whitley County Health Department
		Population Of Each Local Unit	55,465	27,882	69,778	27,963	24,846	31,955
			72	72	72	72	72	72
	70	Completed	C			C		C
		In-Progress					IP	
		Not Started			NS			
		N/A-NOT Local PH Responsibility		X				
WORKFORCE SUPPORT: PSYCHO-SOCIAL CONSIDERATIONS	71	Completed						
		In-Progress				IP		
		Not Started	NS	NS	NS		NS	NS
		N/A-NOT Local PH Responsibility						
	72	Completed						
		In-Progress	IP				IP	
		Not Started		NS	NS	NS		NS
		N/A-NOT Local PH Responsibility						

APPENDIX J – 2006/2007 Master Exercise Plan & Schedule

The Indiana State Department of Health has developed a two-year Pan Flu exercise plan focused on evaluating the ability of the local health departments to coordinate with their local partners and perform their assigned tasks as part of a unified county team.

The subject matter for the exercises has been obtained through gap analysis, after action reviews (AARs) of previous exercises, and CDC Pan Flu goals. From this subject matter we have developed a two year-exercise program that we are coordinating with the Indiana Department of Homeland Security. We are also partnering with Purdue University to develop the exercises.

The program is a two-year program. Year one will consist of drills and table top exercises at the local level. Mixed with the local exercises will be two state level Pan Flu exercises, one multi-state exercise, and a SNS functional exercise. Year two will be functional exercises conducted at a district level. The two-year exercise program is designed so adequate time is available for the AAR process to take place. Also, time is built in to be able to take deficiencies that are identified in the AAR process, develop corrective training plans for them and then retest. The program goal is to conduct full scale exercises in year three.

The following is a copy of the Master Exercise Calendar for August 2006 through August 2007 detailing required elements associated with Priority 2 of the Pandemic Influenza funding guidance.

APPENDIX K – CDC PRIORITY 3: Summary Timeline for planned steps to develop the Anti-Viral Drug Distribution plan

The Indiana Strategic National Stockpile (SNS), Standard Operating Procedure (SOP), is the base plan for all mass medical emergencies. Within this SOP is the distribution plan which is based on a 48 hour response to an aerosolized anthrax mass prophylaxis of a large part of our population. This SNS SOP distribution plan is capable of quickly responding with any medical materials we have access to, to a very large part of our population in a short time. This SOP is expected to be fully operational within several months. Presently it is capable of distribution as may be required.

The antiviral drug distribution plan will become a part of the same SOP as an appendix varying little except for the points of delivery should an event occur.

The antiviral portion of the distribution plan may or will require different points of dispensing. This should be able to be determined within two months following the completion of the base SOP.

Timeline estimate:

Planning for antiviral distribution of state resources started and in process
- State antiviral cache requirements determined – Completed
- Storage location determined – Completed
- Antiviral planning for appendix – In process
- Base SNS SOP approved and operational – November 1, 2006.
- Planning for distribution method - In process
- Antiviral distribution plan approved – April 1, 2006
- Antiviral distribution plan added to Base SNS SOP - May 1, 2006

APPENDIX L – Detailed Budget for University of Illinois Contract for Laboratory Professional Training

Budget 2006-2007 **Indiana contract proposal with CADE for Pandemic Flu Training**
Year 1 **Phase II Pan Flu CDC Dollars**
Costs for Two Courses - costs assume Indiana provides all video for course (no editing required)

Personnel

Last Name	Title	Annual salary	% FTE Appt	Fringe	Fringe Amt	Salary Amt	Total Salary	% FTE Course Development	Cost of Course Development	% FTE Overall Project Admin	Cost of Project Admin
Colleen Monahan	Director	$190,300	2%	0.3578	$1,362	$3,806	$5,168	2%	$5,168		
Nate Shreve	Manager Multimedia Production & Webcasting	$64,050	5%	0.3723	$1,192	$3,203	$4,395	5%	$4,395		
Larry Miller	Multimedia Production & Webcasting	$60,000	30%	0.3723	$6,701	$18,000	$24,701	30%	$24,701		
Jack Neuner	Manager Web Design and Development	$70,000	15%	0.3723	$3,909	$10,500	$14,409	15%	$14,409		
Mark Goodman	Flash Developer and programmer	$63,000	20%	0.3723	$4,691	$12,600	$17,291	20%	$17,291		
Mike Hinds	Course Developer	$66,000	30%	0.3723	$7,372	$19,800	$27,172	30%	$27,172		
Jason McGovern	Project Manager/Script writer	$50,000	30%	0.3723	$5,585	$15,000	$20,585	30%	$20,585		
Montanee Wongchinsri	Finance/HR/Business Office	$65,000	10%	0.3723	$2,420	$6,500	$8,920	0%	$0	10%	$8,920
Chris Hollenbeck	Network Administration	$55,120	10%	0.3723	$2,052	$5,512	$7,564	0%	$0	10%	$7,564
Total Personnel Costs					$30,812	$82,909	**$130,205**	1.32	**$113,721**		$16,484
Total Personnel Deliverable Costs (should = line above)							**$130,205**				

Equipment and Supplies

Audio/video supplies (tapes, batteries etc)							$600		$600		
Computer supplies (Sony 8 mm back up tapes, rewritable CDs, labels, memory etc).							$200		$200		
Office Supplies							$100		$100		
							$900		$900		$0

Travel

Travel	parking, mileage, hotel						$400		$400		
Rental cars to transport A/V equipment							$400		$400		
**** all reimbursement per UIC guidelines											
							$800		$800		$0

Contractual and Services

Fed Ex, mailing shipping charges							$100		$100		
Staff and Server Software Licenses							$520		$520		
phone charges	$20/month for 2 persons x 12 mos						$480		$480		
Contractual staff (Graphic Design/Flash Programmer)							$9,840		$9,840		
							$10,940		$10,940		$0
						Totals	**$142,845**		**$126,361**		**$16,484**
							Total Budget		**Course**		**Admin**
											13.05%

Total Budget	**$142,845**

CADE for Pandemic Flu Training
Phase II Pan Flu CDC Dollars

Lab Course Development Detail for Two Courses

Course for Action # 6		
task	Hours	$$
scope/design	40	$5,400.00
storyboard	40	$5,400.00
Graphics	30	$4,050.00
Content	80	$10,800.00
Multimedia/Flash	60	$8,100.00
assembly	40	$5,400.00
QA	40	$5,400.00
PM	66	$8,910.00
	396	**$53,460.00**

Course for Action # 7		
task	Hours	$$
scope/design	60	$8,100.00
storyboard	60	$8,100.00
Graphics	40	$5,400.00
Content	100	$13,500.00
Multimedia/Flash	70	$9,450.00
assembly	60	$8,100.00
QA	60	$8,100.00
PM	90	$12,150.00
	540	**$72,900.00**

Total **$126,360.00**

APPENDIX M – Detailed Indiana University Bioethics Contract Proposal

Ethical Issues and Pandemic Influenza
2006-2007 Contract Proposal
Indiana University Center for Bioethics

Phase 1 Assessment and Development 2006-2007: (Budget $50,000)

1. Develop an *Ethical Framework for Decision Making During Pandemic Influenza.*
2. Develop and facilitate a Table Top Exercise (TTX) for ISDH that is focused on ethical issues and decision making during pandemic influenza. This exercise will serve to identify gaps and critical ethical issues. The exercise will also include an After Action Report, Improvement Plan, and Debriefing session.
3. Development and facilitate a Technical Advisory Committee (TAC) to address the most critical ethical issues and produce *5 Technical Assistance* documents.
4. Develop an *Ethical Framework for Pandemic Influenza Planning: A Guide for Local Health Departments and Hospitals* that identifies critical ethical issues, decision making framework, and provides guidance and recommendations on strategies.
5. Conduct 5 training sessions at the district level on the *Ethical Framework for Pandemic Influenza Planning: A Guide for Local Health Departments and Hospitals* document to include Indiana's 10 preparedness districts.

Products:

Summary: 3 types of documents (7 total), 1 TTX, and 5 Training Sessions

1. *Ethical Framework for Decision Making During Pandemic Influenza.* **(1 Document)**
2. Ethical Issues and Pandemic Influenza TTX for ISDH **(TTX)**
3. Formation of a Technical Advisory Committee that produces *5 Technical Assistance (TA)* documents on ethical issues under consideration. **(5 TA Documents)**
4. *Ethical Framework for Decision Making During Pandemic Influenza: A Guide for Local Health Departments and Hospitals.* **(1 Document)**
5. 5 District training sessions on *Ethical Framework for Pandemic Influenza Planning: A Guide for Local Health Departments and Hospitals* **(5 training sessions)**

Budget Breakdown: Phase 1 $50,000

1. $5,000 – Ethical Framework Document (100 hours per document, $50 per hour)
2. $5,000 – TTX (100 hours per document, $50 per hour)
3. $25,000 – Technical Advisory Committee to produce 5 Technical Assistance Guidance Documents ($5,000 per document estimating 100 hours per document, $50 per hour)
4. $5,000 – Ethics Framework LHD & Hospital Guidance Document (100 hours per document, $50 per hour)
5. $10,000 – 5 District Training Session ($2,000 per session)

Core Functions and Essential Services

1. Assessment (ES 2) – TTX, TAC
2. Policy Development (ES 3, 4, 5) – TAC, Ethics Framework doc., TA docs., LHD Guidance doc. Assurance (Evaluation) (ES 8, 9, 10) – Education/training campaign, TTX