

Introduction

Background

The 2009 H1N1 influenza pandemic underscored the importance of communities being prepared for potential threats to public health security. Because of its unique abilities to respond to infectious, occupational, or environmental incidents, the Centers for Disease Control and Prevention (CDC) plays a pivotal role in ensuring that state and local public health systems are prepared for these and other public health incidents.

The identification of the novel influenza A (H7N9) virus illnesses in China in 2013 highlights the importance of influenza pandemic preparedness. To date, the reported case fatality ratio from human H7N9 infections is more than 30%. Should the H7N9 virus mutate to allow for sustained human-to-human transmission, it appears capable of causing severe disease in all ages. To better prepare for such a scenario, it is important to understand the collective ability of our nation to prepare for and respond to a pandemic of substantially different epidemiology than the 2009 H1N1 pandemic.

State and local public health departments are first responders for public health incidents. To better prepare these agencies to respond, CDC provides funding and technical assistance for state, local, and territorial public health departments through the Public Health Emergency Preparedness (PHEP) cooperative agreement. CDC's Public Health Preparedness Capabilities: National Standards for State and Local Planning provide national standards that help state and local public health departments strengthen their ability to respond to all hazards, including influenza pandemics, and build more resilient communities. Consistent with this approach, the following Pandemic Preparedness Readiness Assessment for State and Local Public Health Planners specifically aligns with 11 public health preparedness capabilities and administrative preparedness planning goals.

Overview

The Pandemic Preparedness Readiness Assessment for State and Local Public Health Planners promotes state, local, and territorial public health preparedness and immunization program collaboration through the administration of a self-assessment designed to measure jurisdictional readiness to respond to an influenza pandemic. Although the content of this assessment does not encompass every contingency or element necessary to effectively respond to an

influenza pandemic, CDC technical experts in differing programs have helped to arrange content within the following seven priority planning areas:

1. Vaccination Planning
2. Epidemiology and laboratory
3. Medical Care and Countermeasures
4. Healthcare Systems
5. Community Mitigation
6. Public Information and Communication
7. Public Health and Immunization Workforce

Information collected from the assessment will not be used to score or competitively rank public health emergency preparedness or immunization programs. Rather, this assessment is designed to identify preparedness gaps, as well as promising state, local, and territorial preparedness practices. Assessment results will be used by the CDC to inform technical assistance and future program improvement initiatives.

Definitions

Allocation: Amount of pandemic influenza vaccine available for ordering.

Allocating: Process of dividing available vaccine among CDC's PHEP awardees or among registered pandemic influenza vaccine providers and facilities within an awardee's jurisdiction.

Critical infrastructure personnel (CIP): The full list of CIP is defined in Guidance on Allocating and Targeting Pandemic Influenza Vaccine; U.S. Department of Health and Human Services (HHS)/U.S. Department of Homeland Security (DHS); 2008 [Guidance on Allocating and Targeting Pandemic Influenza Vaccine](#)

Distribution: The process of transporting pandemic influenza vaccine from one location to another.

Enrollment: The process of enabling registered healthcare providers and facilities to legally provide pandemic influenza vaccine.

Ordering: Process of requesting pandemic influenza vaccine from either the federal, state, city, or local government. Orders can be placed against an allocation or independent of allocation.

Non-pharmaceutical interventions (NPIs): Those interventions that can mitigate transmission of influenza and do not involve medical countermeasures. NPIs include voluntary home isolation, school closures, respiratory etiquette, hand hygiene, and routine cleaning of frequently touched surfaces and objects.

Peak vaccine administration capacity: The highest rate at which a jurisdiction is able to provide pandemic influenza vaccine to its population; CDC recommends a peak vaccine administration capacity of at least 10% of the population per week.

Point of dispensing (POD) / mass vaccination clinic: Location for dispensing medical countermeasures, specifically for vaccine, during an influenza pandemic response. Located in a public or private space, this clinic is designed to vaccinate a large group of persons over a short time period. The POD or clinic might target the entire population or people in specific priority or high-risk groups. Public and/or private entities can manage a POD or clinic.

Closed POD: Point of dispensing/vaccination clinic closed to the general public and open only to a specific group (e.g., staff of a participating business or healthcare personnel in a specific hospital).

Open POD: Point of dispensing/vaccination clinic open to the general public, specifically to provide vaccine, during an influenza pandemic response.

Recruitment: The process of soliciting healthcare providers and facilities interested in and willing to provide pandemic influenza vaccine.

Registration: The submission of required information, similar to an application, by healthcare providers or facilities interested in providing pandemic influenza vaccinations.

Retail-based clinics: Non-pharmacy businesses that sell retail products (e.g., Walmart, Target) and serve as PODs/mass vaccination clinics.

School-located vaccination clinics: Vaccination clinics that target students and are typically held on school grounds.

Public reporting burden of this collection of information is estimated to average 30 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing 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 Office of Management and Budget control number. Send comments regarding this burden estimate, or any other aspect of this information collection, including suggestions for reducing this burden to CDC/Agency for Toxic Substance and Disease Registry Information Collection Review Office, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; Attention: PRA (0920-0879).

Section VII: Public Health and Immunization Workforce

Goal: Identify potential workforce reductions since 2012 to characterize workforce surge capability within state and local public health immunization and preparedness programs.

Assumptions:

- State, local and Federal funding reductions over time have resulted in immunization and public health preparedness program staffing reductions
- Estimating the probability and risk of an influenza pandemic is challenging and may negatively impact staffing justifications for immunization and preparedness programs

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Section VII: Public Health and Immunization Workforce

Please select your jurisdiction:

- Alabama
- Alaska
- American Samoa
- Arizona
- Arkansas
- California
- Chicago
- Colorado
- Commonwealth of the Northern Mariana Islands
- Connecticut
- Delaware
- Federated States of Micronesia
- Florida
- Georgia
- Guam
- Hawaii
- Idaho
- Illinois
- Indiana
- Iowa
- Kansas
- Kentucky

- Los Angeles County
- Louisiana
- Maine
- Maryland
- Massachusetts
- Michigan
- Minnesota
- Mississippi
- Missouri
- Montana
- Nebraska
- Nevada
- New Hampshire
- New Jersey
- New Mexico
- New York
- New York City
- North Carolina
- North Dakota
- Ohio
- Oklahoma
- Oregon
- Pennsylvania
- Puerto Rico

- Republic of Palau
- Republic of the Marshall Islands
- Rhode Island
- South Carolina
- South Dakota
- Tennessee
- Texas
- U.S. Virgin Islands
- Utah
- Vermont
- Virginia
- Washington
- Washington, DC
- West Virginia
- Wisconsin
- Wyoming

Please select your position:

- PHEP Director
- Grant Manager
- Other (please specify) _____

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Workforce Reductions

1. How has your **immunization program workforce** changed within your jurisdiction since January, 2012?

Immunization program staffing levels have been reduced since January, 2012

Immunization program staffing levels have remained consistent since January, 2012 >>>> Skip to Page 6: 3. How has your **public health preparedness workforce** changed within your jurisdiction since January, 2012?

Immunization program staffing levels have increased since January, 2012 >>>> Skip to Page 6: 3. How has your **public health preparedness workforce** changed within your jurisdiction since January, 2012?

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Workforce Reductions

2. Please identify how your immunization workforce reductions occurred (select all that apply):

- Positions eliminated due to funding reductions
- Mandatory furlough
- Reduction in staff due to attrition
- Layoffs
- Delays in hiring to fill vacated positions

(End of Page 5)

Workforce Reductions

3. How has your **public health preparedness workforce** changed within your jurisdiction since January, 2012?

Public health preparedness staffing levels have been reduced since January, 2012

Public health preparedness staffing levels have remained consistent since January, 2012 >>>> Skip to End Page: Survey Submitted

Public health preparedness staffing levels have increased since January, 2012 >>>> Skip to End Page: Survey Submitted

(End of Page 6)

Workforce Reductions

4. Please identify how your public health preparedness workforce reductions occurred (select all that apply):

- Positions eliminated due to funding reductions
- Mandatory furlough
- Reduction in staff due to attrition
- Layoffs
- Delays in hiring to fill vacated positions

(End of Page 7)
