State and Local Public Health Planners: Pandemic Preparedness Readiness

OSTLTS Generic Information Collection Request
OMB No. 0920-0879

Supporting Statement – Section A

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Section A – Justification

- **Goal of the study:** Assist Public Health Emergency Preparedness (PHEP) awardees in conducting a comprehensive self-assessment of jurisdictional readiness to respond to a novel influenza pandemic, and identify gaps in pandemic influenza planning that can be addressed through improved technical assistance and training.
- **Intended use of the resulting data:** Guide improved efforts in providing state, local and territorial technical assistance and guidance in relation to pandemic influenza preparedness planning; provide information for future funding opportunity announcements.
- **Methods to be used to collect:** Web-based questionnaire (7 sections).
- **The subpopulation to be studied:** 62 state PHEP directors and other identified PHEP staff to complete each of the 7 sections; largest potential number of respondents will be 496.
- **How data will be analyzed:** Analyze data using Microsoft Excel and SAS to gather descriptive statistics, meaning the results will reflect generalizations about the sample group only and not the total STLT population.

1. Circumstances Making the Collection of Information Necessary

Background

This data collection is being conducted using the Generic Information Collection mechanism of the OSTLTS OMB Clearance Center (O2C2) – OMB No. 0920-0879. The respondent universe for this data collection aligns with that of the O2C2. Data will be first be collected from 62 Directors of the Public Health Emergency Preparedness (PHEP) cooperative agreement, who will subsequently identify up to 7 additional people to complete the 7 sections of the Pandemic Readiness Assessment. The anticipated respondents for completing each section are detailed below:

Pandemic Readiness	Anticipated Respondent
Contact Information Form	PHEP Director
Vaccination Planning (Section 1)	Immunization Coordinator
Epidemiology and Laboratory (Section 2)	State Epidemiologist and State Lab Director
Medical Care and Countermeasures (Section 3)	Strategic National Stockpile Coordinator **OR** Healthcare Preparedness Program Director
Healthcare Systems (Section 4)	Healthcare Preparedness Program

	Director
Community Mitigation (Section 5)	PHEP Director **OR** Epidemiologist
Public Information and Communication (Section 6)	Public Information Officer/Staff
Public Health and Immunization Workforce (Section 7)	PHEP Director **OR** Grant Manager

All respondents will be in state, local, and territorial health departments acting in their official capacities. The largest potential number of respondents will be 496 (8 questionnaires multiplied by 62 jurisdictions); however, in pilot testing, some respondents completed more than one section, which would result in fewer total respondents.

This data collection is authorized by Section 301 of the Public Health Service Act (42 U.S.C. 241). This information collection falls under the essential public health services{Centers for Disease Control and Prevention (CDC), #1673}[1] of:

- Monitoring health status to identify and solve community health problems
- Diagnosing and investigate health problems and health hazards in the community
- Mobilizing community partnerships to identify and solve health problems
- Developing policies and plans that support individual and community health efforts
- Assuring a competent public and personal healthcare workforce

In addition to the authority provided by the Public Health Services Act, data collection specifically around pandemic influenza is authorized by Section 319C-1 and 319C-2 of the Public Health Service Act: Public Health Emergencies (42 U.S.C. § 247d-3a(g) and by the Pandemic and All-Hazards Preparedness Act (PAHPA) of 2006 (**see Attachment A – PAHPA 2006**), which requires the 62 Public Health Emergency Preparedness (PHEP) and Hospital Preparedness Program (HPP) cooperative agreement awardees to submit annual pandemic influenza plans. In the reauthorization of PAHPA, signed March 13, 2013, this requirement was modified to allow awardees to submit all-hazards public health emergency preparedness and response plans that include descriptions of their pandemic influenza activities consistent with criteria established by the HHS Secretary. The data collected through this information collection request will be used to meet these reporting requirements.

Public health preparedness and response (PHPR) is a key public health activity supported by the federal government, especially the Office of Public Health Preparedness and Response (OPHPR) within the Centers for Disease Control and Prevention (CDC). It is also supported by other entities, including schools of public health, the Association of State and Territorial Health Officials (ASTHO), the National Association of County and City Health Officials (NACCHO), and others. Further, the role of public health in planning and responding to emergencies is set forth in the Ten Essential Public Health Services, and was recently articulated in the Public Health Accreditation Board (PHAB) Standards and Measures for national accreditation of public health agencies (**see Attachment B – PHAB Standards and Measures**).

A defining characteristic of public health emergency preparedness is the capability of public health systems to prevent, protect against, and quickly respond to public health emergencies,

and especially to unpredictable threats, in a coordinated and continuous manner. To lay the groundwork for a coordinated response to disasters, incidents, and other emergencies, the federal government articulates public health's role in Emergency Support Function (ESF) 8 – Public Health and Medical Services (**see Attachment C – ESF 08**). ESF 8 provides assistance to supplement the resources of state, local, and territorial governmental agencies to help them address core functional areas of public health and medical needs following a disaster. Some of these core functions include surveillance, patient evacuation, behavioral health care, and mass fatality management, among others.

CDC's Division of State and Local Readiness (DSLR) administers the primary tool for supporting public health's role in PHPR – the Public Health Emergency Preparedness (PHEP) cooperative agreement. PHEP provides funding to 62 awardees, including 50 states, 4 localities, and 8 territories. Since 2002, CDC has provided funding to support and advance the ability of state, local, and territorial health departments to respond to public health threats and emergencies and to build resilience (**see Attachment D – PHEP Funding Opportunity Announcement**). Preparedness activities funded by the PHEP cooperative agreement are targeted specifically for the development of emergency-ready public health departments that are flexible and adaptable. State and local public health departments are first responders to a wide variety of health threats; they are called upon to track the source, spread, and severity of health threats; assess the impact of these threats and how the public can be protected; test laboratory samples to identify the cause of infectious and non-infectious health threats; educate the public on how to safeguard their health; and work with elected officials and others to implement measures to protect the public.

CDC also provides supplemental funding through the cooperative agreement program in response to specific incidents. For example, CDC provided supplemental funding to improve response capacity for the H1N1 influenza pandemic in 2009. To help guide awardees' PHPR priorities, CDC developed a set of 15 capabilities that serve as preparedness planning standards for public health agencies. CDC developed the capabilities using evidence, literature, and subject matter expertise (**see Attachment E – CDC PHEP Capabilities**).

PHEP-funded investments in laboratory capacity, notification and syndromic surveillance specifically aimed at pandemic influenza preparedness were critical to providing early information used to characterize the severity and spread of the disease, as well as to identify populations that were at particular risk. PHEP investments in medical countermeasures distribution and dispensing greatly aided in providing antiviral medications and influenza vaccines, and investments in information-sharing and public communications helped state and local health departments to disseminate up-to-date and rapidly-changing information.

Pandemic influenza planning remains a key component of the PHEP program, and in collaboration with the CDC Influenza Coordinating Unit, DSLR identified seven priorities for planning efforts: vaccination planning, epidemiology and laboratory, medical care and countermeasures, healthcare system readiness, community mitigation, public information and

communication and state coordination. The emergence of the novel influenza A (H7N9) virus illnesses in China in 2013, combined with the identification of this virus in a traveler from an H7N9-affected area of China, has raised concerns about the possibility of mutations that would allow for sustained person-to-person transmission. To date, the reported case fatality ratio from human H7N9 infections is more than 30%.[2]{Yu, 2013 #1672}{Yu, 2013 #1672}{Kissin, 2011 #809}{Yu, 2013 #1672}{Yu, 2013 #1672}{Yu, 2013 #1672} Should the H7N9 virus mutate to allow for sustained human-to-human transmission, it appears capable of causing severe disease in all age groups.

To that end, 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. The proposed data collection will assist PHEP awardees with conducting a comprehensive self-assessment of jurisdictional readiness to respond to a novel influenza pandemic, and identify gaps in pandemic influenza planning that can be addressed through improved technical assistance and training. The results will then ultimately be used by CDC to identify promising state, local and territorial preparedness practices that may be shared with other PHEP awardees and to develop future PHEP program improvement initiatives.

Overview of the Data Collection System

The data collection system consists of two stages of web-based assessments:

1. The first stage of data collection will be for the PHEP Directors who are responsible for program operations in each of the awardee jurisdictions. The primary purpose of the first stage is to obtain names and email information for each person who the PHEP director designates to answer each of the 7 sections of the pandemic readiness assessment. The information will be collected via email (**see Attachment F – PHEP Contact Assessment Instrument**).
2. The contact information obtained in stage 1 will be used to identify the appropriate person(s) within each jurisdiction to complete each of the 7 subsequent assessment instruments. The second stage assessments will ask respondents to answer questions within a specific content area about their jurisdictional readiness to respond to an influenza pandemic (**see Attachments G1–M2 and table below**). The assessments will be programmed using the web-based tool, Vovici, which allows users to be able to save their work and come back to it on a later time. The assessments will be distributed by emailing an invitation letter and link to the appropriate assessment tool to the respondents identified in stage 1. While the entire assessment (all sections) will be sent to the PHEP Director for oversight and awareness, it is anticipated that each section will be completed by the appropriate jurisdictional subject matter expert working in conjunction with the PHEP Director, as follows:

Pandemic Readiness Section	Anticipated Respondent	Instrument Attachments: Word, Web Versions*

Contact Information	PHEP Director	F (Word version only)
Vaccination Planning (Section 1)	Immunization Coordinator	G1, G2
Epidemiology and Laboratory (Section 2)	State Epidemiologist and State Lab Director	H1, H2
Medical Care and Countermeasures (Section 3)	Strategic National Stockpile Coordinator OR Healthcare Preparedness Program Director	I1, I2
Healthcare Systems (Section 4)	Healthcare Preparedness Program Director	J1, J2
Community Mitigation (Section 5)	PHEP Director OR Epidemiologist	K1, K2
Public Information and Communication (Section 6)	Public Information Officer/Staff	L1, L2
Public Health and Immunization Workforce (Section 7)	PHEP Director OR Grant Manager	M1, M2

**NOTE: Web versions of the assessment instruments are provided in PDF form. The assessments have already been programmed in the web-based tool, Vovici, and exported in PDF form, which are used as stand-ins for page-by-page screenshots of the instruments, due to large file size and burden of manual copy and paste of numerous pages for all 7 instruments. The PDF versions show the exact questions respondents will see in Vovici.*

The initial assessment was pilot tested by nine PHEP Directors who serve on the Executive Committee of the Directors of Public Health Preparedness. The pilot testing was conducted to: 1) ensure that the questions asked are relevant to the respondent pool; 2) ensure that all items are directly linked to the PHEP capabilities that are the framework for PHEP-funded activities; and 3) identify information that is already available through other data collections. During the pilot testing phase, we discovered that the PHEP Directors did not complete the entire assessment themselves, but rather sent sections to other PHEP and health department staff with more direct knowledge of content areas. Because of this, and other feedback given during a debriefing session, the decision was made to break the assessment into separate sections that could be sent directly to points of contact identified by the PHEP Director. In addition, pilot testing feedback was used to reduce the total number of questions, refine questions, ensure accurate programming and skip patterns, and establish the estimated time required to complete the assessment.

<u>Items of Information to be Collected</u>

The pandemic influenza readiness assessment is organized into 7 sections corresponding to the priority pandemic planning areas listed below. Each section contains a description of an influenza pandemic scenario that sets the context in which the questions should be considered, as well as a goal and set of assumptions specific to each content area. Questions within each assessment section relate directly to PHEP Capabilities as noted below (refer to **Attachment E**

for more information on PHEP Capabilities), and are intended to measure awardee preparedness and identify gaps that will be the target of additional technical assistance and training.

Questions within each section are mutually exclusive, (i.e., the same question does not appear in multiple sections), and include a mixture of yes/no questions, Likert scales, drop down menus and limited character open text. Response-based skip patterns have been incorporated to ensure awardees respond only to questions that are specifically applicable. The assessment content was developed collaboratively between the Division of State and Local Readiness, the Immunization Services Division, and other CDC subject matter experts to align with the ten Public Health Emergency Preparedness Capability Standards that form the core of the PHEP Cooperative Agreement. The assessment questions address the following priority pandemic planning sections:

- **Vaccination Planning**: 62 questions, covering jurisdictional capacity to administer vaccine (n=10), vaccination of critical infrastructure (n=7), plans for allocating vaccine (n=9), vaccine provider enrollment and training (n=21), vaccine ordering and management (n=2), and immunization information systems (n=13). Questions in this section are designed to assess the following PHEP Capabilities: 8 – Medical Countermeasure Dispensing, 9 – Medical Materiel Management and Distribution, 10 – Medical Surge, 14 – Responder Safety and Health, and 15 – Volunteer Management.
- **Epidemiology and Laboratory:** 11 questions, covering capacity to conduct influenza surveillance, contact tracing, basic epidemiological investigation and more detailed epidemiologic investigations, and laboratory capacity to test and transport specimens. Questions in this section are designed to assess the following PHEP Capabilities: 6 – Information-Sharing, 12 – Public Health Laboratory Testing, and 13 – Public Health Surveillance and Epidemiologic Investigation.
- **Medical Care and Countermeasures:** 13 questions, covering ventilator stockpiles, allocation plans and capacity for use; availability and plans for use of respiratory protective devices; and plans for distribution and dispensing of antiviral medications. Questions in this section are designed to assess the following PHEP Capabilities: 8 – Medical Countermeasure Dispensing, 9 – Medical Materiel Management and Distribution, 10 – Medical Surge, and 14 – Responder Safety and Health.
- **Healthcare Systems**: 5 questions, covering plans to address potential staff absenteeism, coordination with the Strategic National Stockpile, and surge demands upon the healthcare and emergency systems. Questions in this section are designed to assess PHEP Capability 10 – Medical Surge.
- **Community Mitigation**: 8 questions, coverings plans for selecting and implementing community-level non-pharmaceutical interventions (such as school closures or cancellation of community events) to slow the spread of influenza. Questions in this section are designed to assess PHEP Capability 11 – Nonpharmaceutical Interventions.
- **Public Information and Communication**: 8 questions, covering pandemic influenza communication plans and the anticipated communication strategies, target audiences, and channels; procedures for clearing information to be released to the public; and plans for

reaching vulnerable and non-English speaking populations. Questions in this assessment section relate directly to PHEP Capability 4 – Emergency Information and Warning.

- **Public Health and Immunization Workforce:** 4 questions, covering how immunization and public health preparedness workforces within the jurisdiction have changed. Questions in this model address administrative preparedness and overall PHEP program capacity.

2. Purpose and Use of the Information Collection

The overall purpose of the data collection is to understand the collective ability of our nation to prepare for and respond to emerging pandemics. The proposed data collection will:

- Allow assessment of the ways in programmatic activities around PHEP Capabilities improve the nation's ability to respond to a novel influenza pandemic.
- Assist state, local and territorial public health programs in a self-assessment of their ability to achieve the goal of vaccinating 80% of the jurisdiction's population with two doses of a pandemic influenza vaccine in less than 16 weeks.
- Identify gaps in pandemic influenza planning that can be addressed through improved technical assistance and training for PHEP awardees.
- Identify effective program practices and strategies for preparing and responding to severe influenza pandemics to share with PHEP awardees.
- Identify areas of improvement in pandemic planning and response that have taken place since the 2009 H1N1 novel influenza pandemic and areas where further improvement is needed.

CDC intends to share readiness assessment results with the Secretary of Health and Human Services to help advance public health and healthcare system pandemic influenza planning. Internally, results from the readiness assessment will be used in the following ways:

- Guide improved efforts in providing state, local and territorial technical assistance and guidance in relation to pandemic influenza preparedness planning.
- Provide information for future funding opportunity announcements.

3. Use of Improved Information Technology and Burden Reduction

Data will be collected via web-based data collection instruments allowing respondents to complete and submit their responses electronically. This method was chosen to reduce the overall burden on respondents. Web-based assessments reduce respondent burden by enabling easy access and completion at a convenient time and location. Vovici, the Deloitte web-based system that will be used to implement the assessment tool, has browser-independence, which ensures that respondents will be able to view the assessment regardless of which Internet browser they are using. Use of a web-based system allows us to seamlessly incorporate response-based skip patterns, thus preventing respondents from having to read through unnecessary questions that do not pertain to them.

Based on feedback from the pilot testing, we have divided the original instrument into seven smaller instruments that target the person with the subject matter expertise, thus minimizing

the number of questions each respondent has to answer and the amount of time needed to gather the information. The majority of assessment questions consist of easy-to-read text with yes-no, multiple choice, or Likert-type response options. Further, the number of open-ended response options was minimized to reduced burden on respondents.

4. Efforts to Identify Duplication and Use of Similar Information

This assessment represents a new effort to conduct a comprehensive assessment of PHEP awardee readiness to respond to a novel influenza pandemic that is aligned with functions and tasks outlined within *Public Health Preparedness Capabilities: National Standards for State and Local Planning*. The development of this assessment tool involved collaboration with CDC's Influenza Coordinating Unit and subject-matter experts from each of the pandemic influenza response Task Forces to identify questions needing to be answered for which data have not been collected. In the process of pilot testing the instrument, CDC identified, and subsequently removed, questions where information was, or could be, collected by other means.

The Vaccination Planning Section (**see Attachment G1 and G2**) contains questions that were asked in an earlier rapid assessment of vaccination capacity among state and local public health departments during the identification of novel influenza A(H7N9) virus infection among humans in China in 2013. Following the 2013 assessment, concerns remained among the Incident Command, CDC Director, and Assistant Secretary of Preparedness and Response about the actual plan of operations for reaching the reported vaccination capacities of state and local public health groups. Because of these concerns, the Incident Command asked the Vaccine Task Force to provide subject matter expertise to the Division of State and Local Response in OPHPR to deploy a more comprehensive assessment of state and local vaccination response and plan of operations.

Follow-up evaluation is still needed urgently for pandemic planning purposes to include updates in state and local vaccination capacity since the initial rapid assessment and to gain more detailed information not gathered previously. This new information includes details about information on plans and systems for vaccine management, logistics of vaccine provider allocations and prioritization, mass vaccination and Points of Dispensing planning, staff and budget planning, Immunization Information System capacity and development, and implication of public health emergency declarations on regulations pertaining to the number and types of potential vaccine providers during a pandemic.

5. Impact on Small Businesses or Other Small Entities

No small businesses will be involved in this data collection.

6. Consequences of Collecting the Information Less Frequently

This data collection is a direct response to CDC's need to assess the readiness of awardees to mount a quick and effective response to a novel influenza pandemic. The consequences of not collecting this information would be:

- Failure to systematically evaluate program improvements made since the 2009 H1N1 pandemic
- Failure to identify the mechanisms and technical assistance needs of PHEP awardees to be able to adequately respond to a novel influenza pandemic
- Failure to develop tools and identify program needs in response to current PHEP awardee needs

This request is for a one time data collection. There are no legal obstacles to reduce the burden.

7. Special Circumstances Relating to the Guidelines of 5 CFR 1320.5

There are no special circumstances with this information collection package. This request fully complies with the regulation 5 CFR 1320.5 and will be voluntary.

8. Comments in Response to the Federal Register Notice and Efforts to Consult Outside the Agency

This data collection is being conducted using the Generic Information Collection mechanism of the OSTLTS OMB Clearance Center (O2C2) – OMB No. 0920-0879. A 60-day Federal Register Notice was published in the Federal Register on October 31, 2013, Vol. 78, No. 211; pp. 653 25-26. No comments were received.

CDC partners with professional STLT organizations, such as the Association of State and Territorial Health Officials (ASTHO), the National Association of County and City Health Officials (NACCHO), and the National Association of Local Boards of Health (NALBOH) along with the National Center for Health Statistics (NCHS) to ensure that the collection requests under individual ICs are not in conflict with collections they have or will have in the field within the same timeframe.

9. Explanation of Any Payment or Gift to Respondents

CDC will not provide payments or gifts to respondents.

10. Assurance of Confidentiality Provided to Respondents

The Privacy Act does not apply to this data collection. Employees of state and local public health agencies will be speaking from their official roles and will not be asked, nor will they provide individually identifiable information.

This data collection is not research involving human subjects.

10.1 Privacy Impact Assessment Information

No individually identifiable information (IIF) will be collected.

11. Justification for Sensitive Questions

No information will be collected that is of a sensitive nature.

12. Estimates of Annualized Burden Hours and Costs

The estimate for burden hours is based on a pilot test of the data collection instrument by nine PHEP Directors on the Executive Council of the Directors of Public Health Preparedness. In the pilot test, the average time to complete the assessment including time for reviewing instructions, gathering needed information and completing the assessment, was approximately 2 hours for the Vaccination Planning assessment. Time to completion for the other assessment sections ranged from 5 minutes to 30 minutes. For the purposes of calculating burden hours for these other instruments, the upper limit was used (i.e., 30 minutes). We discovered during the pilot testing, that rather than completing the entire assessment themselves, the 9 PHEP Directors assigned portions of the assessment to specific subject matter experts within their agency. Based on this approach, the original assessment has been split into 7 assessments, each with a different respondent pool. The estimated times reported in table A-12 were derived from the time it took to complete each survey section in the original assessment.

Estimates for the average hourly wage for respondents are based on the Department of Labor (DOL) National Compensation Survey estimate for management occupations – medical and health services managers in state government (http://www.bls.gov/ncs/ocs/sp/nctb1349.pdf). Based on DOL data, an average hourly wage of $48.90 is estimated for all 496 respondents. Table A-12 shows estimated burden and cost information.

Table A-12: Estimated Annualized Burden Hours and Costs to Respondents

Information collection Instrument: Form Name	Type of Respondent	No. of Respondents	No. of Responses per Respondent	Average Burden per Response (in hours)	Total Burden Hours	Hourly Wage Rate	Total Respondent Costs
PHEP Contact Assessment Instrument	State, Tribal, Local, and Territorial PHEP Grant Contacts for CDC	62	1	30/60	31	$48.90	$1,515.90
Section 1 – Vaccination Planning	State Immunization Coordinator	62	1	2	124	$48.90	$6,063.60
Section 2 – Epidemiology and Laboratory	State Epidemiologist and State Lab Director	62	1	30/60	31	$48.90	$1,515.90

Section 3 – Medical Care Countermeasures	Strategic National Stockpile Coordinator OR Healthcare Preparedness Program Director	62	1	30/60	31	$48.90	$1,515.90
Section 4 – Healthcare Systems	Healthcare Preparedness Program Director	62	1	30/60	31	$48.90	$1,515.90
Section 5 – Community Mitigation	PHEP Director OR Epidemiologist	62	1	30/60	31	$48.90	$1,515.90
Section 6 – Public Information and Communication	Public Information Officer/Staff	62	1	30/60	31	$48.90	$1,515.90
Section 7 – Public Health and Immunization Workforce	PHEP Director OR Grant Manager	62	1	30/60	31	$48.90	$1,515.90
Totals		**496**			**341**		**$16,674.90**

13. Estimates of Other Total Annual Cost Burden to Respondents or Record Keepers

There will be no direct costs to the respondents other than their time to participate in each assessment.

14. Annualized Cost to the Government

There are no equipment or overhead costs. The only cost to the federal government would be the salary of CDC staff and consultant supporting the data collection activities and associated tasks.

The lead staff for this project are a Senior Public Health Advisor (GS-14) and a Senior Epidemiologist (GS-14) in OPHPR's Division of State and Local Readiness. The lead staff developed the assessment, and will collect and prepare the data for analysis; analyze the data; and conduct and prepare the assessment report. The consultant will assist with all of these tasks. The estimated cost to the federal government is $8,498.

Table A-14: Estimated Annualized Cost to the Federal Government

Staff (FTE)	Average Hours per Collection	Average Hourly Rate	Average Cost
Epidemiologist (GS-14) Instrument development, pilot testing, Instrument development, pilot testing, OMB package preparation, data collection, data analysis and report preparation	100	$48.90	$4,890
Public Health Advisor (GS-14) Instrument development, pilot testing, OMB package preparation, data collection, data analysis and report preparation	40	$48.90	$1,956
Consultant (GS-13 equivalent) Instrument development, pilot testing, OMB package preparation, data collection, data analysis and report preparation	40	$41.30	$1,652
Estimated Total Cost of Information Collection			**$8,498**

15. Explanation for Program Changes or Adjustments

This is a new data collection.

16. Plans for Tabulation and Publication and Project Time Schedule

We plan to analyze data using Microsoft Excel and SAS to gather descriptive statistics, meaning the results will reflect generalizations about the sample group only and not the total STLT population. Once analyzed, we plan to share our findings with other CDC stakeholders and CDC leadership via the CDC Public Health Law News, the Public Health Law Program website, peer-reviewed journal articles, and conference presentations.

Project Time Schedule

Design instrument..... Complete
Pre-test instrument..... Complete
Prepare OMB package..... Complete
Submit OMB package..... Complete
OMB approval..... TBD
Launch assessment..... Open 3 weeks
Reminder partial- and non-responders.....Week 1 and 2 of assessment open
Code, enter, and analyze data..... 5 weeks after assessment close
Prepare final report..... 9 weeks after assessment close
Delivery final report..... 10 weeks after assessment close

17. Reason(s) Display of OMB Expiration Date is Inappropriate

We are requesting no exemption.

18. Exceptions to Certification for Paperwork Reduction Act Submissions

There are no exceptions to the certification. These activities comply with the requirements in 5 CFR 1320.9.

LIST OF ATTACHMENTS – Section A

Note: Attachments are included as separate files as instructed.

- **A.** PAHPA 2006
- **B.** PHAB Standards and Measures
- **C.** ESF 08
- **D.** PHEP Funding Opportunity Announcement
- **E.** CDC PHEP Capabilities
- **F.** PHEP Contact Assessment Instrument Word Version
- **G.** Section 1: Vaccination Planning Instrument – Word version (G1) and Web version (G2)
- **H.** Section 2: Epidemiology and Laboratory Instrument – Word version (H1) and Web version (H2)
- **I.** Section 3: Medical Care Countermeasures Instrument – Word version (I1) and Web version (I2)
- **J.** Section 4: Healthcare Systems Instrument – Word version (J1) and Web version (J2)
- **K.** Section 5: Community Mitigation Instrument – Word version (K1) and Web version (K2)
- **L.** Section 6: Public Information and Communication Instrument – Word version (L1) and Web version (L2)
- **M.** Section 7: Public Health and Immunization Workforce Instrument – Word version (M1) and Web version (M2)

REFERENCE LIST

1. Centers for Disease Control and Prevention (CDC). National Public Health Performance Standards Program (NPHPSP): 10 Essential Public Health Services. http://www.cdc.gov/nphpsp/essentialservices.htm. Last accessed: 8/14/14
2. Yu H, Cowling BJ, Feng L, et al. Human infection with avian influenza A H7N9 virus: an assessment of clinical severity. The Lancet 2013;382(9887):138-45.