

Centers for Disease Control and Prevention (CDC)
BP4 Medical Countermeasure (MCM) Operational Readiness Review (ORR) Guidance

Budget Period 4

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Introduction

In July 2014, the Centers for Disease Control and Prevention (CDC) implemented a new method of reviewing state and local medical countermeasure operational readiness. The medical countermeasure (MCM) operational readiness review (ORR) replaces CDC's technical assistance review (TAR) planning tool, which CDC used successfully for nearly a decade to review medical countermeasure planning at the state and local levels. CDC developed the MCM ORR with input from national partner associations and representatives of 19 state and local Public Health Emergency Preparedness (PHEP) jurisdictions. The MCM ORR tool builds on the progress jurisdictions have made over the years in planning for distributing and dispensing medical countermeasures and is intended to identify areas for improved implementation. The purpose of this document is to provide an overview of the MCM ORR tool.

The review process is designed to better determine the ability of a jurisdiction to implement plans in response to an incident or exercise requiring distribution and dispensing of medical countermeasures. The scope of the tool is expanded to align with the following eight public health preparedness capabilities:

- Capability 1: Community Preparedness
- Capability 3: Emergency Operations Coordination
- Capability 4: Emergency Public Information and Warning
- Capability 6: Information Sharing
- Capability 8: Medical Countermeasure Dispensing
- Capability 9: Medical Material Management and Distribution
- Capability 14: Responder Safety and Health
- Capability 15: Volunteer Management

With this process, awardees can expect a standardized approach to promote a more consistent and equitable evaluation of the response capacity within a jurisdiction. In addition, this process directs more attention to the operational implementation associated with planning elements within each capability.

State and Local Tool Application

CDC designed a comprehensive ORR tool for all 62 Public Health Emergency Preparedness (PHEP) cooperative agreement awardees, as well as Cities Readiness Initiative (CRI) local planning jurisdictions. The majority of the elements in the tool should be interpreted and applied at both

jurisdictional levels. Specific responsibilities may vary, and it is imperative that participants review each element carefully to determine relevance. For example, there are elements included in Capability 9 that apply at both the local and state levels.

If local jurisdictions are responsible for a particular function, the state must demonstrate that it provides guidance and assistance to local counterparts, in addition to monitoring, tracking, and evaluating local activities. States should document procedures for monitoring local operational activities for operational elements that truly do not apply to a state. For example, in Capability 8, while primary operational responsibilities pertain to local jurisdictions, the state has a direct role in providing guidance and training, as well as monitoring and evaluating various elements.

Determining Operational Readiness: Four Levels of Implementation

The MCM ORR does not use numerical scoring. Instead, it indicates jurisdictions' readiness status for each element using a continuum of implementation levels: early, intermediate, established, and advanced. The descriptions for these levels reflect enhancements based upon evaluation of Budget Period 3 (BP3) data and jurisdictional feedback. CDC expects that jurisdictions who demonstrate an advanced level of implementation will conduct continuous quality improvement activities within their own jurisdiction (e.g., development of an AAR/IP/CAP) and coordinate efforts with all key partners (i.e., federal, state, local, and community partners), particularly within CRI MSAs. CDC also expects that, over time, jurisdictions will demonstrate progress in implementing their response plans. CDC understands that factors may limit the ability to achieve an advanced level; however, jurisdictions should use continuous quality improvement processes to consistently identify gaps that lead to the improvement of planning and operations.

- **Early Implementation** - Jurisdiction demonstrates *some* of the planning and / or operational criteria.
- **Intermediate Implementation** - Jurisdiction demonstrates *many* of the planning and / or operational criteria.
- **Established Implementation** - Jurisdiction demonstrates *most* of the planning and / or operational criteria.
- **Advanced Implementation** - Jurisdiction demonstrates *all* planning and *all* operational criteria.

For each element in the MCM ORR, the four-implementation levels are defined by specific criteria. For example, under Planning Implementation, Capability 1: Community Preparedness, Function 2, element a. reads:

		Planning Implementation			
		Early	Intermediate	Established	Advanced
Function 2	Build community partnerships to support health preparedness	a. Plans address partner engagement and document written acknowledgment of response roles for the following partners: 1) private sector, 2) local, 3) state, and 4) regional.			
		Written plans include none of the above	Written plans include one or two of the above	Written plans include three of the above	Written plans include all of the above

Demonstrating Operational Readiness

As it relates to medical countermeasures, CDC defines operational readiness as the capability of a jurisdiction to execute their medical countermeasure distribution and dispensing plans during a public health response. Operational readiness is demonstrated by conducting trainings and exercises or responding to incidents according to Homeland Security Exercise and Evaluation Program (HSEEP) guidance. HSEEP is based on national best practices and was developed to support the National Preparedness System. It provides a consistent approach to exercises and measuring progress toward building, sustaining, and delivering core capabilities. Jurisdictions **must** document results of the MCM distribution and dispensing full-scale exercise (FSE) according to HSEEP standards and principles.

Overlap with Performance Measures

CDC has taken into account overlapping PHEP performance measures and other exercise metrics in developing the MCM ORR. CDC does not intend to ask jurisdictions to duplicate efforts but rather to highlight important MCM and general incident planning and operational concepts. To assist jurisdictions in completing the MCM ORR, elements where there are direct synergies with PHEP performance measures are indicated throughout this document. When possible, jurisdictions are strongly encouraged to use program activities to meet these multiple requirements. The MCM ORR tool, and this guidance document, provides all necessary details to complete the review.

Documentation

While the focus of this operational assessment is on readiness to respond to an incident, there are situations where processes outlined in other plans or tested during a non-MCM incident or exercise could be used to meet certain elements of the ORR. Plans will be accepted as evidence to address certain elements of the tool as long as they include the criteria outlined in the tool and can be associated with MCM-specific operational

plans. Evidence from an incident or exercise can also be provided to address certain elements of the tool, regardless of the scenario, as long as the processes, procedures, and personnel used strongly translate to activities that would be expected during an incident or exercise involving MCM. This guidance provides example documentation for each element. Not all of the examples listed are required and some jurisdictions may have documentation that is not listed in the examples. Project officers in CDC's Division of State and Local Readiness (DSLRL) have ultimate discretion in determination of acceptable documentation. Unless otherwise specified, supporting documentation for planning elements (including relevant training records) should be up-to-date, (no older than the date of the previous review). Documentation for operational elements will be accepted if the date of the exercise or incident falls within the timeframe indicated in the specific element.

Implementation

The state, local, tribal, and territorial (SLTT) authorities will use the MCM ORR tool to conduct their reviews. Budget Period 4 BP4 will be considered a baseline period in which CDC will collect data that is representative of MCM ORRs on a national scale. The MCM ORR data for PHEP awardees and CRI local planning jurisdictions will be publicly released.

CDC Implementation:

- CDC will conduct the MCM ORR for all 62 PHEP awardees
- CDC will conduct an MCM ORR for one CRI local planning jurisdiction within each CRI metropolitan statistical area (MSA)
 - For states with CRI MSAs that cross state borders, CDC will review a local planning jurisdiction from the state with the largest population within the MSA.
 - CDC may choose to review additional CRI local planning jurisdictions based on risk, operational gaps, or other criteria.

Awardee Implementation:

- Awardees are required to conduct operational reviews for all remaining CRI local planning jurisdictions and must submit the resulting data to CDC
- Awardees are expected to provide training on the MCM ORR tool and process to all local CRI planning jurisdictions
- Awardees may choose how they conduct reviews (i.e. video-conferences, webinars, conference calls, or a combination of all).

Submission

State and local CRI jurisdictions should complete a self-review and provide DSLRL project officers with all supporting documentation for the MCM ORR at least **10 business days prior to the site visit**. Jurisdictions should use the forms located on the CDC MCM ORR SharePoint Site to conduct

the self-review. Documents must be submitted in final form; documents in draft form will not be accepted. All 62 PHEP awardees and all CRI local planning jurisdictions must submit MCM ORRs and jurisdictional data sheets (JDSs) by **May 1, 2016**.

MCM ORR Tool

Capability 1: Community Preparedness									
		Planning Implementation				Operational Implementation			
		Early	Intermediate	Established	Advanced	Early	Intermediate	Established	Advanced
Function 1	Determine risks to the health of the jurisdiction	a. MCM planning elements include the following based on risk assessments: 1) definition of risk, 2) mapped locations of at-risk populations, 3) evidence of community involvement, 4) assessment of loss or disruption of essential services (i.e. water, sanitation, healthcare services, and public health agency infrastructure).				None			
		Written plans include none of the above	Written plans include one or two of the above	Written plans include three of the above	Written plans include all of the above				
Function 2	Build community partnerships to support health preparedness	a. Plans address partner engagement and document written acknowledgment of response roles for the following partners: 1) private sector, 2) local, 3) state, and 4) regional.				a. Jurisdiction can provide evidence of how the roles and responsibilities of these partners have been used within the last five years.			
		Written plans include none of the above	Written plans include one or two of the above	Written plans include three of the above	Written plans include all of the above	No exercise conducted	Tabletop exercise conducted	Functional exercise conducted	Full-scale exercise or real incident
Function 3	Engage with community organizations to foster public health, medical, and mental/behavioral health social networks	a. Plan addresses engagement with community partners, to include medical and mental/behavioral health agencies to promote an understanding of and connection to MCM activities.				None			
		No engagement procedure in plan	Engagement procedure for some but not all partners is outlined in the plan	Engagement procedure for all partners is outlined in the plan	Engagement procedure for all partners is outlined in the plan, which also includes a process for an information exchange between partners				

Capability 1: Community Preparedness							
Function 4	Coordinate training or guidance to address community engagement in preparedness efforts	a. Provide MCM-related public health preparedness and response training or guidance to community partners, including groups representing at-risk populations, to assist them in educating their own constituency groups regarding emergency preparedness and response plans.				None	
		No training or guidance has been provided to community partners	Training or guidance has been provided to less than 50% of partners	Training or guidance has been provided to 50% or more but less than 100% of partners	Training or guidance has been provided to 100% of all community partners		

Capability 3: Emergency Operations Coordination

		Planning Implementation				Operational Implementation			
		Early	Intermediate	Established	Advanced	Early	Intermediate	Established	Advanced
Function 1	Conduct preliminary assessment to determine need for public activation	a. Plans describe strategies to coordinate with appropriate epidemiology, laboratory, medical, chemical, biological, and radiological subject matter experts (SMEs) to inform MCM decision-making. Plans should include the following elements: 1) analyze data, 2) assess emergency conditions, and 3) determine the activation levels based on the complexity of the event or incident required to support an MCM response.				a. Participation of appropriate subject matter experts to inform MCM decision-making has been exercised within the last five years.			
		Written plans contain none of the above elements	Written plans contain one of the above elements	Written plans contain two of the above elements	Written plans contain all of the above elements	Contact lists for all SMEs are on file	Necessary SMEs included in a tabletop exercise	Necessary SMEs included in a functional exercise	Necessary SMEs included in a full-scale exercise or a real incident
		b. Plans document a process depicting what/when actions would be initiated for 1) pre-event indicators, 2) notifications, 3) activations, 4) logistics, 5) operations, 6) sustained operations, or 7) demobilization.				None			
		Written plans contain none of the above elements	Written plans contain one to three of the above elements	Written plans contain four to six of the above elements	Written plans contain all of the above elements.				
		c. Plans identify the redundant communication platforms that are in place to ensure communications remain available should primary communication systems become unavailable				c. Quarterly testing of redundant communications platforms is conducted and documented.			
		Jurisdiction documents use of one or fewer communication platforms	Jurisdiction documents use of two communication platforms	Jurisdiction documents use of three communication platforms	Jurisdiction documents use of four or more communication platforms	Zero or one communication platform tested quarterly	Two communication platforms tested quarterly	Three communication platforms tested quarterly	Four or more communication platforms tested quarterly

Capability 3: Emergency Operations Coordination

Function 2	Activate public health emergency operations	a. Plans identify staff with the subject matter expertise to fulfill required incident command and emergency management roles in emergency operations centers (EOCs) as required during an MCM response.				a. Incident command and emergency management staff have exercised required EOC roles during an MCM incident during the last five years.			
		0-24% of staff identified	25-49% of staff identified	50-74% of staff identified	75-100% of staff identified	No exercise conducted	Tabletop exercise conducted	Functional exercise conducted	Full-scale exercise conducted or real incident
		b. Plans 1) identify sites or virtual structure to serve as the unified health command (Health EOC), and 2) document procedures for setting up the Health EOC.				b. Site activation (via staff assembly) of Health EOC or virtual structure supporting unified health command during an MCM incident at least every two years. NOTE: For awardees, this element refers to PHEP Performance Measure 3.1			
		Written plans contain none of the above elements	Written plans contain one of the above elements	Written plans contain both of the above elements	Written plans contain both of the above elements and evidence that required parties have been trained	EOC not activated	EOC activated in more than 60 minutes	EOC activated in more than 45 and less than or equal to 60 minutes	EOC activated in 45 minutes or less
Function 3	Develop incident response strategy	a. Plans document processes for completing the following elements required to support an MCM response: 1) incident action plan, 2) situation reports, and 3) finance/administration logs.				None			
		Written plans contain none of the above elements	Written plans contain one of the above elements	Written plans contain two of the above elements	Written plans contain all of the above elements				
Function 4	Manage and sustain the public health response	a. Plans address continuity strategies in the event that primary systems are unavailable during an MCM response, including: 1) activation triggers, 2) loss of facilities (RSS, RDS, PODs, etc.), 3) loss of personnel, 4) orders of succession, and 5) devolution.				a. Continuity plans, as they apply to an MCM response, have been exercised within the last five years.			
		Written plans contain none of the above	Written plans contain one or two of the above	Written plans contain three or four of the above	Written plans contain all of the above	No exercise conducted	Tabletop exercise conducted	Functional exercise conducted	Full-scale exercise conducted or real incident

Capability 3: Emergency Operations Coordination

Function 5	Demobilize and evaluate public health emergency operations	a. Plans describe strategies to demobilize assets and personnel during an MCM incident. This includes the following elements: 1) development of processes with support agencies for collection and transport of assets and personnel, and 2) signed written agreements to support demobilization.				None			
		No written plans in place	Written plans contain one of the above elements	Written plans contain all of the above elements	Written plans contain all of the above elements and demonstrate that required parties have been trained				
		b. Plans identify a sufficient number of staff (as defined by the jurisdiction) are trained in the Homeland Security Exercise and Evaluation Program (HSEEP) to develop after-action reports (AAR) and improvement plans (IP).				None			
		Written plans do not identify exercise/training staff	Written plans identify exercise/training staff, but staffing gaps exist	Written plans identify exercise/training staff, and no staffing gaps exist	Written plans identify exercise/training staff, no staffing gaps exist, and jurisdiction employs at least one certified master exercise practitioner (MEP)				
		c. Plans identify processes and responsibilities for 1) developing a multi-year training and exercise plan (MYTEP), 2) conducting a hot wash, and 3) implementing IPs that incorporate MCM activities.				c. Annual training and exercise plan (TEP) workshop is conducted and a MYTEP is produced that incorporates MCM, and completion of required documentation demonstrating that the IP has been implemented and exercise components have been retested and re-evaluated accordingly.			
		No written plans in place	Written plans contain one of the above elements	Written plans contain two of the above elements	Written plans contain all of the above elements	TEP workshop not conducted	TEP workshop conducted but MYTEP not complete	TEP workshop conducted and MYTEP complete	TEP workshop conducted and MYTEP complete and demonstrates that IP has been developed and retested/re-evaluated

Capability 4: Emergency Public Information and Warning

		Planning Implementation				Operational Implementation			
		Early	Intermediate	Established	Advanced	Early	Intermediate	Established	Advanced
Function 1	Activate the emergency public information system	a. Plans document public information and communication primary and back-up personnel who are trained in MCM responsibilities and current contact lists exist for these individuals.				None			
		Plans do not identify public information and communication staff	Plans identify primary public information and communication staff	Plans identify primary and back-up public information and communication staff	Plans identify primary and back-up public information and communication staff and demonstrate that required parties have been trained				
Function 2	Determine the need for a joint public information system	a. Plans include processes for the establishment of scalable joint information operations with MCM components, including 1) trigger points, and 2) decision criteria.				a. Joint information operations (scaled to the public information demands) have been exercised within the last five years.			
		Written plans include none of the above elements	Written plans include one of the above elements	Written plans include all of the above elements	Written plans include all of the above elements and evidence that relevant parties have been trained	No exercise conducted	Tabletop exercise conducted	Functional exercise conducted	Full-scale exercise conducted or real incident
Function 3	Establish and participate in information system operations	a. Plans include procedures for 1) media notification (including an updated contact list) and credentialing, 2) press advisories and briefings, and 3) media monitoring and validation (including social media).				None			
		Written plans contain none of the above elements	Written plans contain one of the above elements	Written plans contain two of the above elements	Written plans contain all of the above elements				

Capability 4: Emergency Public Information and Warning											
		b. Public health public information officer (PIO) responsibilities are documented in the job aid for the PIO or other MCM-designated staff and include the following elements: 1) coordinating information with the lead PIO and/or joint information center (JIC), 2) serving as the point-of-contact for the media, and 3) controlling public information messages and materials.				None					
		Written job aid not in place or job aid contains none of the above elements	Written job aid contains one of the above elements	Written job aid contains two of the above elements	Written job aid contains all of the above elements						
Function 4	Establish avenues for public interaction and information exchange	a. Plans include methods for the public to contact the health department with MCM-related questions and concerns through 1) phone (i.e., call centers and/or help desks), 2) social media, 3) web chat, 4) e-mail, or 5) other communication platforms.				a. The jurisdiction can provide evidence of participation in an exercise or real incident within the last five years that demonstrates all applicable methods (referenced in the planning element) to address MCM-related questions/concerns from the public.					
		Written plans contain none of the above	Written plans contain one of the above	Written plans contain two of the above	Written plans contain three or more of the above	No exercise conducted	Tabletop exercise conducted	Functional exercise conducted	Full-scale exercise conducted or real incident		
Function 5	Issue public information alerts, warnings, and notifications	a. Plans include procedures for 1) information verification; 2) message development, approval, and clearance; and 3) message dissemination to the public, as they relate to an MCM mission.				a. The jurisdiction can provide evidence of participation in an exercise or real incident within the last five years in which public messages that incorporate MCM elements are created and disseminated.					
		Written plans contain none of the above elements	Written plans contain one of the above elements	Written plans contain two of the above elements	Written plans contain all of the above elements	No exercise conducted	Tabletop exercise conducted	Functional exercise conducted	Full-scale exercise conducted or real incident		
		b. Plans include a process for the pre-incident and real-time translation of information specific to an MCM response to address the following populations of the jurisdiction: 1) non-English speaking, 2) hearing impaired, 3) visually impaired, and 4) limited language proficiency populations.				b. The jurisdiction can provide evidence of participation in an exercise or real incident within the last five years where MCM materials were translated or adapted for applicable at-risk populations.					
		Written plans contain none of the above	Written plans contain one of the above	Written plans contain two of the above	Written plans contain three or more of the above	No exercise conducted	Tabletop exercise conducted	Functional exercise conducted	Full-scale exercise conducted or real incident		

Capability 6: Information Sharing									
		Planning Implementation				Operational Implementation			
		Early	Intermediate	Established	Advanced	Early	Intermediate	Established	Advanced
Function 1	Identify stakeholders to be incorporated into information flow	a. Plans include procedures that 1) identify all stakeholders who would be involved in an MCM incident (including public health, medical, law enforcement and other disciplines), 2) outline communications pathways between and among these stakeholders, and 3) show evidence that current contact lists exist that include multiple contact mechanisms/devices for identified stakeholders.				a. Percentage of local partners that reported requested essential elements of information (EEI) to the public health/medical lead within the required timeframe (awardee defined) during an MCM incident within the last two years. NOTE: This element refers to HPP-PHEP Performance Measure 6.1. This element does not apply to local jurisdictions.			
		Written plans contain none of the above	Written plans contain one of the above	Written plans contain two of the above	Written plans contain all of the above	0-24% report within timeframe	25-49% report within timeframe	50-74% report within timeframe	75-100% report within timeframe
Function 2	Identify and develop rules and data elements for sharing	a. Plans document minimum requirements for information sharing during an MCM incident, including 1) when information should be shared, 2) who is authorized to receive and/or share information, 3) what types of information can be shared, 4) information use and re-release parameters, and 5) protection of information (including legal considerations).				None			
		Written plans contain none of the above	Written plans contain one or two of the above	Written plans contain three or four of the above	Written plans contain all of the above				
Function 3	Exchange information to determine a common operating picture	a. Plans include 1) procedures for sharing MCM-related information to enable a common operating picture, and 2) evidence of access to a platform to share this information,				a. Procedures (as referenced in the planning element) for sharing MCM-related information have been exercised within the last five years.			
		Written plans contain none of the above	Written plans contain one of the above	Written plans contain all of the above	Written plans contain all of the above and evidence that required parties have been trained	No exercise conducted	Tabletop exercise conducted	Functional exercise conducted	Full-scale exercise conducted or real incident

Capability 8: Medical Countermeasure Dispensing									
		Planning Implementation				Operational Implementation			
		Early	Intermediate	Established	Advanced	Early	Intermediate	Established	Advanced
Function 1	Identify and initiate medical counter-measure dispensing	a. Guidance/plans document dispensing strategies (according to a tiered priority or alternate modality) to include: 1) open (public) PODs, 2) Closed PODs, and 3) Populations with Access and Function Needs.				a. Tiered priority or alternate dispensing modalities (as referenced in the planning element) have been exercised within the last five years.			
		Written plans include none of the above	Written plans include one of the above	Written plans include two of the above	Written plans include all of the above	No exercise conducted	Tabletop exercise conducted	Functional exercise conducted	Full-scale exercise conducted or real incident
		b. Guidance/plans document the capability to 1) initiate a dispensing campaign (i.e., initial 10-day prophylaxis regimen for anthrax) and 2) sustain dispensing campaign follow-on needs (i.e., additional 50-day regimen of prophylaxis for anthrax).				b. The capability to initiate a dispensing campaign and transition to sustained dispensing operations has been tested within the last five years.			
		No written plans in place	Written plans include procedures to initiate operations	Written plans include procedures to initiate and procedures to sustain operations are in development	Written plans include completed procedures to initiate and sustain operations for 100% of the jurisdiction’s population	No exercise conducted	Workshop, seminar or equivalent activity has been conducted	Tabletop exercise conducted	Functional, full-scale exercise conducted or real incident
		c. Guidance/plans identify healthcare partners that would participate in MCM activities and include: 1) list of current healthcare partners with appropriate contact information, 2) MOUs (or other signed written agreements) with these organizations, 3) procedures for how these healthcare partners will participate in MCM activities (including asset request procedures), and 4) planning guidance for those partners participating as closed PODs.				c. Jurisdiction has participated in exercises (tabletop, functional or full-scale) or real incidents with healthcare partners related to closed PODs, MCM asset request procedures, or other MCM activities within the last five years.			
		Written plans include none of the above elements	Written plans include one to three of the above elements	Written plans include all of the above elements	Written plans include all of the above elements and evidence that required parties have been trained	Participation with 0-24% of identified healthcare partners	Participation with 25-49% of identified healthcare partners	Participation with 50-74% of identified healthcare partners	Participation with 75-100% of identified healthcare partners

Capability 8: Medical Countermeasure Dispensing									
Function 2	Receive medical countermeasures at POD	a. Guidance/plans for open (public) PODs include dispensing site surveys that document: 1) required equipment and resources, 2) procedures to acquire these resources, 3) current contact lists for site/facility, and 4) Memorandums of Understanding (MOUs) (or other written agreements).				a. Dispensing site set-up has been tested (via drills, functional, or full-scale exercises or a real incident) within the last five years for all open (public) PODs within the planning jurisdiction.			
		Written plans include none of the above	Written plans include one or two of the above	Written plans include three of the above	Written plans include all of the above	0-24% of sites tested	25-49% of sites tested	50-74% of sites tested	75-100% of sites tested
Function 3	Activate dispensing modalities	a. Guidance/plans for open (public) PODs identify all personnel required to staff dispensing sites, in accordance with planning estimates, and contact lists for these individuals are current.				a. Quarterly call down drills conducted among pre-assigned core staff needed to staff dispensing sites.			
		0-24% of personnel identified	25-49% of personnel identified	50-100% of personnel identified	75-100% of personnel identified and pre-assigned according to operational position and geographical assignment	Call down conducted less than quarterly or percent acknowledgment between 0-24%	Call down conducted quarterly and percent acknowledgment between 25-49%	Call down conducted quarterly and percent acknowledgment between 50-74%	Call down conducted quarterly and percent acknowledgment between 75-100%

Capability 8: Medical Countermeasure Dispensing									
Function 4	Dispense medical countermeasures to identified population	a. Guidance/plans address and document operational planning elements necessary to provide MCM to the public at open (public) PODs, including: 1) dispensing flow, 2) screening forms, 3) mechanisms and trigger points to increase throughput, and 4) assisting populations with access and functional needs.				a. Jurisdiction has tested (drill, functional, full scale exercise or real incident) all planning elements necessary to provide MCM to the public within the last five years and has calculated throughput capacity for each dispensing site.			
		Written plans include none of the above	Written plans include one or two of the above	Written plans include three of the above	Written plans include all of the above	0-33% of sites tested	34-66% of sites tested	67-100% of sites tested, but necessary throughput levels not met	67-100% of sites tested, and necessary throughput levels met for all tested sites
		b. Guidance/plans for open (public) PODs include procedures for 1) operating a full medical POD, 2) operating a non-medical POD, and 3) transitioning from one to the other during an MCM incident.				None			
		Written plans include none of the above	Written plans include one of the above	Written plans include two of the above	Written plans include all of the above				
Function 5	Report adverse events	a. Guidance/plans for open (public) PODs evidence that adverse event reporting procedures are included in: 1) dispensing site protocols, 2) job aides, and 3) information sheets provided to the public as they leave the site.				None			
		Procedures are included in none of the above	Procedures are included in one of the above	Procedures are included in two of the above	Procedures are included in all of the above				

Capability 9: Medical Material Management and Distribution

		Planning Implementation				Operational Implementation			
		Early	Intermediate	Established	Advanced	Early	Intermediate	Established	Advanced
Function 1	Direct and activate medical material management and distribution	a. Plans identify receiving locations (receipt, stage and store (RSS) sites/regional distribution sites (RDS)/local distribution sites (LDS)) for medical countermeasures.				a. Receiving sites have been exercised (functional exercise, full scale exercise or real incident) according to distribution plans (RSS/RDS/LDS) within the last five years.			
		0-24% of sites have completed and submitted current site survey	25-49% of sites have completed and submitted current site survey	50-74% of sites have completed and submitted current site survey	75-100% of sites have completed and submitted current site survey	0-24% of sites conducted exercises	25-49% of sites conducted exercise	50-74% of sites conducted exercises	75-100% of sites conducted exercises
		b. Plans identify primary and back-up transportation assets from public and/or private sources and include a transportation asset list.				b. Transportation assets have been exercised according to distribution plans within the last five years.			
		Necessary transportation assets and/or source of these assets is not identified or documented	Necessary transportation assets and source of these assets are identified and documented	Necessary primary and back-up transportation assets and source of these assets are identified and documented	Necessary primary and back-up transportation assets and source of these assets are identified and documented and an MOU (or similar agreement) is in place	No exercise conducted	Tabletop exercise conducted	Functional exercise conducted	Full-scale exercise conducted or real incident
		c. Plans identify all personnel needed to staff receiving sites (RSS/RDS/LDS).				c. Quarterly call-down drills conducted among all personnel needed to staff receiving sites (RSS/RDS/LDS).			
		No written plans in place or no personnel identified	Written plans identify primary personnel	Written plans identify primary and back-up personnel	Written plans identify primary and back-up personnel who have evidence of training <i>and</i> are pre-assigned according to operational position and geographical assignment	Call-down drill conducted less than quarterly or percent acknowledgment between 0-24%	Call-down drill conducted quarterly and percent acknowledgment between 25-49%	Call-down drill conducted quarterly and percent acknowledgment between 50-74%	Call-down drill conducted quarterly and percent acknowledgment between 75-100%

Capability 9: Medical Material Management and Distribution									
Function 2	Acquire medical material	a. Plans include procedures to request medical material from 1) jurisdictional, 2) private, 3) regional, and/or 4) federal partners in alignment with National Incident Management System standards and incident needs.				a. Processes (as referenced in the planning element) for requesting medical material have been exercised within the last five years.			
		No written plans in place or plans do not contain any of the above elements	Written plans contain one or two of the above elements	Written plans contain three of the above elements	Written plans contain all of the above elements	No exercise conducted	Tabletop exercise conducted	Functional exercise conducted	Full-scale exercise or real incident
		b. Plans include procedures to maintain integrity of medical material according to jurisdictional requirements and manufacturer specifications, including 1) cold chain management, 2) tracking by lot number, 3) tracking by expiration date, and 4) chain of custody (controlled and non-controlled substances).				b. Procedures (as referenced in the planning element) to maintain integrity of medical material in accordance with jurisdictional requirements and manufacturer specifications have been exercised within the last five years.			
		No written plans in place	Written plans include one or two of the above elements	Written plans include three of the above elements	Written plans include all of the above elements	No exercise conducted	Seminar, workshop, or equivalent activity conducted	Tabletop exercise conducted	Functional, full-scale exercise or real incident

Capability 9: Medical Material Management and Distribution									
Function 3	Maintain updated inventory management and reporting system	a. Plans include procedures to operate a primary and back-up inventory management system (IMS) during an MCM incident.				a. Demonstrate the ability to receive, store, pick, and ship assets from both primary and backup system.			
		Written plans do not include procedures to operate a primary or backup IMS	Written plans include procedures to operate a primary IMS but not a backup	Written plans include procedures to operate a primary and backup IMS	Written plans include procedures to operate a primary and backup IMS and evidence that pre-identified warehouse staff have been trained on IMS functions	Unable to demonstrate ability	Only the primary IMS has demonstrated the ability to receive, store, pick, and ship assets	Both primary and backup IMS demonstrated the ability to receive, store, pick and ship assets	Both primary and backup IMS demonstrated the ability to receive, store, pick, and ship assets and documentation staff have been trained
		b. Plans outline processes to track and report inventory levels from all entities within a jurisdiction.				b. Procedures to track and report inventory levels have been exercised within the last five years.			
		No plan is in place to collect inventory levels	A plan is in place but unable to collect inventory levels from any entity within the jurisdiction	A plan is in place to collect inventory levels from at least 50% of all entities within a jurisdiction	A plan is in place to collect inventory levels from all entities within a jurisdiction and appropriate staff are trained on collection procedures	Unable to collect and report all inventory levels	All inventory levels can be collected but not reported	All inventory levels can be collected and structure for reporting is in development	All inventory levels can be collected and inventory records can be reported successfully*

Capability 9: Medical Material Management and Distribution

Function 4	Establish and maintain security	a. Plans include procedures to identify, acquire, and maintain security measures at all MCM distribution sites (RSS/RDS/LDS).				a. Security plans for receiving site (RSS, RDS, LDS) have been exercised (tabletop, functional, or full-scale exercise or real incidents) within the last five years.			
		0-24% of all sites have security plans	25-49% of all sites have security plans	50-74% of all sites have security plans	75-100% of all sites have security plans	0-24% of security plans have been exercised	25-49% of security plans have been exercised	50-74% of security plans have been exercised	75-100% of security plans have been exercised
		b. Plans include procedures to identify, acquire, and maintain security measures at all public MCM dispensing sites (general points of dispensing [PODs]).				b. Security plans for public dispensing sites (general PODs) have been exercised (tabletop, functional, or full-scale exercises or real incidents) within the last five years.			
		0-24% of all PODs have security plans	25-49% of all PODs have security plans	50-74% of all PODs have security plans	75-100% of all PODs have security plans	0-24% of security plans have been exercised	25-49% of security plans have been exercised	50-74% of security plans have been exercised	75-100% of security plans have been exercised
		c. Plans include processes for the security of MCM assets through all applicable distribution phases up to and including arrival distribution end points and an MOU (or similar written agreement) is in place with security partners.				c. Transportation security plans for the applicable phases referenced in the planning element have been exercised (tabletop, functional, full-scale exercises or real incidents) within the last five years.			
		No written plans in place	Written plan in place but does not include an MOU (or similar agreement)	Written plans in place that include an MOU (or similar agreement)	Written plans in place that include an MOU (or similar document) and evidence that necessary security partners have been trained	0-24% of security plans have been exercised	25-49% of security plans have been exercised	50-74% of security plans have been exercised	75-100% of security plans have been exercised

Capability 9: Medical Material Management and Distribution									
Function 5	Distribute medical material	a. Plans include procedures to determine allocation and distribution strategy, including 1) delivery locations, 2) routes, and 3) delivery schedule/frequency, based on incident needs.				a. Jurisdiction has demonstrated capacity to transport material from receiving sites (RSS/RDS/LDS) to identified dispensing sites according to planning assumptions (modeling, exercise, or real incident) within the last five years.			
		No written plans in place	Written plans include one of the above elements	Written plans include two of the above elements	Written plans include all of the above elements	No exercise conducted	Tabletop exercise conducted	Functional exercise conducted	Full-scale exercise conducted or real incident
Function 6	Recover medical material and demobilize distribution operations	a. Plans include procedures to 1) recover material, 2) recover equipment, and 3) dispose of biomedical waste materials according to jurisdictional policies and protocols.				a. Recovery and waste disposal procedures have been exercised within the last five years.			
		No written plans in place	Written plans include one of the above elements	Written plans include two of the above elements	Written plans include all of the above elements	No exercise conducted	Tabletop exercise conducted	Functional exercise conducted	Full-scale exercise conducted or real incident

Capability 14: Responder Safety and Health

		Planning Implementation				Operational Implementation			
		Early	Intermediate	Established	Advanced	Early	Intermediate	Established	Advanced
Function 1	Identify responder safety and health risks	a. Plans include procedures for protecting public health staff and volunteer responders, to include 1) identifying and communicating medical and behavioral health risks, 2) validating health and safety recommendations with subject matter experts, and 3) identifying personal protective equipment (PPE), protective actions, or other mechanisms as they relate to an MCM mission.				a. All procedures (as referenced in the planning element) for protecting public health staff and volunteer responders have been exercised within the last five years.			
		Written plans contain none of the above	Written plans contain one of the above	Written plans contain two of the above	Written plans contain all of the above	No exercise conducted, or exercise did not address all procedures	Workshop, or equivalent, conducted	Tabletop exercise conducted	Functional or full-scale exercise conducted or real incident
		b. Plans: 1) identify all responders (including first responders and critical infrastructure staff (CIS)) that would be used in an MCM incident, 2) describe procedures for priority prophylaxis of identified responders (including first responders/CIS), and 3) describe resources necessary to conduct priority prophylaxis of responders (including first responders/CIS).				b. Procedures for the prophylaxis of all responders (including first responders/CIS) have been exercised within the last five years.			
		Written plans contain none of the above	Written plans contain one of the above	Written plans contain two of the above	Written plans contain all of the above	No exercise conducted	Tabletop exercise conducted	Functional exercise conducted	Full-scale exercise conducted or real incident
Function 2	Identify safety and personal protective needs	a. Plans include procedures for 1) training on PPE, 2) PPE fit-testing, 3) medically clearing staff to use PPE, and 4) obtaining additional PPE appropriate for the MCM incident.				None			
		Written plans contain none of the above	Written plans contain one of the above	Written plans contain two or three of the above	Written plans contain all of the above				

Capability 14: Responder Safety and Health									
Function 3	Coordinate with partners to facilitate risk-specific safety and health training	a. Plans document procedures for MCM just-in-time training for 1) first responders, 2) critical infrastructure staff, 3) volunteer responders, and 4) staff responders regarding their own safety and health.				None			
		Written plans include none of the above elements	Written plans include one or two of the above elements	Written plans include three of the above elements	Written plans include all of the above elements				
Function 4	Monitor responder safety and health actions	a. Plan includes procedures for 1) monitoring health and safety of all responders, 2) providing medical and behavioral health services to all responders, and 3) modifying health and safety recommendations based on available surveillance, as they relate to an MCM mission.				a. Procedures for monitoring responder safety and health actions have been exercised within the last five years.			
		Written plans include none of the above	Written plans include one of the above	Written plans include two of the above	Written plans include all of the above	No exercise conducted	Tabletop exercise conducted	Functional exercise conducted	Full-scale exercise conducted or real incident

Capability 15: Volunteer Management

		Planning Implementation				Operational Implementation			
		Early	Intermediate	Established	Advanced	Early	Intermediate	Established	Advanced
Function 1	Coordinate volunteers	a. Plans include procedures for 1) pre-incident volunteer recruitment and identification, including a registration system, 2) pre-incident screening and credential verification, and 3) pre-incident training on public health response capabilities as they relate to an MCM mission.				a. Plans related to volunteer registration systems, pre-incident screening, credentials verification, and pre-incident training have been exercised within the last five years.			
		Written plans contain none of the above	Written plans contain one of the above	Written plans contain two of the above	Written plans contain all of the above	No exercise conducted	Tabletop exercise conducted	Functional exercise conducted	Full-scale exercise or real incident
Function 2	Notify volunteers	a. Plans include procedures for 1) volunteer notification, with redundant systems and template messages, 2) partner agency notifications for staff support, and 3) credential confirmation at time of incident, as they relate to an MCM mission.				a. Jurisdiction conducts annual call-down drill of all volunteers required to support an MCM mission.			
		Written plans contain none of the above	Written plans contain one of the above	Written plans contain two of the above	Written plans contain all of the above	No call-down drill, or percent acknowledgement between 0-24%	Call-down drill conducted and percent acknowledgement between 25-49%	Call-down drill conducted and percent acknowledgement between 50-74%	Call-down drill conducted and percent acknowledgement between 75-100%

Capability 15: Volunteer Management

Function 3	Organize, assemble, and dispatch volunteers	a. Plans include procedures for 1) assembling and rotating volunteers, 2) providing volunteer support services (feeding, housing, etc.), and 3) briefing volunteers through job aids, just-in-time training materials, safety instructions, etc.				None			
		Written plans contain none of the above	Written plans contain one of the above	Written plans contain two of the above	Written plans contain all of the above				
		b. Plans include a process for 1) badging volunteers, 2) managing spontaneous volunteers, and 3) coordinating with emergency management, or other jurisdictional lead, for support of public health volunteers				None			
		Written plans contain none of the above	Written plans contain one of the above	Written plans contain two of the above	Written plans contain all of the above				
Function 4	Demobilize volunteers	a. Plans include procedures (manual or electronic system) for 1) tracking, 2) out-processing, and 3) providing follow-up services to volunteers.				None			
		Written plans contain none of the above	Written plans contain one of the above	Written plans contain two of the above	Written plans contain all of the above				

Capability 1: Community Preparedness

Function 1: *Determine risks to the health of the jurisdiction*

a. Planning Implementation

Intent: To effectively implement a dispensing campaign, jurisdictions must consider numerous community factors. Each of these planning elements is a unique consideration that jurisdictions need to integrate in their MCM plans for an effective response. The intent of this element is to determine whether a jurisdiction’s plans include formal risk assessments (such as jurisdictional risk assessments [JRAs] or hazard vulnerability analyses [HVAs]) and identify the risks that can adversely affect its ability to mount an efficient dispensing campaign and incorporate mitigation strategies into the planning process., based on formal risk assessments (including JRAs/HVAs) Jurisdictions should have or have access to mapped locations of the identified at-risk populations.

This element accounts for all populations that could be considered vulnerable to the identified risk(s), not just those with access and functional needs. These include populations that may have additional needs in one or more of the following functional areas:

- Maintaining independence: individuals in need of support that enables them to be independent in daily activities
- Communication: individuals who have limitations that interfere with the receipt of and response to information
- Transportation: individuals who cannot drive due to the presence of a disability or who do not have a vehicle
- Supervision: individuals who require the support of caregivers, family, or friends or have limited ability to cope in a new environment
- Medical care: individuals who are not self-sufficient or do not have, or have lost, adequate support from caregivers and need assistance with managing medical conditions

In addition to those individuals specifically recognized as at-risk in the Pandemic and All-Hazards Preparedness Reauthorization Act (PAHPRA) (i.e., children, senior citizens, and pregnant women) individuals who may need additional response assistance could include those who have disabilities; live in institutionalized settings; are from diverse cultures; have limited English proficiency or do not speak English; are transportation disadvantaged; have chronic medical disorders; have pharmacological dependency; and are geographically isolated.

Example Documentation or Evidence: Acceptable evidence may include JRAs or HVAs, standard operating procedures, written agreements, etc.

MCM ORR – Capability 1: Community Preparedness

Reference(s): Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness, Version 11; *Public Health Preparedness Capabilities: National Standards for State and Local Planning* (March 2011), Capability 1; Analysis of Risk Communication Strategies and Approaches with At-Risk Populations to Enhance Emergency Preparedness, Response, and Recovery: Final Report (2008); Pandemic and All-Hazards Preparedness Reauthorization Act (PAHPRA) (2013); SNS State TAR User Guide Version 1.0 (2012), Element 1.4

Function 2: *Build community partnerships to support health preparedness*

a. *Planning Implementation*

Intent: An emergency incident will require the coordinated efforts of federal, state, local, and community partners to provide MCM quickly to those who need it. Jurisdictional plans must clearly identify the responsibilities of agencies and organizations with a role during MCM deployment. Plans for coordinated efforts should identify necessary partners and include designated roles and responsibilities for related emergency support function partners and other community partners who will play a role in the MCM response. These necessary partners should be identified by the jurisdiction.

Example Documentation or Evidence: Acceptable evidence includes documentation indicating that all agencies and organizations have acknowledged their roles and responsibilities in MCM planning elements. Examples of supporting documentation include signatory pages, letters of acknowledgment, written agreements, etc.

Reference(s): Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness, Version 11; *Public Health Preparedness Capabilities: National Standards for State and Local Planning* (March 2011), Capability 1

a. *Operational Implementation*

Intent: Demonstrated coordination of government and community partners ensures that these designated entities understand and can execute their roles. Exercise types are defined in accordance with Homeland Security Exercise and Evaluation Program (HSEEP) principles.

NOTE: A jurisdiction can only receive an advanced level of implementation if all applicable criteria from the planning element are tested at the level of exercise/incident indicated for this element. If the jurisdiction tests (via exercise or incident) at least one criterion, but less than the total number of criteria, the jurisdiction will receive an intermediate/established level of implementation

MCM ORR – Capability 1: Community Preparedness

depending on the type of exercise or incident conducted. If the jurisdiction does not test any of the criteria in the planning element, the jurisdiction will receive an early level of implementation.

Example Documentation or Evidence: Acceptable evidence includes AARs, corrective action plans (CAPs), IPs, or other HSEEP-defined exercise planning documents that reference exercises that occurred no more than five years prior to the date of the review.

Reference(s): Homeland Security Exercise and Evaluation Program (https://hseep.dhs.gov/pages/1001_About.aspx)

Function 3: *Engage with community organizations to foster public health, medical and mental/behavioral health social networks*

a. Planning Implementation

Intent: An MCM incident and the subsequent dispensing campaign may have various adverse effects on staff and the general population, including health and/or mental health issues related to the stress of the incident. To help mitigate these concerns, jurisdictions should identify and engage jurisdiction-defined, relevant community partners prior to an incident.

Example Documentation or Evidence: Acceptable evidence may include written agreements, standard operating procedures, sign-in logs or training rosters, training and guidance materials, or other documents that indicate that public health interacts with these community partners.

Reference(s): *Public Health Preparedness Capabilities: National Standards for State and Local Planning* (March 2011), Capability 1; National Biodefense Science Board “Integration of Mental and Behavioral Health in Federal Disaster Preparedness, Response, and Recovery: Assessment and Recommendations” (2010)

Function 4: *Coordinate training or guidance to ensure community engagement in preparedness efforts*

a. Planning Implementation

Intent: For community partners to engage all necessary constituencies, they must have appropriate levels of understanding regarding the jurisdiction’s planned response strategy for an MCM incident. While community partners may vary from jurisdiction to jurisdiction, it is important that a jurisdiction identifies relevant partners to represent all constituencies and provides guidance and training to these groups.

Example Documentation or Evidence: Acceptable evidence may include sign-in logs or training rosters and guidance materials.

MCM ORR – Capability 1: Community Preparedness

Reference(s): *Public Health Preparedness Capabilities: National Standards for State and Local Planning* (March 2011), Capability 1; *Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness, Version 11*; *SNS Local TAR User Guide* (2010), Element 12.6; *SNS State TAR User Guide Version 1.0* (2012), Element 13.6

Capability 3: Emergency Operations Coordination

Function 1: *Conduct preliminary assessment to determine need for public activation*

a. Planning Implementation

Intent: An emergency will require the efforts of various subject matter experts (SMEs) to inform the decision-making process regarding MCM resource needs. To maximize the amount of available time to provide prophylaxis and/or treatment to the population at risk, a jurisdiction should establish processes to inform necessary officials on decisions to request assistance during the early stages of a public health emergency. At a minimum, policies should define the coordination of the SME contributions related to these planning elements.

Example Documentation or Evidence: Acceptable evidence may include standard operating procedures, official policies, etc.

Reference(s): *Public Health Preparedness Capabilities: National Standards for State and Local Planning* (March 2011), Capability 3; *Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness, Version 11*; *SNS State TAR User Guide Version 1.0* (2012), Element 3.2

a. Operational Implementation

Intent: Demonstrated coordination of SMEs ensures that these individuals understand and can execute their roles. Exercise types are defined in accordance with HSEEP principles.

NOTE: A jurisdiction can only receive an advanced level of implementation if all applicable criteria from the planning element are tested at the level of exercise/incident indicated for this element. If the jurisdiction tests (via exercise or incident) at least one criterion, but less than the total number of criteria, the jurisdiction will receive an intermediate/established level of implementation depending on the type of exercise/incident conducted. If the jurisdiction does not test any of the criteria in the planning element, the jurisdiction will receive an early level of implementation.

Example Documentation or Evidence: Acceptable evidence includes AARs, CAPs, IPs, or other HSEEP-defined exercise planning documents that reference exercises that occurred no more than five years from the date of the review.

Reference(s): Homeland Security Exercise and Evaluation Program (https://hseep.dhs.gov/pages/1001_About.aspx)

b. Planning Implementation

Intent: To plan for an effective dispensing campaign, a jurisdiction must define specific actions necessary at various phases of the response. In its plans, the jurisdiction should identify each phase of the response and the associated actions that take place during each phase. A timeline is an optimal format to effectively illustrate required actions in each phase.

Example Documentation or Evidence: Acceptable evidence may include timelines, time flow models, algorithms, etc.

Reference(s): *Public Health Preparedness Capabilities: National Standards for State and Local Planning* (March 2011), Capability 3

c. Planning Implementation

Intent: Because effective communication is critical to successful public health emergency responses, every method of communication between management and command locations and support agencies should have some form of back-up system. Jurisdictions should prioritize redundant communications that use multiple platforms (i.e., cellular technologies) and not multiple devices or methods of communication that operate on the same platform (i.e., cell phone calls and text messages).

Example Documentation or Evidence: Acceptable evidence includes documentation of any of the following systems:

- Landline dependent telecommunications; landline telephones, fax, dial-up/DSL Internet and e-mail
- Non-telephone based Internet, e-mail and Web-based communications access systems; satellite or cable
- Cellular technologies and communications; phone, text messages
- Amateur (HAM) radio
- Two-way VHF/UHF/700/800/900 MHz communications
- Satellite telephone communications

Reference(s): *Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness, Version 11; SNS State TAR User Guide Version 1.0* (2012), Element 4.5

c. Operational Implementation

MCM ORR Guidance – Capability 3: Emergency Operations Coordination

Intent: Routine testing of communication platforms helps ensure their operational readiness for an incident, as well as responder familiarity with these systems. Testing should be emphasized for systems that are not used daily.

Example Documentation or Evidence: Acceptable evidence may include call logs, computer-tracking mechanisms, AARs, drill summary sheets, memos for record, etc.

Reference(s): Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness, Version 11; SNS State TAR User Guide Version 1.0 (2012), Element 4.5

Function 2: *Activate public health emergency operations*

a. Planning Implementation

Intent: Incident Command System (ICS) is a fundamental form of management established in a standard format that enables incident managers to identify the key concerns associated with the incident. Managing the response to a public health emergency will require organizations to collaborate across a variety of incident management functions and emergency management roles. Integration of MCM functions enables effective incident management.

Example Documentation or Evidence: Acceptable evidence may include ICS charts (with specific individuals identified to fill specific roles) and evidence that the following functions have been integrated into the established ICS roles: staffing/volunteer coordination, tactical communications/IT support, security coordination, RSS operations, distribution operations, dispensing site operations, hospital/treatment center coordination, public information and communication, and safety coordination.

Reference(s): Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness, Version 11; SNS State TAR User Guide Version 1.0 (2012), Element 2.2 and 2.5

a. Operational Implementation

Intent: Demonstrated use of ICS that incorporates these MCM functions within the emergency operations center (EOC) ensures that ICS staff members understand and can execute their roles as required during an MCM incident.

Example Documentation or Evidence: Acceptable evidence includes proof of master exercise practitioner (MEP) certification, AARs, CAPs, IPs, or other HSEEP-defined exercise planning documents that reference exercises that occurred no more than five years from the date of the review.

Reference(s): Homeland Security Exercise and Evaluation Program (https://hseep.dhs.gov/pages/1001_About.aspx)

b. Planning Implementation

Intent: A predetermined physical or virtual location is necessary to coordinate unified health command activities and facilitate an effective response. Jurisdictions should define all required procedures for establishing a health EOC and train all responsible parties on those procedures.

Example Documentation or Evidence: Acceptable evidence may include standard operating procedures, as well as written agreements, EOC activation plans, training logs, sign-in sheets, training materials, etc.

Reference(s): *Public Health Preparedness Capabilities: National Standards for State and Local Planning* (March 2011), Capability 3

b. Operational Implementation¹

Intent: To ensure a timely and effective response to an MCM incident, jurisdictions must demonstrate the ability to rapidly assemble public health staff with senior incident management lead roles. For awardees, this element is linked with PHEP performance measure 3.1 (Staff Assembly). There is a two-year timeframe to ensure consistency with this performance measure. Local jurisdictions can use exercises conducted in the context of the staff notification drill as long as they choose to include the EOC staff.

Example Documentation or Evidence: Data from performance measure PHEP 3.1 will be used to populate this element for awardees. CRI planning jurisdictions should provide evidence supporting site activation, including drill summary sheets, sign-in logs, AARs, etc., of the EOC to the reviewer.

Reference(s): PHEP Budget Period 3 Performance Measure Specifications and Implementation Guidance (2014) – Staff Notification Drill: Capability 3, PHEP 3.1; PHEP Medical Countermeasure Reference Guide

Function 3: *Develop incident response strategy*

a. Planning Implementation

¹ Data from performance measure PHEP 3.1 will be used to populate this element for awardees. CRI planning jurisdictions should provide evidence, as described below.

MCM ORR Guidance – Capability 3: Emergency Operations Coordination

Intent: Effective coordination of an MCM incident will require adherence to ICS principles, including processes and procedures for the completion of these planning elements. Successful responses depend upon having written jurisdictional processes and procedures for an MCM incident, including identification of the parties responsible for completing them.

Example Documentation or Evidence: Acceptable evidence may include MCM-specific templates, standard operating procedures, job aids, etc.

Reference(s): *Public Health Preparedness Capabilities: National Standards for State and Local Planning* (March 2011), Capability 3; FEMA, ICS (<http://www.fema.gov/incident-command-system>)

Function 4: *Manage and sustain the public health response*

a. Planning Implementation

Intent: During an MCM incident, it is critical for a jurisdiction to maintain pre-identified essential public health services, including the functions necessary to conduct the dispensing campaign, in the absence of primary operational readiness. Training on these procedures is paramount to ensure viable continuity of operations.

Example Documentation or Evidence: Acceptable evidence may include standard operating procedures, continuity of operations plans (COOP), training logs, sign-in sheets, training materials, etc.

Reference(s): Federal Emergency Management Agency (FEMA), *Continuity of Operations* (<http://www.fema.gov/continuity-operations/continuity-operations-capabilities>); *Public Health Preparedness Capabilities: National Standards for State and Local Planning* (March 2011), Capability 3

a. Operational Implementation

Intent: Due to the complexity of implementing a viable continuity strategy, jurisdictions should test their plans and demonstrate operational readiness. Exercise types are defined in accordance with HSEEP principles.

NOTE: A jurisdiction can only receive an advanced level of implementation if all applicable criteria from the planning element are tested at the level of exercise/incident indicated for this element. If the jurisdiction tests (via exercise or incident) at least one criterion, but less than the total number of criteria, the jurisdiction will receive an intermediate/established level of implementation

MCM ORR Guidance – Capability 3: Emergency Operations Coordination

depending on the type of exercise/incident conducted. If the jurisdiction does not test any of the criteria in the planning element, the jurisdiction will receive an early level of implementation.

Example Documentation or Evidence: Acceptable evidence may include AARs, CAPs, IPs, or other HSEEP-defined exercise planning documents that reference exercises that occurred no more than five years from the date of the review.

Reference(s): Homeland Security Exercise and Evaluation Program (https://hseep.dhs.gov/pages/1001_About.aspx)

Function 5: *Demobilize and evaluate public health emergency operations*

a. Planning Implementation

Intent: It is important that a jurisdiction maintains processes for scaling down the response campaign during (i.e., a reduction in the number of operational points of dispensing [PODs]) and at the conclusion of an MCM incident. Jurisdictions should pre-identify necessary resources according to these planning elements to efficiently restore systems, supplies, and staffing to their normal state of operations.

Example Documentation or Evidence: Acceptable evidence may include standard operating procedures, written agreements, inventory logs, chain of custody forms, disposition logs, etc.

Reference(s): *Public Health Preparedness Capabilities: National Standards for State and Local Planning* (March 2011), Capability 3

b. Planning Implementation

Intent: To plan for MCM-related training and exercises, a jurisdiction should maintain dedicated staff to develop training and exercise programs according to HSEEP guidance (including the development of AARs and IPs). Jurisdictions at an advanced level of implementation should have access to and routinely use a MEP to plan MCM-related training and exercises.

Example Documentation or Evidence: Acceptable evidence may include personnel staffing lists, training certificates, job aids, etc.

Reference(s): Homeland Security Exercise and Evaluation Program (https://hseep.dhs.gov/pages/1001_About.aspx)

c. Planning Implementation

MCM ORR Guidance – Capability 3: Emergency Operations Coordination

Intent: Planning exercises can be time-consuming and expensive; therefore, it is vital to take a long-term approach to exercising. Advance planning provides opportunities to consolidate exercises, thus relieving the burden. MCM activities should be included when developing a multi-year training and exercise plan (MYTEP) and considered in continuous quality improvement activities.

Example Documentation or Evidence: Acceptable evidence may include MYTEPs, AARs, IPs, hot wash documents, etc.

Reference(s): Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness, Version 11; Homeland Security Exercise and Evaluation Program (https://hseep.dhs.gov/pages/1001_About.aspx); SNS State TAR User Guide Version 1.0 (2012), Element 13.3 and 13.4

c. Operational Implementation

Intent: A jurisdiction should conduct an annual training and exercise plan workshop to provide direction for developing its training and exercise plans and increase visibility of participating organizations training and exercise plans. Though exercise planning is a continuous process, updates to the multi-year training and exercise plan (MYTEP) and related IPs must occur at least annually. An advanced level of operational implementation indicates that the jurisdiction has retested and re-evaluated the gaps identified in IPs.

Example Documentation or Evidence: Acceptable evidence may include agendas, meeting minutes, sign-in sheets, IPs, AARs, etc.

Reference(s): Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness, Version 11; Homeland Security Exercise and Evaluation Program (https://hseep.dhs.gov/pages/1001_About.aspx); SNS State TAR User Guide Version 1.0 (2012), Element 13.3 and 13.4

Capability 4: Emergency Public Information and Warning

Function 1: *Activate the emergency public information system*

a. Planning Implementation

Intent: Public information and communication (PIC) personnel regularly inform, educate, and communicate with the public. When planning to respond to an incident that requires mobilizing the public to perform specific actions, it is critical that PIC personnel understand and are involved in the response to provide information that empowers the public to make the right choices for their health. For all identified staff, jurisdictions should maintain and make accessible contact information that is updated quarterly.

Example Documentation or Evidence: Acceptable evidence may include standard operating procedures, communication plans, contact lists, training logs, sign-in sheets, etc.

Reference(s): Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness, Version 11; SNS State TAR User Guide Version 1.0 (2012), Element 5.1

Function 2: *Determine the need for a joint public information system*

a. Planning Implementation

Intent: Depending on the nature of the incident, public information demands may vary. Jurisdictions should have processes in place to establish a scalable joint information center, and plans should include trigger points and decision criteria. A decision matrix will help inform what resources, including personnel resources (such as MCM SMEs) and equipment, may be needed to coordinate the dissemination of information.

Example Documentation or Evidence: Acceptable evidence may include decision matrices, algorithms, standard operating procedures, communication plans, equipment lists, contact lists, etc.

Reference(s): *Public Health Preparedness Capabilities: National Standards for State and Local Planning* (March 2011), Capability 4

a. Operational Implementation

MCM ORR Guidance – Capability 4: Emergency Public Information and Warning

Intent: Jurisdictions should test their ability to scale the dissemination of public information to the specific demands of an MCM incident. Exercise types are defined in accordance with HSEEP principles.

NOTE: A jurisdiction can only receive an advanced level of implementation if all applicable criteria from the planning element are tested at the level of exercise/incident indicated for this element. If the jurisdiction tests (via exercise or incident) at least one criterion, but less than the total number of criteria, the jurisdiction will receive an intermediate/established level of implementation depending on the type of exercise/incident conducted. If the jurisdiction does not test any of the criteria in the planning element, the jurisdiction will receive an early level of implementation.

Example Documentation or Evidence: Acceptable evidence includes AARs, CAPs, IPs, or other HSEEP-defined exercise planning documents that reference exercises that occurred no more than five years from the date of the review.

Reference(s): Homeland Security Exercise and Evaluation Program (https://hseep.dhs.gov/pages/1001_About.aspx)

Function 3: *Establish and participate in information system operations*

a. Planning Implementation

Intent: Jurisdictions should identify methods and mechanisms of communication with media contacts before an incident occurs to ensure media partners are identified and involved in the public information dissemination process. It is also important for jurisdictions to ensure that messages are being accurately and effectively conveyed to the public.

Example Documentation or Evidence: Acceptable evidence may include contact lists, standard operating procedures, communications plans, template for press briefings, job aids, etc.

Reference(s): Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness, Version 11; *Public Health Preparedness Capabilities: National Standards for State and Local Planning* (March 2011), Capability 4; SNS Local TAR User Guide (2010), Element 5.3; SNS State TAR User Guide Version 1.0 (2012), Element 5.4

b. Planning Implementation

Intent: In an MCM incident, trained, knowledgeable personnel are invaluable to communications functions such as interfacing with the media and providing public information at dispensing sites. Job aids should include key PIC responsibilities, as outlined in the planning elements.

Example Documentation or Evidence: Acceptable evidence may include job aids, standard operating procedures, communications plans, etc.

Reference(s): Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness, Version 11; SNS Local TAR User Guide (2010), Element 5.3

Function 4: *Establish avenues for public interaction and information exchange*

a. Planning Implementation

Intent: Jurisdictions should ensure that mechanisms exist for the public to contact the health department with MCM-related questions and concerns and for the health department to disseminate messages to the public. It is important that communications plans include a variety of mechanisms by which the public can contact the health department, as outlined in the planning elements, and that the public is informed of these mechanisms.

Example Documentation or Evidence: Acceptable evidence may include standard operating procedures, communications plans, public information announcements, documentation of hotline numbers, e-mail addresses, social media accounts, etc.

Reference(s): *Public Health Preparedness Capabilities: National Standards for State and Local Planning* (March 2011), Capability 4 (page 41)

a. Operational Implementation

Intent: Jurisdictions should test their procedures for responding to inquiries from the public and demonstrate operational readiness in this area. Exercise types are defined in accordance with HSEEP principles.

NOTE: A jurisdiction can only receive an advanced level of implementation if all applicable criteria from the planning element are tested at the level of exercise/incident indicated for this element. If the jurisdiction tests (via exercise or incident) at least one criterion, but less than the total number of criteria, the jurisdiction will receive an intermediate/established level of implementation depending on the type of exercise/incident conducted. If the jurisdiction does not test any of the criteria in the planning element, the jurisdiction will receive an early level of implementation.

MCM ORR Guidance – Capability 4: Emergency Public Information and Warning

Example Documentation or Evidence: Acceptable evidence includes AARs, CAPs, IPs, or other HSEEP-defined exercise planning documents that reference exercises that occurred no more than five years from the date of the review.

Reference(s): Homeland Security Exercise and Evaluation Program (https://hseep.dhs.gov/pages/1001_About.aspx)

Function 5: *Issue public information alerts, warnings, and notifications*

a. Planning Implementation

Intent: Developing and clearing messages prior to an MCM incident and planning for their dissemination can reduce the timeline required to get the first messages out to all targeted audiences. Well-crafted, accurate, and consistent messages are important during an emergency to help gain trust and encourage the public to make the right choices regarding their health. These key messages are the basis for all communication materials used before, during, and after an incident.

Example Documentation or Evidence: Acceptable evidence may include standard operating procedures, communications plans, and pre-developed fact sheet templates, media kits, press release templates, flyers, brochures, videos, etc.

Reference(s): Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness, Version 11; SNS Local TAR User Guide (2010), Element 5.6; SNS State TAR User Guide Version 1.0 (2012), Element 5.5

a. Operational Implementation

Intent: Jurisdictions should test their plans for message creation and dissemination and demonstrate operational readiness. Exercise types are defined in accordance with HSEEP principles.

NOTE: A jurisdiction can only receive an advanced level of implementation if all applicable criteria from the planning element are tested at the level of exercise/incident indicated for this element. If the jurisdiction tests (via exercise or incident) at least one criterion, but less than the total number of criteria, the jurisdiction will receive an intermediate/established level of implementation depending on the type of exercise/incident conducted. If the jurisdiction does not test any of the criteria in the planning element, the jurisdiction will receive an early level of implementation.

Example Documentation or Evidence: Acceptable evidence includes AARs, CAPs, IPs, or other HSEEP-defined exercise planning documents that reference exercises that occurred no more than five years from the date of the review.

Reference(s): Homeland Security Exercise and Evaluation Program (https://hseep.dhs.gov/pages/1001_About.aspx)

b. Planning Implementation

Intent: Plans to provide information to the population should address segments of the population that may need targeted messages, materials, and/or alternate methods of delivering those messages and materials. Examples of these segments of the population include those with language or literacy barriers. The intent of this element is to help to ensure that those segments of the population are not overlooked and receive the information they need in the manner most useful to them.

Example Documentation or Evidence: Acceptable evidence may include standard operating procedures, communications plans, and pre-developed fact sheets, media kits, press news releases or template releases, flyers, brochures, videos, etc.

Reference(s): Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness, Version 11; SNS Local TAR User Guide (2010), Element 5.7; SNS State TAR User Guide Version 1.0 (2012), Element 5.6

b. Operational Implementation

Intent: Jurisdictions should test message translation capabilities for identified at-risk populations listed in the planning element and demonstrate operational readiness. Exercise types are defined in accordance with HSEEP principles.

NOTE: A jurisdiction can only receive an advanced level of implementation if all applicable criteria from the planning element are tested at the level of exercise/incident indicated for this element. If the jurisdiction tests (via exercise or incident) at least one criterion, but less than the total number of criteria, the jurisdiction will receive an intermediate/established level of implementation depending on the type of exercise/incident conducted. If the jurisdiction does not test any of the criteria in the planning element, the jurisdiction will receive an early level of implementation.

Example Documentation or Evidence: Acceptable evidence includes AARs, CAPs, IPs, or other HSEEP-defined exercise planning documents that reference exercises that occurred no more than five years from the date of the review.

Reference(s): Homeland Security Exercise and Evaluation Program (https://hseep.dhs.gov/pages/1001_About.aspx)

Capability 6: Information Sharing

Function 1: *Identify stakeholders to be incorporated into information flow*

a. Planning Implementation

Intent: Response to a public health emergency requires the support and collective effort of many diverse agencies. Appropriate planning entails coordination, collaboration, and integration between those agencies to ensure a multi-disciplinary approach. Prior to an incident, it is essential for each entity or location involved in the response to know the agency(ies), and the position(s) within those agencies, with whom they must communicate for guidance, requests, and information and identify the communication pathways (or lines of communication) necessary for this information exchange. The intent for this element is to engage the agencies that have the responsibility or authority for the functions that are relevant to the MCM plan. Contact lists should be updated annually.

Example Documentation or Evidence: Acceptable evidence for stakeholder identification includes staff contact lists (updated annually) with multiple contact devices/mechanisms listed (i.e., cell phone, e-mail, etc.), human resources or volunteer database reports, other tracking systems, etc. Acceptable evidence for communication pathways may include flow charts, matrices, graphs, maps using graphic information systems (GIS), lists/paragraphs within the plan, or a completed ICS-205 form.

Reference(s): Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness, Version 11; SNS Local TAR User Guide (2010), Element 1.3; SNS State TAR User Guide Version 1.0 (2012), Element 4.3

a. Operational Implementation²

Intent: The intent of this measure is to determine the extent to which local response entities communicate requested information to the public health/medical lead to facilitate situational awareness and the effective, timely management of resources during an MCM incident. Essential elements of information that may be necessary during an MCM incident include identification of all stakeholders, communication pathway matrix, current contact lists, and the percentage of partners that reported essential elements of information (EEI) during an exercise or incident.

² Data from performance measure HPP-PHEP 6.1 will be used to populate this element for awardees. This measure only applies at the awardee level.

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Example Documentation or Evidence: See PHEP Budget Period 3 Performance Measure Specifications and Implementation Guidance (2014): Capability 6, HPP-PHEP 6.1.

Reference(s): PHEP Budget Period 3 Performance Measure Specifications and Implementation Guidance (2014): Capability 6, HPP-PHEP 6.1

Function 2: *Identify and develop rules and data elements for sharing*

a. Planning Implementation

Intent: Defining clear data sharing parameters helps to ensure appropriate and secure information-sharing practices during an incident. Plans should include procedures related to what information can be shared, when it can be shared, and who it can be shared with, from both operational and legal standpoints. For example, sensitive information about POD operating hours, locations, or operational challenges may only be shared at a jurisdictional level.

Example Documentation or Evidence: Acceptable evidence includes standard operating procedures, written agreements, etc.

Reference(s): *Public Health Preparedness Capabilities: National Standards for State and Local Planning* (March 2011), Capability 6

Function 3: *Exchange information to determine a common operating picture*

a. Planning Implementation

Intent: Establishing a common operating picture is a vital tool to improve situational awareness between and among relevant partners. Some examples of platforms that may be used to establish this common operating picture include Health Alert Network, other notification service/system, e-mail distribution lists, etc.

Example Documentation or Evidence: Acceptable evidence may include standard operating procedures, written agreements, training materials, training rosters, etc.

Reference(s): *Public Health Preparedness Capabilities: National Standards for State and Local Planning* (March 2011), Capability 6

a. Operational Implementation

MCM ORR Guidance – Capability 6: Information Sharing

Intent: Jurisdictions should demonstrate operational information sharing capacity by testing the establishment of a common operating picture. Exercise types are defined in accordance with HSEEP principles.

NOTE: A jurisdiction can only receive an advanced level of implementation if all applicable criteria from the planning element are tested at the level of exercise/incident indicated for this element. If the jurisdiction tests (via exercise or incident) at least one criterion, but less than the total number of criteria, the jurisdiction will receive an intermediate/established level of implementation depending on the type of exercise/incident conducted. If the jurisdiction does not test any of the criteria in the planning element, the jurisdiction will receive an early level of implementation.

Example Documentation or Evidence: Acceptable evidence includes access to or screenshots of data-sharing platforms being used, AARs, CAPs, IPs, or other HSEEP-defined exercise planning documents that reference exercises that occurred no more than five years from the date of the review.

Reference(s): Homeland Security Exercise and Evaluation Program (https://hseep.dhs.gov/pages/1001_About.aspx); PHIN Standards (<http://www.cdc.gov/phin/>)

Capability 8: Medical Countermeasure Dispensing

Function 1: *Identify and initiate medical countermeasure dispensing*

a. Planning Implementation

Intent: Dispensing strategies are necessary to account for the population in need within a jurisdiction. While open (public) PODs may serve the largest population, alternate dispensing modalities, such as closed PODs and strategies to reach those with access and functional needs, should be part of the jurisdictional plan to provide a tiered approach to serve all the population. Such plans must clearly identify processes for providing prophylaxis via the following mechanisms, at a minimum:

- Open (public) PODs: Open PODs have been the primary focus of dispensing operations since the early days of planning for large-scale MCM dispensing campaigns. They are referred to as “open” because there are no restrictions on who can go to them; they are open to everyone.
- Closed PODs: Closed PODs are dispensing sites that are 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).
- Alternate dispensing for populations with access and functional needs: Individuals in need of alternate dispensing mechanisms may include those who have disabilities; live in institutionalized settings; are seniors; are children; are from diverse cultures; have limited English proficiency or are not English speaking; or are transportation disadvantaged.

Example Documentation or Evidence: Evidence that dispensing strategies based on population needs are documented in jurisdictional plans. For example, plans should include:

- Descriptions of open (public) POD strategies
- Descriptions of alternate modalities
- Procedures to initiate, execute, maintain and demobilize alternate modalities
- Identification of partners involved in alternate modalities
- Identification of staffing and resource needs for alternate modalities

Reference(s): Presidential Policy Directive (PPD) 8: National Preparedness (<http://www.dhs.gov/xlibrary/assets/presidential-policy-directive-8-national-preparedness.pdf>); Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness, Version 11; PHEP Budget Period 3 Performance Measure Specifications and Implementation Guidance (2014): Capability 1; Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness, Version 11; SNS Local TAR User Guide (2010), Element 10.4

a. Operational Implementation

Intent: Dispensing strategies for designated special groups will differ from strategies for the general population. Jurisdictions should test plans for all tiers to demonstrate operational readiness. Exercise types are defined in accordance with HSEEP principles. While locals often have direct responsibility for this operational element, states may have a role by dispensing directly to state employees, military installations, federal employees, or tribal nations, in addition to applicable local monitoring and training responsibilities.

NOTE: A jurisdiction can only receive an advanced level of implementation if all applicable criteria from the planning element are tested at the level of exercise/incident indicated for this element. If the jurisdiction tests (via exercise or incident) at least one criterion, but less than the total number of criteria, the jurisdiction will receive an intermediate/established level of implementation depending on the type of exercise/incident conducted. If the jurisdiction does not test any of the criteria in the planning element, the jurisdiction will receive an early level of implementation.

Example Documentation or Evidence: Acceptable evidence includes AARs, CAPs, IPs, or other HSEEP-defined exercise planning documents that reference exercises that occurred no more than five years from the date of the review. These scoring criteria are meant to account for all dispensing strategies. Therefore, the jurisdiction’s implementation level will be reviewed based on the least advanced exercise category. For example, if a jurisdiction conducts full-scale exercises for open (public) POD and closed POD strategies and a tabletop for alternate dispensing strategies for populations with access and functional needs, then that jurisdiction would be considered at an intermediate level.

Reference(s): Homeland Security Exercise and Evaluation Program (https://hseep.dhs.gov/pages/1001_About.aspx)

b. Planning Implementation

Intent: Some dispensing scenarios call for proficiency in initiating a dispensing campaign and later transitioning to a sustained response. For example, an aerosolized anthrax scenario will call for an initial 10-day regimen of prophylaxis, followed by a 50-day regimen of prophylaxis. Similarly, a pandemic influenza response may necessitate a transition from an initial vaccine push to a sustained vaccine administration campaign. To be successful, jurisdictions must be proficient in both initiating and sustaining a dispensing campaign. An advanced level of planning implementation indicates that the jurisdiction can sustain prolonged dispensing operations for 100% of the jurisdiction’s population.

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Example Documentation or Evidence: Acceptable evidence includes documentation of these procedures in jurisdictional plans, including process descriptions, algorithms, flow charts, checklists, and field-operating guides.

Reference(s): CDC POD Standards (April 2008); DSNS Anthrax Response Plan, June 2014

b. Operational Implementation

Intent: Actions necessary for conducting the initial dispensing campaign and transitioning to a prolonged response will have many operational components. Jurisdictions should test these plans to demonstrate operational readiness. Exercise types are defined according to HSEEP principles. While locals often have direct responsibility for this operational element, states may have a role in initiating and sustaining dispensing operations for state employees, military installations, federal employees, or tribal nations, in addition to applicable local monitoring and training responsibilities.

NOTE: A jurisdiction can only receive an advanced level of implementation if all applicable criteria from the planning element are tested at the level of exercise/incident indicated for this element. If the jurisdiction tests (via exercise or incident) at least one criterion, but less than the total number of criteria, the jurisdiction will receive an intermediate/established level of implementation depending on the type of exercise/incident conducted. If the jurisdiction does not test any of the criteria in the planning element, the jurisdiction will receive an early level of implementation.

Example Documentation or Evidence: Acceptable evidence includes AARs, CAPs, IPs, or other HSEEP-defined exercise planning documents that reference exercises that occurred no more than five years from the date of the review.

Reference(s): Homeland Security Exercise and Evaluation Program (https://hseep.dhs.gov/pages/1001_About.aspx)

c. Planning Implementation

Intent: It is important that jurisdictions identify and include their healthcare partners, as defined by the jurisdiction, in MCM-related operational and planning activities.

Example Documentation or Evidence: Documentation of these procedures could include, standard operating procedures, contracts, emergency operations plans (EOP) and annexes that describe roles and responsibilities of healthcare partners, letters of agreement, memoranda of agreement (MOA), memoranda of understanding (MOU), or any other official document which describes the role of these organizations.

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Reference(s): Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness, Version 11; SNS Local TAR User Guide (2010), Section 11; SNS State TAR User Guide Version 1.0 (2012), Section 12.

c. Operational Implementation

Intent: Jurisdictions should coordinate with healthcare partners to ensure that these partners have the operational capacity to respond appropriately to an MCM event. Specifically, jurisdictions should coordinate with healthcare partners, as applicable, to exercise closed POD plans. Similarly, jurisdictions should coordinate with healthcare partners to test MCM asset request procedures, as appropriate.

Example Documentation or Evidence: Evidence may include AARs, CAPs, IPs, or other HSEEP-defined exercise planning documents that reference exercises that occurred no more than five years from the date of the review.

Reference(s): SNS Local TAR User Guide (2010), Section 11; SNS State TAR User Guide Version 1.0 (2012), Section 12; Homeland Security Exercise and Evaluation Program (https://hseep.dhs.gov/pages/1001_About.aspx)

Function 2: *Receive medical countermeasures at POD*

a. Planning Implementation

Intent: Having a pre-established plan or site survey to initiate operations at a POD site shortens the time it takes to begin dispensing to the population in need. Set-up procedures at a dispensing site are conducted more efficiently when administrative details, including necessary resources, contact lists, and written agreements, have been considered prior to the opening of the site. This element applies to open (public) PODs.

Example Documentation or Evidence: Documentation of these procedures could include staff contact lists, standard operating procedures, contracts, EOP with annexes describing roles and responsibilities of jurisdictional agencies. Additional examples include letters of agreement, MOAs, MOUs, mutual aid agreements, or any other official document which describes the role of public health and carries with it an expectation that public health will undertake certain MCM-related activities.

Reference(s): Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness, Version 11; PHEP Budget Period 3 Performance Measure Specifications and Implementation Guidance (2014); SNS Local TAR User Guide (2010), Element 10.7 and 10.8

b. Operational Implementation

Intent: Jurisdictions should test site set-up plans to demonstrate operational readiness. Jurisdictions should conduct site activations that address specific facility characteristics of any potential dispensing site that would be used in an MCM incident. Facility set-up requirements are in the facility set-up drill template included in the MCM Reference Guide. Exercise types are defined according to HSEEP principles, and testing can include a drill, a functional exercise, a full-scale exercise, or an incident. This element applies to open (public) PODs. While locals often have direct responsibility for this operational element, states may have a role in dispensing site set-up for certain facilities, such as universities, in addition to applicable local monitoring and training responsibilities.

NOTE: A jurisdiction can only receive an advanced level of implementation if all applicable criteria from the planning element are tested at the level of exercise/incident indicated for this element. If the jurisdiction tests (via exercise or incident) at least one criterion, but less than the total number of criteria, the jurisdiction will receive an intermediate/established level of implementation depending on the type of exercise/incident conducted. If the jurisdiction does not test any of the criteria in the planning element, the jurisdiction will receive an early level of implementation.

Example Documentation or Evidence: Elements identified in the facility set-up drill template should be documented for each facility set-up.

NOTE: Local jurisdictions are only required to submit one facility set-up drill within DCARS, if they choose to use a facility set-up as one of the three required drills. Acceptable evidence may also include AARs, CAPs, IPs, reference exercises that occurred no more than five years from the date of the review or other HSEEP-defined exercise planning documents that reference exercises that occurred no more than five years from the date of the review.

Reference(s): Homeland Security Exercise and Evaluation Program (https://hseep.dhs.gov/pages/1001_About.aspx); PHEP Medical Countermeasure Reference Guide – Facility Set-Up Drill

Function 3: *Activate dispensing modalities*

a. Planning Implementation

Intent: Successful dispensing campaigns require sufficient personnel resources to staff general dispensing sites. A jurisdiction should determine and document in its plans the necessary number of staff to account for the population to be served. For this element, the denominator will be the number of personnel required to staff all open (public) PODs (planning estimates) and the numerator will be the number of personnel actually identified. An advanced level of implementation indicates a jurisdiction has identified and pre-

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assigned personnel according to operational position and geographical assignment. For all identified staff, jurisdictions should maintain and make accessible contact information that is updated quarterly. This element applies to open (public) PODs.

Example Documentation or Evidence: Acceptable evidence may include staff contact lists, human resources or volunteer database reports, other tracking systems, etc.

Reference(s): Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness, Version 11

a. Operational Implementation

Intent: Core management staff, which will oversee all critical positions (as defined by the jurisdiction) at the dispensing site, should be readily available to activate for a dispensing mission. To effectively assess and improve operational performance and provide a realistic understanding of response capability, jurisdictions should collect data to measure staff performance for each of the required operations and response activities (notification, acknowledgement, and availability to assemble). This element applies to open (public) PODs. Local jurisdictions can use exercises conducted in the context of the staff notification drill as long as they choose to include the POD staff. States may have a role in conducting call down drills for core staff included in dispensing operations for state employees, military installations, federal employees, or tribal nations, in addition to applicable local monitoring and training responsibilities.

Example Documentation or Evidence: Acceptable documentation may consist of tables, spreadsheets, databases, or automated systems (e.g. Health Alert Network) and includes an acknowledgement report for all personnel.

Reference(s): Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness, Version 11; Medical Countermeasure Reference Guide – ‘Staff Notification’ Drill; SNS Local TAR User Guide (2010), Elements 2.3 and 10.9

Function 4: *Dispense medical countermeasures to identified population*

a. Planning Implementation

Intent: For a dispensing campaign to operate smoothly and effectively, there are many operational issues that must be considered during the planning phase. In a large-scale mass prophylaxis/dispensing incident, there may be a need to quickly modify the clinic flow at a site to increase the throughput and improve screening forms to accommodate a changing situation, based on specific trigger points. In addition, jurisdictions will have unique operational issues for populations with access and functional needs, such as

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those who have disabilities; live in institutionalized settings; are seniors; are children; are from diverse cultures; have limited English proficiency or are not English speaking; or are transportation disadvantaged. This element applies to open (public) PODs.

Example Documentation or Evidence: Acceptable documentation may consist of facility flow diagrams, sample screening forms, dispensing algorithms, decision matrices, patient information forms, standard operating procedures that identify care of those with access and functional needs, etc.

Reference(s): Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness, Version 11; PHEP Budget Period 3 Performance Measure Specifications and Implementation Guidance (2014): Capability 1; SNS Local TAR User Guide (2010), Elements 10.2, 10.3 and 10.4

a. *Operational Implementation*

Intent: Jurisdictions must test planning assumptions and demonstrate operational readiness for dispensing site operations. Therefore, all planning elements associated with Function 4(a) should be tested to validate assumptions. This will involve testing the jurisdiction’s required throughput to dispense to the necessary population for a designated dispensing site. The ability to serve the necessary number persons per hour at the dispensing site is crucial to the success of the dispensing campaign, both at the designated dispensing site and for the jurisdiction. Necessary throughput is defined as the hourly throughput to prophylax 75% of the estimated population for that specific POD within the required 48-hour timeframe (as per a CRI scenario). This element applies to open (public) PODs. While locals often have direct responsibility for this operational element, states may have a role in dispensing operations for state employees, military installations, federal employees, or tribal nations, in addition to applicable local monitoring and training responsibilities.

Example Documentation or Evidence: Acceptable evidence includes AARs, CAPs, IPs, or other HSEEP-defined exercise planning documents that reference exercises that occurred no more than five years from the date of the review. POD throughput data can be collected in either of two ways: 1) by recording time to process persons at each POD step or 2) by collecting entry and exit times (“front door to back door”) for each person. Modeling programs, such as RealOpt, can also serve as a baseline for throughput estimates for planning purposes. However, these estimates must be validated through a functional exercise, a full-scale exercise, or an incident. For throughput verification, documentation must provide evidence that planning estimates (i.e., necessary throughput) have been achieved (i.e., actual throughput). **Validation of throughput at a designated dispensing site can serve as validation for other dispensing sites as long as the other sites follow a similar operational design (drive through, walk through, etc.) and will require similar throughputs to serve the required population.**

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To calculate the percent of sites tested for this element, the denominator should include the total number of PODs within the jurisdiction, and the numerator should include all tested PODs. Multiple PODs may be included in the numerator even if they are not directly tested if a POD of the same operational design and necessary throughput has been tested. For example, a jurisdiction has a total of 15 PODs; 10 are walk-through PODs that have similar necessary throughputs and the other five have different operational designs or require different necessary throughputs. If the jurisdiction tested one of the 10 similar walk-through PODs and four of the remaining five PODs, percent of sites tested would be calculated using a denominator of 15 and a numerator of 14, leading to a percent of sites tested of 93% (14/15).

Reference(s): Homeland Security Exercise and Evaluation Program (https://hseep.dhs.gov/pages/1001_About.aspx); Medical Countermeasure Reference Guide – Dispensing Throughput Drill

b. Planning Implementation

Intent: Jurisdictions should understand, prior to an MCM incident, when, why, and by whom changes to the dispensing model can be made. Jurisdictions must pre-determine these protocols, including identifying individuals authorized to alter the clinical model and the steps necessary to transition between models. This element applies to open (public) PODs. For this element, the following terms are defined as:

- Full medical (clinical) POD: In the medical model, each person receives a medical assessment and MCMs from a licensed medical professional. Under this model, medical personnel would dedicate more time to providing a personalized medical evaluation and education on the agent and MCMs to each client at the dispensing site.
- Non-medical (rapid dispensing) POD: The non-medical model refers to a modification of the medical model that streamlines dispensing operations to achieve rapid dispensing. The goal of rapid dispensing is to increase the number of people who can go through a POD, also known as increasing throughput. In light of the anticipated large number of individuals requiring MCMs during an emergency and the timeframe in which the jurisdiction must accomplish dispensing, the non-medical model takes into account limited medical staffing and decreased time to provide MCMs. In this model, individuals might receive a less comprehensive screening form; steps in the dispensing process might be combined or eliminated; or trained nonmedical personnel may dispense MCMs under limited supervision from licensed medical professionals.

Example Documentation or Evidence: Acceptable documentation may consist of standard operating procedures that identify the above issues, in addition to one or more of the following: decision matrix, authorization letter, checklist, algorithm, flow plan, etc.

Reference(s): Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness, Version 11; SNS Local TAR User Guide (2010), Element 10.4

Function 5: Report adverse events

a. Planning Implementation

Intent: Each person who receives medication must also be provided with information about what to do and where to go if they experience an adverse reaction to the medication. Some POD designs involve a group briefing given to individuals by dispensing site staff, and so staff must be familiar with reporting protocols as well. This information should also be incorporated into job aids, handouts and signage. Dispensing plans should consider the language and reading skills of the population. Materials should be designed to accommodate those needs (e.g., multiple languages, use of pictures). This element applies to open (public) PODs.

Example Documentation or Evidence: Acceptable evidence includes job aids (including job action sheets), information sheets, and standard operating procedures that account for the above.

Reference(s): CDC POD Standards (April 2008), Page 16

Capability 9: Medical Material Management and Distribution

Function 1: *Direct and activate medical material management and distribution*

a. Planning Implementation

Intent: The receiving sites are the hubs from which the jurisdiction coordinates the distribution of critical resources. The jurisdiction should have adequate receiving sites to meet the supply and demand for its respective resources and population. *At a minimum, awardees should identify a primary and a back-up RSS site.* These sites should be strategically located to move assets quickly to those in need during an emergency. Additionally, to ensure operational effectiveness, each awardee should complete a current RSS site survey (formerly RSS checklist) for each facility and submit to CDC via the MCM SharePoint site. Per CDC guidance, any facility an awardee designates for potential receipt of federal assets must upload the RSS site survey to CDC’s MCM SharePoint site. Jurisdictions that identify regional distribution sites (RDS) or local distribution sites (LDS) that may only receive assets from the state should submit similar documentation according to state policies and protocols. All site survey documentation should be updated at least every three years.

Example Documentation or Evidence: Acceptable evidence may include CDC RSS site survey form (or similar documentation for RDS/LDS), standard operating procedures, written agreements, GIS overlays and/or maps.

Reference(s): CDC POD Standards (April 2008), 4.3; Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness, Version 11; SNS State TAR User Guide Version 1.0 (2012), Element 7.1

a. Operational Implementation

Intent: Jurisdictions should test their receiving site plans according to CDC’s distribution planning standards and jurisdictional planning assumptions and demonstrate operational readiness. Exercise types are defined according to HSEEP principles.

Example Documentation or Evidence: Acceptable evidence includes AARs, CAPs, IPs, or other HSEEP-defined exercise planning documents that reference exercises that occurred no more than five years from the date of the review.

Reference(s): Homeland Security Exercise and Evaluation Program (https://hseep.dhs.gov/pages/1001_About.aspx); Medical Countermeasure Reference Guide

b. Planning Implementation

Intent: It is vital that jurisdictions identify and establish contractual agreements with the agencies or organizations responsible for providing distribution assets (e.g. vehicles, drivers, mechanics, etc.). Alternate sources of such assets are essential in the event the primary distribution source is either unable to fulfill its requirements or needs additional assistance due to the severity of the incident. Finally, jurisdictions should plan for the appropriate number and type of resources to best support their distribution strategies.

Example Documentation or Evidence: Acceptable evidence may include written agreements, standard operating procedures, transportation assets lists (including number of vehicles needed, types of vehicles needed, number of drivers needed, and type and number of support personnel needed), etc.

Reference(s): Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness, Version 11; SNS State TAR User Guide Version 1.0 (2012), Elements 10.3, 10.4 and 10.5

b. Operational Implementation

Intent: Jurisdictions should test their distribution strategies according to CDC’s distribution planning standards and jurisdictional planning assumptions and demonstrate operational readiness. Exercise types are defined in accordance with HSEEP principles.

NOTE: A jurisdiction can only receive an advanced level of implementation if all applicable criteria from the planning element are tested at the level of exercise/incident indicated for this element. If the jurisdiction tests (via exercise or incident) at least one criterion, but less than the total number of criteria, the jurisdiction will receive an intermediate/established level of implementation depending on the type of exercise/incident conducted. If the jurisdiction does not test any of the criteria in the planning element, the jurisdiction will receive an early level of implementation.

Example Documentation or Evidence: Acceptable evidence includes AARs, CAPs, IPs, or other HSEEP-defined exercise planning documents that reference exercises that occurred no more than five years from the date of the review.

Reference(s): Homeland Security Exercise and Evaluation Program (https://hseep.dhs.gov/pages/1001_About.aspx); Medical Countermeasure Reference Guide

c. Planning Implementation

Intent: To prepare for a successful warehouse operation, jurisdictions must identify personnel for management positions, including back-up personnel, and maintain their contact information for receiving sites. The intent of this element is to determine whether a jurisdiction has identified and trained personnel to ensure coverage for all receiving site (RSS/RDS/LDS) functions. An advanced level of implementation indicates a jurisdiction has identified and pre-assigned trained personnel according to operational position and geographical assignment at a relevant receiving location.

Example Documentation or Evidence: Acceptable evidence may include contact lists, job aids, standard operating procedures, etc.

Reference(s): Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness, Version 11; SNS State TAR User Guide Version 1.0 (2012), Element 7.4

c. Operational Implementation

Intent: All necessary personnel that would be required to fully staff a receiving site fully should be readily available to activate to receive critical resources. To effectively assess and improve operational performance and provide a realistic understanding of response capability, jurisdictions should collect data that allows for measurement of staff performance for each of the required operational and response activities (notification, acknowledgement, and staff assembly). Local jurisdictions can use exercises conducted in the context of the staff notification drill, as long as they choose to include the RDS/LDS staff, if applicable.

Example Documentation or Evidence: Acceptable documentation may consist of tables, spreadsheets, databases, or automated systems (e.g. health alert network) and includes an acknowledgement report for all personnel.

Reference(s): Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness, Version 11; SNS State TAR User Guide Version 1.0 (2012), Element 7.12; Medical Countermeasure Reference Guide – ‘Staff Notification’ Drill

Function 2: *Acquire medical material*

a. Planning Implementation

Intent: To maximize the amount of available time to provide prophylaxis and / or treatment to populations at risk, a jurisdiction should establish processes to inform officials on decisions to request assistance from jurisdictional, private, regional, and/or federal partners during the early stages of a public health emergency.

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Example Documentation or Evidence: Acceptable evidence may include algorithms, decision matrices with trigger points, standard operating procedures, written agreements, etc.

Reference(s): Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness, Version 11; SNS State TAR User Guide Version 1.0 (2012), Element 3.2

a. Operational Implementation

Intent: Jurisdictions should test their requesting procedures and demonstrate operational readiness. The intent of this element is for the jurisdiction to go through the decision-making process and request critical resources through the appropriate channels, not necessarily requesting resources from each individual sector. Exercise types are defined according to HSEEP principles.

NOTE: A jurisdiction can only receive an advanced level of implementation if all applicable criteria from the planning element are tested at the level of exercise/incident indicated for this element. If the jurisdiction tests (via exercise or incident) at least one criterion, but less than the total number of criteria, the jurisdiction will receive an intermediate/established level of implementation depending on the type of exercise/incident conducted. If the jurisdiction does not test any of the criteria in the planning element, the jurisdiction will receive an early level of implementation.

Example Documentation or Evidence: Acceptable evidence includes AARs, CAPs, IPs, or other HSEEP-defined exercise planning documents that reference exercises that occurred no more than five years from the date of the review.

Reference(s): Homeland Security Exercise and Evaluation Program (https://hseep.dhs.gov/pages/1001_About.aspx)

b. Planning Implementation

Intent: Lot numbers and expiration dates will be used to identify products that may be recalled. Therefore, jurisdictions should have plans to track the distribution of MCM by lot number. The Drug Enforcement Administration (DEA) regulates the storage and transfer of controlled substances according to Title 21 of the U.S. Code of Federal Regulations. Plans, policies, and procedures for the chain of custody and cold chain management must comply with all regulatory guidance. A good plan should identify those authorized to sign for controlled substances by position.

Example Documentation or Evidence: Acceptable evidence may include standard operating procedures, written agreements, relevant forms, etc.

Reference(s): Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness, Version 11; Title 21 of the U.S. Code of Federal Regulations; SNS State TAR User Guide Version 1.0 (2012), Elements 8.3 and 8.5

b. Operational Implementation

Intent: Jurisdictions should test their plans to maintain integrity of medical material and demonstrate operational readiness. Exercise types are defined according to HSEEP principles.

Example Documentation or Evidence: Acceptable evidence includes AARs, CAPs, IPs, or other HSEEP-defined exercise planning documents that reference exercises that occurred no more than five years from the date of the review.

Reference(s): Homeland Security Exercise and Evaluation Program (https://hseep.dhs.gov/pages/1001_About.aspx); Title 21 of the U.S. Code of Federal Regulations; Medical Countermeasure Reference Guide

Function 3: *Maintain updated inventory management and reporting system*

a. Planning Implementation

Intent: An inventory management system (IMS) expedites the management, allocation, control and reordering of critical resources for an effective response. For this element, an IMS should be accessible (i.e., “ready to use”) and is defined as a computer-based database for tracking inventory levels and organizing warehouse, orders, sales, and deliveries. A strong IMS should have the capability to perform the following warehouse operations: receive, put away (store), pick (including stage), and ship. Jurisdictions should also identify a back-up system. State facilities are required to report inventory counts during a public health incident. These data elements are important for managing Food and Drug Administration (FDA) recalls by targeting facilities and locations that store or dispense medical countermeasures outlined by the recall.

Example Documentation or Evidence: Acceptable evidence may include standard operating procedures, written agreements, relevant IMS reports, screenshots, system demonstrations, etc.

Reference(s): Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness, Version 11; SNS State TAR User Guide Version 1.0 (2012), Element 8.1

a. Operational Implementation

Intent: Jurisdictions should test their inventory management systems and demonstrate operational readiness to receive, store, pick, and ship assets. Jurisdictions should test the primary and alternate systems and train staff on each system.

NOTE: A jurisdiction can only receive an advanced level of implementation if all applicable criteria from the planning element are tested at the level of exercise/incident indicated for this element. If the jurisdiction tests (via exercise or incident) at least one criterion, but less than the total number of criteria, the jurisdiction will receive an intermediate/established level of implementation depending on the type of exercise/incident conducted. If the jurisdiction does not test any of the criteria in the planning element, the jurisdiction will receive an early level of implementation.

Example Documentation or Evidence: Acceptable evidence includes AARs, CAPs, IPs, or other HSEEP-defined exercise planning documents that reference exercises that occurred no more than five years from the date of the review, training logs, etc.

Reference(s): Medical Countermeasure Reference Guide; Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness, Version 11

b. Planning Implementation

Intent: To expedite a response, it is imperative that public health authorities have knowledge of real-time jurisdictional resource needs. Efficiently tracking and reporting actual inventory levels maintains accountability and enables a timely response. For this element, entity is defined as relevant sites for dispensing or coordinating dispensing of medical countermeasures in the jurisdiction. Jurisdictions should train staff on collection procedures.

Example Documentation or Evidence: Acceptable evidence may include standard operating procedures, training logs, IMS report forms, etc.

Reference(s): Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness, Version 11

b. Operational Implementation

Intent: Jurisdictions should test their ability to effectively track and report on inventory levels to demonstrate operational readiness. Additionally, PHEP *awardees* are now required to report inventory levels to CDC's Division of Strategic National Stockpile (DSNS)

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using IMATS or an existing inventory management system configured with CDC’s “Inventory Data Exchange Specification Standards.” Local jurisdictions should be able to report inventory levels to the states, as appropriate.

NOTE: A jurisdiction can only receive an advanced level of implementation if all applicable criteria from the planning element are tested at the level of exercise/incident indicated for this element. If the jurisdiction tests (via exercise or incident) at least one criterion, but less than the total number of criteria, the jurisdiction will receive an intermediate/established level of implementation depending on the type of exercise/incident conducted. If the jurisdiction does not test any of the criteria in the planning element, the jurisdiction will receive an early level of implementation.

Example Documentation or Evidence: Acceptable evidence includes AARs, IPs, CAPs, drill documentation, or other HSEEP-defined exercise planning documents that reference exercises that occurred no more than five years from the date of the review, CDC/DSNS validation (for Awardees), etc.

Reference(s): CDC, Inventory Data Exchange Specification Standards; Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness, Version 11

Function 4: *Establish and maintain security*

a. Planning Implementation

Intent: The distribution sites (RSS/RDS/LDS) are essential components of a mass prophylaxis campaign. Any incident that compromises security, maintenance, receipt, and distribution activities may result in material not reaching the affected population. Jurisdictions should include the following elements in distribution site security plans.

- Interior physical security of location: security sweep prior to facility use or occupancy by staff or product, establishment of law enforcement officer posts, access control to locations within the facility, and crowd control inside the facility
- Exterior physical security of location: specialized unit needs (canine, explosive ordnance disposal, tactical, traffic, etc.), additional physical barriers (necessity or identification of source), additional lighting (necessity and/or identification of source), staging area for personnel and vehicles, vehicular traffic control (entrances and exits), crowd control outside the facility, and access control to facility
- Command and management: established command center for law enforcement, determined radio channels, ensure communication and coordination between law enforcement organizations, established shifts, and established sufficient number of law enforcement officer assignments
- Evacuation plans

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- Security breach plans

Example Documentation or Evidence: Acceptable evidence may include standard operating procedures, written agreements, etc. for each distribution site.

Reference(s): Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness, Version 11; SNS State TAR User Guide Version 1.0 (2012), Element 6.4

a. Operational Implementation

Intent: Jurisdictions should test the security plans for each distribution site to demonstrate operational readiness. Exercise types are defined according to HSEEP principles.

Example Documentation or Evidence: Acceptable evidence includes AARs, CAPs, IPs, or other HSEEP-defined exercise planning documents that reference exercises that occurred no more than five years from the date of the review for each distribution site exercised.

Reference(s): Homeland Security Exercise and Evaluation Program (https://hseep.dhs.gov/pages/1001_About.aspx)

b. Planning Implementation

Intent: The dispensing sites are also essential components of a mass prophylaxis campaign. Any incident that compromises security, maintenance, receipt, and distribution activities may result in material not reaching the affected population. The jurisdiction should use the expertise of law enforcement and other security professionals to ensure the safety and security of the facility, entrances and exits for vehicular and pedestrian traffic, and emergency response plans for each dispensing site. This allows local departments to conduct life-saving operations quickly and effectively. Well-developed dispensing site security plans should include the following elements.

- Interior physical security of location: security sweep prior to facility use or occupancy by staff or product, establishment of law enforcement officer posts, access control to locations within the facility, and crowd control inside the facility
- Exterior physical security of location: specialized unit needs (canine, explosive ordnance disposal, tactical, traffic, etc.), additional physical barriers (necessity and/or identification of source), additional lighting (necessity or identification of source), staging area for personnel and vehicles, vehicular traffic control (entrances and exits), crowd control outside the facility, and access control to facility

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- Command and management: established command center for law enforcement, determined radio channels, ensure communication and coordination between law enforcement organizations, established shifts, and established sufficient number of law enforcement officer assignments
- Evacuation plans
- Security breach plans.

Example Documentation or Evidence: Acceptable evidence may include standard operating procedures, written agreements, etc. for each dispensing site.

Reference(s): Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness, Version 11; SNS Local TAR User Guide (2010), Elements 6.3 and 6.5

b. Operational Implementation

Intent: Jurisdictions should test the security plans for each dispensing site to demonstrate operational readiness. Exercise types are defined according to HSEEP principles.

Example Documentation or Evidence: Acceptable evidence includes AARs, CAPs, IPs, or other HSEEP-defined exercise planning documents that reference exercises that occurred no more than five years from the date of the review for each dispensing site that is exercised.

Reference(s): Homeland Security Exercise and Evaluation Program (https://hseep.dhs.gov/pages/1001_About.aspx)

c. Planning Implementation

Intent: Jurisdictions must develop plans detailing the security of federal MCM in rapid transit and delivery to the affected population. Crossing jurisdictional lines and governmental sovereignty, if not addressed and coordinated early, may result in delays or restrictions in the delivery of medical material. For this element, distribution phases may include: 1) MCM arriving at RSS, 2) MCM transported from RSS to RDS/LDS/POD, and 3) MCM transported from RDS/LDS to POD (where applicable).

Example Documentation or Evidence: Acceptable evidence may include standard operating procedures, contracts, EOPs and annexes, letters of agreement, MOAs and MOUs, or any other official document that describes the role of these partners, etc.

Reference(s): Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness, Version 11; SNS State TAR User Guide Version 1.0 (2012), Element 6.2

c. Operational Implementation

Intent: Jurisdictions should test the security plans for each phase of transit (referenced in Function 4 (c), Planning) to demonstrate operational readiness. Percentages should be calculated based on phases of transit from the planning element that are applicable to the jurisdiction (i.e., if a jurisdiction is only responsible for three of the phases, the denominator for this calculation should be three). Exercise types are defined according to HSEEP principles.

Example Documentation or Evidence: Acceptable evidence includes AARs, CAPs, IPs, or other HSEEP-defined exercise planning documents that reference exercises that occurred no more than five years from the date of the review for each transportation security plan that is exercised.

Reference(s): Homeland Security Exercise and Evaluation Program (https://hseep.dhs.gov/pages/1001_About.aspx)

Function 5: Distribute medical material

a. Planning Implementation

Intent: Effective, timely, and uninterrupted deliveries are essential to the success of a mass prophylaxis campaign. Plans may include maps showing potential routing strategies, traffic flow patterns, results from modeling programs, strategies for how to handle vehicle repairs, maintenance, fueling and refueling, or other emergent issues with vehicles, and delivery locations identified via maps or GIS software.

Example Documentation or Evidence: Acceptable evidence may include standard operating procedures, written agreements, route optimization reports, allocation tables, GIS overlays, physical maps, etc.

Reference(s): Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness, Version 11; SNS State TAR User Guide Version 1.0 (2012), Element 10.2

a. Operational Implementation

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Intent: Jurisdictions should test their ability to transport critical resources from the receiving sites to the dispensing sites. In PHEP jurisdictions, distribution of critical resources from RSS to all dispensing sites should occur within 12 hours of receipt of material. At the regional or local level, if an RDS or LDS is used, distribution of critical resources should still reach all dispensing sites within the same 12 hours. Therefore, planning assumptions for distribution timelines should account for the time involved to receive material from the RSS. Exercise types are defined according to HSEEP principles.

NOTE: A jurisdiction can only receive an advanced level of implementation if all applicable criteria from the planning element are tested at the level of exercise/incident indicated for this element. If the jurisdiction tests (via exercise or incident) at least one criterion, but less than the total number of criteria, the jurisdiction will receive an intermediate/established level of implementation depending on the type of exercise/incident conducted. If the jurisdiction does not test any of the criteria in the planning element, the jurisdiction will receive an early level of implementation.

Example Documentation or Evidence: Acceptable evidence includes AARs, CAPs, IPs, or other HSEEP-defined exercise planning documents that reference exercises that occurred no more than five years from the date of the review.

Reference(s): PHEP Medical Countermeasure Reference Guide

Function 6: *Recover medical material and demobilize distribution operations*

a. Planning Implementation

Intent: To successfully demobilize distribution operations, jurisdictions need to plan for the recovery of critical resources after an incident. This will enable the jurisdiction to efficiently restore systems, supplies, and staffing as required to support distribution operations. Waste management is of special note in the process of recovering resources, as resources that require special handling and disposition (e.g., biological waste and contaminated supplies, debris, and equipment) are managed according to established regulations and policies. Plans should also consider identifying any sensitive item that is deemed “recoverable” by the federal government.

Example Documentation or Evidence: Acceptable evidence may include standard operating procedures, written agreements, etc.

Reference(s): FEMA, National Incident Management System (NIMS Resource Management)

a. Operational Implementation

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Intent: Jurisdictions should test their recovery and waste disposal plans and demonstrate operational readiness in these areas. Exercise types are defined according to HSEEP principles.

NOTE: A jurisdiction can only receive an advanced level of implementation if all applicable criteria from the planning element are tested at the level of exercise/incident indicated for this element. If the jurisdiction tests (via exercise or incident) at least one criterion, but less than the total number of criteria, the jurisdiction will receive an intermediate/established level of implementation depending on the type of exercise/incident conducted. If the jurisdiction does not test any of the criteria in the planning element, the jurisdiction will receive an early level of implementation.

Example Documentation or Evidence: Acceptable evidence includes AARs, CAPs, IPs, or other HSEEP-defined exercise planning documents that reference exercises that occurred no more than five years from the date of the review.

Reference(s): Homeland Security Exercise and Evaluation Program (https://hseep.dhs.gov/pages/1001_About.aspx)

Capability 14: Responder Safety and Health

Function 1: *Identify responder safety and health risks*

a. Planning Implementation

Intent: An MCM incident and the subsequent dispensing campaign may have various adverse effects on responders, including medical or mental health issues related to the stress of the incident. Jurisdictions should maintain plans to mitigate these risks, as well as offer expert guidance on securing their health and safety.

Example Documentation or Evidence: Acceptable evidence may include standard operating procedures, job aids, SME guidance, responder resource inventory, etc.

Reference(s): PHEP Budget Period 2 Performance Measure Specifications and Implementation Guidance (2013), Capability 14

a. Operational Implementation

Intent: Jurisdictions should test their plans for public health responder protection by incorporating these principles into an exercise or incident that demonstrates operational readiness. Exercise types are defined according to HSEEP principles.

NOTE: A jurisdiction can only receive an advanced level of implementation if all applicable criteria from the planning element are tested at the level of exercise/incident indicated for this element. If the jurisdiction tests (via exercise or incident) at least one criterion, but less than the total number of criteria, the jurisdiction will receive an intermediate/established level of implementation depending on the type of exercise/incident conducted. If the jurisdiction does not test any of the criteria in the planning element, the jurisdiction will receive an early level of implementation.

Example Documentation or Evidence: Acceptable evidence includes AARs, CAPs, IPs, or other HSEEP-defined exercise planning documents that reference exercises that occurred no more than five years from the date of the review.

Reference(s): Homeland Security Exercise and Evaluation Program (https://hseep.dhs.gov/pages/1001_About.aspx)

b. Planning Implementation

Intent: Certain groups of personnel are critical to the execution of a jurisdiction’s distribution and dispensing plans. Therefore, it is essential for jurisdictions to determine how best to provide for these groups and their families while allowing them to continue supporting the operation. For this element, the following terms are defined as:

- First responders: individuals who, in the early stages of an incident, are responsible for the protection and preservation of life, property, evidence, and the environment, including emergency response providers as defined in Section 2 of the Homeland Security Act of 2002 (6 U.S.C. 101). Also included are emergency management, public health, clinical care, public works, and other skilled support personnel (such as equipment operators) who provide immediate support services during prevention, response, and recovery operations.
- Critical infrastructure staff: individuals involved in managing public works, emergency services, transportation, information technology, government, or any other system or asset that would have a debilitating impact on the community if not maintained.

Example Documentation or Evidence: Acceptable evidence may include standard operating procedures, written agreements, staff contact lists, etc.

Reference(s): Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness, Version 11; Presidential Policy Directive (PPD) 8: National Preparedness (<http://www.dhs.gov/xlibrary/assets/presidential-policy-directive-8-national-preparedness.pdf>); SNS Local TAR User Guide (2010), Element 10.5

b. Operational Implementation

Intent: Jurisdictions should test their plans for the priority prophylaxis of staff and volunteer responders, including critical infrastructure personnel and first responders, to demonstrate operational readiness. Exercise types are defined according to HSEEP principles.

NOTE: A jurisdiction can only receive an advanced level of implementation if all applicable criteria from the planning element are tested at the level of exercise/incident indicated for this element. If the jurisdiction tests (via exercise or incident) at least one criterion, but less than the total number of criteria, the jurisdiction will receive an intermediate/established level of implementation depending on the type of exercise/incident conducted. If the jurisdiction does not test any of the criteria in the planning element, the jurisdiction will receive an early level of implementation.

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Example Documentation or Evidence: Acceptable evidence includes AARs, CAPs, IPs, or other HSEEP-defined exercise planning documents that reference exercises that occurred no more than five years from the date of the review.

Reference(s): Homeland Security Exercise and Evaluation Program (https://hseep.dhs.gov/pages/1001_About.aspx)

Function 2: *Identify safety and personal protective needs*

a. Planning Implementation

Intent: An incident requiring the distribution and dispensing of MCM will have the potential to expose staff and volunteer responders to hazardous conditions. Personal protective equipment (PPE) will be required to ensure that responders can safely operate in the affected area. Successful strategies to use PPE will include training, fit-testing, and medical clearance for responders. This applies to any and all responders who may be exposed to hazardous conditions as part of their response roles.

Example Documentation or Evidence: Acceptable evidence may include standard operating procedures, training logs, medical release forms, written agreements, responder resource inventory, etc. For this element, evidence that the PPE planning criteria are met *for at least one MCM scenario* is sufficient for Budget Period 4. If a jurisdiction is not directly responsible for medical clearance of PPE, evidence may be accepted from other entities (i.e., occupational safety and health).

Reference(s): PHEP Budget Period 2 Performance Measure Specifications and Implementation Guidance (2013), Capability 14

Function 3: *Coordinate with partners to facilitate risk-specific safety and health training*

a. Planning Implementation

Intent: Jurisdictions should plan to provide just-in-time training to their responders on MCM-related health risks, including the use of appropriate PPE, dispensing site security protocols, agent-specific threat information, etc. The needs of the various responder groups may differ, and jurisdictions should consider these differences in their training plans. For this element, the following terms are defined as:

- **First responders:** individuals who, in the early stages of an incident, are responsible for the protection and preservation of life, property, evidence, and the environment, including emergency response providers as defined in Section 2 of the Homeland Security Act of 2002 (6 U.S.C. 101). Also included are emergency management, public health, clinical care, public works, and other skilled support personnel (such as equipment operators) who provide immediate support services during prevention, response, and recovery operations.

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- Critical infrastructure staff: individuals involved in managing public works, emergency services, transportation, information technology, government, or any other system or asset that would have a debilitating impact on the community if not maintained.

Example Documentation or Evidence: Acceptable evidence may include training logs, training materials, etc.

Reference(s): PHEP Budget Period 2 Performance Measure Specifications and Implementation Guidance (2013), Capability 14

Function 4: *Monitor responder safety and health actions*

a. Planning Implementation

Intent: Responder injuries, illnesses, exposures, and fatalities are often preventable. To address immediate operational safety and health concerns, jurisdictions must monitor the health of responders and adhere to health and safety recommendations. This includes the provision of medical and behavioral health services and identification of broader programmatic factors for which corrective actions can be developed and implemented.

Example Documentation or Evidence: Acceptable evidence may include standard operating procedures, written agreements for the provision of services, job aids, SME guidance, etc.

Reference(s): PHEP Budget Period 2 Performance Measure Specifications and Implementation Guidance (2013), Capability 14

a. Operational Implementation

Intent: Jurisdictions should test their plans for monitoring responder safety and health according to these planning elements to demonstrate operational readiness. Exercise types are defined according to HSEEP principles.

NOTE: A jurisdiction can only receive an advanced level of implementation if all applicable criteria from the planning element are tested at the level of exercise/incident indicated for this element. If the jurisdiction tests (via exercise or incident) at least one criterion, but less than the total number of criteria, the jurisdiction will receive an intermediate/established level of implementation depending on the type of exercise/incident conducted. If the jurisdiction does not test any of the criteria in the planning element, the jurisdiction will receive an early level of implementation.

Example Documentation or Evidence: Acceptable evidence includes AARs, CAPs, IPs, or other HSEEP-defined exercise planning documents that reference exercises that occurred no more than five years from the date of the review.

Reference(s): Homeland Security Exercise and Evaluation Program (https://hseep.dhs.gov/pages/1001_About.aspx)

Capability 15: Volunteer Management

Function 1: *Coordinate volunteers*

a. Planning Implementation

Intent: Identifying, screening, and training volunteers helps ensure adequate staffing levels for a dispensing campaign will be available in a timely manner. The identification of volunteers from a single point source, such as a volunteer registry tracking system, is optimal for the management and coordination of the volunteer pool that would be used during an MCM incident. Since volunteers may be used for various response activities, jurisdictions should ensure an adequate number of volunteers are dedicated to dispensing operations, according to jurisdictional staffing needs.

Example Documentation or Evidence: Acceptable evidence may include ESAR-VHP documentation, volunteer registry reports, standard operating procedures, training logs, etc.

Reference(s): Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness, Version 11; PHEP Budget Period 2 Performance Measure Specifications and Implementation Guidance (2013), Capability 15; SNS State TAR User Guide Version 1.0 (2012), 11.2

a. Operational Implementation

Intent: Jurisdictions should test their plans for volunteer coordination to support a dispensing campaign and demonstrate operational readiness in this area. Exercise types are defined according to HSEEP principles.

NOTE: A jurisdiction can only receive an advanced level of implementation if all applicable criteria from the planning element are tested at the level of exercise/incident indicated for this element. If the jurisdiction tests (via exercise or incident) at least one criterion, but less than the total number of criteria, the jurisdiction will receive an intermediate/established level of implementation depending on the type of exercise/incident conducted. If the jurisdiction does not test any of the criteria in the planning element, the jurisdiction will receive an early level of implementation.

Example Documentation or Evidence: Acceptable evidence includes AARs, CAPs, IPs, or other HSEEP-defined exercise planning documents that reference exercises that occurred no more than five years from the date of the review.

Reference(s): Homeland Security Exercise and Evaluation Program (https://hseep.dhs.gov/pages/1001_About.aspx)

Function 2: *Notify volunteers*

a. Planning Implementation

Intent: To ensure the timely initiation of dispensing activities, jurisdictions should establish procedures that will be used during a dispensing campaign to notify volunteers and partner agencies of the incident and to confirm the validity of volunteer credentials.

Example Documentation or Evidence: Acceptable evidence may include standard operating procedures, written agreements, contact lists, etc.

Reference(s): *Public Health Preparedness Capabilities: National Standards for State and Local Planning* (March 2011), Capability 15; SNS State TAR User Guide Version 1.0 (2012), Element 2.6

a. Operational Implementation

Intent: It is necessary to test volunteer notification systems and credential verification processes to ensure the timely initiation of dispensing activities.

Example Documentation or Evidence: Acceptable documentation may consist of tables, spreadsheets, databases, or automated systems (e.g. Health Alert Network) and includes an acknowledgement report for all personnel.

Reference(s): *Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness*, Version 11

Function 3: *Organize, assemble, and dispatch volunteers*

a. Planning Implementation

Intent: To ensure an efficient and effective response during an emergency, it is essential to protect the personnel responsible for the various functions of a dispensing campaign. At a minimum, jurisdictions should coordinate necessary support services for volunteer staff. Further, volunteers should understand how they integrate into the response, what their roles are and what support services are available to them.

Example Documentation or Evidence: Acceptable evidence may include job aids, training materials, standard operating procedures, written agreements, briefing materials, guidance materials, etc.

Reference(s): Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness, Version 11; SNS Local TAR User Guide (2010), Element 10.13

b. Planning Implementation

Intent: Establishing access-control measures lessens the probability that unauthorized individuals will gain access to sensitive and/or confidential response areas. Additionally, emergency management or other security resources may need to coordinate the access and management of volunteers, including volunteers who are not associated with any public health or emergency management response system prior to the incident (i.e., spontaneous volunteers).

Example Documentation or Evidence: Acceptable evidence may include job aids, standard operating procedures, written agreements, etc.

Reference(s): Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness, Version 11; FEMA, “Managing Spontaneous Volunteers in Times of Disaster” (<http://www.fema.gov/pdf/donations/ManagingSpontaneousVolunteers.pdf>); SNS Local TAR User Guide (2010), Element 6.4

Function 4: Demobilize volunteers

a. Planning Implementation

Intent: To efficiently and effectively coordinate the demobilization of volunteers, jurisdictions should have processes and systems in place to allow for the tracking, out-processing, and follow-up or provision of contingency services following the incident. For this element, tracking volunteers refers to the process, plans, or procedures to capture volunteer activities, roles, locations, etc. Out-processing volunteers refers to the return of equipment, operational debriefing, and any transfer of command or other responsibilities.

Example Documentation or Evidence: Acceptable evidence may include standard operating procedures, system reports, written agreements, etc.

Reference(s): PHEP Budget Period 2 Performance Measure Specifications and Implementation Guidance (2013), Capability 15

Key Terms

Name	Description
All-hazards	Describing an incident, natural or manmade, that warrants action to protect life, property, environment, and public health or safety, and to minimize disruptions of government, social, or economic activities.
Common Operating Picture	A continuously updated overview of an incident compiled throughout an incident's life cycle from data shared between integrated systems for communication, information management, and intelligence and information sharing. The common operating picture allows incident managers at all levels to make effective, consistent, and timely decisions. The common operating picture also helps ensure consistency at all levels of incident management across jurisdictions, as well as between various governmental jurisdictions and private-sector and nongovernmental entities that are engaged.
Devolution	The capability to transfer statutory authority and responsibility for essential functions from an organization's primary operating staff and facilities to other organization employees and facilities, and to sustain that operational capability for an extended period.
Element	An essential part or aspect of each function within the public health preparedness capability.
Event	A planned, non-emergency activity (e.g., full-scale exercise, sporting event, concert, parade, etc.).
Function	Describes the critical elements that need to occur to achieve the capability.
Hazard Vulnerability Analyses (HVA)	A process to identify hazards and associated risks to persons, property, and structures and to improve protection from natural and human-caused hazards.
Healthcare Partners	A network of healthcare organizations, government agencies and providers working together to strengthen emergency preparedness, response and recovery.
Incident	An occurrence, natural or manmade, that requires a response to protect life, including medical emergencies, and other occurrences requiring an emergency response.
Inventory Management System (IMS)	A database or software application developed to manage information regarding medical and non-medical countermeasures.
Jurisdictional Risk Assessment (JRA)	A process of assessing the potential loss or disruption of essential services such as clean water, sanitation, or the interruption of healthcare services, public health agency infrastructure within a specified community.
Jurisdictions	a) Awardees or local planning jurisdictions (e.g., directly funded cities, states, islands, and territories). b) A range or sphere of authority. Public agencies have jurisdiction at an incident related to their legal responsibilities and authority.).
MCM Dispensing	The ability to provide medical countermeasures (including vaccines, antiviral drugs, antibiotics, antitoxin, etc.) in support of treatment or prophylaxis (oral or vaccination) to the identified population in accordance with public health guidelines and/or recommendations.
MCM Distribution	The ability to acquire, maintain (e.g., cold chain storage or other storage protocol), transport, distribute, and track medical material (e.g., pharmaceuticals, gloves, masks, and ventilators) during an incident and to recover and account for unused medical material, as necessary, after an incident.
MCM Incident	A public health emergency or event that requires rapid deployment of medical countermeasures to protect life.

Name	Description
Medical Model (clinical) POD	<p>A type of dispensing model chosen by the jurisdiction during a public health emergency used to operate a POD. In the medical model, each person receives a medical assessment and MCMs from a licensed medical professional. Jurisdictions typically would use the medical model in a dispensing operation that afforded ideal circumstances, such as adequate time and medical staff. Under this model, medical personnel would dedicate more time to providing a personalized medical evaluation and education on the agent and MCMs to each client at the dispensing site. The medical model makes several assumptions for dispensing operations, including:</p> <ul style="list-style-type: none"> • Each individual is unique, therefore MCMs are provided on a personalized medical evaluation, even if only one or two MCM options are available; • Few or no constraints exist for the type of medical staff who can dispense; • No time constraints exist for conducting medical evaluations or providing MCMs; and • All medical professionals have the necessary training and licensures to provide medical care based on current, best medical practices.
Non-medical Model (rapid dispensing) POD	<p>A type of dispensing model that refers to a modification of the medical model that streamlines dispensing operations in order to achieve rapid dispensing. The goal of rapid dispensing is to increase the number of people who can go through a POD, also known as increasing throughput. In light of the anticipated large number of individuals requiring MCMs during an emergency and the timeframe in which the jurisdiction must accomplish dispensing, the non-medical model takes into account limited medical staffing and decreased time to provide MCMs. In the non-medical model, clients might receive a less comprehensive screening form; steps in the dispensing process might be combined or eliminated; or trained nonmedical personnel may dispense MCMs under limited supervision from licensed medical professionals.</p>
Operational readiness	<p>The capability of a jurisdiction to execute their medical countermeasure distribution and dispensing plans during a public health response.</p>
Orders of Succession	<p>Provisions for the assumption of senior agency offices during an emergency in the event that any of those officials are unavailable to execute their legal duties.</p>
Planning jurisdictions	<p>The number of CRI planning authorities as defined by the state.</p>
Point of Dispensing (POD)	<p>Locations where the members of the public would go to receive life-saving antibiotics or other medical countermeasures during a large-scale public health emergency.</p>
Preparedness	<p>Actions that involve a combination of planning, resources, training, exercising, and organizing to build, sustain, and improve operational capabilities. Preparedness is the process of identifying the personnel, training, and equipment needed for a wide range of potential incidents, and developing jurisdiction-specific plans for delivering capabilities when needed for an incident.</p>
Public Health Emergency	<p>A disease, disorder or significant outbreak of infectious diseases or bioterrorist attacks that presents a risk to the public's health.</p>
Quarterly	<p>Regular intervals every three months, four times a year.</p>
Receiving, Staging, and Storing (RSS) Facility	<p>A site or facility that acts as the hub of the distribution system for the state or jurisdiction to which Strategic National Stockpile (SNS) assets are deployed.</p>
Regional Distribution Site (RDS)/ Local Distribution Site (LDS)	<p>A site or facility selected to receive MCM from the RSS facility for further breakdown and distribution to pre-determined dispensing sites, such as PODs.</p>

Name	Description
Resources	Personnel and major items of equipment, supplies, and facilities available or potentially available for assignment to incident operations and for which status is maintained.
Response	Immediate actions to save lives, protect property and the environment, and meet basic human needs. Response also includes the execution of emergency plans and actions to support recovery.
Third-Party Logistics (3PL)	A company that works with shippers to manage their logistics operations.
Tiered Approach	A systematic and flexible strategy to ensure the entire population is served through POD models that are implemented according to the individual needs of the jurisdiction or community.

References

CDC, *Public Health Preparedness Capabilities: National Standards for State and Local Planning* (March 2011); <http://www.cdc.gov/phpr/capabilities/>

FEMA, Homeland Security Exercise, and Evaluation Program http://www.fema.gov/media-library-data/20130726-1914-25045-8890/hseep_apr13_.pdf

CDC, PHEP Budget Period 2 Performance Measure Specifications and Implementation Guidance (2013); http://www.cdc.gov/phpr/documents/PHEP_BP2_PM_Specifications_and_Implementation_Guidance_v1_1.pdf

CDC, HPP-PHEP Budget Period 3 Continuation Guidance Supplemental Information Performance Measure Specifications and Implementation Guidance (2014)

CDC, PHEP Budget Period 4 Performance Measure Specifications, and Implementation Guidance (2015)

CDC, Medical Countermeasure Reference Guide

CDC, POD Standards (April 2008): http://www.rand.org/content/dam/rand/pubs/technical_reports/2008/RAND_TR553.pdf

CDC, Receiving, Distributing, and Dispensing SNS Assets: A Guide to Preparedness, Version 11

CDC, "Inventory Data Exchange Specification Standards," (http://www.cdc.gov/phinf/library/resources/Tools/IMATS/Inventory_Data_Exchange_Specification.pdf)

DHHS, "Analysis of Risk Communication Strategies and Approaches with At-Risk Populations to Enhance Emergency Preparedness, Response, and Recovery: Final Report (2008)." <http://aspe.hhs.gov/daltcp/reports/2008/emergfres.html>

FEMA, "Managing Spontaneous Volunteers in Times of Disaster" (<http://www.fema.gov/pdf/donations/ManagingSpontaneousVolunteers.pdf>)

National Biodefense Science Board "Integration of Mental and Behavioral Health in Federal Disaster Preparedness, Response, and Recovery: Assessment and Recommendations" (2010)

Pandemic and All-Hazards Preparedness Reauthorization Act (PAHPRA), Public Law No. 113-5 (2013),
(<http://www.phe.gov/Preparedness/legal/pahpa/Pages/pahpra.aspx>)

Presidential Policy Directive (PPD) 8: National Preparedness (<http://www.dhs.gov/xlibrary/assets/presidential-policy-directive-8-national-preparedness.pdf>) (2011)

Title 21 of the U.S. Code of Federal Regulations
(<http://www.fda.gov/MedicalDevices/DeviceRegulationandGuidance/Databases/ucm135680.htm>)

SNS State TAR User Guide Version 1.0 (2012)

SNS Local TAR User Guide (2010)