Iowa Department of Public Health
Division of Epidemiology, EMS, and Disaster Operations

IOWA's Bioterrorism Program

Presentation to the Health and Human Services Appropriations Subcommittee
80th General Assembly 2003

GRANT TEAMS

2002 CDC and HRSA Grant Team Representation

Iowa Local Public Health Agencies (IALPHA)
Tom O'Rourke
Iowa Public Health Association (IPHA)
Kay Leeper
Director's Public Health Advisory Council (DPHAC)
Cindy Kail
Iowa Hospital Association (IHA)
Art Spies
Iowa Health System (IHS)
Dr. Tom Evans
Mercy Health System (MHS)
Joe LeValley
U of I Hygienic Laboratory (UHL)
Dr. Mary Gilchrist
Iowa Health System (HIS) Laboratory Director
Keith Wachter
U of I Center for Public Health Preparedness (CPHP)
Chris Atchison and Dawn Gentsch
Des Moines University (DMU)
Dr. Ryan
Iowa/Nebraska Primary Care Association
Ted Boesen
Metro Medical Response System – Des Moines (MMRS)
David Keenan
National Disaster Medical System (NDMS)
Mike Peters
Emergency Management Division (EMD)
Ellen Gordon and Tom Baumgartner
Attorney General's Office
Heather Adams
Governor's Office
Dawn Wilson and Elizabeth Buck

Iowa Department of Public Health
Bureau of Emergency Medical Services (EMS)
Dr. Tim Peterson, Dick Harmon and Tom Boeckmann
Center for Acute Disease Epidemiology
Dr. Patricia Quinlisk, Dr. Cortland Lohff, Kim Brunette, and Mary Rexroat
Center for Disaster Operations and Response
Jami Haberl
Communications/Information Management
Kevin Teale, Grey Fay, and Jen Hollingsworth
Fiscal Bureau
Marcia Spangler and Carol Ritter

CDC Cooperative Agreement Application FY 2002
GRANT Writing TEAMS

Assignment by Focus Area	Grant Team
A. Preparedness, Planning and Readiness Assessment	**Mary Jones**, Elizabeth Buck, Dawn Wilson, Ellen Gordon or designee
B. Surveillance and Epidemiology Capacity	**Dr. Lohff,** Dr. Quinlisk, Tom O'Rourke, Cindy Kail, Dr. Tom Evans, Joe LaValley, Art Spies
C. Laboratory Capacity – Biological Agents	**Mary Gilchrist**, David Fries, IHS Lab Director, Keith Wachter-MHS Lab Director
D. Laboratory Capacity – Chemical Agents	**No Funding**
E. HAN/Communication and Information Technology	**Greg Fay, Cort Lohff**, ITD Representatives, Dick Harmon, Tom Boeckmann, Mary Jones, Ellen Gordon or designee, Kay Leeper
F. Risk Communication and Health Information Dissemination (PI&C)	**Kevin Teale**, Joe Shannahan, John Lapp
G. Education and Training	**Dr. Quinlisk** Chris Atchison, Dr. Ryan, Tom Baumgartner

Name in BOLD – is responsible for submission of application section to Jami Haberl.

CDC Grant Application FY 2002

Activity Timeline

Activity	Responsibility	Due Date
Grant Team Meeting 1 (assignments)	Dr. Gleason	March 7, 2002 – 11am
Grant Teams Submit Grant Draft by Focus Area	Jami Haberl	March 21, 2002 – by noon
Email 1st Grant Draft (by focus Area) to Grant Teams	Jen Schnathorst	March 25, 2002 – by noon
Grant Team Meeting 2 (review draft)	Dr. Gleason, Dr. Quinlisk Dr. Lohff, Mary Jones	March 28, 2001 – 1 pm
Grant Team Meeting 3 (if necessary)	Dr. Quinlisk, Dr. Lohff, Mary Jones	Open
Submit Grant Draft to Review Team (DPH, EMD, Gov)	Mary Jones	April 1, 2002 – by noon
Grant Review Team Meeting (DPH, EMD, Gov)	Mary Jones	April 2, 2002
Make Revisions to Draft from Review Team	Jami Haberl	April 3, 2002
Submit Final Grant to IDPH Director for Approval	Mary Jones	April 5, 2002
Submit Final Grant to Gov. Office for Approval	Mary Jones	April 6, 2002
Submit Final Grant to CDC	Mary Jones	**April 9, 2002**

HRSA Grant Application FY 2002
GRANT Writing TEAMS

Assignment	Grant Teams
A. Background and History (up to 5 pages)	**Jami Haberl**
B. Needs Assessment (up to 5 pages)	**Dr. Lohff,** Greg Fay, Art Spies
C. Critical Benchmarks #1 and #2 (1-2 pages each) Critical Benchmark #3 (up to 5 pages)	**Mary Jones** **Marvin Firch,** Art Spies, Dr. Evans, Joe LeValley, Ted Boesen
D. First Priority Planning Areas (up to 5 pages) 1. Medications and vaccines 2. PP, quarantine and decontamination 3. Communications 4. Biological Disaster Drills	**Dr. Quinlisk** Mary Rexroat, David Keenan Dr. Lohff, Mary Rexroat, Tom O'Rourke, Cindy Kail Greg Fay, Mary Jones, Tom Boeckmann, Kevin Teale Tom Baumgartner
E. Second Priority Planning (up to 5 pages) 1. Personnel 2. Training 3. Patient Transfer	**Dr. Peterson** Dr. Peterson, Tom Boeckmann Chris Atchison, Dawn Gentsch, Tom Baumgartner Dr. Peterson, Dr. Lohff, Mike Peters
F. Infrastructure (up to 10 pages) 1. Staffing and Medical Direction 2. Coordination and Collaboration 3. System Development 4. Legislation and Regulation	**Mary Jones** Dr. Gleason Dr. Lohff Dr. Gleason, Ellen Gordon, Dawn Wilson/Elizabeth Buck, Mary Jones Dr. Gleason, Ellen Gordon, Dawn Wilson/Elizabeth Buck, Heather Adams, Mary Jones
G. Letters of Support	**Jami Haberl**
H. Budget	**Mary Jones,** Dr. Lohff, Dr. Peterson, department fiscal representative
I. Data Collection, Quality Improvement and Reporting	**Dr. Lohff,** Greg Fay, Dick Harmon, Mary Jones, Jami Haberl.

Name in BOLD – is responsible for submission of application section to Jami Haberl

Activity Timeline

Activity	Responsibility	Due Date
Grant Team Meeting 1 (assignments)	Dr. Gleason	March 7, 2002 – 10am
Grant Team Submit Grant Drafts by Assignment	Jami Haberl	March 21, 2002 – by noon
Email 1st Grant Draft to Grant Team	Jen Schnathorst	March 25, 2002 – by noon
Grant Team Meeting 2 (review draft)	Dr. Peterson, Dr. Lohff, Mary Jones	March 28, 2002 – 10am
Grant Team Meeting 3 (if necessary)	Dr. Peterson, Dr. Lohff, Mary Jones	OPEN
Submit Grant Draft to Review Team (DPH, EMD, Gov)	Mary Jones	April 1, 2002 – by noon
Grant Review Team Meeting (DPH, EMD, Gov)	Mary Jones	April 2, 2002
Make Revisions to Draft from Review Team	Jami Haberl	April 3, 2002
Submit Final Grant to IDPH Director for Approval	Mary Jones	April 5, 2002 – by noon
Submit Final Grant to Gov. Office for Approval	Mary Jones	April 6, 2002 – by noon
Submit Final Grant to HRSA	Mary Jones	**April 9, 2002**– by Fed Ex

PUBLIC HEALTH CONGRESS

DELEGATES

Public Health Congress Delegates

Jun-02

County	Name	City	Telephone	Email
Adair	Nancy Synder	Greenfield	(641)743-6173	adairco@mddc.com
Adams	Kathy Peckham	Corning	(641)322-6283	ahfhc@mddc.com
Allamakee	Jeff Mitchell	Waukon	(563) 568-3411	homecare@vmhospital.com
Appanoose	William Milani	Centerville	(641) 437-1909	adlmenv@jetnetinc.net
Audubon	Lester Larson	Audubon	(712) 563-3385	
Benton	Duane Eldred	Urbana		vghhh063@aol.com
Black Hawk	Mark Linda	Waterloo	(319) 291-2413	mlinda@co.black-hawk.ia.us
Boone	Dr. Wayne E. Rouse	Boone	(515) 432-4460	jrouse@willinet.net
Bremer	Kathy Thoms	Waverly	(319)352-0130	kthoms@co.bremer.ia.us
Buchanan	Amy Marlow	Independence	(319) 334-2818	pmhcc@sbtek.net
Buena Vista	Diane Anderson	Storm Lake	(712)749-2548	dianea@co.buena-vista.ia.us
Butler	Jennifer Becker	Allison	(319) 267-2934	jebecker@butlercoiowa.org
Calhoun	Jane Condon	Rockwell City	(712) 297-8323	jcondon@calhouncountyiowa.com
Carroll	Floyd Klocke	Dedham	(712)683-5716 (H)	ccaud@co.carroll.ia.us
Cass	Lorilyn Schultes	Atlantic	(712)243-8006	schli@casshealth.org
Cedar	Rick Fleshin	Tipton	(563)886-2226	rfleshin@cedarcounty.org
Cerro Gordo	Ronald Osterholm	Mason City	(641) 421-9306	ron@cghealth.com
Cherokee	Mary Benson	Cherokee	(712) 225-6718	mbenson@co.cherokee.ia.us
Chickasaw	Sherry Steinlage	New Hampton	(641) 394-4053	chickphn@iowatelecom.net
Clarke	Sandra Eddy	Osceola	(641)342-3724	clarkeph@pionet.net
Clay	Sylvia Schoer	Sioux Rapids	(712)262-1569	mpitts@co.clay.ia.us
Clayton	Dr. Scott Christiansen	Edgewood	(563) 928-7191 (O)	nancy.yelden@finleyhospital.org
Clinton	Charleen Smith	Clinton	(563)242-3789	lovebooks36@hotmail.com
Crawford	Laura Beeck	Denison	(712)263-3303	cchha@frontiernet.net
Dallas	Ronald Eckoff, JD	Cumming	(515)285-0836	reckoff@radiks.net
Davis	Donnie Herteen	Centerville	(641)437-1909	adlmenv@jetnetinc.net
Decatur	Kathy Lerma	Leon	(641)446-2339	lerma@grm.net
Delaware	Jane Sherman	Manchester	(563) 927-7307	jsherman@regmedctr.org
Des Moines	Barbara Baker	Burlington	(319) 753-8290	bbakedmc@interl.net
Dickinson	Mary Dunleavy	Spirit Lake	(712) 336-2682	mdunleavy@dcmhweb.org

Public Health Congress Delegates

Jun-02

County	Name	City	Telephone	Email
Dubuque	Mary Rose Corrigan	Dubuque	(563) 589-4181	mcorriga@cityofdubuque.org
Emmet	Jerald Johnson	Estherville	(712)362-4989	emmetphn@ncn.net
Fayette	Ruth Schemmel	West Union	(563)422-3811	rschemme@palmerlutheran.org
Floyd	Pat Zwanziger	Charles City	(641)257-6848	fccn@rconnect.com
Franklin	Jane Hirth	Hampton	(641) 456-5820	klingenj@mercyhealth.com
Fremont	Tracy Vanatta	Sidney	(712)374-2685	swihhgch@sidney.heartland.net
Greene	Cynthia Kail	Jefferson	(515)386-2114	cindy.kail@gcmchealth.com
Grundy	Nancy Haren	Grundy Center	(319) 824-6312	nancyh@gccourthouse.org
Guthrie	Janell Stringham	Guthrie Center	(641) 747-3972	gcphns@netins.net
Hamilton	Jacqueline Butler	Webster City	(515)832-9565	jbutler_HamCoPhn@prairieinet.net
Hancock	Kathi Nelson	Garner	(641) 923-3676	scho102w@ncn.net
Hardin	Aaron Budweg	Eldora	(641)858-5227	budwega@hotmail.com
Harrison	Glenna Guttau	Logan	(712) 644-2220	gguttau@harrisoncounty.ia.org
Henry	Doris Grilliot	Mt. Pleasant	(319) 385-6724	grilliotd@hchc.org
Howard	Darrell Knecht	Cresco	(563)547-1165	
Humboldt	Emily Bormann	Humboldt	(515)332-2492	hcc@trvnet.net
Ida	Edward Sohm	Ida Grove	(712) 364-2533	idaemes@pionet.net
Iowa	Gina Maas	Williamsburg	(319) 668-1021	ichd@avalon.net
Jackson	Ann Otteman	Maquoketa	(563)652-4048	jcph@caves.net
Jasper	Sue Irving	Newton	(641) 792-7603	jaspsan@pcpartner.net
Jefferson				
Johnson	Ralph Wilmoth	Iowa City	(319) 356-6040	rwilmoth@co.johnson.ia.us
Jones	Carol Stiffler	Anamosa	(319)462-6135 ext. 6206	cstiffler@n-connect.net
Keokuk	Valerie Hammes	Sigourney	(641) 622-3575	kchealth@lisco.net
Kossuth	Dixie Meyer	Algona	(515) 295-2451 ext 433	meyerd@mercyhealth.com
Lee	Debbie Green	Ft. Madison	(319) 372-5225	healthdepartment@LeeCounty.org
Linn	Tom Hart	Cedar Rapids	(319)892-6030	tom.hart@linncounty.org
Louisa	Alana Poage	Wapello	(319) 523-3981	lcph@louisacomm.net OR apoage7@louisacomm.net
Lucas	Nancy Warren	Chariton	(641)774-4312	warrenn@lucasco.org
Lyon	Dr. Chet DeJong	Rock Rapids	(712) 472-4081	hslc@rockrapids.net

Public Health Congress Delegates

Jun-02

County	Name	City	Telephone	Email
Madison	Kim Hulbert	Winterset	(515) 462-2373	khenke@madisonhealthsystems.org
Mahaska	Berdette Ogden	Oskaloosa	(641) 673-3257	mcch@lisco.com
Marion	Kim Dorn	Knoxville	(641) 828-2238	kdorn@chmarion.org
Marshall	Robert Mandsager	Marshalltown	(641)754-6353	rlmdmm2@aol.com
Mills	Sheri Bowen	Glenwood	(712) 527-9699	mcph@radiks.net
Mitchell	Debra Freeman	Osage	(641)732-6150	mchhcph@osage.net
Monona	Lin Zahrt	Onawa	(712)423-1773	mcphns@pionet.net
Monroe	Dennis Ryan	Albia	(641)932-7705	jbettis@monroecoia.us
Montgomery	Beverly Isaacson	Red Oak	(712) 623-4893	michelty@redoak.heartland.net
Muscatine	Jane Caes	Muscatine	(563)264-9582	jcaes@unityiowa.org
O'Brien	Donna Vander Veen	Primghar	(712) 957-0101	phnurse@tcaexpress.net
Osceola	Derrick Peterson	Sibley	(712)754-2241	bechter@osceolacoia.org
Page	Ray Bryant	Shenandoah	(712)246-4254	rbryant@heartland.net
Palo Alto	Elaine Boes	Emmetsburg	(712) 852-5455	boese@mercyhealth.com
Plymouth	Deb Steffen	LeMars	(712) 546-3335	debra.steffen@floydvalleyhospital.org
Pocahontas	Michele Genine Webbink	Pocahontas	(712)335-4142	pcnhs@ncn.net
Polk	Dr. Carolyn Beverly	Des Moines	(515)286-3759	cbeverl@co.polk.ia.us
Pottawattamie	Kathleen Zajic	McCelland	(712)566-2979	jlightner@vnapc.org
Poweshiek	Karen Fread	Grinnell	(641) 236-2385	kfread@grmedical.com
Ringgold	Becky Fletchall	Mt. Ayr	(641) 464-0691	ringphn@iowatelecom.net
Sac	Cynthia Emery	Sac City	(712) 662-4785	sacphns@pionet.net
Scott	Lawrence Barker	Davenport	(563) 326-8618	lbarker@scottcountyiowa.com
Shelby	Vickie Gillespie	Harlan		vgillespie@shelbycohealth.com
Sioux	Nancy Dykstra	Orange City	(712)737-2971	ndyks@frontiernet.net
Story	Debra Sellers	Ames	(515)239-6730	sellers@mgmc.com
Tama	Debra Denbow Al-Qahtani	Toledo	(641) 484-4788	tcphhc@tamacounty.org
Taylor	Ann Maher	Bedford	(712) 523-3405	amaher@bedford.heartland.net
Union	Wilma Perrin, RN	Creston	(641) 782-3829	wilmap@greaterch.com
Van Buren	Deborah Kirchner	Keosauqua	(319)293-3431	dkirchner@vbcoia.org
Wapello	Lynelle Diers	Ottumwa	(641)682-5434	wcph@pcsia.net

Public Health Congress Delegates

Jun-02

County	Name	City	Telephone	Email
Warren	Rebecca Curtiss	Indianola	(515) 961-1074 (O) (515) 961-2722 (H)	rebeccac@co.warren.ia.us
Washington	Edie Nebel	Washington	(319) 653-7758	enebel@washph.com
Wayne	Pat Tresemer	Corydon	(641) 872-1167	ptresem@grm.net OR wayneph@grm.net
Webster	Vicki Gill	Ft. Dodge	(515) 573-4107	vgill@webstercountyia.org
Winnebago	Jan Rauk	Forest City	(641) 585-4763	angels@wctatel.net
Winneshiek	Nancy Sacquitne	Decorah	(563)382-4662	wcphns@phn.co.winneshiek.ia.us
Woodbury	Frances Sadden	Sioux City	(712) 279-6119	fsadden@sioux-city.org
Worth	Dr. Stephanie Seemuth	Northwood	(641)324-1221	petersjk@mercyhealth.com
Wright	Linda Klehm	Clarion	(515)532-3761	lklehm@wrightcounty.org

IOWA HEALTH DISASTER COUNCIL (IHDC) MEMBERSHIP

AND

SUBCOMMITTEE MEMBERSHIPS

Iowa Health Disaster Council (IHDC) Membership January 13, 2003

Mission: To provide an effective statewide and sustainable program of health and public health components for Iowa's disaster/terrorism services across organizational boundaries of all stakeholders. This program is fully integrated into Iowa's Homeland Security and Emergency Response Plan.

Purpose: The purpose of this committee is to serve as an information-sharing venue regarding public health and healthcare preparedness and response activities including the CDC and HRSA cooperative agreements, the NPS, and the IA-DMAT. This committee shall make final recommendations to the Director of IDPH on issues germane to the mission.

Organization/Agency	Individual
American Red Cross	Marvin Shulz or Marlys Devries
Des Moines University	Dr. Kathleen Schneider
Director's Public Health Advisory Committee Co-Chairs (DPHAC)	Cindy Kail, Mary Rose Corrigan
FBI (Iowa)	Kevin Curran
Fire Chiefs Association	Charles Conklin
Fire Service Training Bureau	Randy Novak
Indian Health Services	Mark Merrick
Iowa Association of Local Public Health Agencies (IALPHA)	Frances Sadden, Keith Erickson
Iowa Center for Public Health Preparedness	Chris Atchison
Iowa Chief of Police Association	Doug Book
Iowa Department of Public Safety – Commissioner	Kevin Techau
Iowa Environmental Health Association (IEHA)	Donn Dierks
Iowa Emergency Management Association	Barry Halling
Iowa EMS Association	Jeff Messerole
Iowa Health System	Dr. Tom Evans
Iowa Hospital Association	Art Spies
Iowa Hazmat Team Association	Bob Platts
Iowa Medical Society	Denise Hill
Iowa/Nebraska Primary Care Association Executive Director	Ted Boesen
Iowa Nurses Association	Linda Goeldner
Iowa Osteopathic Medical Association	Leah McWilliams
Iowa Pharmacy Association	Nancy Bell
Iowa Poison Control Center	Dr. Ed Bottei or Linda Kalin
Iowa Public Health Association (IPHA)	Larry Barker
Iowa Sheriffs Association	Scott Anderson
Iowa State University College of Veterinary Medicine	James A. Roth
Iowa National Guard 71st CST	LTC Daniel Robbins
Metro Medical Response System (City of Des Moines)	David Keenan
Mercy Health Network	Joe LeValley
National Veterinary Services Laboratory	Beverly Schmitt
Professional Fire Chiefs Association	Mark Wessel
University Hygienic Laboratory	Dr. Mary Gilchrist
University of Iowa Hospitals and Clinics	Dr. Pat Hartley
Veterans Hospital (NDMS)	Mike Peters
State or Assistant State Epidemiologist	Dr. Patricia Quinlisk or Dr. Cort Lohff
State Bureau of Healthcare Access, Critical Access Hospitals	Marvin Firch
State Department of Public Health, Director	Jane Colacecchi, Acting Director
State Emergency Management Administrator, Homeland Security Advisor	Ellen Gordon
State EMS Medical Director/Chief	Dr. Tim Peterson
State Governor's Office Representative	Dawn Wilson
State Hospital Bioterrorism Medical Director	Dr. Claudia Corwin
State Medical Examiner's Office	Dr. Dennis Klein
State Division of Epidemiology, EMS and Disaster Operations	Mary Jones

Subcommittee Chairs	
CDC Cooperative Agreement Subcommittee Chair	Tom Hart
HRSA Cooperative Agreement Subcommittee Chair	Dr. Tom Evans/Dr. Claudia Corwin
NPS Subcommittee Chair	Dr. Carolyn Beverly
IA-DMAT Subcommittee Co-Chairs	Dr. David Stilley
HAN/Disease Reporting Chair	Keith Erickson

This committee may not be all-inclusive, membership may increase/decrease as needed.

CDC Cooperative Agreement Subcommittee Membership January 6, 2003

Mission: To provide a statewide, effective, and sustainable program of public health disaster and/or terrorism services across organizational boundaries of all stakeholders that is fully integrated into Iowa's Homeland Security and Emergency Response Plan.

Purpose: The purpose of this subcommittee is to actively participate in the development and implementation of local and state public health preparedness and response planning/operational procedures for bioterrorism, other outbreaks of infectious disease, and other public health threats and emergencies. *It is the responsibility of the membership to provide regular updates and communication regarding the activities and progress made by this subcommittee to the constituents they represent.*

ORGANIZATION/AGENCY	INDIVIDUAL
Congressional District 1 Public Health representative	Tom Hart, Linn County (Chair) Alana Poage, Louisa County
Congressional District 2 Public Health representative	Jennifer Becker, Butler County Dr. Stephanie Seemuth, Worth County
Congressional District 3 Public Health representative	Valerie Hammes, Keokuk County Rebecca Curtiss, Warren County
Congressional District 4 Public Health representative	Dr. Carolyn Beverly, Polk County Sheri Bowen, Mills County
Congressional District 5 Public Health representative	Vicki Gill, Webster County Nancy Dykstra, Sioux County
Director's Public Health Advisory Council Co-Chairs (DPHAC)	Cindy Kail, Mary Rose Corrigan
Iowa Association of Local Public Health Agencies (IALPHA)	Frances Sadden
Iowa Center for Public Health Preparedness	Chris Atchison
Iowa Civil Support Team 71st	CPT Amy Price
Iowa Emergency Management Association	Barry Halling or designee
Iowa Emergency Management Division/Homeland Security	Ellen Gordon or designee
Iowa Environmental Health Association (IEHA)	Donn Dierks
Iowa Hospital Association	Art Spies
Iowa Medical Society	Denise Hill
Iowa Public Health Association (IPHA)	Larry Barker
Iowa Poison Control	Dr. Ed Bottei or designee
Region 1 Representative	Dr. Ron Eckhoff or designee
Region 2 Representative	Jennifer Becker or designee
Region 3 Representative	Mary Benson or designee
Region 4 Representative	Kathy Lerma or designee
Region 5 Representative	Kim Dorn or designee
Region 6 Representative	Ralph Wilmoth or designee
University Hygienic Laboratory	Dr. Mary Gilchrist or designee
State Emergency Medical Services Medical Director and Chief	Dr. Tim Peterson
State Epidemiologist and Medical Director or Assistant State Epidemiologist	Dr. Patricia Quinlisk or Dr. Lohff
State Division of Epidemiology, EMS, and Disaster Operations	Mary Jones
State Hospital Disaster/Terrorism Medical Director	Dr. Claudia Corwin

This subcommittee may not be all-inclusive; membership may increase/decrease as needed.

HRSA Cooperative Agreement Subcommittee Membership January 13, 2003

Mission: To provide a statewide, effective, and sustainable program of hospital and EMS disaster/terrorism services across organizational boundaries of all stakeholders that is fully integrated into Iowa's Homeland Security and Emergency Plan.

Purpose: The purpose of this subcommittee is to actively participate in the development and implementation of hospital and EMS preparedness and response planning/operational procedures for statewide and regional hospital disaster/terrorism activities. *It is the responsibility of the membership to provide regular updates and communication regarding the activities and progress made by this subcommittee to the constituents they represent.*

Organization/Agency	Individual
Health system designee	Dr. Tom Evans or designee
Health system designee	Joe LeValley
American Red Cross	Marlys DeVries
Iowa Poison Control Center	Dr. Ed Bottei or Linda Kalin
Infection Control Practitioner (ICP) Nurse	Paula Simplot
Iowa Emergency Management Association	Barry Halling or designee
Iowa EMS Advisory Council Chair	Dr. Fred Hansen or designee
Iowa EMS Association President	Jeff Messerole or designee
Iowa Hospital Association President or designee	Art Spies
Iowa/Nebraska Primary Care Association Executive Director	Ted Boesen or designee
Local Public Health Representative	Denise Schrader
Local Public Health Representative	Dr. Carolyn Beverly
Iowa Pubic Health Association (IPHA)	Larry Barker
Metropolitan Medical Response System Coordinator or Assistant Coordinator (City of Des Moines)	David Keenan or Tim Luloff
Region 1 Representative	Suzanne Cooner or designee
Region 2 Representative	Diane Kajewski or designee
Region 3 Representative	Jeff Berens or designee
Region 4 Representative	Robin Olson or designee
Region 5 Representative	Veronica Fuhs or designee
Region 6 Representative	Dr. Pat Hartley
Physician (Infectious Disease Epidemiologist)	Dr. Greg Gray
University of Iowa Hospitals and Clinics (Pulmonologist)	Dr. Pat Hartley
Veterans Administration Hospital (NDMS Coordinator)	Mike Peters
State or Assistant State Epidemiologist	Dr. Patricia Quinlisk or Dr. Cort Lohff
State Bureau of Healthcare Access, Critical Access Hospital Coordinator	Marvin Firch
State Emergency Management Division and Homeland Security Advisor	Ellen Gordon /Tom Baumgartner
State Governor's Office Representative	Dawn Wilson
State Hospital Disaster/Terrorism Preparedness Coordinator	John Carter
State Hospital Disaster/Terrorism Preparedness Medical Director	Dr. Claudia Corwin (Chair)
State Medical Director/Chief Emergency Medical Services	Dr. Tim Peterson
State Division of Epidemiology, EMS and Disaster Operations	Mary Jones

This subcommittee may not be all-inclusive; membership may increase/decrease as needed.

IA-DMAT Subcommittee Membership January 2, 2003

Mission: The mission of the volunteer Iowa Disaster Medical Assistance Team(s) is to provide medical care and public health services to disaster/terrorism victims and supplement and support disrupted or overburdened local medical/public health personnel and resources at or near the disaster site during the first 24-72 hours of the incident when requested. IA-DMAT will not self-deploy.

Purpose: The purpose of the IA-DMAT Subcommittee is to actively engage in the development and implementation of a statewide plan and operational procedures for mobilization and deployment of volunteer medical care, public health practitioners/services, and other disaster experts to or near the disaster site when local resources have been overburdened or exhausted. *It is the responsibility of the membership to provide regular updates and communication regarding the activities and progress made by this subcommittee to the constituents they represent.*

ORGANIZATION/AGENCY	INDIVIDUAL
Health System Designee	Dr. David Stilley (Chair)
Director's Public Health Advisory Council (DPHAC)	Cindy Kail
Congressional District 1 Public Health representative	Tom Hart, Linn County Alana Poage, Louisa County
Congressional District 2 Public Health representative	Jennifer Becker, Butler County Dr. Stephanie Seemuth, Worth County
Congressional District 3 Public Health representative	Valerie Hammes, Keokuk County Rebecca Curtiss, Warren County
Congressional District 4 Public Health representative	Dr. Carolyn Beverly, Polk County Sheri Bowen, Mills County
Congressional District 5 Public Health representative	Vicki Gill, Webster County Nancy Dykstra, Sioux County
Iowa Association of Local Public Health Agencies (IALPHA)	Karen Fread
Iowa Emergency Management Association	Barry Holling or designee
Iowa EMS Association	Jeff Messerole or designee
Iowa Poison Control Center	Dr. Ed Bottei or Linda Kalin
Iowa Public Health Association (IPHA)	Bonnie Rubin
Iowa Hospital Association (IHA)	Art Spies
Veterans Hospital (NDMS)	Mike Peters
Resource and Regional Trauma Care Facilities (1 representative from each = 12)	U of I – Iowa City IMMC-Des Moines MMC – Des Moines, Sioux City, Cedar Rapids, Dubuque, Mason City St. Luke's – Cedar Rapids Finley – Dubuque Covenant – Waterloo Allen - Waterloo Genesis - Davenport
University Hygienic Lab	Dr. Mary Gilchrist or designee
Assistant State Epidemiologist	Dr. Cort Lohff
State Center for Disaster Operations and Response Operations Officer	John Stark
State Emergency Management Division Administrator/Homeland Security Advisor	Ellen Gordon or designee
State EMS Medical Director and Chief	Dr. Tim Peterson
State Division of Epidemiology, EMS and Disaster Operations	Mary Jones

This subcommittee may not be all-inclusive; membership may increase/decrease as needed.

NPS Subcommittee Membership August 21, 2002

Mission: To provide a statewide, effective plan and operational procedures to ensure Iowa is prepared to receive and distribute the assets of the National Pharmaceutical Stockpile and ensure integration into Iowa's Homeland Security and Emergency Plan.

Purpose: The purpose of the NPS Subcommittee is to actively engage in the development and implementation of the NPS plan for Iowa to request, receive, organize, distribute, dispense and recover the 12-hour Push Package and the Vendor Managed Inventory (VMI) as needed during or immediately following an act of biological or chemical terrorism when local and statewide resources have been overwhelmed or exhausted. *It is the responsibility of the membership to provide regular updates and communication regarding the activities and progress made by this subcommittee to the constituents they represent.*

Special Considerations

There are two airports in the state that have the capacity to receive the NPS by air in a single load (Des Moines and Cedar Rapids).

Organization/Agency	Individual
Congressional District 4 Public Health representative	Dr. Carolyn Beverly (Chair) Sheri Bowen, Mills County
Cedar Rapids NPS Receiving Team Officers	See description below.
Congressional District 1 Public Health representative	Alana Poage, Louisa County Tom Hart, Linn County
Congressional District 2 Public Health representative	Jennifer Becker, Butler County Dr. Stephanie Seemuth, Worth County
Congressional District 3 Public Health representative	Valerie Hammes, Keokuk County Rebecca Curtiss, Warren County
Congressional District 5 Public Health representative	Vicki Gill, Webster County Nancy Dykstra, Sioux County
Des Moines NPS Receiving Team Officers	See description below.
Dispensing Site Officers (county board of health representatives)	TBD
Iowa Emergency Management Association	Barry Holling or designee
Iowa Poison Control Center	Dr. Ed Bottei or Linda Kalin
Iowa Hospital Association (advise on 2 hospital representatives)	Art Spies (TBD)
Linn County Board of Health Representative (NPS receiving airport)	Marty Ralston
Polk County Board of Health Representative (NPS receiving airport)	Jane Riggins
State Emergency Management Division/Homeland Security	Tracey Epps
State Division of Epidemiology, EMS and Disaster Operations	Mary Jones
State Center for Disaster Operations and Response	Mary Rexroat

This subcommittee may not be all-inclusive; membership may increase/decrease as needed.

NPS Receiving Team Officers

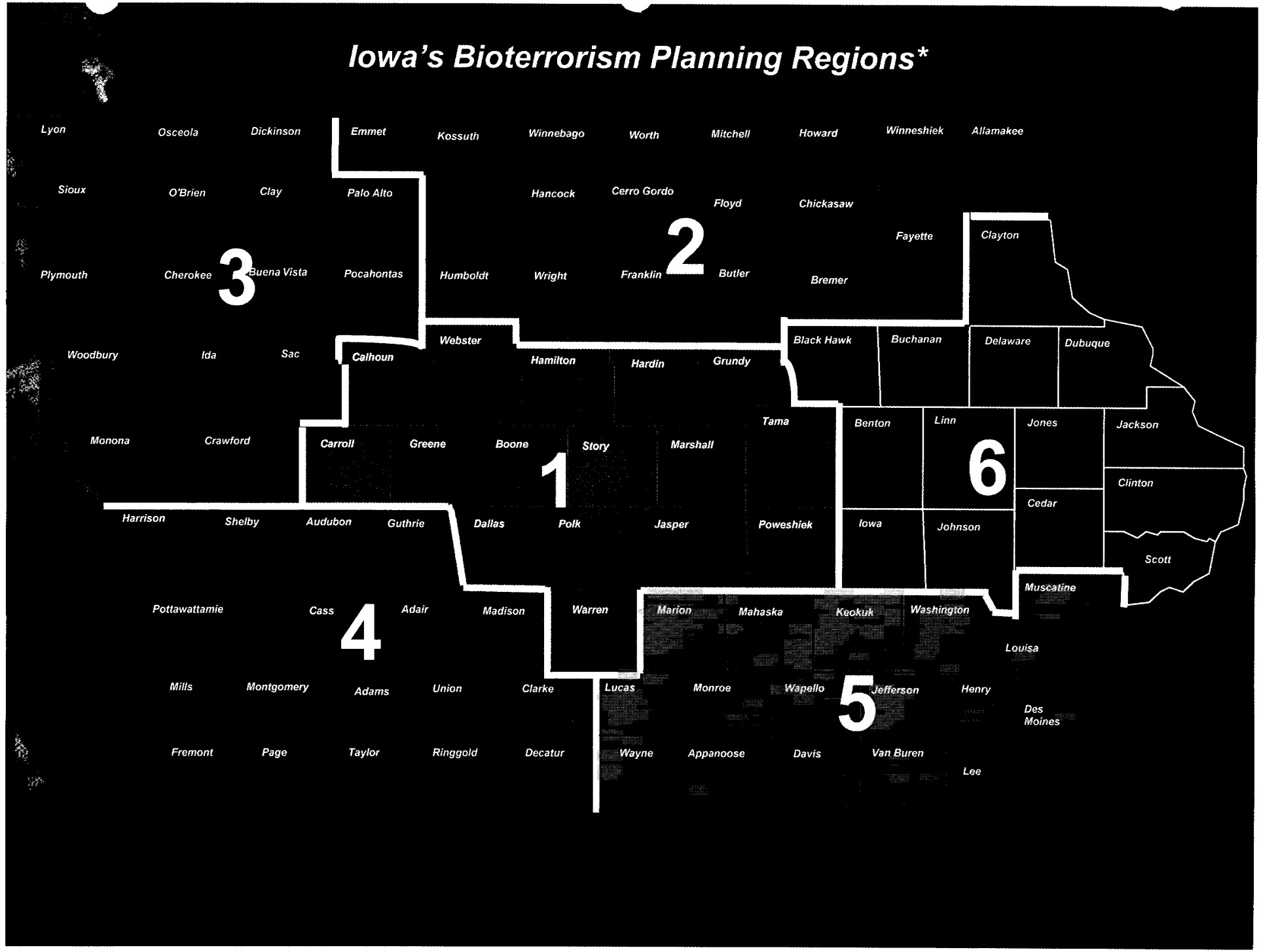
Physician Medical Director
Pharmacy Board Advisor
Pharmacy Association Advisor
Chief of Operations
Assistant Operations Coordinator
Logistics Coordinator
Assistant Logistics Coordinator
Communication Coordinator
Equipment Coordinator
Distribution Coordinator
Storage Facility Coordinator
Security Coordinator
Staff Processing and Resource Coordinator
Airport Operations Coordinator
PIO Coordinator

MAP OF BIOTERRORISM PLANNING REGIONS

AND

STEERING COMMITTEE MEMBERSHIPS

Iowa's Bioterrorism Planning Regions*



Regional Steering Committee Membership

CDC

1. **County Public Health** – one representative from each county health department in the defined region.

2. **Emergency Management Association** – two county emergency coordinators per region as appointed by the Iowa Emergency Management Association.

3. **Hospitals** – two hospital representatives per region as appointed by the Iowa Hospital Association.

4. **EMS** – two EMS providers per region (one volunteer rural and one career urban) as appointed by the Iowa EMS Association.

5. **Community Health Centers** – on representative per region as appointed by the Iowa/Nebraska Primary Care Association

6. **Expertise** – Medical – Doctors, nurses, infection control practitioners
   Technical assistance – DPH (CDOR/CADE/EMS) & Emergency Management Division

HRSA

1. **Hospitals** – each hospital in the planning region will be offered one administrator and one primary care (physician or nurse) seat on the committee. (11-18 x 2)

2. **EMS** – one career/urban and one rural/volunteer provider as designated by the Iowa EMS Association on each planning region steering committee. (2)

3. **Community Health Centers** – one seat per planning region shall be designated for the Iowa/Nebraska Primary Care Association or designee. (1)

4. **Emergency Management Association** – two seats per planning region steering committee shall be designated for county emergency management coordinators. (2)

5. **County Public Health** – one urban and one rural county public health representative shall be designated to each planning region steering committee. (2)

6. **Expertise & Technical Assistance**
   Medical – Doctors, nurses, infection control practitioners
   Technical assistance – DPH (CDOR/CADE/EMS) & Emergency Management Division

NOTE: Indian tribal groups shall be included in respective region with 1 representative from each group.

CDC COOPERATIVE AGREEMENT SUMMARY OF FOCUS AREAS

Centers for Disease Control and Prevention (CDC)
Public Health Preparedness and Response for Bioterrorism Cooperative Agreement FY 2002

SUMMARY

Purpose of the Cooperative Agreement

To upgrade local and state public health preparedness for and response to bioterrorism, other outbreaks of infectious disease, and other public health threats and emergencies. There are 6 focus areas that require development of preparedness and response plans. Each focus area requires activity timelines for development of critical capacities and critical benchmarks. Critical capacities must be completed prior to end of cooperative agreement period.

Focus Area A: Preparedness Planning and Readiness Assessment

This focus area establishes a mechanism to build infrastructure support for strategic leadership, direction, interagency collaboration and coordination of the public health community to ensure state and local preparedness and readiness to respond to bioterrorism or other public health emergencies. It provides support to conduct a comprehensive needs assessment of public health, hospital, and EMS preparedness and response capacity. This focus area also provides support to develop and implement state and local emergency response plans and to develop, implement and exercise the National Pharmaceutical Stockpile (NPS) plan. Lastly, this focus area provides the foundation to ensure all activities are integrated into Iowa' Homeland Security and Emergency Plan.

Focus Area B: Surveillance and Epidemiology Capacity

This focus area establishes mechanisms to rapidly detect a terrorist incident through a reportable disease surveillance system to be used by health care providers and laboratories. This focus area provides the mechanism to develop and implement comprehensive epidemiologic response plans (state and local) that addresses surge capacity including delivery of mass prophylaxis (oral antibiotics) and immunizations. Additionally, this focus area provides the foundation to assure 24/7 reporting and alerting capabilities between state and local health departments, hospitals/clinics, and laboratories.

Focus Area C: Laboratory Capacity – Biological Agents

This focus area provides the mechanism to develop and implement a jurisdiction-wide program of rapid and effective laboratory services to support response to bioterrorism or other public health emergencies. It enables purchase of equipment to rapidly detect and correctly identify biological agents likely to be used in a bio-terrorist incident. Additionally, this focus area provides support for the development of laboratory plans that direct how laboratories are to respond to a bio-terrorist incident and operational procedures for safe packaging and transport of specimens.

Focus Area E: Health Alert Network/Communications and Information Technology

This focus area provides for effective communication connectivity (Health Alert Network) among public health departments and healthcare organizations through high-speed Internet, email, and development of a comprehensive directory of public health and clinical personnel covering all jurisdictions. This will allow for a flow of 24/7 critical health information and ensures that 90% of the population is covered by the network. This focus area also ensures the establishment of a 24/7 emergency notification system for emergency public health response. The notification systems will be redundant and include email, blast fax, and paging systems. Lastly, this focus area ensures protection of critical data and information that will be exchanged between clinical, laboratory, and public health officials.

Focus Area F: Risk Communication and Health Information Dissemination

This focus area supports the development of a risk communication plan and process to disseminate and educate the public regarding exposure risks and effective public response. It provides the foundation to build a team of public information officers (across the state) to respond in the event of a bio-terrorist incident with pre-established "Go Kits". A series of educational programs will be provided for local public health and emergency managers on risk communication. As well, a series of town meetings and educational activities for the public will be developed and implemented. A variety of public information materials will be developed disseminated through multiple venues.

Focus Area G: Education and Training

This focus area ensures the delivery of multiple education and training sessions to key public health, infectious disease specialists, emergency department personnel, and other health care providers in preparedness for and response to bioterrorism and other public health emergencies. Partnerships will be formed with schools of public health and medicine and other academic institutions for the provision of this education and training. Multiple delivery methods to provide the education and training will be used, i.e. ICN, web-based, in-person, etc. This focus area also provides support to exercise biological preparedness and response. Additionally, a bioterrorism speaker's bureau of local, state, and national experts will be established.

CDC GRANT

CRITICAL CAPACITIES, BENCHMARKS AND ACTIVITIES

CDC Critical Capacities and Benchmarks FY 2002-2003

FOCUS AREA A.
Preparedness Planning and Readiness Assessment

CRITICAL CAPACITY I.
Establish a process for strategic leadership, direction, coordination and assessment.

Benchmark

1) Designate senior public health official with state health department.
2) Establish an advisory committee.

Activities

1) Ensure high level policy makers and elected officials at the state and local level is provided regular updates.
2) Establish coordinated and integrated process for monitoring progress, allocation of resources, and developing work plans.
3) Sponsor jurisdiction-wide conferences and workshops bringing together partners and stakeholders.
4) Ensure that parts of the public health system not directly involved in bioterrorism preparedness are aware of and, when appropriate, participate in planning and implementation of activities.
5) Ensure competency of project leadership through technical, managerial, and leadership training and career development activities.

CRITICAL CAPACITY II.
Conduct an integrated assessment of public health system capacity related to bioterrorism, other infectious outbreaks and other public health threats and emergencies.

Benchmark

1) Prepare timeline for assessment of emergency preparedness response capabilities related to bioterrorism, other infectious outbreaks and other public health threats and emergencies.
2) Prepare a timeline for assessment of statutes, regulations and ordinances within the state and local public health jurisdictions and provide for credentialing, licensure and delegation of authority for executing emergency public health measures as well as provisions for liability, for healthcare personnel in coordination with adjacent states.

Activities

1) Review results of existing assessments of the public health system's capacity to determine response status of the state and local public health system.
2) Ensure sufficient state and local public health agency staff to manage a system that will assess system capacity.
3) Ensure state and local public health agency staff competency by providing equipment, supplies and training.

4) Provide results of system assessments to all components of the state and local public health agency and to elected officials responsible for oversight of health agency activities.

CRITICAL CAPACITY III.

Ability to respond to emergencies caused by bioterrorism, other infectious disease outbreak, other public health threats and emergencies through the development and exercise of a comprehensive public health emergency preparedness and response plan.

Benchmark

1) Prepare timeline for development of a statewide plan for responding to incidents of bioterrorism, other infectious outbreaks and other public health threat and emergencies. Must have a provision for regular exercises.
2) Prepare a timeline for development of regional plans to respond to bioterrorism, other infectious outbreaks and other public health threats and emergencies.

Activities

1) Designate senior public health professional to serve as the lead for developing and implementing planning activities associated with this cooperative agreement.
2) In collaboration with other federal agencies assess readiness of hospitals and EMS to respond to bioterrorism and include them in state/local plan development.
3) Establish and maintain a system of 24/7 notification or activation of the public health emergency response system.
4) Exercise plans at least annually to demonstrate proficiency in responding to bioterrorism.
5) Develop capacity within state health department by:
-identifying dedicated preparedness and response staff
-develop rapid reliable communications systems
-coordinate efforts with the medical community
-participate in multi-agency incident command and unified incident command
6) Develop capacity within local health departments by:
-identifying an emergency response coordinator in each agency
-ensure development of local health department preparedness and response plan that is integrated with and supports plans of other local agencies
-ensure local health departments participate in response exercises and training activities
-ensure that local health departments establish and maintain a system of 24/7 emergency notification
-work with medical community and other to plan coordinated delivery of critical health services and effective medical management in emergencies

CRITICAL CAPACITY IV

Insure state, local and regional preparedness for and response to bioterrorism, other infectious outbreaks, and other public health threats and emergencies are effectively coordinated with federal response assets.

Benchmark

1) Develop an interim plan to receive and manage items from the National Pharmaceutical Stockpile, including mass distribution of antibiotics, vaccines, and medical material. Within this interim plan, identify personnel to be trained for these functions.

Activities

1) Ensure that that all preparedness and response planning is coordinated within the existing emergency management infrastructure that is facilitated and supported by the Federal Response Plan, Metro Medical Response System, disaster medical assistance teams, and hospital preparedness planning.
2) Participate in regional exercises conducted by federal agencies.

CRITICAL CAPACITY V

To effectively manage the CDC National Pharmaceutical Stockpile (NPS), should it be deployed – translating NPS plans into firm preparations, periodic testing of NPS preparedness, and periodic training for entities and individuals that are part of NPS preparedness.

Activities

1) Develop infrastructure with the state-level department that is dedicated to effective management and use of the NPS statewide.
2) Provide fiscal support to assist regional and local governments develop similar components dedicated to effective management and use of the NPS.
3) Prepare state plan with integrated regional and local components for distribution and dispensing of the NPS.
4) In collaboration with local and regional NPS planning components, follow development of a NPS plan with preparations that result in documented commitments by all individuals, agencies, organizations and corporations identified in the plan.
5) In collaboration with regional and local NPS planning components and provide basic orientation, training and periodic readiness exercises.
6) Develop plan for distribution of antibiotics, chemical nerve agent antidotes and symptomatic treatment packages that meet specifications for environmental acceptability.

FOCUS AREA B.
Surveillance and Epidemiology Capacity

CRITICAL CAPACITY I.

To rapidly detect a terrorist event through a highly functioning, mandatory reportable disease surveillance system, as evidenced by ongoing timely and complete reporting by providers and laboratories in a jurisdiction, especially of illnesses and conditions possibly resulting from bioterrorism, other infectious disease outbreaks, and other public health threats and emergencies.

Benchmark

1) Prepare a timeline for developing a system to receive and evaluate urgent disease reports from all parts of your state and local public health jurisdictions on a 24-hour per day, 7-day per week basis.

Activities

1) Ensure legal authority to require and receive reports on and investigate any suspect cases, potential terrorist events, or unusual illnesses.
2) Assess the timeliness and completeness of your reportable disease surveillance system.
3) Ensure the existence of systems to provide ongoing disease surveillance and epidemiological training for public health, clinical and other healthcare professionals.
4) With input from local public health, evaluate and improve the timely and complete reporting of outbreaks of illness and reportable diseases.
5) Assess capacities associated with monitoring dermatological conditions/rash illnesses and develop plans to improve this component of the surveillance system.
6) Ensure sufficient epidemiological staffing capacity to manage the reportable disease system at the state and local level.
7) Ensure competence of staff by providing necessary supplies and equipment and training in epidemiology, surveillance, and interpretation of clinical and laboratory information.
8) Educate and provide feedback to reporting sources in jurisdiction about notifiable diseases, conditions and syndromes.
9) Enhance reporting protocols, procedures, surveillance activities, information dissemination, or analytical methods that improve the usefulness of the reportable disease.
10) Apply technology according to established specifications and including NEDSS development or the NEDSS Base System to develop or enhance electronic applications for reportable diseases surveillance, including electronic laboratory-based disease reporting.

CRITICAL CAPACITY II.

To rapidly and effectively investigate and respond to a potential terrorist event as evidenced by a comprehensive and exercised epidemiologic response plan that addresses surge capacity, delivery of mass prophylaxis and immunizations, and pre-event

development of specific epidemiologic investigation and response needs.

Benchmark

1) Assess current epidemiologic capacity and prepare a timeline for achieving the goal of providing at least one epidemiologist for each Metropolitan Statistical Area (MSA) with a population greater than 500,000.

Activities

1) Ensure that a fulltime response coordinator for bioterrorism has been designated at the appropriate state and/or local level.
2) Coordinate all epidemiological response planning in this section with your jurisdiction's overall planning conducted in focus A.
3) Train state and local public health staff who would respond to a bioterrorism event in their roles and responsibilities.
4) Ensure performance of risk and vulnerability assessments of food and water to include assessments of production, processing and or distribution of facilities.
5) Develop and train epidemiologic response teams capable of conducting field investigations, rapid needs assessments, exposure assessments, and response activities.
6) Establish a secure web-based communications system that provides for rapid and accurate reporting and discussion of disease outbreaks and other acute health events that might suggest bioterrorism. Include provision for multiple channels of communications.
7) Provide and evaluate bioterrorism epidemiological response training for state and local public health agency personnel, healthcare providers, law enforcement etc.
8) Develop and disseminate information and facts sheets about bioterrorism for public use during a terrorism event.
9) Identify physicians and other providers with key bioterrorism related skills.

CRITICAL CAPACITY III.

To rapidly and effectively investigate and respond to a potential terrorist event, as evidenced by ongoing effective state and local response to naturally occurring individual cases of urgent public health importance, outbreaks of disease, and emergency public health interventions such as emergency chemoprophylaxis or immunization activities.

Activities

1) Achieve around the clock capacity for immediate response to reports of urgent cases including any events that suggest intentional release of a biologic agent.
2) Assess adequacy of state and local public health response to outbreaks of disease and other public health emergencies.
3) Assess and strengthen links with animal surveillance systems and the animal health community.

4) Ensure sufficient staff to respond to urgent cases, disease outbreaks, and public health emergency interventions at the state and local level.

FOCUS AREA C.
Laboratory Capacity – Biologic Agents

CRITICAL CAPACITY I.

To develop and implement jurisdiction-wide program to provide rapid and effective laboratory services in support of the response to bioterrorism, other infectious disease outbreaks, and other public health threats and emergencies.

Benchmark

1) Prepare a timeline for the development of a plan to improve working relationships and communication between Level A (clinical) laboratories and Level B/C Laboratory Response Network laboratories to ensure that Level A laboratories maintain core capability to: (a) perform rule-out testing on critical BT agents; (b) safely package and handle specimens; and (c) refer to higher level laboratories for further testing.

Activities

1) Develop response plan that directs how the laboratories within the jurisdiction will respond to a bioterrorism incident.
2) Establish operational relationships with local members of Hazmat Teams, first responders, law enforcement, FBI to provide laboratory support for their response to bioterrorism.
3) Enhance relationships with community laboratory practitioners, university labs, and infectious disease physicians through participation in infectious disease rounds and conferences.

CRITICAL CAPACITY II.

As a member of the Laboratory Response Network (LRN), to ensure adequate and secure laboratory facilities, reagents, and equipment to rapidly detect and correctly identify biological agents likely to be used in a bioterrorism incident.

Activities

1) Develop comprehensive preparedness and response operational plans, protocols and procedures.
2) Ensure capacity exists for LRN-validated testing of category A agents.
3) Ensure at least one public health laboratory has appropriate instrumentation and staff to perform CDC PCR and TRF rapid assays.
4) Conduct at least one simulation exercise per year that specifically tests laboratory readiness and capability to detect and identify at least one BT threat agent on the category A list.
5) Ensure at least one BSL-3 facility in your jurisdiction.
6) Ensure laboratory security is consistent, at minimum with guidelines set forth in BMBL (Biosafety in Microbiological and Biomedical Laboratories) appendix F.

7) Enhance electronic communications within the LRN to enable network capacity monitoring, BT sentinel surveillance, support proficiency testing, multi-center validation studies for new methods, and support for future LRN site enhancements.

FOCUS AREA E.
Health Alert Network/Communications and Information Technology

CRITICAL CAPACITY I.

To ensure effective communications connectivity among public health departments, healthcare organizations, law enforcement organizations, public officials, and others as evidenced by: a) continuous, high speed connectivity to the Internet; b) routine use of e-mail for notification of alerts and other critical communication; and c) a directory of public health participants (including primary clinical personnel), their roles, and contact information covering all jurisdictions.

Benchmark

1) Prepare a timeline for a plan that ensures that 90 percent of the population is covered by the Health Alert Network.
2) Prepare a timeline for the development of a communications system that provides a 24/7 flow of critical health information among hospital emergency departments, state and local health officials, and law enforcement officials.

Activities

1) Ensure at least 90% of your population is covered by state and local health agencies that have HAN.
2) Provide for 24/7 flow of critical information including alerts, critical event data with local public health, hospitals, law enforcement and other key partners.
3) Ensure that directory information is up to date and complete.
4) Inventory existing communication capabilities relating to information technology.
5) Routinely assess the delivery of email messages to recipients with documentation that the messages have been read.
6) Regularly exchange directory information with key stakeholders and partners.
7) Establish a website that contains current and relevant public health information including health alerts, advisories, and updates.

CRITICAL CAPACITY II.

To ensure a method of emergency communication for participants in public health emergency response that is fully redundant with e-mail.

Activities

1) Assess the capacity for redundant communication devices, capacity of existing systems, at the state and local level to broadcast, autodial to automatically distribute alerts and messages.

2) Routinely assess the timeliness and completeness of the redundant method of alerting, as it exists to reach participants in public health response.
3) Develop broadcast auto-dialing voice4 messaging capabilities.
4) Provide technological and staffing redundancy of critical information and communications systems to support these functions.
5) Implement a second method of receiving critical alerts such as pagers, cell phones, voice mail, email etc....

CRITICAL CAPACITY III.

To ensure the ongoing protection of critical data and information systems and capabilities for continuity of operations

Activities

1) Assess the existing capacity regarding policies and procedures for protecting and granting access to secure systems for management of secure information, system back-ups and system redundancy.
2) Perform regular independent validation and verification of Internet security, vulnerability assessment, and security and continuity of operational practice.
3) Establish a firewall for the protections of critical information resources from the Internet.
4) Implement Public Key Encryption (PKI) methods of strong authentication for remote access from the Internet.
5) Develop role-based authorization to information resources.
6) Institute server and client based virus-checking software to protect critical systems.
7) Contract with an independent IT security firm to perform ongoing penetration testing and vulnerability analysis.
8) Integrate all remote access to health department IT resources using commercial off-the-shelf products for single method of authentication.
9) Implement software systems and or serves to support critical capacities elsewhere in this guidance.
10) Provide training and support on these systems to improve ability of public health practitioners to effectively use them.

CRITICAL CAPACITY IV.

To ensure secure electronic exchange of clinical, laboratory, environmental, and other public health information in standard formats between the computer systems of public health partners. Achieve this capacity according to the relevant IT Functions and Specifications.

Activities

1) Assess existing capacity to exchange electronic date in compliance with public information and data elements exchange standards, vocabulary, and specifications in NEDSS.
2) Ensure technical infrastructure exist to exchange a variety of data types.

3) Regularly confirm the successful transmission and receipt of information to and from public health partners.
4) Develop firewall capabilities and Web technology and expertise to implement ebXML-compliant SOAP service for secure exchange of information over the Internet.
5) Develop systems and databases to implement the specifications to exchange like date with public health partners.
6) Implement message parsing technology to allow for the creation and processing of public health information messages.
7) Participate in national stakeholders meetings, data modeling, and joint development sessions.

FOCUS AREA F.
Risk Communication and Health Information Dissemination (Public Information and Communication)

CRITICAL CAPACITY I.

To provide needed health/risk information to the public and key partners during a terrorism event by establishing critical baseline information about the current communication needs and barriers within individual communities, and identifying effective channels of communication for reaching the general public and special populations during public health threats and emergencies

Benchmark

1) Develop an interim plan for risk communication and information dissemination to educate the public regarding exposure risks and effective public response.

Activities

1) Conduct needs assessment to evaluate the communication and information needs for health and risk information for public health threats and emergencies.
2) Review risk communication strategies and resources from private, media, federal emergency management resources.
3) Identify key public health spokespersons and ensure their competency to communicate to the public.
4) Establish an emergency public information system, call-down lists etc.
5) Institute regular testing program for routine and emergency communications channels and equipment.
6) Ensure access to key technical communication expertise.

FOCUS AREA G.
Education and Training

CRITICAL CAPACITY I.

To ensure the delivery of appropriate education and training to key public health professionals, infectious disease specialists, emergency department personnel, and other

healthcare providers in preparedness for and response to bioterrorism, other infectious disease outbreaks, and other public health threats and emergencies, either directly or through the use (where possible) of existing curricula and other sources, including schools of public health and medicine, academic health centers, CDC training networks, and other providers.

Benchmark

1) Prepare a timeline to assess training needs – with special emphasis on emergency department personnel, infectious disease specialists, public health staff, and other healthcare providers.

Activities

1) Assess the existing capacity to conduct training needs assessment and planning for public health and private professionals.
2) Provide access to training on bioterrorism.
3) Develop ongoing plan fro meeting training needs through multiple sources.
4) Develop capacity at the state and or local public health agency to facilitate or provide education and training sessions and services on bioterrorism – this should include trained distance learning coordinator and access to distance learning capabilities.
5) Develop formal relationships with schools of public health and medicine, other academic institutions, and other organizations for the provision of education and training.
6) Ensure educational expertise and review of training program content and curricula.

CDC

BIOTERRORISM FUNDING SUMMARY & BREAKDOWN 2002-2003

CDC Bioterrorism Funding for Iowa 2002 – 2003
SUMMARY

Center for Disease Control and Prevention (CDC) Funding

Total award for Iowa was $11.5 million

- 5.5 million to County Boards of Health and Public Health Planning Regions
- Public Health Congress held June 2002 to determine allocation local public health funds and the building of planning regions (98 of 99 counties represented)
  - ▶ 2.2 million to County Boards of Health (includes initial urgent costs)
  - ▶ 1.7 million to Public Health Planning Regions
  - ▶ 1.6 million redirected back to state by Public Health Congress
- 6.0 million to state
  - ▶ 4.1 million to Iowa Department of Public Health
  - ▶ 1.5 million to University Hygenic Laboratory
  - ▶ $334,166 to Emergency Management Division

CDC Cooperative Agreement Budget Breakdown
Per Public Health Congress Outcomes
June 2002

Allocated to the County Boards of Health

NOTE: Does NOT include initial urgent costs paid to county health departments for response activities during 9/11 and subsequent anthrax calls and responses totaling approximately $510,000.

Activity	Description of Activity	Funding	
Focus Area A			
1. Needs Assessment	Provide local public health staff salary and fringe for completing needs assessment.	$153,135	Equally among 99 counties
Focus Area B			
1. Communication	For local public health to purchase and maintain communication equipment (i.e., cell phones, pagers) based on needs. 24/7 notification.	$100,000	Equally among 99 counties based on need
2. Travel	Local public health reimbursement for travel and per diem to attend state-sponsored instruction in surveillance and epidemiology.	$44,848	Equally among 99 counties
3. Printing/Mailing	Printing and mailing of disease reports and surveillance information and 24/7 contact notification information. • Based on number of health care providers within each county • Definition of Healthcare provider per Iowa Code	$100,000	Among 99 counties
6. Alert Notification System	Funds for local public health to purchase alert notification equipment/systems i.e., fax, computers, pagers, phones, etc.	$235,968	Equally among 99 counties based on need
7. Reference materials	Funds for local public health to purchase reference materials on surveillance and epidemiology.	$99,000	Equally among 99 counties
Focus Area E			
2. Needs Assessment	Local public health staff salary and fringe for completing IT assessment.	$72,400	Equally among 99 counties
3. High-speed Internet	Acquisition of high-speed Internet connection services for local public health. * priority to those without high-speed & those with pro-rated amount	$699,479	Among 99 counties
Focus Area F			
1. Risk Communication Training	Reimbursement for local public health officials (PIO officers) travel, meals, and accommodations related to attending risk communication training.	$50,000	Equally among 99 counties
2. Public Risk Communication Materials	Funds for local public health to develop and produce health emergency preparedness materials.	$100,000	Equally among 99 counties
Focus Area G			
1. Train-the-Trainer	Reimbursement (per diem, travel, meals) for local health participants attending Train-the-Trainer seminar.	$66,600	Equally among 99 counties
			TOTAL $1,721,430

Allocated to the County Board of Health – Governed by Regions

Activity	Description of Activity	Funding	
Focus Area A			
1. Urgent costs	• Development of critical benchmarks and/or recipient activities (focus area A) • Preparedness planning and assessment, epidemiologic assessments/investigations, health alerting capacities	$641,466	Equally among 99 counties – governed by regions
2. Exercises	Fiscal support for the development of local public health plans and to conduct trainings, meetings, and tabletop exercises. Funds will also support instructor/evaluator expenses, facility expenses and provide participants with lunches, training materials and reimbursement.	$80,000	Equally among 99 counties – Governed by regions
Focus Area B			
9. Plan development	Fiscal support for local public health for development of county epidemiologic response plans.	$261,926	Equally among 99 counties – governed by regions
Focus Area G			
2. Bioterrorism Training	Funds to support speakers for local presentations/trainings and for materials/supplies for bioterrorism training.	$313,919	Equally among 99 counties – governed by regions
3. Bioterrorism Speakers	Funds to support bioterrorism speakers (speakers bureau) travel, per diem, meals, and accommodations.	$112,500	Equally among 99 counties – governed by regions
			TOTAL $ 1,409,811

Allocated to the Public Health Regions

Activity	Description of Activity	Funding	
Focus Area A			
3. Plan Development	For the development of consortia/regional public health emergency response plans.	$100,000	Regions
6. NPS Receiving and Dispensing Sites	Fiscal support for communication devices, telephone lines, Internet connections, computers, printers, locked storage containers for controlled substances, and supplies for two NPS receiving sites and multiple dispensing sites to be determined.	$200,000	Regions
			TOTAL $ 300,000

Redirected from County Board of Health to the Iowa Department of Public Health as result of the Public Health Congress

Activity	Description of Activity	Funding	
Focus Area A			
2. Needs Assessment	To develop, conduct, prepare, and present results of a comprehensive needs assessment of state and local public health, EMS, and hospitals in preparedness for and response to disaster/terrorism incidents.	$200,000	IDPH
4. IA-DMAT	Fiscal support for six IA-DMATs for plan development, training, equipment and supplies.	$210,000	IDPH
6. NPS Receiving and Dispensing Sites	Fiscal support for communication devices, telephone lines, Internet connections, computers, printers, locked storage containers for controlled substances, and supplies for two NPS receiving sites and multiple dispensing sites to be determined.	$58,000	IDPH
Focus Area B			
4. Epidemiologists	Salary and fringe for consortia/regional epidemiologists to improve local surveillance and epidemiologic investigation/response capacity.	$339,606	IDPH
5. Epidemiologists	Funds for consortia/regional epidemiologist's travel, office equipment, training, printing, mailing, duplication, and supplies.	$130,800	IDPH
8. EPI-X	Funds to establish a statewide alert system.	$270,300	IDPH
Focus Area E			
1. Needs Assessment	To develop, conduct, prepare, and present results of an all-encompassing IT assessment for local and state public health, EMS, hospital emergency departments, and law enforcement in preparedness for and response to disaster/terrorism incidents.	$100,000	IDPH
4. Autodial System	Development, implementation, and maintenance of an auto-dial notification system for local public health notification by state public health.	$65,000	IDPH
5. Blast Fax	Creation, establishment and maintenance of a blast-fax notification system for local public health by state public health.	$65,000	
6. NEDSS	To acquire assistance for the National Electronic Disease Surveillance System (NEDSS) application development and consulting services.	$130,000	IDPH
Focus Area G			
4. Continuing Education Approval	Funds to obtain CME/CEU/CEH approval at state/national levels.	$10,000	IDPH
5. First Responder Instructor Training	Funds to train first responder instructors who in turn will offer terrorism awareness training to first responders.	$35,000	IDPH
			TOTAL $ 1,613,706

CDC Public Health Preparedness and Response to Bioterrorism Program
FY 2002 – 2003 Budget

County Board of Health	Funding
Needs Assessment	$153,135
Communication Equipment	$100,000
Travel for surveillance and epidemiology	$44,848
Disease reports and surveillance information printing/mailing	$100,000
Alert Notification System	$235,968
Reference Materials	$99,000
IT Needs Assessment	$72,400
High-Speed Internet Connectivity	$699,479
Risk Communication Training	$50,000
Public Risk Communication Materials	$100,000
Train-the-Trainer	$66,600
Urgent Costs – Expenses September 11, 2001 – April 1, 2002	$510,013
Total	$2,231,443

Note: The following activities were originally allocated to the county boards of health. Per the outcomes of the Public Health Congress, these funds were reverted back to the Iowa Department of Public Health:

- Needs Assessment $200,000
- IA-DMAT $210,000
- NPS Receiving/Dispensing Sites $58,000
- Epidemiologists $470,406
- EPI-X $270,300
- IT Needs Assessment $100,000
- Autodial System $65,000
- Blast fax System $65,000
- NEDSS $130,000
- Continuing Education Approval $10,000
- First Responder Instructor Training $35,000.

6 Public Health Regions	Funding
Remaining Urgent Costs	$641,466
Exercises/Drills	$80,000
Epidemiologic Response Plan Development	$261,926
Regional Public Health Emergency Response Plans	$100,000
NPS Receiving and Dispensing Sites	$200,000
Bioterrorism Training	$313,919
Bioterrorism Speakers' Bureau	$112,500
Total	$1,709,811

6 Regional Epidemiologist – Placed in County Health Departments	Funding
Personnel (6 FTE's)	$254,664
Travel	$71,882
Equipment	$41,881
Supplies	$29,881
Contractual	-
Other	$22,800
Indirect	$86,546
Total	$507,654

University Hygienic Laboratory	Funding
Personnel (9.9 FTE's)	$674,143
Travel	$64,100
Equipment	$692,229
Supplies	$43,950
Contractual	-
Other	$22,500
Indirect	-
Total	$1,496,922 rounded up to 1.5M for cover document.

Iowa Emergency Management Division	Funding
Personnel (3 FTE's)	$158,032
Travel	$32,689
Equipment	$16,875
Supplies	$11,000
Contractual	$0
Other	$115,570
Total	$334,166

Iowa Department of Public Health	Funding
Personnel (21.2 FTE's)	$1,217,676
Travel	$118,000
Equipment	$416,885
Supplies	$266,239
Contractual	$2,450,171
Other	$407,795
Indirect	$358,024
Total	$5,234,790

HRSA GRANT

CRITICAL CAPACITIES, BENCHMARKS AND ACTIVITIES

HRSA Critical Capacities and Benchmarks FY 2002-2003

1. Program Direction

There must be leadership at the health department level to ensure coordination of all three funding streams. In addition, specific direction for the hospital preparedness plan will be needed.

The state department of public health is responsible for implementing the needs assessment and operational plans for hospital/EMS bioterrorism preparedness in the State.

- Provide medical direction for the program.
- Designate a Coordinator for Bioterrorism Hospital/EMS Preparedness Planning.
- Provide administrative support staff for the program.

2. Hospital/EMS Preparedness Planning Committee

This committee will have been established during Phase 1. It should meet at least once during the planning phase, and quarterly during the implementation phase, to provide guidance, direction and oversight to the State health department in planning for bioterrorism response.

- Establish description or charter defining the mission and duties of this planning committee.
- Establish current roster of the planning committee, and the rationale for inclusion of each member.
- Review, comment and sign off on State or regional hospital/EMS preparedness plans.

3. Regional Hospital Plans

It is critical that the State health department plan for a potential epidemic involving at least 500 patients in each State or region. Recognizing that many of these patients may come from rural areas served by referral centers in metropolitan areas, planning must include the surrounding counties likely to impact the resources of these cities.

- Establish a timeline that describes the approach to development and implementation of regional hospital/EMS plans for large-scale epidemics, to include the following issues.

- Describe the plan for increasing hospital bed capacity to accommodate increases in admissions from an infectious disease epidemic over an extended period of time.

- Describe the plan for providing isolation and quarantine for casualties, using such references as CDC's for Type C (contagious) facilities.[5]

- Describe the plan to address overcrowding and the need for hospital diversion, with large numbers of acute casualties arriving on their own or by ambulance, including a rapid communication plan with EMS units that allows them to determine a destination immediately at any time.

- Describe how hospitals will receive patients on a daily basis when several hospitals are on diversion simultaneously.

- Describe the plan for ensuring movement of equipment maintained by hospitals or EMS systems to the scene of a bioterrorist event.

- Describe how the special needs of children, pregnant women, the elderly and those with disabilities will be addressed in ensuring access to medically appropriate care. Planning for children should include school settings and the clinicians caring for them there.

- Describe how essential goods and services such as food, water, electricity and shelter will be delivered to patients and hospitals.

- Describe how hospital security will be provided (crowd control, patient traffic to support triage decisions, prevention of further terrorist attacks at the hospital).

- Describe procedures for safe and appropriate disposal of medical waste.

HRSA GRANT

CRITICAL CAPACITIES, BENCHMARKS AND ACTIVITIES

HRSA Bioterrorism Funding 2002 – 2003
SUMMARY

Total award for Iowa was 1.3 million

- $132,823 to local hospitals to begin planning and assessment activities
- $834,762 to hospital/EMS planning regions
- $416,091 to the Iowa Department of Public Health

HRSA Bioterrorism Hospital Preparedness Program Budget Breakdown
FY 2002 - 2003

Activities	Funding
• Needs assessment and preparedness planning	$132,823
• Hospital/EMS development/implementation of regional hospital/EMS emergency response plans	$755,459
• IA-DMAT development and implementation	$79,302

Local Hospitals	Funding
Needs Assessment and preparedness planning – 116 Hospitals	$132,823

6 Hospital/EMS Regions	Funding
Hospital/EMS development/implementation of regional hospital/EMS emergency response plans • Medications & vaccines • Personal protection, quarantine & decontamination • Communications • Biological disaster drills • Personnel • Training • Patient transfer • Iowa Disaster Medical Assistance Teams	$834,761

Iowa Department of Public Health	Funding
Personnel (2.8 FTE)	$256,223
Travel	$3,000
Equipment	$5,500
Supplies	$3,000
Contractual	$10,000
Indirect (34%)	$138,368
TOTAL	$416,091

SAMPLE

LOCAL, REGIONAL AND STATE BIOTERRORISM PROGRAM ACTIVITES

Summary (not all inclusive) Bioterrorism Preparedness and Response Activities

Iowa Department of Public Health Activities
➢ Develop, coordinate and manage IHDC, subcommittees and regional steering committees
➢ Conduct comprehensive bioterrorism preparedness and response capacity needs assessment for public health, hospitals, and EMS
➢ Conduct comprehensive review of model draft legislation and develop public health disaster legislation for spring 03' session
➢ Develop, coordinate, implement and manage six regional IA-DMAT teams
➢ Develop and implement regional smallpox public health and health care response teams
➢ Develop state smallpox plan and operating procedures
➢ Develop and implement state National Pharmaceutical Stockpile (NPS) Plan and Operating Procedures
➢ Develop and conduct NPS tabletop and full-scale exercises
➢ Identify and establish NPS receiving and distribution sites
➢ Enhance and implement the National Electronic Disease Surveillance System (NEDSS)
➢ Develop and implement an Epidemiology Exchange (EPI-X) System
➢ Develop and disseminate education materials on infectious diseases and bioterrorism
➢ Conduct statewide information technology needs assessment
➢ PKI/token based authentication for secure data transmission
➢ Establish T1 lines where necessary
➢ Develop and implement a statewide hospital resources tacking system
➢ Enhance Critical Incident Stress Management Network training
➢ Develop and implement statewide blast-fax system
➢ Establish statewide paging system for all 99 county health departments
➢ Develop and implement a statewide auto-dial emergency notification system
➢ Provide statewide First Responder Bioterrorism Instructor Train the Trainer courses
➢ Provide statewide First Responder Bioterrorism education/training materials
➢ Provide equipment and supplies to state medical examiners office for mass fatality response
➢ Provide statewide ICN – education and training sessions on infectious diseases and bioterrorism to public health, hospitals and EMS
➢ Provide satellite downlink and hook ups for local education programs
➢ Provide statewide continuing education – CME/CEU/CEH for educational programs
➢ Develop and disseminate risk communication resource packets for local use
➢ Provide regional Town Hall meetings for dissemination of public information on bioterrorism
➢ Provide Regional Risk Communication Training to local public health agencies
➢ Develop and implement a statewide Learning Management System
➢ Enhance technology for distance based training and education
➢ Establish regional bioterrorism speakers bureau
➢ Develop and implement regional bioterrorism scenario-based tabletop exercises for each region
➢ Develop and distribute county and regional bioterrorism planning templates

Local and Regional Activities
➢ Participate in development of and completion of comprehensive needs assessment
➢ Purchase and maintain communication equipment, service agreements and or contracts to assure 24/7 emergency notification capability
➢ Participate in surveillance and epidemiological educational sessions
➢ Participate in other public health emergency preparedness educational sessions
➢ Purchase alert notification equipment such as fax machines, computers etc..
➢ Duplicate and disseminate disease reporting and surveillance information and 24/7 contact notification information
➢ Purchase reference materials on surveillance and epidemiology, infectious diseases, and public health emergency planning and preparedness materials
➢ Acquire high-speed internet connectivity as identified by the needs assessment
➢ Attend risk communication training
➢ Develop county and regional public health bioterrorism/epidemiological response plans
➢ Participate in county and regional planning meetings
➢ Participate on IHDC subcommittees
➢ Purchase equipment and supplies for hospital and EMS response to bioterrorism
➢ Develop regional 500 patient hospital surge capacity plan
➢ Develop and implement process to provide isolation and quarantine for mass casualties
➢ Address communication issues with hospitals, public health, EMS, law and fire services
➢ Develop plan for handling large numbers of "worried well" patients
➢ Establish plans for hospitals and local public health agencies to receive assets from the NPS and distribute to the public
➢ Establish local public health alert notification system
➢ Develop or enhance local epidemiological surveillance capacity