

Mid Year 2006 Progress Report for Indiana (08/31/06-08/30/07)

Privileged Communication
 Centers for Disease Control and Prevention
 Public Health Preparedness and Emergency Response for Bioterrorism
 Program Announcement AA154
 Report Date: 5/31/2007 Grantee: IN

Progress on Cross-Cutting Activities		
Question #	Question Text	Answer
1	Describe your Senior Advisory Committee (SAC) . How does your SAC function? What agencies are represented? Does the SAC include agencies that address natural and technological environmental hazards as well as infectious hazards? Specifically, is your State Office on Aging or equivalent a member of your SAC? What issues have been addressed and what products have been created by the SAC in the past year? What barriers have been overcome, and how was that accomplished? What barriers have not been overcome, and what are you doing to address these? What assistance, if any, would you like from CDC to improve your SAC?	<p>The ISDH will maintain the Public Health Preparedness Senior Advisory Committee (SAC), previously established to solely support the state's preparedness planning activities. The SAC was created and convened by the State Health Officer and includes representatives from the Indiana Department of Homeland Security, local health officers and other representatives of local health departments, hospital administrators and representation from the Indiana Health and Hospital Association, the state's HRSA Hospital Preparedness Program Director, the state's CDC Program Director/Primary Investigator, the state administrative agencies including Budget and Administration, and representatives from other state and local agencies and NGOs with a stake in preparedness planning. The ISDH convenes the SAC for quarterly meetings, and meetings are chaired by the state's CDC Program Director/Principal Investigator. The ISDH has enhanced and broadened membership to include support for pandemic influenza planning and the HRSA ESAR-VHP advisory committee for volunteer solicitation and management. We are also establishing advisory committees to address rural health issues and special needs population.</p> <p>In the past, ISDH has simply provided information regarding activities that were underway as a means to facilitate communicate project updates throughout the year. This group was never given any charges or issues to resolve. However, that is changing and we are restructuring this committee to actively engage the skill sets of its incumbents, to create solutions and address issues that can not solely be tackled from the top down.</p> <p>As we move out of just a planning phase and more into mitigation, exercise, response, and recovery, it is our belief that this restructuring is essential. With the shift of activities of the committee, it will also be necessary for us to change the membership of the SAC. It is our hope that this will also resolve a barrier we have been facing over the last year, which is complacency of existing representatives.</p>
1a	What agencies/groups are represented on your Senior Advisory Committee (SAC)?	<ul style="list-style-type: none"> • CDC Program Director/Primary Investigator • DHS Program Director/Primary Investigator • HRSA Hospital Bioterrorism Preparedness Coordinator • HRSA Program Director/Primary Investigator • State Administrative Agency (SAA) • State Public Health Officer • Business and Industry
1b	Please list (up to 5) the most-engaged Business and Industry organizations on your SAC. (Please separate names by semi-colons)	

Pharmacy	
2	How do you engage your local health departments (or, in their absence, communities) in planning for public health emergency preparedness? What method is used to determine PHEP award amounts that go directly to local health departments or communities? How do you ensure the accountability of funded local health departments? What preparedness activities do you support or provide on behalf of the local health departments? What assistance, if any, would you like from CDC to enhance relationships with local health departments?
<p>The Indiana State Department of Health (ISDH) is currently providing grants to local health departments, supporting 87 out of 94 local health departments. These grants are used by the local health department to improve their readiness at the local level. Funding amounts established for these grants are based on accomplishment of deliverables identified within the local preparedness grant, and negotiated to ensure adequate funding is available to support the Local Public Health Coordinator's position and other operating expenses. ISDH has established 10 districts in the state and have a Public Health Coordinator in each of the districts who work with the local health department in the development of their plans and to insure that they are meeting their grant requirements. ISDH has furnished the local health departments with templates of Mass Prophylaxis plans and Pandemic Influenza plans. The ISDH District Public Health coordinators also assist the local health departments in exercise planning and execution. ISDH has also contacted with outside sources to provide exercise support to local health departments. Indiana is a home rule state which can be a barrier in the development of local preparedness. However, we have been able to overcome this barrier and move ahead with our preparedness planning.</p>	
3	Describe your progress in implementing PHIN-compliant public health information systems to support preparedness and response, including the percent of critical requirements you have met in each functional area. Describe any plans you have for interacting with regional health information organizations for electronic data exchange. What can CDC do to assist you in implementing PHIN-compliant information systems for public health?
<p>Based on the earlier PHIN Certification Requirements we completed a needs-assessment and formed teams to review the requirements. We have completed requirements documents in all the areas except one and will finish it shortly. Once the new PHIN certification requirements and procedures are finalized, we will move ahead on certification in a couple areas.</p>	
4	How are you coordinating pre-incident activities with partners to assess and map local communities, build social networks, and develop community outreach information networks that define, locate and reach at-risk populations ? ^[1] What groups of at-risk individuals do you include in your preparedness plans for emergency public information and warning, all-hazards preparedness planning and exercises? How do you ensure that representatives of these groups are actively involved in developing public health emergency plans, exercising the plans, and contributing to after-action reports and subsequent corrective action to address identified gaps in planning? What have been your most significant accomplishments in this area? What barriers have been overcome, and how was that accomplished? What barriers have not been overcome, and what are you doing to address these? What assistance, if any, would you like from CDC? ^[1] This term refers to individuals or groups with specific disabilities, conditions or circumstances that create unique challenges in a public health emergency response situation. These may include, but are not limited to, mobility impairments, lack of transportation, geographic isolation, inability to read, pregnancy, chronic disease, and social isolation.
<p>The Indiana State Department of Health, ISDH, is currently providing grants to support 87 out of 94 local health departments. These grants are used by the local health department to improve their readiness at the local level. ISDH has established 10 districts in the state and have a Public Health Coordinator in each of the district who works with the local health department in the development of their plans and to insure that they are meeting their grant requirements. The district public health coordinators conduct monthly reviews of the local health departments' preparedness activities and how they are progressing on their requirements identified in the grants we provided them. We are working with local health departments to identify the at risk populations and plan for them. We are looking at the faith based community to assist us in our communications efforts with at risk populations. We have also work with our long term care division of the State Department of Health to assist Nursing home in the development of their preparedness plans. Our SAC has established a committee to address at risk populations in the rural areas. ISDH has also furnished the local health departments with templates of Mass Prophylaxis plans and Pandemic Influenza plans that address at-risk populations. We are continuing our at -risk population planning. The ISDH District Public Health coordinators also assist the local health departments in exercise planning and execution. ISDH has also contacted with outside sources to provide exercise support to local health departments. ISDH has contracted with Purdue University to conduct training in exercise development, exercise execution and AAR development. ISDH has developed and placed on its Portal an AAR format that is HSEEP compliance. Indiana is a home rule state which can be a barrier in the development of local preparedness. However, we have been able to overcome this barrier and move ahead with our preparedness planning.</p>	
5	CDC expects PHEP grantees to work with one or more of the funded Centers for Public Health Preparedness (CPHPs) to provide training and education to enhance the competence of first responders and the public health community. With which CPHPs have you worked? What services/products did you request and/or were provided? Did you collaborate with the CPHP in the creation or tailoring of these products/services to your identified needs? Did the services/product meet your identified needs and help to improve your overall preparedness? If you have not worked with any CPHPs, describe barriers that have prevented this interaction

and possible solutions to overcoming these barriers. How can the CPHP program help you better meet your training and education goals in the future?

The Indiana State Department of Health has worked most closely with the Illinois Public Health Preparedness Center (IPHPC), specifically to provide maintenance and technical assistance to our Indiana Learning Management System (LMS). The LMS provides an interface for State and local staff to access and complete required training and courses that are available on-line from other Public Health Preparedness training centers such as: the Emergency Management Institute, New York/New Jersey Public Health Training Center, the Center for Public Health Preparedness at the University of North Carolina (UNC), the University at Albany's Center for Public Health Preparedness, the University of Minnesota Center for Public Health Preparedness, as well as a number of other organizations.

This year has included support from the IPHPC relative to the development of an Indiana specific laboratory course for pandemic influenza which is to be completed by August 2007. Additionally, Indiana participated in the piloting of an online LMS POD simulation for anthrax which is in final development by the IPHPC.

The ISDH has been working with the Upper Midwest Center for Public Health Preparedness in Iowa (UMCPHP) along with our partner states to more judiciously expend our dollars by collaboratively prioritizing and sharing in the cost for LMS system enhancements that benefit all partner states using the IPHPC LMS. The UMCPHP has provided significant consultation time and guidance to Indiana relative to LMS course development and preparing of reports for training documentation.

Consultation was also provided by the University of Minnesota's Centers for Public Health Education and Outreach relative to PH Preparedness competencies in the development of Indiana's training plans.

The ISDH works with institutions of higher education within its state as well. For example, the ISDH has contracted with Indiana University to provide course content development for training and education offered through the LMS, and for Preparedness trainings and seminars offered to students enrolled in Medical and/or Public Health programs offered at Indiana University. In addition, ISDH works with the Purdue Homeland Security Institute. Purdue has provided training on exercise development, execution and AAR development to state and local public health personnel. They have also written table top exercises and drills for ISDH to use at the county level specifically in association with Pandemic Influenza. Overall we have been very satisfied with the products/services these entities have produced for us. Other education and training offerings from Indiana University, Purdue University, and the University of Illinois in the past have included Public Health leadership and decision making training for State and local personnel. However, due to significant reductions in funding and priority changes as identified within the scope of the cooperative agreement, many of these relationships and specific activities that each are engaged in have been eliminated from the ISDH Public Health & Emergency Response program.

There is a continual need expressed by the preparedness community that professional development, certifications, continuing education units and/or graduate credit be offered through the LMS at little or no cost to the learner. It would be helpful to have guidance from the CPHP on course groupings for specific types of certificate programs. Credits are also extremely expensive for individual states to address alone. It would be helpful to have all CPHPs agree to absorb such a cost, with CDC support, as this will provide tremendous incentive for lifelong learning which is critical for preparedness. A mechanism to connect all LMS systems together is critical to provide seamless learning, data reports, and management of thousands of learners nationwide. Currently LMS systems do not integrate with one another to allow for sharing of data. Learners may have completed courses in a myriad of systems of which their primary LMS cannot document without significant global administrator effort. An enhancement to help resolve this issue might be for all LMS systems throughout the country is to include a drop down menu within registrants' profiles that identifies the "primary" LMS to which the learners are registered. When a learner takes a course in a separate system, then that system would communicate to the primary LMS system when the registrant has successfully completed his/her course. This would decrease confusion and increase system use by learners. It would also allow course developers to continue to track and evaluate their courses while allowing for a more seamless management of thousands of learners nationwide.

6 How do you engage **American Indian/Alaska Native** tribal governments or tribal organizations located within your jurisdiction in planning for public health emergency preparedness? What method is used to determine PHEP award amounts that go directly to tribes in your jurisdiction? How do you ensure the accountability of funded tribes? What preparedness activities do you support/provide on behalf of the tribes? What assistance, if any, would you like from CDC to enhance these relationships?

Not Applicable. There are no federally recognized tribes in Indiana.

Progress for Goal 1: Planning

Question #	Question Text	Answer
1	What steps have you taken to identify and document the hazards and vulnerabilities in your jurisdiction? What steps have you taken to mitigate these risks and vulnerabilities including written annexes to your all-hazards plan? Where is this information maintained for use during an emergency? Has this information been shared with other planning and response partners? How often will this information be updated?	
		<p>The Indiana Department of Homeland Security conducted a formal state-wide hazard and vulnerability assessment which was finalized in mid-2005. However this assessment did not accurately or realistically reflect Indiana's possible threat targets, or hazards and vulnerabilities. Therefore, through the partnerships of the State agencies who actively participate on the states Counter Terrorism and Security Council, these vulnerabilities are being reviewed and revised based on information and requirements imposed by the United States Department of Homeland Security.</p> <p>However, the Indiana State Department of Health (ISDH) has developed an all-hazards medical response plan that will accommodate the requirements of most natural or man-made disasters. Our ISDH Operations plan is supported by standard operating procedures which are represented as detailed annexes created in conjunction with our planning partners and agreed to in writing by each agency official. Our plan is updated constantly to incorporate lessons learned, corrective actions, incorporation of policy and procedural changes, or even personnel changes that might have been identified in previous versions, as well as further role development for individuals identified in ICS roles. In addition, ISDH/IDHS support GIS mapping of the state for hazard and vulnerability analysis, mitigation, and response. ISDH works with state and federal homeland security agencies to share information with local health departments and all other first responders at the county level. This information is updated yearly through a coordinated effort by the IDHS and the county emergency management personnel. The hazards and vulnerabilities identified are part of the county emergency response plan and are managed by each county Emergency Management Agency.</p>
2	How have you and the local communities within your jurisdiction developed partnerships with non-governmental organizations and the business community to integrate the full community (law enforcement, public works, radiation control, transportation, housing, corps of engineers, and emergency responders) into the overall preparedness plan? Statewide, what partnerships exist between businesses and local jurisdictions or communities? Which would you characterize as effective relationships, and why? Which partners have participated in exercises or real-world events? What have been your most significant accomplishments in this area? What barriers have been overcome, and how was that accomplished? What barriers have not been overcome, and what are you doing to address these? What assistance, if any, would you like from CDC in developing effective partnerships?	
		<p>Indiana Department of Homeland Security has the responsibility to establish relationship between non-governmental organizations and the business community to integrate the full community (law enforcement, public works, radiation control, transportation, housing, corps of engineers, and emergency responders) into the overall preparedness plan at the state level and local emergency management doing the same at county level. ISDH has recognized the difficulty many of our local jurisdictions have in trying to create critical local relationships within their communities. As a result, the ISDH has taken the lead in helping establish necessary partners at the state level and convincing them of the necessity of using their influence to help establish relationships and partnering locally. A prime example is the law enforcement (security) requirement to protect our citizens and medical assets during a major event. No community has enough law enforcement to stand alone in a large scale event. The Indiana Sheriffs Association and the Indiana Association of Chiefs of Police are preparing to provide cross jurisdictional support to areas requiring supplemental law enforcement. The Indiana Broadcasters Association and the Hoosier State Press Association are working with our Risk Communications to both prepare the Indiana public for an event and then to properly notify and guide them to a safe conclusion. Our state pharmacists and a local university with a college of pharmacology are helping our planning process and their involvement as well. We are partnered with many agencies and organizations who are all very willing partners. Exercises are a continuous part of the planning process. The exercise program has had many businesses participate at the local level, such local retail business, pharmacies, hospitals and utility companies. The State Department of Health participated in a preparedness exercise conducted by General Motors.</p>
3	Do you have a State Emergency Operations Center? Are there policies in place for guiding or elevating a response? How is your EOC linked to the CDC EOC? To neighboring states' EOCs? By what process do you integrate the health EOC operations with the hospitals in your jurisdiction? With the local health department EOCs? What Incident Management/Incident Command positions have been identified at your local/state Departments of Health, and how have these been tested?	
		<p>The state has established a State Emergency Operations Center (EOC) which is operated via the Indiana Department of Homeland Security. This center has been stood up to handle a variety of emergency responses since its establishment, and allows for integration of response activities across all of the state agencies who may become involved in natural or man-made disasters or other emergencies. In addition, the Indiana State Department of Health has an established Department Operation Center (DOC), fully staffed, according to ICS, with a written SOP. This DOC was established to facilitate and operate either in congruence with the State EOC and other local EOCs. The ISDH DOC may also be stood up to coordinate response to a Public Health Emergency that would not require management via the State EOC. The DOC has been drilled, and the staff have completed through DOC training. The latest exercise was May 10 through May 12, 2007 in support of a national level exercise, Ardent Sentry. In this exercise we did notify CDC telephonically that we were establishing our DOC. We were in contact with local health departments, hospitals, state and local EOCs with the 800MHz radio system,</p>

as well as via E-Mail and phone. We also used the Indiana Health Alert Network to communicate with our local and state partners during the exercise. We are currently preparing the AAR for this exercise. We have also purchased a high frequency radio and are in the installation process which will provide us an additional redundant communication method with CDC and various other state and local response partners.

4 Has your EOC been activated in either an exercise or a real-world incident? Specify incident(s) and briefly describe how the core functions of command, response, and recovery were addressed and documented using your incident command/incident management system. What assistance, if any, would you like from CDC in developing, conducting or evaluating exercises around Incident Command/National Incident Management (NIMS)?

The ISDH Public Health Preparedness & Emergency Response program conducts a monthly call down of our DOC staff using the Indiana Health Alert Network (IHAN). We have only addressed command and response in our exercises. The DOC is established using an incident command structure with primary and secondary identification of an Incident Manager, Operations Chief, Logistics Chief, Public Affairs Chief, and Legal representation. Based on the size of the situation initially or as it grows, DOC Support personnel, Planning Chief, Tactical Communications Chief, and Finance and Administration Chief may be added to the ISDH incident management structure. The ISDH Department Operation Center has been stood up to take part in several exercises and was partially stood up to respond to a Hepatitis-A exposure, preventing an outbreak in August and September of 2006. During the event we addressed a number of command, response and recovery issues. However, we are still technically in a recovery phase from this incident, as Fiscal and legal responsibility disputes remain unresolved..

The ISDH has established a position within the Public Health Preparedness & Emergency Response program whose role is to develop, conduct, and evaluate exercises that occur not only at the State level but at the local level, as well. This position often works with the exercise development team at the Indiana Department of Homeland Security to create and conduct exercises that may be able to incorporate more than simply Public Health Personnel, and accomplish exercise requirements outlined for various Incident response personnel.

The CDC should be taking an active role addressing NIMS and Incident command as it relates to public health. The standards established under HSEEP often do not address or can not effectively evaluate Public Health response activities, as they were not written to recognize Public Health as a primary first response entity. Perhaps CDC could work on modifying the existing HSEEP standards to better incorporate the Emergency Response activities that Public Health will likely become involved in. Otherwise it would be beneficial for CDC to adopt other good evaluation models that could be integrated into the HSEEP requirements.

Progress for Goal 2: Information Gathering and Recognition of Indicators and Warning

Question #	Question Text	Answer
1	Describe the structure and function of your disease surveillance systems for early incident detection and how you analyze and monitor that system (e.g. Early Aberration Reporting System (EARS), National Electronic Disease Surveillance system (NEDSS)) to include how notification of incidents or suspect cases is received. Detail the sources (emergency department or other healthcare data, absenteeism, 911 calls, etc), the number of sites, and their locations (cities or other localities). If you use a syndromic surveillance system, describe your system and how you integrate your disease and syndromic surveillance systems. How many local sites use BioSense for early event detection and in what way is it being used?	<p>The ISDH utilizes reportable disease surveillance, sentinel surveillance, and syndromic surveillance for early event detection. The Public Health Emergency Surveillance System (PHESS), Indiana's syndromic surveillance system, includes 72 hospital emergency departments (ED) throughout the state and school absenteeism reporting. Over-the-counter retail drug sales were included but dropped due to lack of available funding to support the service. By August 30, 2007, the PHESS is expected to include 77 hospital ED and one urgent care system. These entities transmit chief complaint data to Regenstrief Institute, an ISDH partner, which captures the data and transmits it to the ISDH via HL7 messaging every three hours. These same data is then transmitted from ISDH into BioSense: Indiana became the first state to transmit statewide data into BioSense in December, 2006. Chief complaint data is analyzed using the ESSENCE system, obtained from the Johns Hopkins University Applied Physics Laboratory. The ISDH syndromic surveillance epidemiologist reviews these data streams at least twice daily seven days per week. If an alert is detected, the syndromic surveillance epidemiologist will notify the appropriate subject matter epidemiologist, Field Epidemiology Director, and Director of Surveillance and Investigation for follow up with the local health department of jurisdiction. Event-specific queries have been developed to alert subject matter epidemiologists to chief complaints related to specific events, such as tuberculosis, meningitis, and rabies exposure. The syndromic surveillance epidemiologist is providing ESSENCE training for connected entities and local health departments so they can access and</p>

analyze their local data. This training is scheduled for completion by December 31, 2007. Indiana law requires school officials to report absenteeism rates of 20% or greater to local health departments for follow up. While this is a phone-based system, experience has shown it to be effective in detecting issues of public health concern.

Development of the I-NEDSS system for reportable disease surveillance is underway and scheduled for completion in early 2008. This will provide a secure, web-based system for reportable disease notification, case investigation, and laboratory reports from providers, hospitals, local health departments and laboratories. It will integrate with the STARLIMS laboratory reporting system and comply with PHIN requirements. Currently, reportable disease surveillance is paper-based, and subject matter epidemiologists review reports at least once daily. In addition, communicable disease laboratory data is received via our partnership with the Indiana Network for Patient Care (INPC) as facilitated by our PHESS vendor, the Regenstrief Institute. It is downloaded daily, reviewed by the appropriate epidemiologist within our surveillance program, and then directed to the appropriate Local Health Department based on the original sample locality. The Communicable Disease Reporting Rule for Physicians, Hospitals, and Laboratories (410 IAC 1-2.3) mandates that reportable disease diagnoses and laboratory results are reported to local health departments or the ISDH for investigation. Local health departments forward investigations to the ISDH. Data is entered into the CDC NETSS database and transmitted to CDC weekly. ISDH subject matter epidemiologists routinely review NETSS data to identify trends and possible outbreaks.

The ISDH maintains a year-round sentinel surveillance program for influenza and other respiratory diseases. This program includes the number of regularly-reporting providers recommended by the CDC for Indiana's population. The ISDH respiratory epidemiologist reviews influenza-like illness case data and laboratory results for specimens submitted from sentinel providers and compiles and distributes regular reports to sentinels highlighting statewide data and national data provided by the CDC. The respiratory epidemiologist also compares the sentinel ILI data with the PHESS respiratory chief complaints to determine consistency of data and indications of disease activity from two different sources.

2 How do you assess the timeliness and completeness of your surveillance systems? How do you assure 24/7/365 reporting? How have you improved the reporting of suspicious symptoms, illnesses, or circumstances to the public health agency?

Our current PHESS system and developing INEDSS system are part of our Health Net Portal, a secure web-based system. As such, they receive feeds from external sources (e.g. the Indiana Regenstrief Institute) 24x7. We are in the process of implementing our new INEDSS system. As part of the implementation plan we are aggressively expanding the scope (i.e. diseases detected) and sources of monitoring data. These two systems have improved and will continue to improve disease reporting by greatly enhancing access, providing greater security of information, and significantly reducing notification time. The ISDH quality assurance epidemiologist assesses the timeliness and completeness of the reportable disease surveillance system at least annually and assesses outstanding reportable disease follow up monthly. The syndromic surveillance epidemiologist assesses the PHESS on an ongoing basis leading to improvements such as the event-specific queries (see above), and the respiratory epidemiologist routinely assesses the influenza sentinel surveillance system to monitor the number of regularly-reporting sentinel providers and completeness of data.

The ISDH maintains a 24/7/365 duty officer system staffed by experienced subject matter epidemiologists and public health officials. All public health officials potentially responding to an event are equipped with a cell phone, blackberry, or pager. Nine field epidemiologists stationed in public health preparedness districts statewide provide real-time assistance 24/7/365 to local health departments and health care providers for disease-related issues.

The Indiana Health Alert Network (IHAN) is a secure system for disseminating public health information to individuals identified by role codes based on the CDC role code list. This system allows for rapid information dissemination via e-mail, phone, and fax. The ISDH has utilized this system many times to relay information related to outbreaks, disease cases, and CDC public health alerts and advisories.

3 Are there environmental monitoring systems in place? Does the disease surveillance system(s) include monitoring for chemical and radiological related disease? How does the Department of Health receive notice of suspected cases?

Indiana participates in the BioWatch program, with monitoring systems in place in Indianapolis. The ISDH, particularly the ISDH Laboratories, coordinates with the Marion County (Indianapolis) Health Department for BioWatch surveillance. The PHESS includes monitoring for chemical and radiological chief complaints. The ISDH receives notification of suspected cases through PHESS, e-mail, phone and fax. In addition, the ISDH receives reports from the Indiana Department of Environmental Management identifying possible chemical, environmental, or radiological incidents and exposures that may affect the public's health.

4 Describe how you share information garnered from your surveillance system(s) with key partners, for example, using Epi-X, Electronic Foodborne Outbreak Reporting System (EFORS), PulseNet, newsletters, annual reports or other similar means. How can you quickly notify key stakeholders of an emergency situation?

The ISDH uses the CDC Epi-X system, EFORS, PulseNet, the Indiana Epidemiology Newsletter, and the Annual Report of Communicable Diseases to communicate with key partners. Subject matter epidemiologists, field epidemiologists, upper agency management, and several local health departments use Epi-X. The ISDH quality assurance

epidemiologist conducts notification proficiency tests annually. The ISDH enteric epidemiologist has received EFORS training and submitted all 2006 data in April, 2007. The ISDH Laboratory routinely uses PulseNet to post PFGE patterns and compare posted patterns with patterns identified in the laboratory. The Indiana Epidemiology Newsletter is published monthly and posted to the ISDH web site. The Annual Report of Communicable Disease summarizes reportable disease data and is also posted on the ISDH web site.

We use our IHAN system (response #2 above) to reach key stakeholders around the state. IHAN is available through the Health Net Portal 24x7. As part of our IHAN system we are working with the CDC and IL, WI and MN to develop automated communications through IHAN. This tool has proven invaluable to communicate with many stakeholders quickly in the event of an outbreak or exercise. The ISDH also utilizes blast e-mail, phone, and fax to quickly notify stakeholders of an emergency situation.

5 Describe any data sharing agreements e.g., MOUs, that facilitate immediate sharing of data for rapid decision-making among jurisdiction and federal partners (such as HHS, CDC, EPA, DoJ, DoD, etc). Describe any data sharing agreements with neighboring states, within your region, or with other entities. Describe any efforts you are undertaking to develop standardized instruments for rapid needs assessment and public health intervention data collection among partners.

The ISDH has a data sharing agreement with CDC to provide hospital chief complaint data from PHESS to BioSense. The ISDH maintains an agreement with the Marion County Health Department (Indianapolis) to provide ESSENCE data for jurisdictional use. An MOU is in progress between Indiana and Ohio to share cross-border data, including standardized methods, and discussions are underway to create a similar data sharing program with Michigan. Discussions are also underway to participate in the International Society for Disease Surveillance ILI national project.

Progress for Goal 3: Public Health Laboratory Testing

Question #	Question Text	Answer
1	<p>Describe the actions you have taken to:</p> <ul style="list-style-type: none"> • Ensure availability of at least one operational Biosafety Level 3 (BSL-3) laboratory (or have formal arrangements in place for this capacity to be acquired). • Identify and coordinate with all sentinel (biological) labs in your jurisdiction. • Identify and coordinate with public and private laboratories in your jurisdiction that can identify chemical and radiological agents in clinical (human and animal) and environmental specimens. • Ensure the ability to perform analyses of clinical specimens for toxic industrial chemicals (TICs) and chemical warfare agents (CWAs). • Ensure the capacity to perform Laboratory Response Network (LRN)-validated testing and reporting for Variola, and non-Variola orthopox viruses in both human and environmental samples. • Test and maintain the competencies of the BT laboratory coordinator and Chemical Terrorism lab coordinator for his/her ability to advise on proper collection, packaging, labeling, shipping and chain of custody procedures for samples. • Test and maintain the competency of sentinel laboratories to properly send samples to an LRN Reference Laboratory in their region. • Maintain supply levels and equipment necessary for BT response efforts and high throughput considerations for pandemic influenza. • Perform full-scale, fully-integrated public health exercises that include critical laboratory response functions, from collection of the sample, to triage, accessioning, laboratory diagnostics, results processing, reporting back to sending entity, as well as exercise review assessments. 	
<p>The week of February 26, 2007, the ISDH Laboratories were relocated to a new facility that enhanced our BSL-3 space with 14 BSL-3 labs. We also maintain our modular BSL-3 facility. Quantity Purchase Awards (QPA), Indiana procurement contracts, have either been setup or are in the bid negotiation process for the procurement of critical or high volume BT/Pan Flu supplies. Four robotics systems are being procured and additional real-time PCR instruments have been procured to provide high throughput testing. Different platforms are available to ensure availability of reagents, supplies and technical support.</p> <p>The ISDH Lab has successfully participated in the PopPT, SCPaS, and the LRN 24/7 telephone notification drill. We used the SCPaS as an opportunity to assess the competency of level 3 labs to properly send samples to our LRN Reference Laboratory and then on to CDC, and to test the competency of the BT/CT laboratory coordinator to advise on</p>		

proper collection, packaging, labeling, shipping and chain of custody procedures for samples. AAR's were prepared. Assessing competencies was also performed on the submission of clinical specimens for BT rule out. Sentinel Labs will be encouraged to participate in the CAP LPS module. The ISDH maintains a 24/7/365 contact list for the agency duty officer, BT/CT laboratory coordinator and backup or alternate staff, and laboratory staff responsible for receiving samples and performing tests.

The ISDH is working to maintain current staffing and is re-evaluating current staffing and equipment for BT readiness. We continue to monitor the LRN for new or updated procedures and subsequently develop procedures that incorporate new methodologies or testing algorithms.

The ISDH has filled the training coordinator position and is pursuing training activities such as the development of Learning Management System (LMS) modules for disseminating pandemic influenza information to laboratories and clinicians. The new lab includes a training laboratory where wet workshops will be developed for sentinel labs. Training, or update training, for sentinel/level 3 labs, first responders, etc. on packaging, labeling, and shipping of samples for BT/CT continues.

An internet based questionnaire tool has been developed and tested for identifying sentinel and level 3 labs to determine their ability to rule out BT agents and ship samples including those for CT testing and coordination with our LRN lab. The identified labs will be included in IHAN to facilitate rapid communication. A similar tool will be developed to identify public and private laboratories that can identify chemical and radiological agents in clinical animal and environmental specimens.

Personnel have attended CDC and manufacturer training for VOC and are scheduled for LC/MS/MS nerve agent training at CDC later this year. Equipment including an LC/MS/MS, ICP/MS, LC for speciation on the ICP/MS, TurboVap, and an SPE Liquid Handler were procured to enhance CT testing. VOC materials are being procured and we'll work to finalize the VOC validation. We are approved for all other level 2 activities.

The ISDH has current capacity to perform vaccinia and varicella testing. The ISDH has sought approval to perform Variola major testing (PCR) since opening our modular BSL-3 facility. That request is pending. The BSL-3+ modular lab allows the ISDH to provide LRN orthopox testing methodologies upon LRN approval. The ISDH is looking to identify an EM facility for Variola support.

2	<p>Describe the plans and progress you have made to:</p> <ul style="list-style-type: none"> • Increase timeliness of reporting of results from the confirmatory LRN laboratory back to sentinel laboratories, with subsequent reporting to CDC as appropriate. • Comply with PHIN requirements, including: a) the linkage of laboratory orders and results from sentinel and confirmatory LRN labs to relevant public health (epidemiology) data and b) maintenance of chain of custody.
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The ISDH has procured StarLIMS, a PHIN compliant laboratory information management system that is being implemented in three phases with pandemic influenza/virology included in phase 1. StarLIMS implementation is part of the ISDH five year PHIN Certification plan. StarLims has worked with CDC to develop a BT module that includes the functionality of the LRN Messenger 2, but also provides features such as reporting, specimen tracking, quality assurance, etc. that will allow real-time reporting to sentinel labs and CDC. This functionality will be part of phase 2 implementation. StarLIMS' MyLIMS tool did not provide the necessary functionality to provide a real-time reporting system. LIMSNet, an internet accessible interface to StarLIMS, was developed in-house to allow specimens to be submitted to our lab through the assignment of a bar coded tracking number. Submitters can subsequently track the progress of their sample and obtain reports in real time. The system has security that allows only the submitter to see their results.

In addition, StarLIMS is being developed to integrate lab data into our INEDSS system. This integration will allow our Epidemiology Surveillance staff to review lab test results. It is assumed that this integration will also decrease the time required to initiate an epidemiologic investigation after lab tests indicate an event that could result in an urgent public health consequence as identified in Performance Measure 2 of Target Capability 2A.

3	<p>List and describe any obstacles that have interfered with your ability to carry out any items from Questions 1 and 2. Describe how you plan to overcome these obstacles. What assistance, if any, would you like from CDC?</p>
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The appropriate drills and exercises have not been developed to fully test the laboratory's ability to meet critical task requirements, demonstrate competency, evaluate surge capacity, and identify unmet needs. We'll work with the ISDH Public Health Preparedness and Emergency Response Program to ensure a lab component is included in appropriate drills and exercises. Hiring and retention of qualified lab scientists has been problematic. Agency executives are investigating possible changes in the salary structure for laboratory scientists and supervisors to resolve hiring and retention issues for qualified staff.

Progress for Goal 4: Intelligence Analysis and Production

Question #	Question Text	Answer
1	Describe the methods and procedures that you use to evaluate, integrate, analyze, and interpret health data to detect aberrations in normal data patterns.	
	<p>The ISDH uses several methods. Subject matter epidemiologists review reportable disease cases daily to detect possible links and also compare case incidence with comparable time periods in past years using the NETSS database. The ISDH is currently developing an INEDSS system to replace NETSS; This electronic system will allow for more rapid data analysis and interpretation and integrate with other systems, such as the ISDH Laboratories' STARLIMS system. Influenza is not reportable in Indiana, but data on influenza cases are collected via year-round sentinel surveillance. However, the ISDH is proposing a change to the Communicable Disease Reporting Rule (410 IAC 1-2.3) that would make influenza a reportable disease if and when a pandemic were declared. The sentinel statewide data reports are compared with national influenza data and laboratory result data to identify abnormal disease incidence and unusual strains. Although West Nile virus infection is reportable, sentinel surveillance is useful to identify dead birds and positive mosquito pools. This information, in conjunction with GIS mapping, helps to indicate areas of transmission and is compared with locations of human cases. The Public Health Emergency Surveillance System (PHESS), Indiana's syndromic surveillance system, captures and analyzes chief complaint data, utilizing an ESSENCE analyzing tool, from 72 hospitals to indicate possible disease outbreaks prior to diagnosis. The ISDH utilizes the PulseNet and ArboNet databases to identify and report cases of enteric bacterial illnesses and arboviral illnesses respectively. These tools greatly assist epidemiologists to link seemingly unrelated cases and identify outbreaks otherwise undetected. See also response to Goal 2, items 1 and 4.</p>	
2	Describe the integration of existing health information systems, analysis and distribution of information compliant with PHIN requirements, including those systems used for identification and tracking of zoonotic diseases and potential radiological contaminating incidents.	
	<p>The PHESS was developed to meet PHIN requirements, and data are transmitted into the CDC BioSense system. The PHESS is designed to identify and track zoonotic diseases and potential radiological contaminating incidents as well as other infectious diseases and chemical exposures.</p> <p>As part of our PHIN Certification efforts, we are implementing an INEDSS system to comply with specific certification requirements. We are waiting for the new PHIN Certification requirements and procedures.</p> <p>The ISDH is also identifying functional requirements to evaluate outbreak management systems. The outbreak management system will be developed to meet PHIN requirements and share data using the ISDH health systems portal. Using this system, the ISDH and other public health partners can share data related to outbreak investigations, including zoonotic diseases and radiological incidents, in a rapid, secure manner.</p>	
3	Describe the outcomes of your health intelligence analysis activities ^[2] . ^[2] Updated Guidelines for Evaluating Public Health Surveillance Systems; http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5013A1.htm	
	<p>The ISDH quality assurance epidemiologist assesses the timeliness and completeness of the reportable disease surveillance system at least annually and assesses outstanding reportable disease follow up monthly. The QA epidemiologist documents these findings in a report to the Director of Surveillance and Investigation and are then shared among staff members with recommendations for improvement of any deficiencies. The ISDH has reviewed the Communicable Disease Reporting Rule and identified several areas for revision to reflect current science and best practices. The final draft of the revised rule is scheduled for completion by June 15, 2007, followed by review from internal and external stakeholders.</p> <p>The syndromic surveillance epidemiologist assesses the PHESS on an ongoing basis leading to improvements such as the event-specific queries. Other surveillance systems under development, such as INEDSS and the outbreak management system are developed with these evaluation processes in mind.</p>	

Progress for Goal 5: Epidemiologic Investigation and Surveillance

Question	Question Text	Answer
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1	Describe your epidemiologic and scientific capacity to coordinate and respond to surveillance reports indicating the need for investigation and/or outbreak management. Be sure to include personnel structure and staff skills for investigations, information/data gathering processes, information/data analysis and reporting processes, outbreak management system(s), and early detection system(s) and their status in complying with PHIN requirements.
	<p>The ISDH Surveillance and Investigation Division includes nine field epidemiologists, a Field Epidemiology Director, ten subject matter epidemiologists, and four administrative staff supervised by the Director of Surveillance and Investigation. The ISDH has designated the Director of Surveillance and Investigation as the Epidemiologic Response Coordinator and BT Epidemiologist for Indiana. All positions are currently filled with personnel who have a masters' level degree or a professional licensure, such as an RN. All field epidemiologists, four subject matter epidemiologists, two administrative staff, and the Division Director are funded by this cooperative agreement. Epidemiology capacity is further enhanced by an experienced and recognized GIS team, two members of which are supported by this cooperative agreement, and an Indoor Air & Radiological Health Division, two members of which are supported by this cooperative agreement. In addition, the ISDH hosts a CDC career epidemiology field officer, also supported by this cooperative agreement.</p> <p>The ISDH finalizing the Indiana Epidemiology Response Plan (ERP), which is scheduled for completion by August 30, 2007. This plan will outlines surveillance and outbreak investigation protocols, also references the Indiana Pandemic Influenza Response Plan and the protocol for notification a positive "hit" from an early detection device. The ERP will be updated as necessary to improve our response to food-, water-, or air-borne diseases or threats. The ISDH has demonstrated over the past year through investigating multiple outbreaks of enteric and other illnesses that we can mount a rapid and effective response to these outbreaks. These outbreak investigations have also provided insight into development of the ERP. Plans are under consideration to conduct an exercise in the fall of 2007 that will evaluate the ERP in conjunction with SNS deployment and agency DOC activation.</p> <p>The ISDH will continue to work through its Food Protection Program to improve ISDH staff's capability to conduct environmental inspections and track food complaints and inspections using the Food Inspection Regulatory Management System (FIRMS). This system allows for the automation of much of the inspection procedure and for rapid and effective response to food-related public health emergencies. The FIRMS system developer is supported by this cooperative agreement.</p> <p>The ISDH will continue to support its Food Security Task Force, composed of appropriate stakeholders from the food industry, state and local public and environmental health, and other parties. The ISDH will continue to support its food security specialists, who work with suppliers to enhance their security. These staff members make direct assessments of the security infrastructure of food suppliers and recommend changes to policies and procedures to improve security. They also provide training to food suppliers in security and risk assessment. Both ISDH Food Security Specialists are funded by this cooperative agreement.</p> <p>The ISDH, through its chemical epidemiologist, will support response plans and integrate with internal and external partners to address issues of chemical terrorism.</p> <p>We currently have an Outbreak Management System (OMS) that is manually intensive. As part of our PHIN Certification efforts, we have identified specific OMS requirements and are in the process of completing a recommendation. We are also waiting for the new PHIN Certification requirements and procedures. The ISDH will also continue to expand the PHESS as financially feasible and expand the IHAN as necessary. See also response to Goals 2 and 4.</p>
2	What plans are in place for monitoring people for potential radiological contamination following the detonation of a nuclear or an explosive radiological dispersion device?
	<p>The ISDH has a training program for first responders which include the proper method to check for radiological contamination using hand-held radiation devices. The ISDH has a portal monitor (a radiation detecting device that people can walk through slowly and will detect if people are contaminated with radiation) to check for radiological contamination. The ISDH also coordinates with the Indiana National Guard Civil Support Team that is trained to respond to biological, chemical, and radiological incidents. This unit has radiation detection equipment and members have been trained to properly monitor people for radiation exposure.</p>

Progress for Goal 6: Communications

Question	Question Text	Answer
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1	<p>Who is responsible for coordinating the development and implementation of your redundant communication systems? Describe the communication systems that are in place to ensure your capability to effectively reach essential partners and agencies in an emergency that eliminates the following communication systems: telephone, cell phone, internet and commercial power grids.</p> <p>Our IHAN Coordinator has overall communication responsibilities. Our primary method of communications is through land lines. In addition to our primary access point, our disaster recovery site and government center both go through a separate POP. We have provided Blackberries for cell voice and data connection for all key preparedness staff. We have also provided data Blackberries for Public Health Coordinators for most of Indiana's Local Health Departments. In addition to primary Internet access through the State IT department, we have redundant access through our Disaster Recovery site and cellular air cards provided to key preparedness staff. While the Department of Health is actually in two connected buildings, each building is on a separate power grid. Our Disaster Recovery site is connected to two separate grids and has ups / generator backup.</p>
2	<p>What is the call-down and response process and timeframe for internal incident response information based on implemented drills, exercises or real incidents?</p> <p>We use our IHAN system for many of our incident response activities. We have complete redundancy with it at our disaster recovery site; all data is mirrored real time. In addition to using IHAN for traditional messaging activities we have segmented IHAN into separate areas to support activities such as setting up the ISDH Emergency Operations Center, invoking the SNS Plan, Media communications and food safety. This approach allows us to take advantage of our IHAN communications capabilities but still maintain the separate security needs of each area. We test these capabilities as part of each exercise.</p> <p>In addition, the ISDH maintains a 24/7/365 duty officer system staffed by experienced subject matter epidemiologists and public health officials. In order to facilitate communication with a Public Health Professional after normal business hours, ISDH has established an answering service. This service filters calls received, and if necessary facilitates contact from the public, local health departments, hospitals, labs, or other medical professionals with the Duty Officer that would initiate the call-down and response process. All public health officials potentially responding to an event are equipped with a cell phone, blackberry, or pager, and may be issued or instructed to monitor traffic via our 800 MHz radios during elevated alert periods. Nine field epidemiologists stationed in public health preparedness districts statewide provide real-time assistance 24/7/365 to local health departments and health care providers for disease-related issues.</p>
3	<p>Describe how you assure 24/7/365 notification of at least 90% of key stakeholders and the system(s)' status in meeting PHIN requirements.</p> <p>Through our IHAN system we can redundantly contact people by e-mail (primary and secondary), voice (office, home and cell) and fax. We have capabilities to include message acknowledgement in our messages. We regularly test these capabilities. The ISDH maintains a 24/7/365 duty officer system staffed by experienced subject matter epidemiologists and public health officials. All public health officials potentially responding to an event are equipped with a cell phone, blackberry, or pager. Nine field epidemiologists stationed in public health preparedness districts statewide provide real-time assistance 24/7/365 to local health departments and health care providers for disease-related issues.</p>

Progress for Goal 6: Emergency Public Information and Warning

Question #	Question Text	Answer
1	Describe how public information officers are integrated into the all-hazard planning, response activities and exercises within your agency, and your plan for coordinating public information messages with federal, local and other partner agencies to ensure consistency.	<p>During a bioterrorism event, the Indiana State Department of Health (ISDH) Risk Communication staff, as part of the Public Health Preparedness and Emergency Response (PHPER), will coordinate and deliver risk communication and public health information to the public through every available channel, including</p> <ul style="list-style-type: none"> • the media (through a Joint Information Center (JIC), if activated). • The ISDH Web site.

- The ISDH phone bank.
- The Indiana Health Alert Network (IHAN) system.
- Community meetings.
- Distributed flyers.
- Through partners/stakeholders.

These operations will be accomplished in close coordination with the Governor's Press Office, the Indiana Department of Homeland Security (IDHS) public information officer (PIO), other appropriate State agency PIOs, and local health departments, in accordance with federal, state, and local emergency plans.

The ISDH communicates through these channels and responsibilities during an exercise as well.

All messages are distributed through e-mail lists that reside on ISDH servers. Backup copies of these lists are on all Risk Communication staff laptops. The IHAN system is regularly used in conjunction with regular emails.

Line & staff responsibilities for Risk Communication and Office of Public Affairs

Command and control – The Risk Communication Director or his or her designee, in cooperation with the Office of Public Affairs staff will assume these responsibilities:

- Direct the work related to the release of information to the media, public, and partners.
- Activate the plan based on careful assessment of the situation and the expected demands for information by media, partners, and the public.
- Coordinate with horizontal communication partners as outlined in the plan to ensure that messages are consistent and within the scope of ISDH's responsibility.
- Provide updates to the State Health Commissioner, the Director of Emergency Preparedness, EOC command and Governor's Office, as determined in the plan.
- Advise the State Health Commissioner, the Governor's Office, and the chain of command regarding information to be released, based on the ISDH role in the response.
- Ensure that risk communication principles are employed in all contact with the media, public, and partner information release efforts.
- Be familiar with incident-specific policy, science, and situation.
- Review and approve materials for release to media, public, and partners.
- Obtain required clearance of materials for release to media on all information not previously cleared.
- Determine the operational hours/days, and reassess these throughout the emergency response.
- Ensure that resources are available (people, equipment, and supplies).

Direct media – The Risk Communication Director or his or her designee, in cooperation with the Office of Public Affairs staff, will jointly assume these responsibilities, as directed by the State Health Commissioner or his/her designee:

- Assess media needs and organize mechanisms to fulfill those needs during the crisis.
- Triage the response to media requests and inquiries.
- Ensure that media inquiries are addressed as appropriate.
- Support spokespersons, including the field staff public information officers (PIOs).
- Develop and maintain media contact lists and call logs.
- Produce and distribute media advisories and news releases.
- Produce and distribute materials, like fact sheets, audio releases, and video releases.
- Oversee media monitoring system and reports.
- Analyze news clips and video clips to determine needed messages.
- Discover which information needs to be corrected.
- Identify concerns, interests, and needs arising from the crisis and the response.
- Ensure that risk communication principles to build trust and credibility are incorporated into all public messages delivered through the media.
- Serve as a liaison from the ISDH and, if appropriate, act as a member of the JIC or field site team for media relations.

Direct public information – The Risk Communication Director or his or her designee, in cooperation with the Office of Public Affairs staff, will jointly assume these responsibilities:

- Coordinate/supervise the efforts of the field staff PIOs as they work with their assigned districts and local health departments (LHDs), including JICs
- Manage the mechanisms to respond to the public who request information directly from the organization by telephone, in writing, or by e-mail.
- Activate and supervise the emergency telephone bank, in conjunction with the PHER IT department.
- Manage the e-mail inquiries coming in over the Web site.
- Assist, as requested, in the public correspondence response system.

- Organize and manage, with the Webmaster, the emergency response Web site and Web pages, including establishing links to other emergency response Web sites.
- Contact reporters and/or editors to correct misinformation and rumors in articles and news segments.

Direct partner/stakeholder information – If assigned by the State Health Commissioner or his/her designee, the Risk Communication Director or his or her designee will assist the director of Public Health Preparedness and Emergency Preparedness (PHER), the director of the Office of Legislative Affairs, the director of the Local Liaison Office, and other executive staff in carrying out these duties:

- Establish communication protocols based on prearranged agreements with identified partners and stakeholders.
- Arrange regular partner briefings and updates.
- Solicit feedback and respond to partner information requests and inquiries.
- Oversee partner/stakeholder monitoring systems and reports (analyzing environment and trends to determine needed messages, to discover which information needs to be corrected and to identify concerns, interests, and needs arising from the crisis and the response).
- Help organize and facilitate official meetings to provide information and to receive input from partners or stakeholders.
- Develop and maintain lists and call logs of legislators and special interest groups.
- Respond to requests and inquiries from legislators and special interest groups.

Content and material for public health emergencies – The Risk Communication Director or his or her designees, as requested by the director of PHER, or the State Health Commissioner or his/her designee, will assume the following responsibilities:

- Develop and establish mechanisms to rapidly receive information from the EOC regarding the public health emergency.
- Translate EOC situation reports and meeting notes into information appropriate for public and partner needs.
- Work with subject matter experts to create situation-specific fact sheets, Q/A sheets, and updates.
- Compile information on possible public health emergency topics for release when needed.
- In consultation with appropriate staff, test messages and materials for cultural and language requirements of special populations.
- Receive input from other communication team members regarding content and message needs.
- Use analysis from media, public, and partner monitoring systems to adopt messages.
- Identify additional content requirements and material development.

2	Describe your plans to stand up a Joint Information Center (JIC) if appropriate. How do you coordinate with the mainstream and ethnic media? Include media partners and how they are engaged during an incident.
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Activating a Joint Information Center

The JIC will be activated during a disaster or large scale emergency at the discretion of the ISDH Risk Communication Director or his/her designee. Notification of the JIC staff will be made by all means available, including telephone, e-mail, and the Indiana Health Alert Network (IHAN). After the decision has been made to activate the JIC, the Risk Communication Director will notify the PIOs with the other agencies involved in the response to the event.

Once the JIC is open and has an appropriate number of staff present, a media advisory will be issued. This advisory will announce the JIC has been activated and will provide important information for news media representatives covering the emergency.

Although the number of telephones needed varies with each incident, adequate lines will be necessary to handle media inquiries, community inquiries, a fax machine and a computer/modem connection. Several phone lines should be reserved for outgoing calls. Space should be reserved for:

- Supervisors.
- News release writers.
- Phone staff.
- Work space to collate news releases, fact sheets, etcetera.
- Status boards/maps.
- Copy and fax machines.

Additional space outside of the JIC command center is also needed for media briefings and a media working area. The media briefing room needs to be large enough to accommodate a large number of television, radio and newspaper reporters and photographers.

Coordinating with the mainstream and ethnic media

The Risk Communication staff and the Office of Public Affairs regularly coordinate with mainstream and ethnic media during emergencies and non-emergency events. Press releases, media advisories, and other information are emailed to all Indiana news media outlets, including TV, radio, and newspaper (approximately 720 outlets).

ISDH has begun inviting all news media to join the Indiana Health Alert Network (IHAN). This system provides redundant broadcast communication services by email (business, home, and other), voice (business, home, and cell), and fax.

On occasion, it may be necessary to organize a press pool in the event of a pandemic flu or other contagious massive medical emergency. A pool will be organized during specific situations, such as physical space limitations or if a contagious agent has been used.

To be a part of the pool, each outlet is required to have equipment and personnel to perform the duties required while acting in the interests of all media outlets participating in the pool. Each pool participant needs to have a representative at either to act as a photographer or to edit and transmit the pool images to their own outlet. This can be waived if the outlet agrees to transmit photos to other outlets in a timely fashion by deadline.

The pool coordinator will be chosen by agreement among all media outlets that wish to photograph the event. In most cases, the pool coordinator will be chosen from among participating TV stations. The pool coordinator is responsible for working with all representatives, TV, radio, and newspaper.

Engaging the media during an incident

The Risk Communication staff and Office of Public Affairs regularly engage the Indiana news media on a variety of subjects, both emergency and non-emergency. In all cases, the ISDH relies on communication by delivery and phone, with redundant systems in place with IHAN and fax.

The list of Indiana news outlets – mainstream and ethnic – includes approximately 540 different TV, radio stations, newspapers, and health reporter. Some of these outlets include.

Advance Leader (Ligonier)
Advance-News (Nappanee)
Associated Press – IN Bureau
Banner Graphic (Greencastle)
Banner-Gazette (Pekin)
Chronicle-Tribune (Marion)
Daily Journal of Johnson County (Franklin)
Daily Reporter (Greenfield)
El Mexicano Newspaper (Fort Wayne)
El Puente (Goshen)
Evansville Courier and Press
Gary Crusader
Goshen News
Greensburg Daily News
Herald-Argus (LaPorte)
Herald-Bulletin (Anderson)
Herald-Times (Bloomington)
Indianapolis Recorder
Indianapolis Star
Journal and Courier (Lafayette)
Journal Gazette (Fort Wayne)
Kokomo Tribune
La Ola Latino-Americana (Indianapolis)
La Prensa (Columbus)
La Voz de Indiana (Indianapolis)

Lafayette Journal & Courier (Spanish Edition)
 Mail-Journal/The Paper (Milford)
 Metro Networks (Indianapolis)
 Mi Gente (Fort Wayne)
 Mishawaka Enterprise
 News-Sentinel (Fort Wayne)
 Palladium-Item (Richmond)
 Rising Sun Recorder/Ohio County News
 Star Press (Muncie)
 The Republic (Columbus)
 Times-Union (Warsaw)
 Wakarusa Tribune
 WAWC-FM (Syracuse)
 WFIE-14 (Evansville)
 WFIU-FM (Bloomington)
 WFYI-FM/WFYI-20 (Indianapolis)
 WISE-33 (Fort Wayne)
 WISH-8 (Indianapolis)
 WIUS-AM (Bloomington)
 WLBC/WXFN (Muncie)
 WLFI-18 (West Lafayette)
 WNDU-16 (South Bend)
 WRSW-Radio (Warsaw)
 WRTV-6 (Indianapolis)
 WSJV-28 (South Bend)
 WTHR-13 (Indianapolis)
 WTIU-30 (Bloomington)
 WVPE-FM (Elkhart)

3	<p>Summarize your Crisis and Emergency Risk Communication (CERC) plans for information dissemination, including a list of trained spokespersons identified to represent your agency in an emergency. How do you promptly and effectively communicate with first responders? With public and private health care providers? What communication channels do you use to issue health directives and messages to the general public regarding specific actions consistent with agents, symptoms, hazards and potential exposures/injuries and measures that will lessen the risk of morbidity and mortality? Once the decision has been made to issue a health directive or a message, how long does it take to get it issued? Have you exercised this plan? If yes, describe the results and actions taken to improve the plan. What assistance would you like from CDC in this area?</p>
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Identified Vehicles of Crisis Information Dissemination

The Risk Communication staff will use the following vehicles to provide risk communication and to inform and instruct the media, citizens, and partners/stakeholders about health and medical factors involved in the emergency:

- E-mail, using prepared media, LHD, and partner/stakeholder lists and list-servs.
- Indiana Health Alert Network (IHAN), which is part of the Public Health Information Network (PHIN) system.
- Telephone, with calls made to media and partners/stakeholders and received on our phone bank from citizens.
- Fax, using pre-programmed broadcast fax lists on a fax computer and a separate (redundant) fax machine.
- Partner newsletters and fax and/or e-mail distribution lists.
- Mail and overnight delivery to send video news releases and other non-electronic items. In some cases, hand delivery to local media may be possible.
- Face-to-face, including media briefings and community/public meetings.
- ISDH Web site, partner/stakeholder Web sites, and media Web sites.
- Media, including print, radio, and television.
- Printed materials, including Quick Facts sheets (available on the Web) and other specially prepared leaflets.
- 2-1-1 system

- Leaflet drop
- Bullhorn

The ISDH traditionally uses the first three methods for message distribution. We have used most of these other methods at one time or another in the past. The last three methods have never been tried, but would typically be used for statewide emergencies and during power outages.

Internal Information Verification and Approval Procedures

Three or four people should officially clear a document before it is released from ISDH:

1. The State Health Commissioner or his/her designee
2. The Risk Communication Director and/or the Director, Public Affairs
3. The subject matter expert (usually the State Epidemiologist).

This clearance should take place simultaneously and in person, whenever possible.

Some releases, especially those that deal with Administration policy, should be cleared by the Governor's Office.

Have as much information as possible on a topic pre-developed and pre-cleared. But make sure that this prepared information is sensitive to a crisis situation. When people are sick and frightened, the words you choose will naturally have to be more careful, so choose them that way from the start.

Designated Spokespersons

For ISDH:

- State Health Commissioner, Judith (Judy) Monroe, M.D.
- Risk Communication Director Erik Dickers
- Director, OPA Jennifer Dunlap
- Media Relations Coordinator Ken Severson

For Bioterrorism Planning:

- State Health Commissioner, Judith (Judy) Monroe, M.D.
- Public Health Surveillance & Preparedness Deputy Assistant Commissioner, Theodore (Ted) Bailey, M.D.
- Public Health Surveillance & Preparedness Assistant Commissioner, Joe Hunt
- PPHPER Division Director, Gary Couch

For Bioterrorist Agents:

- State Health Commissioner, Judith (Judy) Monroe, M.D.
- Deputy Assistant Commissioner, Public Health Surveillance & Preparedness Theodore (Ted) Bailey, M.D.
- Acute & Infectious Disease Epidemiologist Jim Howell, D.V.M.
- Director, Surveillance & Investigation Pam Pontones
- State Epidemiologist Robert Teclaw, Ph.D., D.V.M

For Nuclear Event:

- State Health Commissioner, Judith (Judy) Monroe, M.D.
- Public Health Surveillance & Preparedness Deputy Assistant Commissioner, Theodore (Ted) Bailey, M.D.
- PPHPER Director, Gary Couch
- Radiological Services Director, John Ruyack
- Risk Communication Director, Erik Deckers
- Office of Public Affairs (OPA) Director, Jennifer Dunlap

For Flu Pandemic:

- State Health Commissioner, Judith (Judy) Monroe, M.D.

- Public Health Surveillance & Preparedness Deputy Assistant Commissioner, Ted Bailey, M.D.
- PHER Director, Gary Couch
- Acute & Infectious Disease Epidemiologist Jim Howell, D.V.M.
- Respiratory Epidemiologist, Shawn Richards
- Risk Communication Director, Erik Deckers
- Office of Public Affairs Director, Jennifer Dunlap

In a crisis, the spokespersons will be designated based on the following criteria:

1. Can speak with knowledge, authority, credibility, and empathy on the topic.
2. Have a clear understanding of the principles of risk communication in a crisis.
3. Can stick to key messages, and will not easily be angered, flustered, or steered off-message.
4. Can speak in simple, easy-to-understand language.

As soon as a crisis develops, spokespersons will be designated based upon the criteria stated above. In most cases, spokespersons will be identified prior to a crisis.

Risk Communication staff, in cooperation with OPA, will support the designated spokespersons by:

- Developing lists of questions likely to be asked by the media.
- Developing key messages.
- Developing and distributing talking points.

Length of Time for Message Delivery

From the time a decision has been made, a message typically takes 1 – 4 hours to create, edit, and get approval of all stakeholders before it is issued via our email and IHAN distribution system.

We exercise this plan every time a public health emergency or crisis arises; we also exercise this plan every time the ISDH has good news to promote to the media. We have done this for something as large as the lead-contaminated toys that were distributed at public libraries around the United States (ISDH was the group that started the national recall), to something as small as the first West Nile virus-positive mosquito pool of the year. We also exercised this in a Risk Communication exercise in February 2007, as well as participating in the Ardent Sentry national exercise in May 2007.

We would like some exercises and drills from the CDC on how to run a Joint Information Center.

4	What materials are pre-developed and ready for distribution? How do your plans ensure that materials developed are culturally and linguistically appropriate for the intended audiences?
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ISDH has pre-developed a number of public information messages, including press releases, talking points, "First Hours" messages, and anticipated media questions. We have also distributed thousands of informational brochures from the Channing-Bete company to schools, businesses, civic groups, and individuals throughout the state.

In the event of a public health emergency, one of the greatest challenges will be to communicate effectively with Indiana's special populations. A broad-based, multi-faceted strategy will be implemented to meet the specific needs of Indiana's special populations. For the purposes of this plan, special populations include any individual, group, or community whose physical, mental, emotional, cognitive, cultural, ethnic, socio-economic status, language, or circumstance, creates barriers to understanding or the ability to communicate and act/react in the manner in which the general population has been requested to proceed.

The communication implementation strategy will include, at least, the following activities:

- Channel public information through Indiana's 2-1-1 system (170 languages and TDY capability).
- Deliver communication materials to key stakeholder/partner organizations, including community organizations, churches, home health care agencies, schools, etc..
- Distribute and utilize communication checklist (developed by a coalition of community organizations representing special populations) for use by communities during a crisis/emergency.

- Make every attempt to communicate information in a culturally sensitive fashion.
- Deliver emergency broadcast messages in both Spanish and English.

Other methods of dissemination

People who are deaf or hearing impaired will be able to watch local TV news via closed captioning, read online and print newspaper reports about public health emergencies and crises, and preparedness and prevention information. People who are blind or visually impaired can listen to the television or radio, and can use a screen reader (software that makes a computer talk) to access online newspapers. Some communities also use a reading service, which is a telephone-based newspaper and magazine reading service that is free for the blind and visually impaired. News stories are read and recorded by volunteers, and then accessed over the telephone.

ISDH recognizes that while English and Spanish are the prevalent languages in the state, other languages also are represented. Those local health departments, in areas of the state other languages are spoken, are encouraged to have translated materials ready for printing and distribution.

Of Hoosiers over the age of five, 92.7% of Indiana speaks only English, 7.3% speaks a language other than English (411, 064 of 5,663,249). According to the U.S. Census, the top five languages in Indiana are Spanish/Spanish Creole, German, French (including Patois and Cajun), Chinese, and Korean.

5 What are your plans for hotline activation and surge capacity?

The ISDH has not been able to find a cost-effective solution for hotline activation on a statewide level, other than utilization of our own internal personnel. Initial estimates were approximately \$80,000 – \$90,000 per month to reserve this capacity, without actually using it. The ISDH continues to pursue a hotline solution that can be contracted to an outside entity, allowing ISDH subject matter staff available to participate and provide intelligence on DOC operations or to maintain continuity of daily operations.

The ISDH continue use the phone line centers established both in an ISDH centralized location and at one of our annex facilities utilizing personnel outside of the Public Health Preparedness program. Other alternative plans include use of the 2-1-1 information system as well as local health department hotlines.

Progress for Goal 6: Responder Safety and Health

Question #	Question Text	Answer
1	What medical surveillance and monitoring protocols are in place for preparation, response and recovery of public health responders?	The ISDH has the capacity to develop surveillance and monitoring systems for specific populations, such as public health responders, when necessary. In addition to the PHESS and reportable disease surveillance systems, the ISDH has enacted active surveillance during several specific public health emergencies, such as the 2003 monkeypox outbreak, the 2005 Hurricane Katrina response, and most recently, the March 2007 case of smallpox vaccine-acquired eczema vaccinatum. These active surveillance programs are conducted in collaboration with local health departments and hospitals, and include daily telephone calls for symptom monitoring and documentation.
2	Describe the plan to provide prophylaxis to first responders and their families.	The ISDH established evaluation criteria to ensure that Local Health Departments included provisions within their local level mass prophylaxis plans to provide prophylaxis to first responders and their families. Depending on the event, a determination will be made as to the necessity of prophylaxis. First responders reporting for duty and requiring prophylaxis will receive it as they report for duty. If the first responder has family that also requires prophylaxis, then at the end of the first responder's shift they will receive the family's medication to take home with them. This serves several purposes: First, it assures a full first shift response. Second, it assures the responders family will be provided for with out having to go to a POD and stand in line. While all of Indiana's counties may have a different method every county has a plan for protecting and caring for first responders. They vary from the method listed above to separate reporting sites for first responders. As every county is responsible for their first responders they do it the way they think it will work best for their way of doing business.
3	What personal protective equipment (PPE) and countermeasures are being stockpiled for first responders? How are they maintained and issued? What training	

	programs are in place to train first responders in the proper selection and use of PPE?
	<p>Indiana maintains a large stockpile of PPE in a central location where it can be delivered to any part of the state that requires it in a matter of hours. It is located in a warehouse that is part of the SNS plan and therefore can be rapidly committed. We have approached storage in this method, but have considered alternative pre-positioned locations either within each local unit or district location. However the locals continue to report lack of physical storage space for these materials.</p> <p>A plan is in place that will provide rapid staging, transportation and security resources in a short period of time. Shortly, antiviral medications purchased by the state will be stockpiled in an RSS warehouse and therefore immediately available for shipments statewide when required. This warehouse is climate controlled and allows for shipments within hours of notification. Counties around the state have purchased PPE and are training in its proper use. The CST has been used in the training of public health first responders. The local health departments have just in time training in their Mass Prophylaxis plans for public health first responders. State agencies are required to purchase and store PPE for their first responders.</p>
5	Personal protective equipment and countermeasures are stockpiled for first responders (score individually):

Progress for Goal 6: Isolation and Quarantine

Question #	Question Text	Answer
1	Who in the state has legal authority to order or cease isolation and quarantine? What agency(ies) are/have been responsible for imposing, monitoring, and maintaining isolation and/or quarantine? How do you engage CDC quarantine stations in planning and exercising this capability?	<p>In the State of Indiana, a public health authority has the legal authority to seek orders of isolation and quarantine. A public health authority is defined as the state health commissioner, a deputy or assistant state health commissioner, or a local health officer. The state health department has concurrent authority with local health departments to implement isolation or quarantine. The implementing public health authority would be responsible for monitoring those isolated or quarantine and would be responsible for coordinating the maintenance of those isolated or quarantined. The implementing public health authority would seek the assistance of emergency management and volunteer agencies in gathering necessities. There is no CDC quarantine station in the State of Indiana.</p>
2	What plans are in place to coordinate, monitor and communicate with those in quarantine? What strategies have been developed specifically to address the needs of at-risk individuals in quarantine?	<p>Using the planning assumption that legal implementation of isolation and quarantine will be of little use at the local level during a pandemic, people are still being encouraged to self-isolate and self-quarantine. Therefore, local communities must be able to assist those who choose to do so and are responsible for monitoring the health status of the population. To ensure the Local communities are addressing these issues within their operations plans, the ISDH has included this within the template provided to the locals for writing their pandemic preparedness plans. Other resource needs are managed at the local level by Emergency Management, Red Cross, Faith Based Organizations and other volunteer groups.</p> <p>At risk individuals are being educated to address their special needs in advance of the pandemic. During the pandemic, local support groups, already in place for people with special needs, will continue to provide support to their constituents as will the groups mentioned above.</p>
3	How has the public health agency integrated with hospitals to maximize and coordinate the effective use of hospital negative pressure isolation and cohort isolation capabilities as identified in the HRSA National Hospital Bioterrorism Cooperative Agreement?	<p>The hospitals within Indiana's 10 Public Health Preparedness Districts, have met the HRSA requirements for negative pressure isolation beds, surpassing them in all the districts. The Indiana State Department of Health, Bioterrorism Hospital Planning program has procured a bed tracking system that is being implemented during this fiscal year. This system will include information on isolation beds which will also be available to local public health officials throughout the state to utilize when the situation arises.</p>

Hospital preparedness planning is an integral part of our overall preparedness planning at the local, district and state level.

4 What plans exist to communicate with the public regarding quarantine risks and protective actions?

The SNS plan has the support of the Indiana Health Alert Network (IHAN) to instantly notify all necessary elements of our state and local emergency medical response personnel. The IHAN system has our state and local responders listed by the categories of those needed and can either call them into action as a specific group or as a whole or alert them as may be required. All RSS responders are a response component and when notified of an event have detailed plans as to who and how many are to report without the need for phone calls, discussions or meetings to discuss requirements. Their response will be immediate and automatic. These details are written in the SNS Standing Operating Procedures which are agreed to and signed by specific agency heads. Public communications with the public are already in place but in process of being significantly upgraded by planning meetings with the cooperation of our media organizations throughout Indiana.

For additional information, please review responses under Goal 6: Emergency Public Information and Warning.

Progress for Goal 6: Mass Prophylaxis

Question #	Question Text	Answer
1	Describe the progress in your jurisdiction in implementing a mass prophylaxis plan to cover your entire project area population. What have been your most significant accomplishments in this area? What barriers have been overcome, and how was that accomplished? What barriers have not been overcome, and what are you doing to address these? How are local mass prophylaxis plans evaluated? What assistance, if any, would you like from CDC to improve your jurisdiction's mass prophylaxis planning?	<p>Mass prophylaxis planning and response are carried out by local health departments, and not directly by the State Health Department. Our responsibility is limited to technical advisory, planning, oversight and facilitating response plan efforts. As part of our efforts last fiscal year, we engaged local health departments throughout the state to write mass prophylaxis operations plans. All of these plans are being updated during the current year and each will be individually reviewed and evaluated by using a template for assuring all requirements were checked. Weak areas were reported back to the local health departments with timelines established for corrections. Not all local mass prophylaxis plans are of the quality we would like but strides are being made.</p> <p>The progress of Indiana Mass Prophylaxis planning has made a number of significant breakthroughs statewide. Most important, was to correct a major weakness pointed out in last year's CDC State Technical Assessment Review which concluded that security at our PODs was rated RED. In response to that, we assisted the counties by developing a security template for local law enforcement to use to evaluate the security requirements for each POD. Most local law enforcement had no experience with site security planning.</p> <p>When the templates were ready we met with the State Associations for our County Sheriffs and Chiefs of Police. They were quickly convinced of the need for these site security plans and endorsed a letter of explanation from the State Health Department along with a copy of the template to every member. Within several months 70% of these have been completed.</p> <p>We at the state level have realized that we can help the locals by working at the state level with state level organizations whether they are government agencies or private associations by convincing them of their roles in a massive medical emergency. We ask them to carry our message to their members and thereby opening doors for the local cooperation we need.</p>
2	What have been your Cities Readiness Initiative's (CRI's) most significant accomplishments in mass prophylaxis? What barriers have been overcome, and how was that accomplished? What barriers have not been overcome, and what is being done to address these? How is the CRI being monitored and evaluated by the State? What assistance, if any, would you like from CDC to assist your jurisdiction with the CRI?	<p>To increase the capacity of CRI Metropolitan Statistical Areas (MSA's), the ISDH has completed contracts with CRI MSA's for this fiscal year. One State level FTE is assigned to CRI activities for the state's 21 CRI counties. The CRI Coordinator works closely with the SNS Coordinator, Training, Education and Evaluation Coordinator, Chief Nurse Consultant, District Public Health Coordinators in the CRI MSAs and the Learning Management System Coordinator. Through intensive technical assistance, our largest CRI MSA is functioning in a more cooperative manner and that is our greatest accomplishment to date. Mass prophylaxis plans for CRI MSAs have shown improvement from previous</p>

years but there remains much to do. Indiana evaluates CRI entities using the DSNS Local Assessment Tool. The CDC brought the Mass Antibiotic Dispensing training to Indiana for two, two-day sessions. Due to their vital importance, both training sessions consisted of CRI MSA staff. We have not overcome the barrier of full collaboration with all of our CRI cross-border partners. There are twenty one counties in Indiana. Four of the counties are in Northwest Indiana and fall under the Chicago, Illinois CRI; seven counties border either Kentucky or Ohio and are therefore in either the Louisville or Cincinnati CRI MSAs and ten counties are in Central Indiana. Due largely to staff vacancies we have not achieved the level of collaboration we had planned. During the last months of this grant year we plan to reach out to all of our cross-border partners and come to an agreement for plans to prophylax those areas during an event.

3	Describe the methods and resources used to recruit, retain, train and protect from liability volunteer staff (e.g., logistics, health and medical, security and law enforcement, tactical communications, public information and communications, ICS staff, etc.) that will support a mass prophylaxis campaign.
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Health and medical volunteers are recruited in cooperation with the Indiana Professional Licensing Agency during the license renewal process. At re-licensing, every two years, fifteen disciplines of licensed health care professionals are asked to submit to a survey where they indicate their willingness to volunteer during a disaster or public health emergency. Though volunteer information will eventually be stored in the ESAR-VHP database, currently all volunteer information is distributed to local health departments for further recruitment and training efforts. The state health department does not assist local health departments at this time in the recruitment of non-medical volunteers.

The state health department recently completed the competitive Request for Proposal (RFP) process to bring a vendor onboard to assist in volunteer management and planning activities. By August 30, 2007, this vendor will complete the following deliverables: (1) Conduct a volunteer needs assessment for the provision of public health services that may be performed or supported by a local health department in response to a public health threat or emergency; (2) Determine in what roles local health departments may utilize volunteers in their POD operations, alternate care site support, or isolation and quarantine support functions and determining the skill sets required for each role; (3) Create job action sheets and training needs for each identified volunteer role; (4) Create just-in-time training modules for essential POD roles to be filled by volunteers; (5) Design tabletop and functional exercise scenarios to reinforce the just-in-time training modules; (6) Assess the risks that volunteers may be asked to assume during the performance of their duties and providing strategies to address them; and (7) Identify further volunteer recruitment and retention strategies for implementation at the state and local levels. This project will do much to assist local health departments in the management of their volunteers.

At this time, volunteer training is handled by local health departments. The state health department does provide the Learning Content Management System as a free, online resource to local health departments to assist in their training efforts. There volunteers can take courses on mass prophylaxis or receive training in NIMS at their convenience.

There are several possible immunities from civil liability that could apply to volunteers during a public health emergency. Per Ind. Code § 10-14-3-15(a), a volunteer identified as an emergency management worker (as defined in Ind. Code § 10-14-3-3) who is complying or attempting to comply with the emergency management law is not liable for death or injury to persons or damage to property as a result of such activity, except in cases of willful misconduct, gross negligence, or bad faith. This immunity would apply to individuals working on behalf of or at the request of the State or a political subdivision. In addition, per Ind. Code §34-30-13.5, a person who has a license to provide health care services under Indiana law or the law of another state and provides a health care service within the scope of the person's license to another person at a location where health care services are provided during an event that is declared as a disaster may not be held civilly liable for an act or omission relating to the provision of health care services in response to such an event absent gross negligence or willful misconduct. These two immunity protections are the most relevant to the support of a mass prophylaxis campaign.

4	What is the current status of the development, structure, and testing of your system to rapidly alert and assemble personnel and volunteers that will staff your Strategic National Stockpile (SNS) response components (especially dispensing, distribution, security, RSS, and public communication) in an actual public health emergency?
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We have segmented our HAN system into separate areas including the SNS Plan. This approach allows us to take advantage of our HAN communications capabilities but still maintain the separate security that SNS requires. Through it we can immediately contact everyone involved in invoking the SNS Plan. The initial focus is to assemble the key players required to create an operational RSS. The focus then moves to receiving and allocation. As part of our setup we use our HAN system to contact INDOT (provides trucks for distribution to PODs / hospitals and the State Police (shipment security).

5	What preparations have you made to communicate relevant messages via the mass media in an actual public health emergency to direct the general population to, and inform them about, services for dispensing materiel from the SNS?
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Indiana has created a strong partner relationship with the broadcast and print media statewide. Numerous meetings with Indiana State Department of Health and the Indiana media executives and associations have provided the basis for how the media will work to assure correct information will be disseminated to the general public statewide. This is an ongoing process but the Indiana Broadcasters Association (radio and TV) and the Hoosier Press Association (print) are solid partners and fully understand their role in

protecting public safety. They are a part of the Indiana Health Alert Network as a media notification group and in the event of an emergency will receive a contact alert advising them to contact us for details. They are also aware and have agreed not to report specific parts of the SNS process that might endanger or put the SNS process at risk. The meetings have been confidential and only with the top executive staff. We have and continue to provide them with the materials they will need to play their response to an event.

Progress for Goal 6: Medical Surge

Question #	Question Text	Answer
1	Who in your agency is responsible for coordinating public health preparedness activities with your hospital based preparedness program?	<p>Organizationally, the Public Health Preparedness & Emergency Response Program within the Indiana State Department of Health consists of both the CDC Preparedness Staff as well as the OASPR Hospital Based Preparedness Program. Specifically the Indiana Hospital Preparedness Program is managed by John A. Braeckel, and has been since its inception in 2002. With integration of Mr. Braeckel and his staff into the overall Indiana Public Health Program, coordination with the Hospital program happens collaboratively across the CDC and OASPR programs.</p>
2	What tracking or early warning systems, (e.g., over the counter (OTC) purchases, self-medicating measures, school or work absences, outpatient visits, ER visits, hospital admissions) are in place to augment the surveillance of available beds accomplished through the hospital program?	<p>See Goal 2, Question 1.</p>
3	What has been the extent of your involvement in establishing, maintaining or using the Emergency System for Advanced Registration of Volunteer Health Professionals (ESAR-VHP)? Are public health professionals currently included on the ESAR-VHP roster? (NOTE: The Pandemic and All-Hazards Preparedness Act requires that all grantees participate in ESAR-VP by FY 2009.)	<p>The State of Indiana was designated a Phase III state for ESAR-VHP development and implementation. ISDH is on schedule to meet an August 2008 deadline to create an interactive ESAR-VHP registry of fifteen different disciplines of licensed health care professionals who individually indicated, during the licensure renewal process, their willingness to volunteer in case of a disaster or public health emergency. The registry will include physicians, registered nurses, social workers, clinical social workers, marriage and family therapists, mental health counselors, licensed practical nurses, pharmacists, psychologists, respiratory care practitioners, pharmacy technicians, dentists, dental hygienists, physician assistants, and environmental health specialists. Some of these disciplines are not required by OASPR to be included in the registry. ISDH awaits new guidance from OASPR (promised June 30, 2007) to determine current compliance status and directions for expansion.</p> <p>Public health professionals are included in ESAR-VHP rosters. When health care professionals are surveyed, the specialties and principal practice settings of the volunteers are captured.</p> <p>The ISDH will utilize the Indiana Health Alert Network (IHAN) to contact volunteers during an emergency. The Indiana Health Alert Network already communicates with hospitals, local health departments, and other preparedness partners.</p>

Progress for Goal 6: Mass Care

Question #	Question Text	Answer
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1	What steps have been taken to develop and implement systems that can track cases, exposures and adverse incidents long-term?
<p>Currently, the ISDH monitors data to track cases, exposures, and adverse incidents long-term using an internal outbreak log. The log is an Access database located in a shared folder with secure access provided to required and approved users. If the event involves a reportable disease, the current paper-based reportable disease surveillance system may provide data. In addition, the PHESS (see Goal 2, response 1) may also provide data for biological, chemical and radiological events.</p> <p>In the future, the NEDSS system will have the ability to prompt investigators for long-term follow-up for those cases that need it. In addition, the ISDH has identified functional requirements for an outbreak management system. This system will incorporate the current outbreak log and include much more functionality. It will also link to the NEDSS system. Being electronic, these systems will allow for much faster tracking.</p> <p>ISDH investigators will also partner with other agency programs, such as Food Protection, Vector-Control, and Radiological Health and other agencies, such as the Indiana Department of Environmental Management and the Indiana Department of Homeland Security, to issue guidance on risk, health education, and protective action by monitoring air, water, food, soil quality, vector control, and environmental decontamination.</p>	
2	What indicators have you established/used to identify the threshold for transition from response to recovery efforts? What individual has the authority to initiate public health recovery efforts? What policies and procedures are in place for the early development and implementation of recovery planning during the response phase?
<p>The Indiana Department of Homeland Security is the lead agency for planning and directing recovery efforts. However the ISDH has played a supporting role in response recovery efforts. For instance, during biological events, once surveillance data indicate that transmission is slowing or stopped, transition from response to recovery will begin. For chemical and radiological events, the ISDH will partner with other state agencies, including IDEM and IDHS, to determine the transition from response to recovery. The State Health Commissioner has the authority to initiate public health recovery efforts.</p> <p>Policies and procedures for the early development and implementation of recovery planning during the response phase of a biological event are provided in the ISDH Epidemiology Response Plan (Recommendations for Public Health Action). Once the disease agent is known (or if epidemiologic information can reasonably identify an agent prior to laboratory confirmation), some recovery efforts may begin in conjunction with response.</p>	

Progress for Goal 8: Economic and Community Recovery

Question #	Question Text	Answer
1	What plans are in place for promoting mental health resiliency for your community following an emergency/disaster?	<p>The Indiana Division of Mental Health & Addiction (DMHA), Office of Emergency Preparedness & Response in partnership with Indiana State Department of Health (ISDH) and Indiana Department of Homeland Security (DHS) has created 10 Indiana District Disaster Mental Health Response Teams. DMHA has appointed a Team Leader and Clinical Director for each district team. The teams will train, exercise, and respond to local, regional, state or possible national disasters by administering psychological first aid and crisis counseling to other disaster responders and victims. Each team member has completed a full day training session (with certification) and a FEMA National Incident Management System (NIMS) course. In addition, District Team Leaders completed a leader training session and advanced NIMS courses.</p> <p>In an effort to build and expand the resources and knowledge of the 10 Disaster Mental Health District Teams, "train-the-trainer" Psychological First Aid courses were conducted for leaders in each district. DMHA also created tools to assist the district teams included a Data Collection Book (FEMA required forms), a Disaster Mental Health Intervention Field Guide and a district tool and to-go kit (training and deployment items).</p> <p>This summer, the agencies will continue their partnerships by holding Psychological Impacts of Mass Disasters training and discussion forums throughout Indiana. The goal is to strengthen local community partnerships and integrate response plans.</p>

Approximately 400 individuals have been trained and certified statewide under the leadership of Andrew P. Klatte, Assistant Deputy Director, Office of Emergency Preparedness and Response, Indiana Division of Mental Health and Addiction.

2 How have you worked with your SAC and business community to anticipate the short and long-term economic consequences of public health emergencies?

Our SAC has been established for four years. During the last year we have been working with our business community through town hall meetings and exercises. Unfortunately this subject is one that has received little documented attention in comparison to other issues and immediate concerns presented to this group for resolution. It is our hope that this issue will become a priority which can be actively addressed in the future.

Progress for Goal 9: Planning

Question #	Question Text	Answer
1	Describe your use of After Action Reports (AARs) to evaluate drills/exercises or real emergency response incidents. Are you following the Department of Homeland Security guidance on content and process for developing an AAR and Corrective Action Plan (CAP)? Describe your methods to develop and implement CAPs. What efforts have been taken to improve the jurisdiction's public health emergency response plans according to the results of AARs and subsequent CAPs? What have been your most significant accomplishments in the area of quality improvement? What barriers have been overcome, and how was that accomplished? What barriers have not been overcome, and what are you doing to address these? What assistance, if any, would you like from CDC in developing and conducting AARs and CAPs?	<p>Indiana PHER utilizes the guidance and standards set forth by the Homeland Security Exercise and Evaluation Program (HSEEP) for After Action Reports (AAR) to evaluate exercises, drills, and actual emergency events. The PHER Program cycle culminates in a period of evaluation and improvement planning which includes a Corrective Actions Program (CAP). As the cooperative agreement grant functions on a yearly cycle, the PHER Program utilizes a yearly schedule to conduct training, exercises, evaluation, improvement planning, and corrective action programs.</p> <p>The PHER Program is characterized by a four phase approach. Ideally, the majority of training takes place in the first quarter, followed by exercises in the second, evaluation in the third, and the implementation of a corrective action program in the fourth. The fourth phase includes a team evaluation of the AAR/IP. Significant issues are identified; action items are defined; assignments for follow up and management are given to specific people within the respective programmatic areas. The development of the CAP coincides with CDC cooperative agreement guidance for the following grant year. Thus, any outstanding issues that are not resolved can be addressed in the following grant cycle at the state level and with our local health departments and partners.</p> <p>Many efforts have been made to improve Indiana's public health emergency response plans as a result of CAP. Two examples include improvements in the area pandemic planning and school closures and the ISNS program. In October of 2006 the Indiana State Department of Health (ISDH) partnered with the Indiana Department of Homeland Security (IDHS) and the Indiana National Guard (ING) to conduct a statewide pandemic influenza tabletop exercise (TTX). This exercise involved more than three hundred participants from each of Indiana's 10 emergency preparedness districts. While this exercise had many cross-cutting objectives, areas most specific to ISDH were non-pharmacological interventions with a focus on school closures, epidemiological investigation and reporting, laboratory testing procedures, and requesting and utilizing SNS assets during a pandemic.</p> <p>Recommendations for improvements from the October exercise included clarifying authorities for closing schools, the use of community containment issues, and requesting and reordering SNS assets. As a result of this exercise the ISDH developed a community containment plan, a guidance document on the complexity of the decision to "re-open" schools, a policy statement clarifying the procedures to request and reorder SNS assets, and the development and conduct of follow up exercises. In February of 2007, the ISDH, in conjunction with IDHS and the Indiana Department of Education (IDOE), conducted a re-evaluation TTX focused specifically on the issue of school closure. This exercise was broadcast via webinar technology and included representatives from 14 LHD from Indiana's 10 emergency preparedness districts. An objective of this exercise was to address issues noted in the improvement plan from the October exercise. A result of this exercise was a new CAP that included the formation of a joint task force between ISDH and IDOE to address additional concerns raised during the exercise. For example this joint task force is creating a pandemic influenza "planning template" for schools. An additional result of the October exercise, was the development and conduct of a Full-scale SNS exercise that was conducted in May of 2007. One of the objectives</p>

of this exercise was to focus on requesting and reordering SNS assets from PODs and hospitals (treatment centers), as this was part of the CAP.

The largest barrier achieved thus far is the implementation of an exercise program that includes AAR/IP development and re-evaluation. It was, perhaps, more typical in the past to conduct single exercise with little direct follow-up. The transition to implementing improvement plans has taken some time to embrace. The PHER program has made tremendous strides in establishing a process to train, exercise, evaluate, and improve our emergency response plans. What we would like to see from the CDC is explicit directions on the preferred exercise protocols. For instance, public health exercises do not always fit within the HSEEP structure. The CDC webpage posts the Columbia University guide for exercises and evaluation, but this is not the HSEEP methodology recommended and as such this is a source of confusion. Furthermore, some of exercise guidance coming from the CDC appears to utilize a different format other than HSEEP (e.g. school closure exercise). Perhaps, the development of a training and exercise page on the CDC's website that is specific to public health preparedness and emergency response, which posts examples and templates in CDC preferred formats, would be very valuable.

Estimated Financial Status Report (FSR)

Question #	Question Text	Answer