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United States General Accounting Office
Washington, DC 20548

February 10, 2004

Congressional Committees

Subject: *HHS Bioterrorism Preparedness Programs: States Reported Progress but Fell Short of Program Goals for 2002*

The anthrax incidents during the fall of 2001 raised concerns about the nation's ability to respond to bioterrorist events and other public health threats. The incidents strained the public health system, including surveillance¹ and laboratory workforce capacities, at the state and local levels.² Several months after the incidents, the Congress appropriated funds to strengthen state and local bioterrorism preparedness.³ The Department of Health and Human Services' (HHS) Centers for Disease Control and Prevention (CDC) and Health Resources and Services Administration (HRSA) distributed the funds in 2002 through two cooperative agreement programs with state, municipal, and territorial governments.⁴

To strengthen preparedness, the two cooperative agreement programs—CDC's Public Health Preparedness and Response for Bioterrorism Program and HRSA's National Bioterrorism Hospital Preparedness Program—require participants to complete specific activities designed to build public health and health care capacities. The 2002 cooperative agreements for both programs ended on August 30, 2003. For the 2002

¹Public health surveillance uses systems that provide for the ongoing collection, analysis, and dissemination of health-related data to identify, prevent, and control disease.

²See U.S. General Accounting Office, *Bioterrorism: Public Health Response to Anthrax Incidents of 2001*, [GAO-04-152](#) (Washington, D.C.: Oct. 15, 2003).

³Department of Defense and Emergency Supplemental Appropriations for Recovery from and Response to Terrorist Attacks on the United States Act, Pub. L. No. 107-117, 115 Stat. 2230, 2314 (2002), and the Departments of Labor, Health and Human Services and Education, and Related Agencies Appropriations Act of Fiscal Year 2002, Pub. L. No. 107-116, 115 Stat. 2186, 2198.

⁴A cooperative agreement is used as a mechanism to provide financial support when substantial interaction is expected between the executive agency and a state, local government, or other recipient carrying out the funded activity. Under their programs, CDC and HRSA made funding available to the following: all 50 states; the District of Columbia; the country's three largest municipalities (New York City, Chicago, and Los Angeles County); the territories of American Samoa, Guam, and the U.S. Virgin Islands; and the commonwealths of the Northern Mariana Islands and Puerto Rico. CDC also made funding available to the republics of Palau and the Marshall Islands and the Federated States of Micronesia.

cooperative agreements, CDC's and HRSA's programs distributed approximately \$918 million and approximately \$125 million, respectively.⁵

The Public Health Security and Bioterrorism Preparedness and Response Act of 2002 directs us to report on federal programs that support preparedness efforts at the state and local levels.⁶ We have previously reported on state and local efforts and hospital preparedness.⁷ As agreed with the committees of jurisdiction, for this report, we examined the extent to which states completed 2002 cooperative agreement requirements and whether states identified any factors that hindered implementation of CDC's program and HRSA's program. In this report, we use the term "state" to refer to the 50 states, the District of Columbia, New York City, Chicago, and Los Angeles County. Enclosure I contains the information we provided during our January 14, 2004 briefing of your staff.

To determine the extent to which states had completed program requirements, we relied primarily on the cooperative agreement progress reports that CDC and HRSA required the states to submit. We checked the data for internal consistency as well as consistency with other sources and determined that they were adequate for our purposes. We reviewed semi-annual progress reports submitted by the states, covering the period through August 30, 2003, for CDC's program and through July 1, 2003, for HRSA's program.⁸ For a number of reasons, we use broad categories to describe the degree of progress states have made in completing requirements. These reasons include: CDC and HRSA changed the reporting formats over the course of the agreements, states had varying interpretations of what constituted completion of the requirements, and the final reports do not reflect follow-up by CDC and HRSA to clarify states' responses. We also interviewed officials and reviewed relevant documents from CDC, HRSA, and HHS's Office of the Assistant Secretary for Public Health Emergency Preparedness. We also interviewed officials from 10 states, 1 local health department within each of these states, and 2 major metropolitan areas directly funded by CDC and HRSA.⁹ The program participants are not identified in this report because of the sensitive nature of the issue. In addition, we interviewed representatives and reviewed documents from the Association of State and

⁵In 2003, the Congress appropriated additional funds for bioterrorism preparedness. Consolidated Appropriations Resolution, 2003, Pub. L. No. 108-7, Division G, Title II, 117 Stat. 11, 322. HHS renewed the cooperative agreements for the period of August 31, 2003 through August 30, 2004. CDC's and HRSA's programs distributed about \$870 million and about \$498 million, respectively.

⁶Pub. L. No. 107-188, § 157, 116 Stat. 594, 633 (2002).

⁷U.S. General Accounting Office, *Bioterrorism: Preparedness Varied across State and Local Jurisdictions*, [GAO-03-373](#) (Washington, D.C.: Apr. 7, 2003), and *Hospital Preparedness: Most Urban Hospitals Have Emergency Plans but Lack Certain Capacities for Bioterrorism Response*, [GAO-03-924](#) (Washington, D.C.: Aug. 6, 2003).

⁸The final progress report for one state was missing for the CDC program. HRSA did not require states to complete some of the requirements until March 31, 2004.

⁹We selected these program participants in order to provide a range of population sizes, geographic locations, and experience with responding to disasters and conducting large drills and exercises. Each of the 10 local health departments in our sample serves a major metropolitan area within a state.

Territorial Health Officials and the American Hospital Association and its affiliates. We reviewed documents from the National Association of County and City Health Officials, the Council of State and Territorial Epidemiologists, and the Association of Public Health Laboratories. We performed our work from June 2003 through February 2004 in accordance with generally accepted government auditing standards.

Results

States reported progress toward the CDC program's goal of strengthening public health preparedness, but identified factors that hindered them from meeting all of CDC's 2002 cooperative agreement requirements. All states reported progress in developing the capacities CDC considers critical for public health preparedness, but no state completed all program requirements. Some of the 14 requirements that CDC considers critical benchmarks of preparedness were more likely to be completed than others. Four critical benchmarks were met by most of the states. These benchmarks included the establishment of a bioterrorism advisory committee and coverage of 90 percent of the state's population by the Health Alert Network—a nationwide program designed to ensure communication capacity at all state and local health departments. Two critical benchmarks were met by few of the states: development of a statewide response plan and development of a regional response plan. The remaining eight critical benchmarks were met by around half the states. These benchmarks included assessment of emergency preparedness and response capabilities, development of a system that can receive and evaluate urgent disease reports at all times, and development of an interim Strategic National Stockpile¹⁰ plan. In addition, state and local officials reported three main factors that hindered their ability to complete all of CDC's requirements: (1) redirection of resources to the National Smallpox Vaccination Program,¹¹ (2) difficulties in increasing personnel as a result of state and local budget deficits, and (3) delays caused by state and local management practices, such as contracting and hiring procedures.

Similarly, states reported progress toward the HRSA program's goal of strengthening hospital preparedness but identified factors that have hindered their efforts to complete all of HRSA's 2002 program requirements. While no state has completed all of HRSA's requirements—to conduct needs assessments, to meet three critical benchmarks of hospital preparedness, and to address priority issues—states have until March 31, 2004, to complete most of them. No state reported completing all components of its needs assessment. Almost all states reported that they had met two of the three critical benchmarks: designation of a coordinator for hospital preparedness planning and establishment of a hospital preparedness planning

¹⁰The Strategic National Stockpile, formerly the National Pharmaceutical Stockpile, is a repository of pharmaceuticals and medical supplies that can be delivered to the site of a biological or other attack.

¹¹In December 2002, HHS directed states to offer smallpox vaccination to public health and health care workers; however, additional funds (\$100 million) were not made available to carry out the vaccinations until May 2003. For more information on the National Smallpox Vaccination Program, see U.S. General Accounting Office, *Smallpox Vaccination: Implementation of National Program Faces Challenges*, [GAO-03-578](#) (Washington, D.C.: Apr. 30, 2003).

committee. No state reported meeting the third benchmark—development of a plan for the hospitals in the state to respond to an epidemic involving at least 500 patients. States reported varying degrees of progress in addressing the priority issues that HRSA required them to address, such as receipt and distribution of medications and vaccines, personal protection of health care workers, quarantine capacity, and communications. State officials expressed concern that HRSA funding was insufficient for states to meet the requirements of the 2002 program. Similarly, hospital representatives reported that redirection of resources to the National Smallpox Vaccination Program and delays caused by lengthy contracting processes for distributing funds from the state to the hospitals hindered efforts to implement the program.

In summary, although the states' progress fell short of 2002 program goals, CDC's and HRSA's cooperative agreement programs have enabled states to make much needed improvements in the public health and health care capacities critical for preparedness. States are more prepared now than they were prior to these programs, but much remains to be accomplished.

Agency Comments

We provided a draft of this report to HHS. HHS informed us that it had no comment on the draft report but provided technical comments, which we incorporated where appropriate.

We are sending copies of this report to the Secretary of HHS, the Director of CDC, the Administrator of HRSA, and other interested officials. We will also provide copies to others upon request. In addition, the report will be available at no charge on the GAO Web site at <http://www.gao.gov>.

If you or your staff have any questions or need additional information, please contact me at (202) 512-7119. Another contact and key contributors are listed in enclosure III.



Janet Heinrich
Director, Health Care—Public Health Issues

Enclosures - 3

List of Committees

The Honorable Judd Gregg
Chairman

The Honorable Edward M. Kennedy
Ranking Minority Member
Committee on Health, Education, Labor, and Pensions
United States Senate

The Honorable Ted Stevens
Chairman

The Honorable Robert C. Byrd
Ranking Minority Member
Committee on Appropriations
United States Senate

The Honorable W.J. "Billy" Tauzin
Chairman

The Honorable John D. Dingell
Ranking Minority Member
Committee on Energy and Commerce
House of Representatives

The Honorable C.W. Bill Young
Chairman

The Honorable David R. Obey
Ranking Minority Member
Committee on Appropriations
House of Representatives



HHS Bioterrorism Preparedness Programs: States Reported Progress but Fell Short of Program Goals for 2002

Briefing for Congressional Staff

Senate Committee on Health, Education, Labor, and Pensions
Senate Committee on Appropriations

House Committee on Energy and Commerce
House Committee on Appropriations

January 14, 2004



Congressional Mandate

The Public Health Security and Bioterrorism Preparedness and Response Act of 2002 directs us to report on federal programs that support preparedness efforts at the state and local levels

We previously reported that although preparedness efforts had improved the ability of state and local jurisdictions to respond to infectious disease outbreaks and other major public health threats, gaps in preparedness remained

We also reported that most urban hospitals lacked certain health care capacities for bioterrorism response



Objectives

Examine extent to which states completed 2002 cooperative agreement requirements and whether states identified any factors that hindered implementation of

- CDC’s program for Public Health Preparedness and Response for Bioterrorism

- HRSA’s National Bioterrorism Hospital Preparedness Program



Scope and Methodology

We reviewed the 2002 cooperative agreement semi-annual progress reports CDC and HRSA required states¹ to submit

CDC's progress reports covered the period from February 19, 2002 through August 30, 2003

HRSA's progress reports covered the period from April 1, 2002 through July 1, 2003

¹"State" refers to the 50 states, the District of Columbia, and the three municipalities that participate in the cooperative agreement programs (New York City, Chicago, and Los Angeles County).



Scope and Methodology (cont.)

We checked the data for internal consistency as well as consistency with other sources and determined that they were adequate for our purposes

For a number of reasons, we use broad categories to describe the degree of progress states have made in completing requirements, including

- CDC and HRSA introduced new formats for the final progress reports
 - States had varying interpretations of what constituted completion of the requirements
 - The progress reports do not reflect follow-up by CDC and HRSA to clarify states' responses
-



Scope and Methodology (cont.)

We interviewed officials from 10 states, 1 local health department within each of these states, and 2 metropolitan areas

We interviewed officials and reviewed relevant documents from CDC, HRSA and HHS's Office of the Assistant Secretary for Public Health Emergency Preparedness

We interviewed representatives from professional organizations representing state health officials and hospitals



Goal of CDC and HRSA Cooperative Agreement Programs

The common goal of the CDC and HRSA cooperative agreement programs is to improve state and local preparedness to respond to bioterrorist events and other public health emergencies

The focus of CDC's program is public health preparedness

The focus of HRSA's program is hospital preparedness



CDC Funding of Public Health Preparedness and Response for Bioterrorism

In 1999, CDC began funding states as part of HHS's Bioterrorism Initiative to improve the nation's public health capacity to respond to bioterrorism

<u>Fiscal Year</u>	<u>Funding (in millions)</u>
1999	\$40.7
2000	\$41.9
2001	\$49.9
2002	\$918.0
2003	\$870.0 ²

² Although 2002 funding for CDC's program included support for activities connected with the Strategic National Stockpile, its 2003 funding did not because responsibility for funding these activities had been transferred to the Department of Homeland Security in March 2003.

Note: In May 2003, HHS announced that an additional \$100 million would be available to states for their smallpox vaccination programs. 8



Distribution of CDC's 2002 Funding

CDC distributed \$5 million plus a per capita amount to each state

States had flexibility on how to distribute CDC funds to local health agencies; allocation formulas used by states included

- Base amounts plus per capita amounts
- Larger amounts to designated local health agencies with regional coordination responsibilities
- Larger amounts to selected local health agencies for specific projects

The proportion of total funds that states reported distributing directly to local health agencies varied



CDC Identified Focus Areas to Improve Public Health Capacity

- Preparedness Planning and Readiness Assessment
- Surveillance and Epidemiology³
- Laboratories (Biologic Agents)
- Health Alert Network/Communications and Information Technology
- Risk Communication and Health Information Dissemination
- Education and Training

³Epidemiology is the study of the distribution and causes of disease or injury in a population.



CDC Identified Capacities That Are Critical for States to Be Prepared

Within the focus areas, CDC identified a total of 16 critical capacities for preparedness

Under the critical capacities, CDC specified a total of 74 requirements, and allowed states to determine what specific activities to undertake to complete the requirements

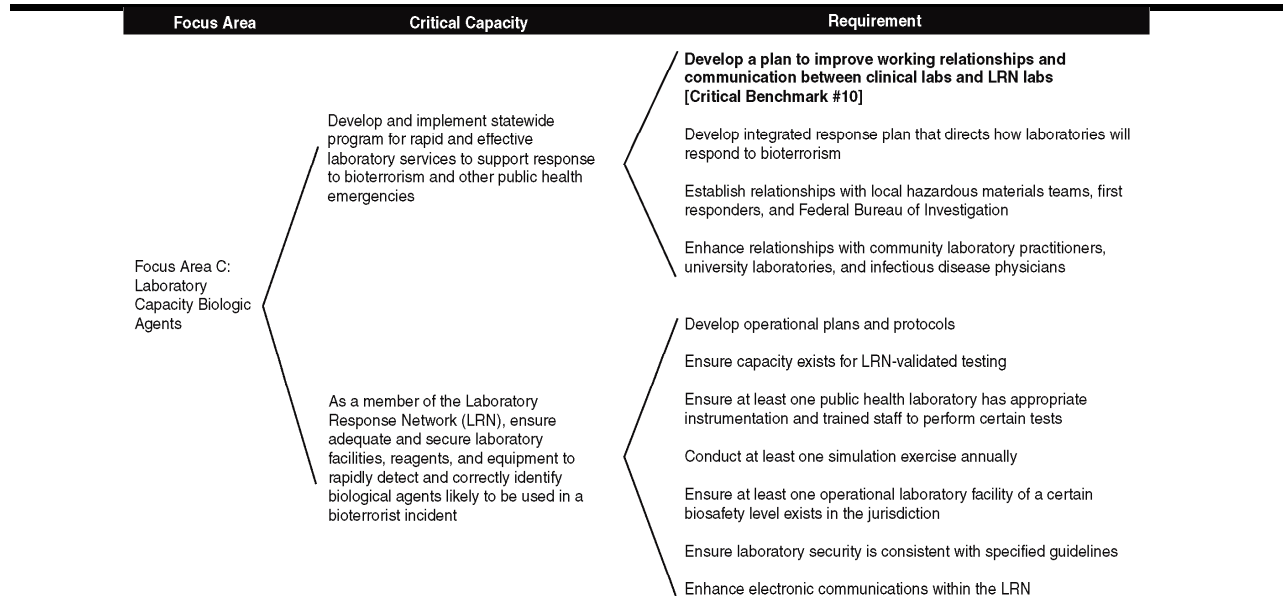
CDC required states to complete the requirements by the end of the 2002 cooperative agreement

CDC designated 14 of these requirements as critical benchmarks for tracking progress⁴

⁴See enclosure II.



Example of CDC Requirements for States



Source: CDC



How CDC Monitors Progress

To monitor states' implementation of 2002 cooperative agreements, CDC

- Required states to submit semi-annual progress reports that track states' progress toward completion of requirements
- Conducted site visits
- Assigned project officers (who also provided technical assistance)



HRSA Funding of National Bioterrorism Hospital Preparedness Program

HRSA's program was established in 2002 to facilitate state and regional planning with local hospitals, emergency medical services systems, and other health care facilities to improve the capacity to respond to bioterrorist attacks and other public health emergencies

<u>Fiscal Year</u>	<u>Funding (in millions)</u>
2002	\$125
2003	\$498



Distribution of HRSA's 2002 Funding

HRSA distributed \$250,000 plus a per capita amount to each state⁵ and required that at least 74 percent of the funds be allocated to hospitals or other health care entities

The remaining amount supported states' administrative costs and needs assessments

States distributed most of the funds to hospitals; a small portion went to other entities, such as community health centers, emergency medical services, and poison control centers

⁵The base allocation was \$500,000 for the District of Columbia.



Distribution of HRSA's 2002 Funding (cont.)

Some states administered HRSA funds themselves; others through hospital associations

Allocation formulas used by states included

- Equal allotment to each hospital
- Amounts based on emergency department admissions
- Higher levels of funding to larger hospitals

State officials we interviewed reported that the funds allocated to individual hospitals ranged from \$1,000 to \$80,000



HRSA Requirements

HRSA required states to

- Conduct needs assessments
- Meet critical benchmarks
- Address priority issues

HRSA required states to complete requirements by
March 31, 2004



HRSA Requirements (cont.)

HRSA required states to meet the following three critical benchmarks

- Designation of a coordinator for bioterrorism hospital preparedness planning⁶
- Establishment of a hospital preparedness planning committee⁶
- Development of a plan for the hospitals in the state to respond to a potential epidemic involving at least 500 patients

⁶HRSA required these critical benchmarks to be met within the first few months of the program.



HRSA Requirements (cont.)

HRSA identified priority issues for states to address

- Medications and Vaccines (stockpile receipt and distribution)
- Personal Protection (for health care workers and patients), quarantine, and decontamination
- Communications
- Biological Disaster Drills
- Personnel (i.e., hospital and emergency medical services)
- Training
- Patient Transfer

Note: HRSA put a higher priority on the first four issues.

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How HRSA Monitors Progress

To monitor states' implementation of 2002 cooperative agreements, HRSA

- Required states to submit semi-annual progress reports
- Conducted site visits
- Assigned project officers (who also provided technical assistance)



Progress on CDC Requirements

States reported progress in completing CDC's 2002 cooperative agreement requirements

However, states identified factors that hindered them from completing all requirements by August 30, 2003



Progress Reported but No State Completed All of CDC's 2002 Requirements

All states reported progress in developing the capacities CDC considers critical for public health preparedness

However, no state completed all requirements

Some of the 14 requirements that CDC designated as critical benchmarks were more likely to be completed than others



CDC Critical Benchmarks: 4 of 14 Reported Met by Most States

Each of the following four critical benchmarks was reported met by most states by August 30, 2003

- Designation of an executive director of the bioterrorism preparedness and response program
- Establishment of a bioterrorism advisory committee
- Assessment of epidemiologic capacity and achievement of the goal of at least one epidemiologist for each Metropolitan Statistical Area
- Coverage of 90 percent of the population by the Health Alert Network



CDC Critical Benchmarks: 2 of 14 Reported Met by Few States

Each of the following two critical benchmarks was reported met by few states

- Development of statewide response plan for incidents of bioterrorism and other public health threats and emergencies and provisions for exercising the plan
- Development of regional response plan across state borders for incidents of bioterrorism and other public health threats and emergencies



CDC Critical Benchmarks: 8 of 14 Reported Met by Around Half the States

Each of the remaining eight critical benchmarks was reported met by around half the states

- Assessment of emergency preparedness and response capabilities
 - Assessment of statutes, regulations, and ordinances that provide for credentialing, licensure, and delegation of authority for executing emergency public health measures
 - Development of interim plan to receive and manage items from the Strategic National Stockpile
 - Development of a system to receive and evaluate urgent disease reports at all times
 - Development of a plan to improve working relationships and communication between clinical and public health laboratories
 - Development of a communications system that provides for flow of critical health information at all times
 - Development of an interim plan for risk communication
 - Preparation of a timeline to assess training needs
-



Factors Cited as Hindering Completion of CDC's 2002 Requirements

State and local officials identified three main factors that hindered their ability to complete program requirements

- Redirection of resources to the National Smallpox Vaccination Program
- Difficulties in increasing personnel as a result of state and local budget deficits
- Delays caused by state and local management practices



National Smallpox Vaccination Program

CDC directed states to offer vaccinations to public health and health care workers beginning January 24, 2003, and expected vaccinations to be completed within 30 days; however, no additional funds were provided until May 2003⁷

Many states reported that the smallpox vaccination program disrupted their general bioterrorism preparedness activities because personnel and resources were redirected to implement the program

⁷CDC instructed states to redirect funds previously distributed under the 2002 cooperative agreement program.



Budget Deficits and Management Practices

State and local officials reported that budget deficits led to

- Hiring freezes
- Reductions in public health personnel

State and local officials also reported that management practices delayed hiring and distribution of funds

- Salary levels led to difficulties in attracting and retaining personnel
- Lengthy contracting procedures delayed distribution of funds to local health agencies



Progress on HRSA Requirements

States reported progress in completing HRSA's 2002 cooperative agreement requirements

However, states identified factors that have hindered their efforts to complete HRSA requirements

While no state reported completing all HRSA requirements, states have until March 31, 2004, to complete them



Progress Reported on Needs Assessments Required by HRSA

No state reported completing all components of its needs assessment

For example, most states reported that they had not yet identified

- Which hospitals in the state to target for capital improvements (e.g., for quarantine and decontamination)
- The need for bioterrorism-related diagnostic and treatment protocols and mechanisms to bring clinicians up to speed on these protocols



Progress on HRSA Benchmarks

Almost all states reported meeting two of the three critical benchmarks of preparedness required by HRSA

- Designation of a coordinator for hospital preparedness planning
- Establishment of a hospital preparedness planning committee

No state reported meeting the third benchmark—a plan for the hospitals in the state to respond to an epidemic involving at least 500 patients



Progress on Third HRSA Benchmark

Components of a hospital response plan not reported as complete by most states included

- Mechanism to ensure the movement of equipment maintained by hospitals or emergency medical services systems to the scene of a bioterrorist event
- System that allows for the delivery of essential goods and services to patients and hospitals during an incident
- System to ensure access to medically appropriate care to children, pregnant women, the elderly and those with disabilities during a terrorist incident



Progress on HRSA Priority Issues

States reported varying degrees of progress in addressing priority issues, for example, the extent to which they had developed mechanisms

- To stage prophylaxis and immunization clinics for large numbers of patients
- That provide redundancy in communication systems



States Reported Factors Hindering Implementation of HRSA's Program

State officials expressed concern that HRSA funding was insufficient to accomplish the 2002 goals of the cooperative agreement program; some reported that HRSA funds were spread thinly across many hospitals and other health care entities



Hospital Representatives Reported Factors Hindering Implementation of HRSA’s Program

Hospital representatives reported two factors that hindered efforts to implement the cooperative agreements

- Redirection of resources to the National Smallpox Vaccination Program
- Delays caused by lengthy contracting processes for distributing funds from the states to hospitals



Concluding Observations

Although states' progress fell short of 2002 program goals, CDC's and HRSA's cooperative agreement programs have enabled states to make much needed improvements in the public health and health care capacities critical for preparedness

States are more prepared now than they were prior to these programs, but much remains to be accomplished

CDC Focus Areas, Critical Capacities, and Critical Benchmarks (2002)

To strengthen public health preparedness, CDC identified focus areas for states to improve their public health capacity. Within each focus area, CDC identified the specific capacities that are critical for states to be prepared to respond to a bioterrorist event or other public health emergency. To guide states in building these critical capacities, CDC specified a number of requirements for the 2002 cooperative agreements, and designated some of them as critical benchmarks. Table 1 lists the focus areas and their associated critical capacities and critical benchmarks.

Table 1: CDC Focus Areas, Critical Capacities, and Critical Benchmarks for the 2002 Cooperative Agreements

Focus area	Critical capacity	Critical benchmark
Focus area A:	Preparedness Planning and Readiness Assessment	
	<p>Critical capacity #1: To establish a process for strategic leadership, direction, coordination, and assessment of activities to ensure state and local readiness, interagency collaboration, and preparedness for bioterrorism, other outbreaks of infectious disease, and other public health threats and emergencies.</p>	<p>Critical benchmark #1: Designate an executive director of the bioterrorism preparedness and response program.</p> <p>Critical benchmark #2: Establish a bioterrorism advisory committee.</p>
	<p>Critical capacity #2: To conduct integrated assessments of public health system capacities related to bioterrorism, other infectious disease outbreaks, and other public health threats and emergencies to aid and improve planning, coordination, and implementation.</p>	<p>Critical benchmark #3: Assessment of emergency preparedness and response capabilities.</p> <p>Critical benchmark #4: Assessment of statutes, regulations, and ordinances that provide for credentialing, licensure, and delegation of authority for executing emergency public health measures.</p>
	<p>Critical capacity #3: To respond to emergencies caused by bioterrorism, other infectious disease outbreaks, and other public health threats and emergencies through the development and exercise of a comprehensive public health emergency preparedness and response plan.</p>	<p>Critical benchmark #5: Development of a statewide response plan and provisions for exercising the plan.</p> <p>Critical benchmark #6: Development of regional response plans.</p>
	<p>Critical capacity #4: To ensure that state, local, and regional preparedness for and response to bioterrorism, other infectious outbreaks, and other public health threats and emergencies are effectively coordinated with federal response assets.</p>	<p>Critical benchmark #7: Develop an interim plan to receive and manage items from the Strategic National Stockpile (SNS).</p>
	<p>Critical capacity #5: To effectively manage the CDC SNS, should it be deployed—translating SNS plans into firm preparations, periodic testing of SNS preparedness, and periodic training for entities and individuals that are part of SNS preparedness.</p>	<p>No critical benchmarks were identified for 2002 cooperative agreements.</p>

Focus area	Critical capacity	Critical benchmark
Focus area B: Surveillance and Epidemiology Capacity		
	Critical capacity #6: To rapidly detect a terrorist event through a highly functioning, mandatory reportable disease surveillance system, as evidenced by ongoing timely and complete reporting by providers and laboratories, especially of illnesses and conditions possibly resulting from bioterrorism, other infectious disease outbreaks, and other public health threats and emergencies.	Critical benchmark #8: Develop a system to receive and evaluate urgent disease reports on a 24-hour-per-day, 7-day-per-week basis.
	Critical capacity #7: To rapidly and effectively investigate and respond to a potential terrorist event as evidenced by a comprehensive and exercised epidemiologic response plan that addresses surge capacity, delivery of mass prophylaxis and immunizations, and pre-event development of specific epidemiologic investigation and response needs.	Critical benchmark #9: Assess current epidemiologic capacity and achieve the goal of at least one epidemiologist for each metropolitan statistical area.
	Critical capacity #8: To rapidly and effectively investigate and respond to a potential terrorist event, as evidenced by ongoing effective state and local response to naturally occurring individual cases of urgent public health importance, outbreaks of disease, and emergency public health interventions such as emergency chemoprophylaxis or immunization activities.	No critical benchmarks were identified for 2002 cooperative agreements.
Focus area C: Laboratory Capacity—Biologic Agents		
	Critical capacity #9: To develop and implement a statewide program to provide rapid and effective laboratory services in support of the response to bioterrorism, other infectious disease outbreaks, and other public health threats and emergencies.	Critical benchmark #10: Develop a plan to improve working relationships and communication between clinical labs and higher level Laboratory Response Network (LRN) ^a labs.
	Critical capacity #10: As an LRN member, to ensure adequate and secure laboratory facilities, reagents, and equipment to rapidly detect and correctly identify biological agents likely to be used in a bioterrorist incident.	No critical benchmarks were identified for 2002 cooperative agreements.
Focus area D: Laboratory Capacity—Chemical Agents		
	No critical capacities/benchmarks were identified for 2002 cooperative agreements.	
Focus area E: Health Alert Network/Communications and Information Technology		
	Critical capacity #11: To ensure effective communications connectivity among public health departments, health care organizations, law enforcement organizations, public officials, and others by: (a) continuous, high-speed connectivity to the Internet; (b) routine use of e-mail for notification of alerts and other critical communication; and (c) a directory of public health participants (including primary clinical personnel), their roles, and contact information covering all jurisdictions.	Critical benchmark #11: Ensure that 90 percent of the population is covered by the Health Alert Network. Critical benchmark #12: Develop a communications system that provides a 24-hour-per-day, 7-day-per-week flow of critical health information.
	Critical capacity #12: To ensure a method of emergency communication for participants in public health emergency response that is fully redundant with e-mail.	No critical benchmarks were identified for 2002 cooperative agreements.
	Critical capacity #13: To ensure the ongoing protection of critical data and information systems and capabilities for continuity of operations.	No critical benchmarks were identified for 2002 cooperative agreements.

Focus area	Critical capacity	Critical benchmark
	Critical capacity #14: To ensure secure electronic exchange of clinical, laboratory, environmental, and other public health information in standard formats between the computer systems of public health partners.	No critical benchmarks were identified for 2002 cooperative agreements.
Focus area F: Risk Communication and Health Information Dissemination		
	Critical capacity #15: To provide needed health/risk information to the public and key partners during a terrorism event by establishing critical baseline information about the current communication needs and barriers within individual communities, and identifying effective channels of communication for reaching the general public and special populations during public health threats and emergencies.	Critical benchmark #13: Develop an interim plan for risk communication and information dissemination.
Focus area G: Education and Training		
	Critical capacity #16: To ensure the delivery of appropriate education and training to key public health professionals, infectious disease specialists, emergency department personnel, and other health care providers in preparedness for and response to bioterrorism, other infectious disease outbreaks, and other public health threats and emergencies, either directly or through the use (where possible) of existing curricula and other sources, including schools of public health and medicine, academic health centers, CDC training networks, and other providers.	Critical benchmark #14: Prepare a timeline to assess training needs.

Source: CDC.

^aCDC established the LRN to maintain state-of-the-art capabilities for biological agent identification and characterization. The LRN is a multilevel system designed to link state and local public health laboratories with advanced capacity clinical, military, veterinary, agricultural, water, and food-testing laboratories.

GAO Contact and Staff Acknowledgments

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Acknowledgments

The following staff members made important contributions to this work: Angela Choy, Chad Davenport, Maria Hewitt, Krister Friday, and Nkeruka Okonmah.

(290293)

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