DEPARTMENT OF HEALTH AND HUMAN SERVICES

AGENCY: U.S. Department of Health and Human Services (HHS), Assistant Secretary for Preparedness and Response (ASPR), Office of Preparedness and Emergency Operations (OPEO), Division of National Healthcare Preparedness Programs (DNHPP)

FUNDING OPPORTUNITY TITLE: Announcement of Availability of Funds for the Hospital Preparedness Program

ANNOUNCEMENT TYPE: New Cooperative Agreement

Funding Opportunity Number: Not Applicable

CFDA NUMBER: 93.889

Key Dates: To receive consideration, applications **must be received** no later than 5:00 p.m. Eastern Standard Time on August 1, 2007 through one of the three application mechanisms specified in Section IV.

The application due date requirement in this announcement supersedes the instructions in the OPHS-1 form.

I. FUNDING OPPORTUNITY DESCRIPTION

1. Purpose

The Office of Preparedness and Emergency Operations (OPEO), Hospital Preparedness Program (HPP), requests applications for State and jurisdictional hospital preparedness cooperative agreements (CA), as authorized by section 2802(b) of the Public Health Service (PHS) Act, as amended by the Pandemic and All-Hazards Preparedness Act (PAHPA) (P.L. 109-417)" authorizing the Secretary of Health and Human Services (HHS) to award competitive grants or cooperative agreements to eligible entities to enable such entities to improve surge capacity and enhance community and hospital preparedness for public health emergencies. Funding for these awards is provided by the Revised Continuing Appropriations Resolution, 2007 (Public Law 110-5).

Funds from this HPP guidance will be used to build medical surge capability through associated planning, personnel, equipment, training and exercise capabilities at the State and local levels. Developing medical surge capability is a complicated process that includes many different aspects referred to in this guidance as "sub-capabilities."

Activities supported through funds under this announcement must help award recipients to meet not only the National Preparedness Goal (The Goal) established by the Department of Homeland Security (DHS) in 2005, but also the following goals as outlined in section 319C-2 of the PHS Act, as amended by the PAHPA:

- **Integration:** Insure the integration of public and private medical capabilities with public health and other first responder systems, including -
  (A) The periodic evaluation of preparedness and response capabilities through drills and exercises; and
  (B) Integrating public and private sector public health and medical donations and volunteers.

- **Medical**- Increasing the preparedness, response capabilities, and surge capacity of hospitals, other health care facilities (including mental health facilities), and trauma care and emergency medical service systems, with respect to public health emergencies. This shall include developing plans for the following:
  (A) Strengthening public health emergency medical management and treatment capabilities.
  (B) Medical evacuation and fatality management.
  (C) Rapid distribution and administration of medical countermeasures, specifically to hospital based healthcare workers and their family members or partnership entities.
  (D) Effective utilization of any available public and private mobile medical assets and integration of other Federal assets.
  (E) Protecting health care workers and health care first responders from workplace exposures during a public health emergency.

- **At-Risk Individuals-** Being cognizant of and prepared for the medical needs of at-risk individuals in their community in the event of a public health emergency. Applications must clearly articulate what at-risk individuals with medical needs are served by the partnership and the activities the partnership will undertake with respect to the needs of these individuals. Medical needs include behavioral health consisting of both mental health and substance abuse considerations. The term `at-risk individuals' means children, pregnant women, senior citizens and other individuals who have special needs in the event of a public health emergency.

- **Coordination**- Minimizing duplication of, and ensuring coordination between, Federal, State, local, and tribal planning, preparedness, response and recovery activities (including the State Emergency Management Assistance Compact). Planning shall be consistent with the National Response Plan, or any successor plan, and National Incident Management System and the National Preparedness Goal as well as any State and local plans.

- **Continuity of Operations -** Maintaining vital public health and medical services to allow for optimal Federal, State, local, and tribal operations in the event of a public health emergency

The HPP will continue to support capabilities-based planning by setting priorities that must be met by the end of the budget period (September 1, 2007 – August 8, 2008). In an

effort to continue strengthening healthcare medical surge capability across the nation, this announcement mandates five (5) sub-capabilities that all award recipients are expected to possess by August 8, 2008:

A. Interoperable communication system
B. Bed tracking system
C. ESAR-VHP System
D. Fatality management plans
E. Hospital evacuation plans

Training, exercises and corrective actions, National Incident Management System (NIMS) compliance and needs of at-risk populations shall be considered components of each sub-capability addressed by the States and jurisdictions and incorporated into all work on the sub-capabilities.

2. Background

National Preparedness Goal (The Goal)

The goal is a collective vision for National preparedness, and establishes National Priorities to guide preparedness efforts at the Federal, State, local and tribal levels. The Goal establishes a framework that guides entities at all levels of government in the development and maintenance of capabilities to prevent, protect against, respond to, and recover from major events, including Incidents of National Significance as defined in the National Response Plan (NRP). Additionally, the Goal will assist entities at all levels of government in the development and maintenance of the capabilities to identify, prioritize, and protect critical infrastructure.

The Goal outlines seven priorities that fall into two categories: (1) three overarching priorities and (2) four capability-specific priorities.

Overarching:
1. Expanded Regional Collaboration
2. Implement the NIMS and NRP
3. Implement the National Infrastructure Protection Plan (NIPP)

Capability-specific
4. Strengthen Information Sharing and Collaboration Capabilities
5. Strengthen Interoperable Communications Capabilities
6. Strengthen Chemical, Biological, Radiological/Nuclear, and Explosive (CBRNE) Detection, Response, and Decontamination Capabilities
7. Strengthen Medical Surge and Mass Prophylaxis

Integrating Preparedness Activities

In June 2005, DHS and HHS established a Joint Grant Program Steering Committee to facilitate the integration of preparedness activities across state and local preparedness

programs managed by both Departments.

In the FY 2006 program guidances, both DHS and HHS included common language urging the integration of preparedness activities across disciplines and agencies, and also requiring a capabilities-based planning framework that leverages resources from DHS, HHS, and other Federal and State partners. Award recipients shall, to the extent practicable, ensure that activities carried out under this award are coordinated with the activities of relevant local Metropolitan Medical Response Systems (MMRS), local Medical Reserve Corps (MRC), the Cities Readiness Initiative (CRI), and local emergency plans.

In FY 2007, grantees shall continue to implement this planning framework, using the Senior Advisory Committees established to coordinate Federal preparedness programs, including those supported by the DHS, Federal Emergency Management Agency (FEMA), National Preparedness Directorate, and HHS. Examples of activities that may be addressed through collaboration at the State, local and tribal level among public safety, emergency management, health and medical communities, and non-governmental entities are:

- Developing clear public health emergency plans that delineate who will do what during each stage of a response;
- Identifying the specific competencies needed to complete the tasks associated with the operational plan;
- Implementing effective training programs that specifically support the competencies related to the public health emergency plan;
- Conducting joint exercises to meet multiple requirements from various grant programs;
- Engaging at-risk populations and/or those who represent them in preparedness planning and exercise activities; and
- Conducting joint training for local decision-makers (including government administrators, health and medical professionals, and emergency managers) on issues of joint concern, such as pandemic flu preparedness or risk communication.

DHS and HHS will continue to take steps to increase collaboration and coordination at the Federal level while supporting the enhancement of capabilities at the State and local levels. Various opportunities for collaboration among the distinct, yet related grant programs at DHS and HHS currently exist and recipients are strongly encouraged to take advantage of them. More information about possible integration may be found in Appendix A.

DHS and HHS grantees are strongly encouraged to design, conduct, and evaluate exercises collaboratively and in accordance with the Homeland Security Exercise and Evaluation Program (HSEEP). This includes collaborating in the annual Training and Exercise Plan Workshop to coordinate exercises that satisfy the requirements of DHS and HHS grants and cooperative agreements. It also includes entry of all DHS and HHS sponsored drills and exercises in the National Exercise Schedule (NEXS) System.

Joint exercises funded through DHS and HHS preparedness assistance programs may become a requirement in future grant cycles. Consequently, recipients should begin working together in the joint design and execution of exercises in anticipation of future requirements. The establishment and achievement of joint exercise activities will also begin to address recommendations outlined in the *Federal Response to Hurricane Katrina: Lessons Learned* report, which can be found at http://www.whitehouse.gov/reports/katrina-lessons-learned/.

3. Project Description

Level One Required Sub-Capabilities

To continue building on previous years' work, and to meet the applicable preparedness goals described in section 2802(b) of the PHS Act, award recipients shall use FY 2007 funding to build the following capabilities:

A. Interoperable communications system - This system shall connect the healthcare system both horizontally and vertically to the tiered response system outlined in the Medical Surge Capacity and Capability (MSCC) handbook[1] and the FY 2006 HPP program guidance (previously known as the National Bioterrorism Hospital Preparedness Program guidance).
B. Bed tracking system - This system shall be capable of reporting bed categories that are consistent with Hospital Available Beds in Emergencies and Disasters (HAvBED) requirements and definitions.
C. Emergency Systems for Advance Registration Volunteer Health Professionals (ESAR-VHP) - Recipients shall have a fully operational Emergency System for the Advance Registration of Volunteer Health Professionals (ESAR-VHP) system.
D. Fatality management plans - all participating hospitals must possess and exercise fatality management plans that are integrated into the local jurisdiction and State plans for the disposition of the deceased. States should work closely with hospitals to ensure integration of these plans.
E. Hospital evacuation plans - all participating hospitals must possess and exercise evacuation plans that are integrated in the local jurisdiction and State plans for moving patients. States should work closely with hospitals to ensure integration of these plans.

A. Interoperable Communications System

Since FY 2003 healthcare entities, public health and other response partners have been directed to build redundant communications systems with multiple communication technologies that would ensure connectivity and operability in the event of a public health emergency.

[1] Institute for Public Research. Medical Surge Capacity and Capability: A Management System for Integrating Medical and Health Resources During Large-Scale Emergencies. Alexandria: The CNA Corporation, 2004.

During FY 2007, recipients shall build or complete development of an operational redundant communication system that is capable of communicating both horizontally between healthcare providers and vertically with the jurisdiction incident command structure as described in the tiered response system outlined in the MSCC handbook and in the HPP FY 2006 guidance. The system shall link all health related organizations that participate in the program and deemed necessary to the State and local jurisdiction health and medical response operations plan, including law enforcement, public works and others. This system should have the ability to exchange voice and/or data with all partners on demand, in real time, when needed, and as authorized in the operational plans developed by the State and local jurisdictions.

All systems shall meet SAFECOM requirements for communications interoperability, as established in April 2004 by DHS, and introduced in the FY 2006 HPP guidance. SAFECOM defines the future requirements for crucial voice and data communications in day-to-day, task force and mutual aid operations, and establishes parameters around owned or leased radio equipment use.

When procuring equipment for communication system development and expansion, a standards-based approach should be used to support multi-jurisdictional and multi-disciplinary interoperability. Specifically, all new voice systems should be compatible with the ANSI/TIA/EIAA-102 Phase 1 (Project 25 or P25) SAFECOM suite of standards. Further information about SAFECOM requirements can be found at: http://www.safecomprogram.gov .

Funding requests by agencies to replace or add radio equipment to an existing non- P25 system will be considered if there is an explanation as to how their radio selection will allow for improving interoperability or eventual migration to interoperable systems. This guidance does not preclude funding of non-Project 25 equipment when there are compelling reasons for using other solutions. Absent these compelling reasons, SAFECOM intends that Project 25 equipment will be preferred for digital systems to which the standard applies. The SAFECOM grant guidance materials are available in their entirety on the SAFECOM website in the electronic library at: http:///www.safecomprogram.gov OR http://www.safecomprogram.gov/SAFECOM/library/grant/1016_safecomgrant.htm.

B. Bed Tracking System

States are required to complete development of an operational bed tracking system compatible with the HAvBED data standards and definitions. Systems may meet this requirement in one of two ways:

1) States may choose to use the HAvBED web-portal to enter their bed data directly to the HHS SOC. Data is to be reported in aggregate by the State, therefore the State must have a system that collects the data from the participating hospitals, or

2) States may use existing systems and ensure they are compatible with the requirements and definitions set by HAvBED to ensure seamless linkage to the web-based HAvBED system housed at the HHS SOC.

Either way the State chooses to report the data, the system must adhere to the following requirements and definitions:

1. Requirements

a) Report aggregate State level data to the HHS SOC no more often than twice daily during emergencies. The frequency of data required from the hospitals is dependent on the incident. The time necessary for data entry must be minimized so that it does not interfere with the other work responsibilities of the hospital staff during a mass casualty incident (MCI). Ideally, all institutions would enter data at the same time on similar days in order to reduce variability due to daily and weekly fluctuations in bed capacity.

i. Possess the following Hospital Identification Information:
ii. Hospital Name
iii. Contact Name
iv. Street Address
v. City
vi. State
vii. Zip Code
viii. Area Code
ix. Local Telephone Number
x. County

b) Report on the following categories as defined in the HHS HAvBed system Vacant / Available Bed Counts:
i. Intensive Care Unit (ICU)
ii. Medical and Surgical (Med/Surge)
iii. Burn Care
iv. Peds ICU
v. Pediatrics (Peds)
vi. Psychiatric (Psych)
vii. Negative Pressure Isolation
viii. Emergency Department Divert Status
ix. Decontamination Facility Available
x. Ventilators Available

2. Bed Definitions

a) Vacant/Available Beds: Beds that are vacant and to which patients can be transported immediately. These must include supporting space, equipment, medical material, ancillary and support services, and staff to operate under

normal circumstances. These beds are licensed, physically available, and have staff on hand to attend to the patient who occupies the bed.

b) Adult Intensive Care (ICU): Can support critically ill/injured patients, including ventilator support.
c) Medical/Surgical: Also thought of as "Ward" beds.
d) Burn or Burn ICU: Either approved by the American Burn Association or self-designated. (These beds should not be included in other ICU bed counts.)
e) Pediatric ICU: The same as adult ICU, but for patients 17 years and younger
f) Pediatrics: Ward medical/surgical beds for patients 17 and younger
g) Psychiatric: Ward beds on a closed/locked psychiatric unit or ward beds where a patient will be attended by a sitter.
h) Negative Pressure/Isolation: Beds provided with negative airflow, providing respiratory isolation. Note: This value may represent available beds included in the counts of other types.
i) Operating Rooms: An operating room that is equipped and staffed and could be made available for patient care in a short period.

The HHS SOC will accept data only from the States and not jurisdictions inside a State. Jurisdictions receiving funding from this program should work closely with the respective State to ensure hospitals in the jurisdiction participate in the reporting of bed availability to the State.

Use of these standardized definitions and estimates of future bed availability will provide greater consistency among hospitals in reporting bed availability information. Further information on the HAvBED system can be found at http://www.ahrq.gov/research/havbed/.

Award recipients should note that the HHS SOC plans on conducting a nationwide exercise involving HAvBED reporting ability by the States. All States will be expected to participate in this exercise to determine the reporting capability across the country. Further details will be made as they become available.

C. ESAR-VHP

Recipients shall have a fully operational Emergency System for the Advance Registration of Volunteer Health Professionals (ESAR-VHP) system by August 8, 2008.

The purpose of the ESAR-VHP program is to establish a national network of State-based programs to effectively facilitate the use of volunteers in local, territorial, State, and Federal emergency responses. The experiences gained through the development of the ESAR-VHP program and efforts to respond to Hurricane Katrina have shown that State ESAR-VHP programs must be more than an electronic system for registering volunteers if they are to successfully support the use of health professional volunteers at all tiers of response. In addition to electronic registries, State ESAR-VHP programs must work to ensure program viability and operability through the development of plans to: 1) recruit and retain volunteers, 2) coordinate with other volunteer health professional/emergency

preparedness entities; and 3) link State ESAR-VHP programs with State emergency management authorities to ensure effective movement and deployment of volunteers in all tiers of response.

To help States develop their ESAR-VHP programs, a draft set of *ESAR-VHP Compliance Requirements* defining the capabilities of such a program was developed and released for comment via the ESAR-VHP listserv on November 2, 2006. Comments were received and incorporated into the second draft of the *ESAR-VHP Compliance Requirements* document attached in Appendix B. **To be fully operational, ESAR-VHP systems must meet compliance requirements 1-6.**

The final version of the compliance document and specific guidance on how to meet the compliance requirements will be included in the draft *FY 2007 ESAR-VHP Technical and Policy Guidelines, Standards and Definitions* (Guidelines) to be released in the summer of 2007. However, the Guidelines are intended to be a living document. It is anticipated that sections of the Guidelines will be continuously refined and updated as new information is available.

D. Fatality Management

Award recipients shall begin focusing or continue working on the development of fatality management plans with healthcare entities, public health departments, and the State Chief Medical Examiners office and/or jurisdictional Medical Examiner/Coroners. States are encouraged to build plans based on the estimated number of fatalities they can expect. Planning should address the need for expanded refrigerated storage capacity and body bags for deaths occurring in hospitals and delineate roles and responsibilities of other agencies involved in mass fatality management under both natural and criminal/terrorist circumstances. Recipients should consider the cultural, religious, legal and regulatory issues involved with the respectful retrieval, tracking, transportation, identification, death certificate completion, and disposition of the deceased under conditions of a natural disease outbreak, natural disaster, and criminal/terrorist events.

E. Hospital Evacuation

Award recipients shall begin focusing or continue working on the development of hospital plans to ensure the safety of patients, visiting family members and staff in the hospital during an emergency. States and local partners shall weigh the options of hospital evacuation or shelter-in-place to accomplish this important task. Either option requires planning at the community level to ensure the safety and health of the people in the hospital.

Proactive planning and preparation will ensure successful operational plans. States should develop plans based on a hazard vulnerability assessment (HVA) done at the community and state level to identify the imminent threat to life in the area. The nature of the vulnerability and the hazards posed by the vulnerability should help the States and healthcare entities plan for the event. States should build their plans based on the

personnel, equipment and systems, planning, and training needed to ensure the safe and respectful movement of patients, the safety of personnel and family members in the hospital. Plans for evacuating hospitals should be included in exercises as appropriate.

Level Two Sub-Capabilities

Award recipients can use funds to address level two sub-capabilities only if they can clearly demonstrate and provide a statement that all Level-One Capabilities have either already been met or are prioritized in such a way that they will be completed by August 8, 2008. Once that determination has been made, States may build workplans and dedicate funding around the following level two sub-capabilities for FY 2007:

A. Alternate Care Sites (ACS)

Establishment of alternate care sites – ACS (e.g., schools, hotels, airport hangars, gymnasiums, armories, stadiums, convention centers) is critical to providing supplemental surge capacity to the healthcare system, with the goal of providing care and allocating scarce equipment, supplies, and personnel. Planning should therefore include thresholds for altering triage algorithms and otherwise optimizing the allocation of scarce resources. Effective planning and implementation will depend on close collaboration among State and local health departments (e.g., State Public Health Agencies, State Medicaid Agencies, State Survey Agencies), provider associations, community partners, and neighboring and regional healthcare facilities. States should use FY 2007 funding to continue work begun in previous years and continue to identify gaps regarding ACS within its current system.

Use of existing buildings and infrastructure as ACS is the most probable solution should a surge medical care facility need to be opened. When identifying sites, States should consider how ACS will interface with other State and Federal assets. Federal assets may require an "environment of opportunity" for set up and operation and may not be available for 72 hours. Therefore, it is critical that healthcare, public health systems and emergency management agencies work with other response partners when choosing a facility to use as an ACS. Many of the partners may have already identified sites that will be used during an event (i.e., American Red Cross). The Agency for Healthcare Research and Quality (AHRQ) has developed a tool that serves to identify a facility within a region that could be utilized for the purpose of an ACS. This tool can be found at http://www.ahrq.gov/research/altsites/alttool1.htm.

B. Mobile Medical Assets

Awardees must have the ability to provide care outside of the hospital or healthcare system. Use of mobile medical assets may be an option for some jurisdictions until large population centers can be evacuated to outlying less affected areas with intact healthcare delivery systems. States may continue to develop or begin to establish plans for a mobile medical capability, working with State and local stakeholders to ensure integration of plans and sharing of resources. Mobile Medical plans must address staffing, supply and re-supply, and training of associated personnel.

C. Pharmaceutical Caches

Each award recipient may develop an operational plan that assures storage and distribution of critical medications through the supply chain during an emergency for healthcare providers and their families in a timely manner. Although many States should already have caches in place due to the multiple years of funding for this activity, States may continue to establish or enhance caches of specific categories of pharmaceuticals available on-site in hospitals, cached within regions or at the State level that would be accessible during an event. FY 2007 funding can be used to purchase pharmaceuticals only if the purchases are clearly linked to a Hazard Vulnerability Assessment (HVA) and gaps identified that show where and why sufficient quantities do not currently exist.

Caches should be placed in strategic locations based on the same HVA and stored in appropriate conditions to rotate stock and maximize shelf life. Designation of emergency contacts that will have access to the cache in addition to a contingency plan for access, should be developed. On-site caches or an increase in stock levels within a healthcare facility would assure immediate access to the medications. It is understood that hospital space is limited; therefore, caches may be stored on a regional or state-wide basis. If caches are located regionally or at the State level, a plan should be developed that would assure the integrity of the supply line and how it will be managed in an event. Mutual aid agreements may need to be developed to assure that access to the caches is timely for all healthcare centers. States should coordinate these efforts through the Strategic National Stockpile (SNS).

States are encouraged to work with stakeholders (Schools of Pharmacy, State Boards of Pharmacy, hospitals, pharmacy organizations, public health organizations and academia) for guidance and assistance in identifying medications that may be needed and a plan to provide access to all healthcare partners during an event. States should also work with these stakeholders to develop training and education for healthcare providers on the available assets and how those assets would be utilized to maximize response efforts.

Allowable purchases

The following are allowable purchases to provide for hospital personnel (medical and ancillary), hospital based emergency first responders and their families (both pediatric doses and adult doses shall be considered). States may consider a phased approach for pharmaceutical purchases in the following order of precedence:

1) Antibiotics for prophylaxis and post-exposure prophylaxis to all biological agents for at least three days.

2) Nerve agent antidotes either with or without the use of CHEMPACK:

   Funding for the initial cost of the CHEMPACK cache site modification and the sustainment over time of the cache sites can be defrayed by a variety of funding

sources including local, state, and other federal agencies or programs including the Metropolitan Medical Response System (MMRS) and private funds. In previous years, the HPP has joined with the Division of the Strategic National Stockpile (DSNS) Program CHEMPACK Project to support these caches and the use of funds (up to $2500 per CHEMPACK site) to offset reasonable costs associated with the retrofit of CHEMPACK cache storage facilities to meet the Food and Drug Administration's (FDA) Shelf Life Extension Program (SLEP) requirements.

Up to $2500 of FY 2007 funds can be used to retrofit newly developed CHEMPACK sites. In addition, for sites that have already been retrofitted, funds can be used to continue the support of maintenance costs (e.g. phone line, security cameras, etc.).

3) Antivirals:

In general, the purchase of antivirals is allowed through the HPP, however, purchases are limited to treatment purposes only and are limited to coverage for hospital staff and their family members and hospital based EMS providers and their family members. Purchases for prophylaxis and for populations outside of those identified are not allowable at this time. Plans should consider the following: cost, dispensing prioritization, storage location, rotation of stock and distribution mechanisms.

Purchases must be coordinated with the CDC and their efforts through the Pandemic Influenza Supplemental Funding and the HHS Subsidy Program.

4) Medications needed for exposure to other threats (i.e., radiological events).

D. Personal Protective Equipment

Each recipient should ensure adequate types and amounts of personal protective equipment (PPE) to protect current and additional healthcare personnel during an incident. The amount should be tied directly to the number of healthcare personnel needed to support bed surge capacity during an MCI. In addition, recipients should develop contingency plans to establish sufficient numbers of PPE to protect both the current and additional healthcare personnel expected in support of the events of highest risk identified through a State-based HVA or assessment work.

The level of PPE should be established based on the HVA and the level of decontamination that is planned in each region. For example, those hospitals that have identified probable high-risk scenarios (i.e., the hospital functions near an organophosphate production plant with a history of employee contamination incidents) should have higher levels of PPE, and more stringent decontamination processes.

Equipment purchased under this sub-capability should be interoperable with equipment purchased with funds from the DHS State Homeland Security Grant Program (SHSGP)

Standardized Equipment List (SEL) for first responders. This list is accessible through the DHS Responder Knowledge Base. Please login as a guest on their website at https://www.rkb.mipt.org.

E. Decontamination

Each recipient should ensure adequate portable or fixed decontamination system capability exists Statewide for managing adult and pediatric patients as well as healthcare personnel, who have been exposed during a chemical, biological, radiological, or explosive incident. The level of capability should be in accordance with the number of required surge capacity beds expected to support the events of highest risk identified through a State-based HVA or assessment work. All decontamination assets shall be based on how many patients/providers can be decontaminated on an hourly basis.

According to the *Occupational Safety and Health Agency (OSHA) Best Practices for Hospital-Based First Receivers of Victims from Mass Casualty Incidents Involving the Release of Hazardous Substances:*

> "*All participating hospitals shall be capable of providing decontamination to individual(s) with potential or actual hazardous agents in or on their body. It is essential that these facilities have the capability to decontaminate more than one patient at a time and be able to decontaminate both ambulatory and stretcher bound patients. The decontamination process must be integrated with local, regional and State planning.*"

The OSHA best practices guide can be found at http://www.osha.gov/dts/osta/bestpractices/firstreceivers_hospital.pdf.

Equipment purchased under this sub-capability should be interoperable with equipment purchased with funds from the DHS State Homeland Security Grant Program (SHSGP) for first responders. This list is accessible through the DHS Responder Knowledge Base. Please login as a guest on their website at https://www.rkb.mipt.org.

In addition, the American Society for Testing and Materials (ASTM) International Subcommittee Decontamination (E54.03) has established tasks groups around decontamination standards development:

- E54.03.01 – Biological Agent Decontamination;
- E54.03.02 – Chemical Agent Decontamination;
- E54.03.03 – Radionuclide and Nuclear Decontamination; and
- E54.03.04 – Mass Decontamination Operations.

Please visit the ASTM website at http://www.astm.org.

Overarching Requirements

The following four sub-capabilities must be incorporated into the development and maintenance of **all** the sub-capabilities being built in the States: (1) NIMS; (2) Education and Preparedness Training; (3) Exercises, Evaluation and Corrective Actions; and (4)

Needs of At-Risk Population.

A. National Incident Management System

In accordance with Homeland Security Presidential Directive (HSPD) -5, NIMS provides a consistent approach for Federal, State, and local governments to work effectively and efficiently together to prepare for, prevent, respond to, and recover from domestic incidents, regardless of cause, size, or complexity. As a condition of receiving HPP funds, recipients shall be NIMS compliant, and work to assure sub-recipients continue adopting and implementing NIMS compliance activities as outlined in FEMA, National Integration Center, Incident Management Systems Division document entitled "NIMS Implementation Activities for Hospitals and Healthcare Systems" found at http://www.fema.gov/pdf/emergency/nims/imp_hos.pdf.

In FY 2006, States were required to complete elements 7, 9, 10 and 11. Please provide a statement that confirms the State has met these requirements as described in the FY 2006 HPP guidance, or funds will be withheld until the requirement is met.

In accordance with the eligibility and allowable uses of funds awarded through this announcement, recipients shall direct FY 2007 funding towards finishing the remaining NIMS implementation activities for hospitals and healthcare systems by August 8, 2008. These NIMS compliance activities can be found in Appendix C of this document and at the FEMA, National Integration Center, Incident Management Systems Division document entitled "NIMS Implementation Activities for Hospitals and Healthcare Systems" found at http://www.fema.gov/pdf/emergency/nims/imp_hos.pdf.

Hospital and healthcare systems refer to all facilities that receive medical and trauma emergency patients on a daily basis. These terms do not include nursing homes, assisted living communities, long-term care facilities, and specialty hospitals (i.e. psychiatric, rehabilitation facilities). However, these facilities are strongly encouraged to work with local hospitals and emergency management to integrate applicable elements of NIMS Implementation (i.e. planning, communications, resources).

B. Education and Preparedness Training

Recipients shall assure that education and training opportunities or programs exist for adult and pediatric pre-hospital, hospital, and outpatient healthcare personnel that will respond to a terrorist incident or other public health emergency, around the sub-capabilities described in the FY 2007 HPP guidance. Also, recipients shall undertake activities to ensure all training opportunities or programs (including those in local health departments, major community healthcare institutions, emergency response agencies, public safety agencies, etc.) collectively enhance the ability of workers to respond in a coordinated, non-overlapping manner that minimizes duplication and fills gaps in the event of a bioterrorist attack or other public health emergency.

The award recipient shall describe how the education and training activities discussed in

their workplan will be linked to exercises/drills and with the overall State/jurisdiction preparedness plan. FY 2007 funds may be used to offset the cost of hospital personnel participation in training, around sub-capability development, to prepare staff with the necessary knowledge, skills and abilities to perform/enhance the capability, in addition to participating in drills and exercises. The HPP fully expects that recipients will work closely with their sub-recipients in determining cost-sharing arrangements that will facilitate the maximum number of personnel being able to participate in drills and exercises.

As in previous years, release time for staff to attend trainings, drills and exercises is an allowable cost under the cooperative agreement. **Salaries for back filling of personnel are not allowed.**

Recipients shall develop a system for tracking all HPP funded training, drills and exercises. This system shall detail the subject matter, the date of the training, the objectives of the training, and the number trained by healthcare specialty.

C. Exercises, Evaluations and Corrective Actions

To meet the applicable goals described in section 2802(b) of the PHS Act, all applications must address plans to ensure the integration of public and private medical capabilities with public health and other first responder systems, including evaluation of State and local preparedness and response capabilities through drills and exercises. In FY 2007, awardees shall continue to use the Senior Advisory Committees established to coordinate Federal preparedness programs and encourage collaboration at the State and local level among public safety, emergency management, health and medical communities to develop an exercise plan for conducting joint exercises to meet multiple requirements from various grant programs. Exercise planning must also include special needs populations and/or those who represent them in preparedness planning and exercise activities

ASPR, CDC and G&T grantees are strongly encouraged to design and conduct exercises collaboratively. This includes collaborating in the annual Training and Exercise Plan Workshop to facilitate the design and execution of exercises to satisfy the requirements of DHS and HHS grants and cooperative agreements. The Department of Homeland Security (DHS) has developed a centralized, secure web-based scheduling system developed to give visibility on the variety of National, Federal, State, territorial and local-level exercises. The National Exercise Schedule (NEXS) enables leadership, exercise planners and exercise schedulers to see opportunities for scheduling, de-conflicting, and synchronizing exercises with neighbors, and others. Exercise synchronization facilitates better allocation of resources and limits the potential for exercise fatigue. HPP program coordinators should contact their State Administrative Agent (SAA) about entering exercise information into the NEXS.

<u>Exercise Requirements</u>

The sub-capabilities outlined in this cooperative agreement guidance should be the main

focus of the exercises supported by this funding, although this goal can be accomplished in conjunction with larger exercises. The type of exercise that best meets a jurisdiction's requirements is identified through analysis of the stated exercise purpose, proposed objectives, experience, operations, historical precedence, and recommended levels of participation. HHS recommends that awardees exercise plans build from the bottom up, by beginning with a basic tabletop exercise to identify needs and gaps, building up to a functional exercise. A Full-Scale exercise should only be considered once the State has conducted both a Tabletop and a functional exercise in order to obtain the most benefit from a Full-Scale exercise.

States shall develop and submit an exercise plan that includes conducting at least one functional exercise during this funding cycle. The exercise plan must include not only a proposed exercise schedule, but a discussion of the State plan for a comprehensive exercise program that includes plans for development, conduct, evaluation and improvement planning.

Healthcare entities, local partners and Healthcare Facilities Partnerships (HFP) must be involved in planning, conducting, participating in and evaluating preparedness exercises and drills that occur at sub-State regional and State levels. As with all other activities discussed in this guidance, state exercise plans must demonstrate coordination with relevant local entities such as local healthcare partnerships, MMRS, local Medical Reserve Corps (MRC), and the Cities Readiness Initiative (CRI).

Additional activities for funding consideration under this capability include:

- Enhancement and upgrade of emergency operations plans based on the exercise evaluation and improvement plan.
- Release time for staff to attend drills and exercises. **Salaries for back filling are not allowed costs under the cooperative agreement.**
- Costs associated with development of exercises and drills.

States must submit the exercise plan as Appendix A. Further information is listed under the Content section of this guidance.

<u>The Homeland Security Exercise and Evaluation Program (HSEEP)</u>

During the FY 2008 program and budget year, exercise programs funded all or in part by HHS HPP cooperative agreement funds will have to demonstrate full compliance with the Homeland Security Exercise and Evaluation Program (HSEEP). **In anticipation of this requirement HHS strongly encourages all awardees in FY2007 to begin developing an exercise program capable of being fully compliant with HSEEP in order to meet the requirements of the FY2008 program year.**

The HSEEP is a capabilities and performance-based exercise program. The intent of HSEEP is to provide common exercise policy and program guidance capable of constituting a national standard for all exercises. HSEEP includes consistent terminology

that can be used by all exercise planners, regardless of the nature and composition of their sponsoring agency or organization.

HSEEP compliance is defined as adherence to specific HSEEP-mandated practices for exercise program management, design, development, conduct, evaluation and improvement planning. In order for an entity to be considered HSEEP compliant an awardee will have to satisfy four distinct performance requirements:

1) Conduct an annual training and exercise workshop and develop and maintain a multi-year training and exercise plan.
2) Planning and conducting exercises in accordance with the guidelines set forth in HSEEP Volumes I-III.
3) Developing and submitting a properly formatted After-Action/Improvement Plan (AAR/IP). The format for the AAR/IP is found in HSEEP Volume III.
4) Tracking and implementing corrective actions identified in the AAR/IP.

Additional information on HSEEP is available at https://hseep.dhs.gov/.

D. Needs of At-Risk Population

Considerations for at-risk populations must be addressed when developing response plans. All goals, objectives and activities proposed in the application should account for the public health and medical needs of at-risk individuals. Medical needs include behavioral health consisting of both mental health and substance abuse considerations. Section 2802(b)(4)(B) of the PHS Act defines at-risk population as, "children, pregnant women, senior citizens and other individuals who have special needs in the event of a public health emergency."

4. Additional Considerations

A. Partnership Development

States are strongly encouraged to continue and in some cases begin developing healthcare partnerships to build community/regional medical capability to successfully provide care during an MCI. Partnerships are expected to unify and strengthen the efforts of response plans in these areas by proactively assigning roles and responsibilities to participating partners and coordinate all plans and preparedness efforts with the State, as outlined in section 319C-2 of the PHS Act and the companion guidance for the Healthcare Facilities Partnership (HFP) Program.

Partnerships should actively engage healthcare and other community partners to plan, develop, and exercise a local community response capability. When facilitating the development of Partnerships, States should refer to section 319C-2 of the PHS Act and the companion competitive HFP guidance as a guide for developing membership for the coalition. Partnerships must consist of:

- one or more hospitals, at least one of which shall be a designated trauma center, consistent with section 1213(c) of the PHS Act;

- one or more other local healthcare facilities, including clinics, health centers, primary care facilities, mental health centers, mobile medical assets, or nursing homes; and
- one or more political subdivisions;
- one or more States; or
- one or more States and one or more political subdivision

Partnerships are to be developed in the previously established sub-state regions. For States that do not have trauma centers in sub-state regions, partnerships may include trauma centers in neighboring States that are willing to become partners.

Since partnerships focus on promoting collaborative planning across competing entities, it is important that facilities belonging to one healthcare system alone do not dominate any partnership. Successful partnerships are strongly encouraged to include facilities belonging to more than one healthcare system so that the partnership adequately represents all healthcare partners in the defined geographic area.

Partnerships shall proactively plan and develop memorandums of understanding (MOUs) to share assets, personnel and information. They shall also develop plans to unify management of healthcare during a public health emergency and integrate communication with jurisdictional command in the area. Partnerships are not expected to be operational entities and replace or relieve individual organizations of their institutional responsibilities during an emergency. Instead partnerships should unify the management capability of the healthcare system to a level that will be necessary if the normal day to day operations and standard operating procedures of the health system are overwhelmed.

Partnerships shall be able to strategically:

- Integrate plans and activities of all participating partners into the jurisdictional response plan and the State response
- Increase medical response capabilities in the community
- Prepare for the needs of at-risk individuals in their community in the event of a public health emergency
- Coordinate activities to minimize duplication of, and ensure coordination between, Federal, State, local, and tribal planning, preparedness, and response activities (including the State Public Health Agency, State Medicaid Agency, State Survey Agency, and State Management Assistance Compact)
- Maintain continuity of operations in the community vertically with the local jurisdictional emergency management organizations
- Require all participating hospitals to achieve and maintain NIMS compliance outlined in the HPP FY 2006 guidance

B. Emerging Item of Interest

Critical Infrastructure Protection

Protecting the critical infrastructure and key resources (CI/KR) of the United States is

essential to the Nation's security, economic vitality, and way of life. Mandated by HSPD-7 and published in June 2006, the final NIPP Base Plan sets forth a national model to protect critical assets, systems, networks, and functions in each of the 13 critical infrastructures and 4 key resources (CI/KR) by establishing an unprecedented partnership model of private sector and government partners. The protection of CI/KR is, therefore, an essential component of the homeland security mission to make America safer, more secure, and more resilient from terrorist attacks and other natural and man-made disasters.

The NIPP completes the continuum of readiness by adding CI/KR protection to the efforts of the NPG, NRP, and NIMS. The Sector Partnership model serves each of these readiness levels, solidifying and coordinating all readiness relationships and efforts within a sector. All levels of the readiness continuum are ideally served by six broad category approaches: identifying the roles and responsibilities, building partnerships and information sharing, utilizing a risk framework, data use and protection, leveraging ongoing emergency preparedness activities, and integrating Federal protection and preparedness activities.

Applicants are not required to submit a plan for critical infrastructure protection at this time; however, this issue may be included as a requirement in future requests for proposals. For those interested in further information on the NIPP and CI/KR Protection, refer to the FEMA ICS course on the NIPP (IS-860), which is available for free online. The direct link to the course is: http://www.training.fema.gov/EMIWEB/is/is860.asp.

II. AWARD INFORMATION

The HPP will provide funding during the Federal fiscal year (FY) 2007. Approximately $ 415,032,000 will be available for the development of medical surge response capability to the 62 recipients of this award for the budget and project period of September 1, 2007 – August 8, 2008. (**Note: For the purpose of this guidance, reference to "FY 2007" is the time period September 1, 2007 – August 8, 2008)**. Awards will be issued as cooperative agreements, a form of grant that allows for substantial federal involvement. Substantial federal involvement by the HHS may include but is not limited to the following functions and activities:

1. In accordance with applicable laws, regulations, and policies, the authority to take corrective action if detailed performance specifications (e.g. activities in this funding guidance; approved work plan activities; budgets; performance measures and reports) are not met.

2. Review and approval of work plans and budgets before work can begin on a project during the period covered by this assistance or when a change in scope of work is proposed.

3. Review of proposed contracts.

4. Involvement in the evaluation of the performance of key recipient personnel supported through this assistance.

5. HHS and recipient collaboration or joint participation in the performance of the activities supported through this assistance.

6. Monitor to permit specified kinds of direction or redirection of the work because of interrelationships with other projects.

7. Substantial and/or direct operational involvement or participation during the performance of the assisted activity prior to award of the cooperative agreement to ensure compliance with such generally applicable statutory requirements as civil rights, environmental protection, and provision for the disabled.

Funding beyond this year is dependent on the availability of appropriated funds in subsequent fiscal years, satisfactory performance, and a decision that funding is in the best interest of the Federal government.

III.ELIGIBILITY INFORMATION

1. Eligible Applicants

Eligible applicants include the 50 States; the District of Columbia; the three metropolitan areas of New York City, Los Angeles County and Chicago; the Commonwealths of Puerto Rico and the Northern Mariana Islands; the territories of American Somoa, Guam and the U.S. Virgin Islands; the Federated States of Micronesia; and the Republics of Palau and the Marshall Islands. Applicants are encouraged to reach out to a broad range of healthcare partners to participate in the program. Hospitals, outpatient facilities, community health centers, poison control centers, tribal health facilities and other healthcare partners should work directly with the appropriate State health departments regarding participation in the program. To the extent that such facilities apply for State funding and provide requisite documentation, the State could award funding based on appropriate State law and procedures.

(Note: For the purposes of this guidance, the use of the term "State" may include the State, municipality, or associated territory for which a grant is received).

2. Cost sharing or matching

Cost sharing or matching is not required during FY2007.

3. Maintenance of Funding

States will be responsible for describing how they will maintain expenditures for healthcare preparedness at a level that is not less than the average of such expenditures maintained by the entity for the preceding 2 year period. These expenditures encompass all funds spent by the state for health care preparedness regardless of the

source of funds. To be eligible for funding under this announcement, a State must demonstrate in the budget narrative that they intend to budget at least, and not less than, the average of their FY 2005 and FY 2006 total spending for healthcare preparedness. See the example below:

MAINTENANCE OF FUNDING: EXAMPLE

STATE 1 EXPENDITURES - HEALTH CARE PREPAREDNESS

	STATE	FEDERAL	TOTAL
FY 05	$1,000,000	$4,000,000	$5,000,000
FY 06	$1,200,000	$3,500,000	$4,700,000
		AVERAGE	$4,850,000

FOR FY 07, STATE 1 SHALL MAINTAIN EXPENDITURES FOR HEALTH CARE PREPAREDNESS OF AT LEAST $4,850,000.

IV. APPLICATION AND SUBMISSION INFORMATION

1. Address to Request Application Package

Application kits may be obtained by accessing Grants.gov website at http://www.grants.gov or the Grant Solutions System website at www.GrantSolutions.gov. To obtain a hard copy of the application kit, contact WilDon Solutions at 1-888-203-6161. Applicants may fax a written request to WilDon Solutions at (240) 453-8823 or email the request to OPHSgrantinfo@teamwildon.com. Applications must be prepared using Form OPHS-1, which can be obtained at the websites noted above.

A Dun and Bradstreet Universal Numbering System (DUNS) number is required for all applications for Federal assistance. Organizations should verify that they have a DUNS number or take the steps necessary to obtain one. Instructions for obtaining a DUNS number are included in the application package, and may be downloaded from the OPA web site (opa.osophs.dhhs.gov/duns.html).

2. Content and Form of Application Submission

A. Form

In preparing the application, it is important to follow ALL instructions and public policy requirements provided in the application kit. Applications must be submitted on the forms supplied (OPHS-1, Revised 03/2006) and in the manner prescribed in the application kits provided by the OPHS. Applicants are required to submit an application signed by an individual authorized to act for the applicant agency or organization and to assume for the organization the obligations imposed by the terms and conditions of the

grant award. The program narrative must be printed on 8½ by 11 inch white paper, with one-inch margins, **double-spaced** with an easily readable 12-point font. All pages must be numbered sequentially not including appendices and required forms. The program narrative should not exceed 85 double-spaced pages, not including appendices and required forms. All pages, figures and tables must be numbered sequentially. Do not staple or bind the application package. Please use rubber bands or clips.

B. Content

The narrative section should be able to stand alone in terms of depth of information. This section should be succinct, self-explanatory and well organized so that reviewers can understand the proposed project. It is strongly recommended that recipients follow the outline below when writing the narrative. The narrative should be written as if the reviewer knows nothing or very little about State preparedness planning. The narrative description of the project must contain the following sections using the specified page limits:

Summary (5 pages): This section should be an abstract of the narrative sections of the application. It should be succinct, self-explanatory and well organized so that reviewers can understand the proposed project.

Description of Applicant Organization (5 pages): In this section describe the decision-making authority and structure (e.g. department, division, branch or government and any contractors that work on the project), its resources, experience, existing program units and/or those planned to be established. This description should address personnel, time and facilities and contain evidence of the organization's capacity to provide the rapid and effective use of resources needed to conduct the project, collect necessary data and evaluate it. Recipients should include a description of how they incorporate the input of their partners at the State and local level. It is recommended that applicants place an organizational chart in the Appendices of the application.

Current Status of Sub-capabilities (5 pages maximum): In this section describe the current status of the sub-capabilities that will be addressed with this funding. States should provide a statement that all Level-One Capabilities have either already been met or are prioritized in such a way that they will be completed by August 8, 2008 prior to addressing any funding that will be applied to the Level-Two Capabilities. This section should address each sub-capability separately in terms of development to date, by explaining how the sub-capability can currently support hospital medical surge capacity and capability. Describe in the narrative how the hospitals and healthcare partners have been a part of the process and their role in further development of the sub-capability. Recipients shall describe involvement of participating hospitals and how the recipient engages the hospital and healthcare partner participation in the project. As an appendix to the application recipients shall submit maps of the State indicating the sub-state regions that have been recreated to implement the program.

Needs Statement (20 pages maximum): In this section identify the sub-capabilities to be addressed separately and describe the need for further work to develop the sub-capabilities. Describe the envisioned final product in terms of personnel, training, equipment or systems, organizational, or planning needs that will be addressed with this funding. Descriptions should be detailed enough to provide sufficient information to allow the reviewer to understand the depth and breadth of the activities.

Program Outcome Objectives (40 pages maximum): In this section describe the overall goal of the project, outline the objectives to be accomplished and the activities that will occur to achieve the objective and ultimately support achievement of the goal. The goal(s), objectives and activities should describe the steps that will be taken to achieve the sub-capabilities to be addressed during this funding period. In addition describe how the final products will be tested during the full scale exercise required by this cooperative agreement.

Award recipients are strongly encouraged to consider the following guidance when completing this section. When writing goals and objectives, goals should be expressed in terms of the desired long-term impact on the overall preparedness of the State as well as reflect the program goals contained in this program announcement. When writing the outcome objectives they should be written as a statement which defines measurable results that the project expects to accomplish (e.g., operational ESAR-VHP system that meets the requirements set forth in the ESAR-VHP section of this guidance). All outcome objectives should be described in terms that are specific, measurable, achievable, realistic, and time-framed (S.M.A.R.T.).

> **S**pecific: An objective should specify one major result directly related to the program goal, state who is going to be doing what, to whom, by how much, and in what time-frame. It should specify what will be accomplished and how the accomplishment will be measured.
> **M**easurable: An objective should be able to describe in realistic terms the expected results and specify how such results will be measured.
> **A**chievable: The accomplishment specified in the objective should be achievable within the proposed time line and as a direct result of program activities and services.
> **R**ealistic: The objective should be reasonable in nature. The specified outcomes, expected results, should be described in realistic terms.
> **T**ime-framed: An outcome objective should specify a target date or time for its accomplishments. It should state who is going to be doing what, by when, etc.
> The Public Management Institute, How to Get Grants (1981).

Applications will be reviewed and assessed using these criteria for review. Award recipients are strongly encouraged to follow these criteria when writing the application.

Workplan and Timetable (5 pages maximum): In this section outline the objectives and activities that will occur to accomplish the goal. The workplan should be written in terms of who, what, when, where, why and how much. This section should include a budget justification that specifically describes how each item will support the achievement of the

proposed objectives in an 11 month and one week timeframe. Line item information must be provided to explain the costs entered on the OPHS-1. **The budget justification must clearly describe each cost element and explain how each cost contributes to meeting the project's objectives/goals. Consistent with prior years, the HPP will adhere to a fifteen-percent cost cap on all direct costs that collectively include personnel, fringe, travel, supplies and equipment, specifically for administration of the program.**

Evaluation Plan (5 pages): In this section please describe the systems and processes in place to track funding and gather data from hospitals and other partners to track expenditures, monitor progress and aggregate data in order to report performance measures and data elements in the mid-year and end-of-year reports.

Appendix A- Exercise Plan (5 pages maximum): In this section applicants should submit an exercise plan to include the following: proposed dates of exercises, type of exercise, exercise scenario, potential partners, and estimated cost. States must also;

1) Describe the role of healthcare facilities and partnerships in the exercise process to include exercise development, participation, evaluation, after action reports, and; the evaluation and improvement plan;

2) Describe how the awardee will ensure that lessons learned from after action reports are shared back to the healthcare facilities and partnerships and that the emergency operations plans of those facilities are then modified;

3) Describe how plans for training are integrated with the exercise program;

3. Submission Dates and Times

To be considered for review, applications must be received by the Office of Public Health and Science, Office of Grants Management, c/o WilDon Solutions, by 5:00 p.m., Eastern Standard Time on August 1, 2007. Applications will be considered as meeting the deadline if they are received on or before the deadline date. The application due date requirement in this announcement supersedes the instructions in the OPHS-1 form.

The Office of Public Health and Science (OPHS) provides multiple mechanisms for the submission of applications, as described in the following sections. Applicants will receive notification via mail from the OPHS Office of Grants Management confirming the receipt of applications submitted using any of these mechanisms. Applications submitted to the OPHS Office of Grants Management after the deadlines described below will not be accepted for review. Applications which do not conform to the requirements of the grant announcement will not be accepted for review and will be returned to the applicant.

While applications are accepted in hard copy, the use of the electronic application submission capabilities provided by the GrantSolutions system or the Grants.gov Website

Portal is encouraged. Applications may only be submitted electronically via the electronic submission mechanisms specified below. Any applications submitted via any other means of electronic communication, including facsimile or electronic mail, will not be accepted for review. Electronic grant application submissions must be submitted no later than 5:00 p.m. Eastern Time on the deadline date specified in the DATES section of the announcement using one of the electronic submission mechanisms specified below. All required hardcopy original signatures and mail-in items must be received by the OPHS Office of Grants Management no later than 5:00 p.m. Eastern Time on the next business day after the deadline date specified in the DATES section of the announcement.

In order to apply for new funding opportunities which are open to the public for competition, you may access the Grants.gov website portal. All OPHS funding opportunities and application kits are made available on Grants.gov. If your organization has/had a grantee business relationship with a grant program serviced by the OPHS Office of Grants Management, and you are applying as part of ongoing grantee related activities, please access GrantSolutions.gov.

Applications will not be considered valid until all electronic application components, hardcopy original signatures, and mail-in items are received by the OPHS Office of Grants Management according to the deadlines specified above. Application submissions that do not adhere to the due date requirements will be considered late and will be deemed ineligible.

Applicants are encouraged to initiate electronic applications early in the application development process, and to submit early on the due date or before. This will aid in addressing any problems with submissions prior to the application deadline.

Electronic Submissions via the Grants.gov Website Portal

The Grants.gov Website Portal provides organizations with the ability to submit applications for OPHS grant opportunities. Organizations must successfully complete the necessary registration processes in order to submit an application. Information about this system is available on the Grants.gov website at http://www.grants.gov.

In addition to electronically submitted materials, applicants may be required to submit hard copy signatures for certain Program related forms, or original materials as required by the announcement.

It is imperative that the applicant review both the grant announcement and the application guidance provided within the Grants.gov application package, to determine such requirements. Any required hard copy materials, or documents that require a signature, must be submitted separately via mail to the OPHS Office of Grants Management, and, if required, must contain the original signature of an individual authorized to act for the applicant agency and the obligations imposed by the terms and conditions of the grant award. When submitting the required forms, do not send the entire application. Complete hard copy applications submitted after the electronic submission will not be considered

for review.

Electronic applications submitted via the Grants.gov Website Portal must contain all completed online forms required by the application kit, the Program Narrative, Budget Narrative and any appendices or exhibits. All required mail-in items must received by the due date requirements specified above. Mail-In items may only include publications, resumes, or organizational documentation. When submitting the required forms, do not send the entire application. Complete hard copy applications submitted after the electronic submission will not be considered for review.

Upon completion of a successful electronic application submission via the Grants.gov Website Portal, the applicant will be provided with a confirmation page from Grants.gov indicating the date and time (Eastern Time) of the electronic application submission, as well as the Grants.gov Receipt Number. It is critical that the applicant print and retain this confirmation for their records, as well as a copy of the entire application package.

All applications submitted via the Grants.gov Website Portal will be validated by Grants.gov. Any applications deemed "Invalid" by the Grants.gov Website Portal will not be transferred to the GrantSolutions system, and OPHS has no responsibility for any application that is not validated and transferred to OPHS from the Grants.gov Website Portal. Grants.gov will notify the applicant regarding the application validation status. Once the application is successfully validated by the Grants.gov Website Portal, applicants should immediately mail all required hard copy materials to the OPHS Office of Grants Management to be received by the deadlines specified above. It is critical that the applicant clearly identify the Organization name and Grants.gov Application Receipt Number on all hard copy materials.

Once the application is validated by Grants.gov, it will be electronically transferred to the GrantSolutions system for processing. Upon receipt of both the electronic application from the Grants.gov Website Portal, and the required hardcopy mail-in items, applicants will receive notification via mail from the OPHS Office of Grants Management confirming the receipt of the application submitted using the Grants.gov Website Portal. Applicants should contact Grants.gov regarding any questions or concerns regarding the electronic application process conducted through the Grants.gov Website Portal.

Electronic Submissions via the GrantSolutions System

The electronic grants management system, GrantSolutions.gov, provides for applications to be submitted electronically. When submitting applications via the GrantSolutions system, applicants are required to submit a hard copy of the application face page (Standard Form 424) with the original signature of an individual authorized to act for the applicant agency and assume the obligations imposed by the terms and conditions of the grant award. If required, applicants will also need to submit a hard copy of the Standard Form LLL and/or certain Program related forms (e.g., Program Certifications) with the original signature of an individual authorized to act for the applicant agency. When submitting the required forms, do not send the entire application. Complete hard copy

applications submitted after the electronic submission will not be considered for review.

Electronic applications submitted via the GrantSolutions system must contain all completed online forms required by the application kit, the Program Narrative, Budget Narrative and any appendices or exhibits. The applicant may identify specific mail-in items to be sent to the Office of Grants Management separate from the electronic submission; however these mail-in items must be entered on the GrantSolutions Application Checklist at the time of electronic submission, and must be received by the due date requirements specified above. Mail-In items may only include publications, resumes, or organizational documentation. When submitting the required forms, do not send the entire application. Complete hard copy applications submitted after the electronic submission will not be considered for review.

Upon completion of a successful electronic application submission, the GrantSolutions system will provide the applicant with a confirmation page indicating the date and time (Eastern Time) of the electronic application submission. This confirmation page will also provide a listing of all items that constitute the final application submission including all electronic application components, required hardcopy original signatures, and mail-in items, as well as the mailing address of the OPHS Office of Grants Management where all required hard copy materials must be submitted.

As items are received by the OPHS Office of Grants Management, the electronic application status will be updated to reflect the receipt of mail-in items. It is recommended that the applicant monitor the status of their application in the GrantSolutions system to ensure that all signatures and mail-in items are received.

Mailed or Hand-Delivered Hard Copy Applications

Applicants who submit applications in hard copy (via mail or hand-delivered) are required to submit an original and two copies of the application. The original application must be signed by an individual authorized to act for the applicant agency or organization and to assume for the organization the obligations imposed by the terms and conditions of the grant award.

Mailed or hand-delivered applications will be considered as meeting the deadline if they are received by the OPHS Office of Grant Management , c/o WilDon Solutions on or before 5:00 p.m. Eastern Time on the deadline date specified in the DATES section of the announcement. The application deadline date requirement specified in this announcement supersedes the instructions in the OPHS-1. Applications that do not meet the deadline will be returned to the applicant unread. The following address should be used if submitting the application by hard copy:

Office of Grants Management, Office of Public Health and Science (OPHS)
U.S. Department of Health and Human Services (HHS)
c/o WilDon Solutions, Office of Grants Management Operations Center
515 Wilson Blvd.

Third Floor Suite 310
Arlington, VA 22209
Attention: Division of National Healthcare Preparedness Programs (DNHPP)

4. Intergovernmental Review

Applications under this announcement are subject to the review requirements of E.O. 12372, "Intergovernmental Review of Federal Programs," as implemented by 45 CFR part 100, "Intergovernmental Review of Department of Health and Human Services Programs and Activities." E.O. 12372 sets up a system for state and local government review of proposed Federal assistance applications. As soon as possible, the applicant (other than Federally- recognized Indian tribal governments) should contact the State Single Point of Contact (SPOC) for each state in the area to be served. The application kit contains the currently available listing of the SPOCs which have elected to be informed of the submission of applications. For those states not represented on the listing, further inquiries should be made by the applicant regarding submission to the relevant SPOC. Information about the SPOC is located on the OMB website at http://www.whitehouse.gov/omb/grants/spoc. The SPOC's comment(s) should be forwarded to the OPHS Office of Grants Management, 1101 Wootton Parkway, Suite 550, Rockville, MD 20852. The SPOC has 60 days from the closing date of this announcement to submit any comments.

5. Funding Restrictions

Grant funds may be used to cover costs of personnel, consultants, equipment, supplies, grant-related travel, and other grant-related costs. **Grant funds may not be used for construction or major renovations, fund raising activities, or political education and lobbying.** Guidance for completing the application can be found in the Program Guidelines, which are included with the complete application kits. Applicants for discretionary grants are expected to anticipate and justify their funding needs and the activities to be carried out with those funds in preparing the budget and accompanying narrative portions of their applications. The basis for determining the allowability and allocability of costs charged to Public Health Service (PHS) grants is set forth in 45 CFR parts 74 and 92. If applicants are uncertain whether a particular cost is allowable, they should contact the OPHS Office of Grants Management at (240) 453-8822 for further information.

V. APPLICATION REVIEW INFORMATION

1. Criteria

Applications will be reviewed based on the following criteria listed in descending order of priority:

- Clarity of the needs in terms of personnel, organizational/leadership, equipment and systems, planning. And how well applications describe how training and

exercises will support building the sub-capabilities
- Clarity of how well the goals, objectives and activities outlined in the application address the needs
- Extent to which goals, objectives and activities are written in SMART (specific, measurable, achievable, realistic and time-framed) format
- Extent to which the needs of pediatrics and other vulnerable populations are addressed in the plan
- Clarity of which the budget justification reflects the costs associated with the activities to be completed

Applicants are strongly encouraged to follow the SMART criteria described on page 23 when drafting the workplan and timeline sections of the application.

2. Review and Selection Process

As a formula award, these applications will be reviewed internally within ASPR using an objective review process. If the application fulfills the review criteria, awards will be made by September 1, 2007. If recommendations from these reviews result in conditions of award the conditions shall be addressed as instructed in the Notice of Grant Award (NGA).

3. Anticipated Announcement and Award

The OPEO anticipates announcing and awarding by September 01, 2007 for an 11 month, 1 week period ending August 8, 2008.

VI. AWARD ADMINISTRATION INFORMATION

1. Award Notices

When these decisions have been made, the applicant's authorized representative will be notified of the outcome of their application by postal mail. **The official document notifying an applicant that the application has been approved for funding is the Notice of Grant Award, signed by the Grants Management Officer, which specifies to the grantee the amount of money awarded, the purposes of the grant, the length of the project period, terms and conditions of the grant award, and the amount of funding to be contributed by the grantee to project costs.**

2. Administrative and National Policy Requirements

The regulations set out at 45 CFR parts 74 and 92 are the Department of Health and Human Services (HHS) rules and requirements that govern the administration of grants. Part 74 is applicable to all recipients except those covered by Part 92, which governs awards to State and local governments. Applicants funded under this announcement must be aware of and comply with these regulations. The CFR volume that includes

parts 74 and 92 may be accessed at
http://www.access.gpo.gov/nara/cfr/waisidx_03/45cfrv1_03.html

When issuing statements, press releases, requests for proposals, bid solicitations, and other documents describing projects or programs funded in whole or in part with Federal money, all award recipients shall clearly state the percentage and dollar amount of the total costs of the program or project which will be financed with Federal money and the percentage and dollar amount of the total costs of the project or program that will be financed by non-governmental sources.

Grantees that fail to comply with the terms and conditions of this cooperative agreement, including responsiveness to program guidance, measured progress in meeting the performance measures outlined in the critical benchmarks, and adequate stewardship of these federal funds, may be subject to an administrative enforcement action. Administrative enforcement actions may include temporarily withholding cash payments or restricting a grantee's ability to draw down funds from the Payment Management System until the grantee has taken corrective action.

3. Reporting Requirements

A. Audit Requirements

Not less often than once every 2 years, audit of expenditures from amounts received under this award shall be conducted by an entity independent of the agency administering the program. These audits shall be conducted in accordance with the Comptroller General's standards for auditing governmental organizations, programs, activities, and functions and generally accepted auditing standards. Within 30 days following the completion of each audit report, a copy of that audit report shall be submitted to the Secretary of Health and Human Services.

Audits must comply with audit requirements of Office of Management and Budget (OMB) Circular A-133. Information on the scope, frequency, and other aspects of the audits can be found on the Internet at www.whitehouse.gov/omb/circulars.

B. Progress Reports and Financial Reports

Applicants funded under this announcement will be required to electronically submit a Mid-Year Report, as well as an End-of-Year Report, and an annual Financial Status Report (FSR) SF-269, 90 days after the grant budget period ends. Reporting formats are established in accordance with provisions of the general regulations which apply under 45 CFR parts 74 and 92. In light of the increased emphasis on performance measurement and accountability in the PAHPA, grantees are advised that project progress reports (midyear and end of year) are expected to be timely, consistent, and complete using a template to be provided. Incomplete or inconsistent reports will be returned to the grantee for corrections.

C. Performance Measures and Data Elements

Performance Measures

As required by the Paperwork Reduction Act (PRA), HHS is awaiting OMB approval to request the following seven performance measures and additional supporting data elements. Templates for data collection and submission will be released to awardees as soon as they are approved. These performance measures will be reported twice annually and are listed below. Calculation of results based on numerator and denominator information submitted by States will be conducted by staff in the Evaluation Section at HHS. **States shall maintain all documentation that substantiates the answers to these measures (site visits, surveys, exercises etc) and make those documents available to Federal staff as requested during site visits or through other requests.**

1. The percent of participating hospitals that can report available beds, according to HAvBED definitions, to the State EOC within 60 minutes of a State request.
   a. Numerator: The number of participating hospitals able to report.
   b. Denominator: The total number of participating hospitals in the State.
   c. FY 07 Target: At least 75% of participating hospitals in each State will be able to report.
2. The percent of State EOCs that can report available beds, for at least 75% of participating hospitals, according to HAvBED definitions, to the HHS SOC with 4 hours of a request, during an incident or exercise.

   Note: Each State will be asked to report "Yes" or "No." Individual responses will be aggregated into a national measure.
   a. Numerator: The number of State EOCSs able to report for 75% or more of participating hospitals.
   b. Denominator: The total number of States.
   c. FY 07 Target: 100% of States can report for at least 75% of their participating hospitals.
3. The percent of participating hospitals that have demonstrated dedicated, redundant communications capability during an exercise or incident, as evidenced by exercise evaluations or after action reports.
   a. Numerator: The number of participating hospitals with demonstrated communications capability.
   b. Denominator: The total number of participating hospitals
   c. FY 07 Target: 75%
4. The percent of participating hospitals that have demonstrated two-way communications capability with the Incident Command and Tier 2 partners during

an exercise or incident, as evidenced by exercise evaluations or after action reports.

a. Numerator: The number of participating hospitals with demonstrated capability.

b. Denominator: The total number of participating hospitals.

c. FY 07 Target: 50%

5. The percent of States able to compile and verify a roster of potential volunteer health professionals, by category, for a specified mission assignment within 2 hours of a request being issued by the HHS SOC or other requesting body.

Note: Each State will be asked to report "Yes" or "No." Individual responses will be aggregated into a national measure.

a. Numerator: The number of States able to report.

b. Denominator: The total number of States.

c. FY 07 Target: 50%

6. The percent of States that can report a verified list of available, willing, and credentialed volunteers within 8 hours of a request being issued by the HHS SOC or other requesting body.

Note: Each State will be asked to report "Yes" or "No." Individual responses will be aggregated into a national measure.

a. Numerator: The number of States able to report a verified list within the requested timeframe.

b. Denominator: The total number of States.

c. FY 07 Target: 50%

7. The Grantee has submitted timely and complete data for the midyear report, the end-of-year report, and the final FSR. (Yes/No)

Scoring: The measure will be scored by ASPR staff. A "yes" requires two conditions to be met:

a. Each required report is submitted electronically to the Grants Office and the Project Officer by the published deadline.

Exceptions: A single 2-week extension period may be requested in hardship cases, which must be documented and approved in writing by the Grants Office in advance of the due date.

b. Each report includes all requested information.

Exceptions: There are no exceptions. Grantees who require clarification of any requested element or question must contact the project officer in

writing at least one week in advance of the report due date.

Data Elements

Data elements will be requested for program monitoring purposes. They may be used to calculate percentages for the performance measures above, to enable other data analyses, and to respond to routine requests for information about the program. They will not be used to evaluate grantee performance. Data elements will only be reported in the end of year reports.

Once HHS receives approval from OMB, the specific data elements that will be collected and a template to support collection of these data will be released. The template will include definitions, response choices, due dates and instructions for completing the template.

VII. AGENCY CONTACTS

1. Administrative and Budgetary Contacts

For application kits, submission of applications, and information on budget and business aspects of the application, please contact: WilDon Solutions, Office of Grants Management Operations Center, 1515 Wilson Blvd., Third Floor Suite 310, Arlington, VA 22209 at 1-888-203-6161, email OPHSgrantinfo@teamwildon.com, or fax 703-351-1138.

2. Program Contacts

Program Requirements:
Mollie Mahany
Hospital Preparedness Program
US Department of Health and Human Services (HHS)
Office of the Assistant Secretary for Preparedness and Response (ASPR)
Office of Preparedness and Emergency Operations (OPEO)
330 C ST., SW, Rm 5625
Washington DC 20201
(office) 202.205.8648
Mollie.mahany@hhs.gov

Data and Evaluation Requirements:
Mrs. Janet Schiller, Ed.D.
Section Chief for Evaluation
State and Local Initiatives Team
US Department of Health and Human Services (HHS)
Assistant Secretary for Preparedness and Response (ASPR)
Office of Preparedness and Emergency Operations (OPEO)
330 C ST., SW, Rm 5615
Washington DC 20201

(office) 202.205.8742
janet.schiller@hhs.gov

ESAR-VHP Requirements:
Jennifer Hannah
Acting Team Leader
Emergency Systems for Advance Registration
for Volunteer Health Professionals (ESAR-VHP)
US Department of Health and Human Services (HHS)
Assistant Secretary for Preparedness and Response (ASPR)
Office of Preparedness and Emergency Operations (OPEO)
330 C ST., SW, Room 5523
Washington, DC 20201
(office) 202.205.8578
Jennifer.Hannah@hhs.gov

APPENDIX A
DHHS and DHS Joint Program Allowable Costs and TCL Crosswalk Tables

Table 1 – FY 2007 Allowable Cost Matrix

Allowable Program Activities Current as of FY 2007 Programs* See the respective program guidance for additional details and/or requirements *As of Publication	DHS												HHS		
	HSGP							IPP							
	SHSP	UASI	LETPP	MMRS	CCP	Firefighters	EMPG	BZPP	TSGP	PSGP	IBSGP	CEDAP	HPP	BTCDP	PHEPCA
Allowable Planning Costs															
Public education & outreach	Y	Y	Y	Y	Y	Y	Y		Y						Y
Develop and implement homeland security support programs and adopt ongoing DHS National Initiatives	Y	Y	Y	Y	Y		Y	Y	Y						Y
Develop and enhance plans and protocols	Y	Y	Y	Y	Y		Y	Y	Y	Y			Y		Y
Develop or conduct assessments	Y	Y	Y	Y	Y	Y	Y		Y	Y			Y	Y	Y
Establish, enhance, or evaluate Citizen Corps related volunteer programs	Y	Y	Y	Y	Y		Y		Y						Y
Hiring of full- or part-time staff or contract/consultants to assist with planning activities (not for the purpose of hiring public safety personnel fulfilling traditional public safety duties)	Y	Y	Y	Y	Y		Y	Y	Y				Y	Y	Y
Conferences to facilitate planning activities	Y	Y	Y	Y	Y		Y	Y	Y				Y		Y
Materials required to conduct planning activities	Y	Y	Y	Y	Y		Y	Y	Y				Y		Y
Travel/per diem related to planning activities	Y	Y	Y	Y	Y		Y	Y	Y				Y	Y	Y
Overtime and backfill costs (IAW operational Cost Guidance)	Y	Y	Y	Y	Y		Y	Y	Y						

Other project areas with prior approval from G&T	Y	Y	Y	Y	Y	Y	Y		Y	Y					

Allowable Program Activities Current as of FY 2007* Programs See the respective program guidance for additional details and/or requirements *As of publication	DHS												HHS		
	HSGP							IPP							
	SHSP	UASI	LETPP	MMRS	CCP	Firefighters	EMPG	BZPP	TSGP	PSGP	IBSGP	CEDAP	HPP	BTCDP	PHEPCA
Allowable Organizational Activities															
Overtime for information, investigative, and intelligence sharing activities (up to 25 percent of the allocation)		Y	Y												
Reimbursement for select operational expenses associated with increased security measures at critical infrastructure sites incurred during periods of DHS-declared Code Orange		Y	Y												
Hiring of full- or part-time staff or contractors for emergency management activities					Y	Y	Y								
Hiring of contractors/consultants for participation in information/intelligence analysis and sharing groups or fusion center activities (limited to 25 percent of the allocation)		Y	Y												
Allowable Equipment Categories															
Personal Protective Equipment	Y	Y	Y	Y		Y			Y	Y		Y	Y		Y
Explosive Device Mitigation and Remediation Equipment	Y	Y	Y			Y		Y	Y	Y	Y				
CBRNE Operational Search and Rescue Equipment	Y	Y	Y	Y		Y		Y*	Y	Y	Y	Y			
Information Technology	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y
Cyber Security Enhancement Equipment	Y	Y	Y	Y	Y		Y	Y	Y	Y	Y				
Interoperable Communications Equipment	Y	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y		Y
Detection Equipment	Y	Y		Y		Y	Y	Y	Y	Y	Y	Y	Y		Y
Decontamination Equipment	Y	Y		Y		Y			Y				Y		Y

Medical Supplies and Limited Pharmaceuticals	Y	Y		Y	Y	Y	Y		Y				Y		
Power Equipment	Y	Y	Y	Y	Y	Y		Y	Y	Y	Y				
CBRNE Reference Materials	Y	Y	Y	Y	Y	Y	Y		Y		Y		Y	Y	Y
CBRNE Incident Response Vehicles	Y	Y	Y	Y		Y	Y		Y						

Allowable Program Activities Current as of FY 2007 Programs* See the respective program guidance for additional details and/or requirements *As of publication	DHS											HHS		
	HSGP							IPP						
	SHSP	UASI	LETPP	MMRS	CCP	Firefighters	EMPG	BZPP	TSGP	PSGP	IBSGP	CEDAP	HPP	BTCDP	PHEPCA
Terrorism Incident Prevention Equipment	Y	Y	Y			Y		Y	Y	Y	Y				
Physical Security Enhancement Equipment	Y	Y	Y				Y	Y	Y	Y	Y	Y	Y		
Inspection and Screening Systems	Y	Y	Y	Y		Y		Y	Y	Y	Y				
Agriculture Terrorism Prevention, Response, and Mitigation Equipment	Y	Y		Y				Y							
CBRNE Response Watercraft	Y	Y	Y						Y						
CBRNE Aviation Equipment	Y	Y													
CBRNE Logistical Support Equipment	Y	Y	Y	Y		Y	Y		Y		Y				
Intervention Equipment	Y	Y	Y					Y	Y		Y				
Other Authorized Equipment	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y		
Allowable Training Costs															
Overtime and backfill for emergency preparedness and response personnel attending G&T-sponsored and approved training classes and technical assistance programs	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y				
Overtime and backfill expenses for part-time and volunteer emergency response personnel participating in G&T training	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y				
Training workshops and conferences	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y		Y	Y	Y
Full- or part-time staff or contractors/consultants	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y		Y	Y	Y
Travel	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y		Y	Y	Y
Supplies	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y		Y	Y	Y
Tuition for higher education	Y	Y	Y	Y	Y	Y									
Other items	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y				
Allowable Exercise Related Costs															
Design, Develop, Conduct and Evaluate an Exercise	Y	Y	Y	Y	Y		Y		Y	Y	Y		Y		
Exercise planning workshop	Y	Y	Y	Y	Y		Y		Y	Y	Y				Y

												Y			
Full- or part-time staff or contractors/consultants	Y	Y	Y	Y	Y		Y		Y	Y	Y		Y		Y
Overtime and backfill costs, including expenses for part-time and volunteer emergency response personnel participating in G&T exercises	Y	Y	Y	Y	Y		Y		Y	Y	Y				
Implementation of HSEEP	Y	Y	Y	Y	Y		Y						Y		
Travel	Y	Y	Y	Y	Y		Y		Y	Y	Y		Y Y		Y
Supplies	Y	Y	Y	Y	Y		Y		Y	Y	Y		Y		Y
Other items	Y	Y	Y	Y	Y		Y		Y	Y	Y		Y		

Allowable Program Activities Current as of FY 2007 Programs* See the respective program guidance for additional details and/or requirements *As of publication	**DHS**												**HHS**		
	HSGP							**IPP**							
	SHSP	**UASI**	**LETPP**	**MMRS**	**CCP**	**Firefighters**	**EMPG**	**BZPP**	**TSGP**	**PSGP**	**IBSGP**	**CEDAP**	**HPP**	**BTCDP**	**PHEPCA**
Allowable Management & Administrative Costs															
Hiring of full- or part-time staff or contractors/consultants to assist with the management of the respective grant program, application requirements, compliance with reporting and data collection requirements	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y		Y
Development of operating plans for information collection and processing necessary to respond to G&T data calls	Y	Y	Y	Y	Y		Y	Y	Y	Y	Y				
Overtime and backfill costs	Y	Y	Y	Y	Y		Y								Y
Travel	Y	Y	Y	Y	Y		Y	Y	Y	Y	Y		Y		Y
Meeting related expenses	Y	Y	Y	Y	Y		Y	Y	Y	Y	Y		Y		Y
Authorized office equipment	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y			Y		
Recurring expenses such as those associated with cell phones and faxes during the period of performance of the grant program	Y	Y	Y	Y	Y	Y	Y	Y					Y		Y
Leasing or renting of space for newly hired personnel during the period of performance of the grant program	Y	Y	Y	Y	Y	Y	Y	Y					Y		

Below, “Y” denotes a direct role for the capability, while “*” denotes a supporting role.

Table 2 – Relationship between Grant Programs and Target Capabilities

37 Target Capabilities and Categories	Grant Programs													
	DHS											HHS		
	HSGP					IPP								
	SHSP	UASI	LETPP	MMRS	CCP	BZPP	TSGP	PSGP	IBSGP	EMPG	Firefighters	HPP	BTCDP	PHEPCA
Common Target Capabilities														
Planning	Y	Y	Y	Y	*	Y	Y	Y	Y	Y	Y	Y		Y
Community Preparedness and Participation	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y			
Communications	Y	Y	Y	Y	*	Y	Y	Y	Y	Y	Y	Y		Y
Risk Management	Y	Y			*	Y	Y	Y	Y	Y				
Prevent Mission Area Target Capabilities														
Info Gathering and Recognition of Indicators and Warnings	Y	Y	Y	Y	*	Y	Y	Y	Y					
Law Enforcement Investigation and Operations	Y	Y	Y		*	Y	Y	Y						
Intelligence Analysis and Production	Y	Y	Y		*	Y	Y	Y						
CBRNE Detection	Y	Y	Y	Y	*	Y	Y	Y	Y	Y	Y	Y	Y	
Intelligence / Information Sharing and Dissemination	Y	Y	Y		*	Y	Y	Y	Y	Y				
Protect Mission Area Target Capabilities														
Critical Infrastructure Protection	Y	Y	Y		*	Y	Y	Y	Y			Y		
Epidemiological Surveillance & Investigation	Y	Y		Y		Y						Y	Y	Y
Public Health Laboratory Testing	Y	Y		Y		Y						Y	Y	Y
Food and Agriculture Safety and Defense	Y	Y			*	Y				Y				

37 Target Capabilities and Categories	Grant Programs													
	DHS											HHS		
	HSGP					IPP								
	SHSP	UASI	LETPP	MMRS	CCP	BZPP	TSGP	PSGP	IBSGP	EMPG	Firefighters	HPP	BTCDP	PHEPCA
Respond Mission Area Target Capabilities														
Onsite Incident Management	Y	Y			*	*	Y	*		Y	Y	Y		
Citizen Protection: Evacuation and/or In-Place Protection	Y	Y		Y	*		Y	*	*	Y				
Emergency Operations Center Management	Y	Y			*	*	Y	Y		Y				
Isolation and Quarantine	Y	Y		Y	*					Y		Y		Y
Critical Resource Logistics and Distribution	Y	Y		Y	*	*	Y	*	*	Y				
Urban Search & Rescue	Y	Y		Y	*		*			Y	Y			
Volunteer Management and Donations	Y	Y			*					Y		Y		
Emergency Public Information and Warning	Y	Y		Y	*	*	Y	Y	*	Y				Y
Responder Safety and Health	Y	Y		Y	*		*	*		Y	Y	Y	Y	Y
Triage and Pre-Hospital Treatment	Y	Y		Y	*		Y				Y	Y	Y	
Public Safety and Security Response	Y	Y		Y	*	*	Y	Y		Y	Y			
Medical Surge	Y	Y		Y	*							Y	Y	
Animal Health Emergency Support	Y	Y			*								Y	
Medical Supplies Management and Distribution	Y	Y		Y	*		*	*	*	Y		Y	Y	
Environmental Health	Y	Y		Y	*									Y
Mass Prophylaxis	Y	Y		Y	*			*		Y		Y	Y	Y
Explosive Device Response Operations	Y	Y			*	*	Y	Y	Y		Y			
Mass Care	Y	Y		Y	*					Y				
Firefighting Operations/Support	Y	Y		Y	*			*			Y			
Fatality Management	Y	Y		Y	*					Y		Y		
WMD/Hazardous Materials Response and Decontamination	Y	Y		Y	*	*	Y		Y	Y	Y	Y	Y	
Recover Mission Area Target Capabilities														
Structural Damage and Mitigation Assessment	Y	Y			*		Y							
Economic & Community Recovery	Y	Y			*					Y				
Restoration of Lifelines	Y	Y			*				Y					

APPENDIX B
ESAR-VHP Requirements

Emergency Systems for Advance Registration of Volunteer Health Professionals (ESAR-VHP) Draft Compliance Requirements (revised May 1, 2007)

The following draft ESAR-VHP compliance requirements identify capabilities and procedures that State[2] ESAR-VHP programs must have in place to ensure effective management and inter-jurisdictional movement of volunteer health personnel in emergencies. Although each State is required to meet all of the compliance requirements, **each State is expected to have a fully operational ESAR-VHP system by the end of the FY 2007 budget period of the Hospital Preparedness Program (HPP).** To be fully operational, ESAR-VHP systems must meet compliance requirements 1-6. The final version of the compliance document and specific guidance on how to meet the compliance requirements will be included in the draft *FY 2007 ESAR-VHP Technical and Policy Guidelines, Standards and Definitions* (Guidelines) to be released in the summer of 2007. All States must report progress toward meeting these compliance requirements on Mid-Year and End-of-Year Progress Reports for the Hospital Preparedness Program.

I. ESAR-VHP Electronic System Requirements

1. Each State is required to develop an electronic registration system for recording and managing volunteer information based on the data definitions to be presented in the ESAR-VHP Guidelines. These systems must :
    a) Offer WWW-based registration
    b) Ensure that volunteer information is collected, assembled, maintained and utilized in a manner consistent with all Federal, State and local laws governing security and confidentiality.
    c) Identify volunteers via queries of critical variables.
    d) Generate electronic data files in a secure format that can be read and used by other authorities managing volunteers.
    e) Track volunteers during deployment and maintain a history of volunteer deployments.
    f) Ensure that the system is redundant.

2. Each electronic system must be able to register and collect the credentials and qualifications of health professionals that are then verified with the issuing entity or appropriate authority identified in the *ESAR-VHP Guidelines* to be released in the summer of 2007.

    a) Each State must collect and verify the credentials and qualifications of the following health professionals.

[2] For purpose of this document, State refers to any Hospital Preparedness Program grantee, including States, Territories, Cities, Counties, the District of Columbia, Commonwealths, and the sovereign nations of the Republic of Palau, the Republic of the Marshall Islands, and the Federated States of Micronesia.

1) Physicians
2) Registered Nurses, including Advanced Practice Registered Nurses (APRNs). APRNs include Nurse Practitioners, Certified Nurse Anesthetists, Certified Nurse Midwives, and Clinical Nurse Specialists.
3) Pharmacists
4) Psychologists
5) Clinical Social Workers
6) Mental Health Counselors
7) Radiologic Technologists
8) Respiratory Therapists
9) Clinical Laboratory Technologists and Technicians
10) Licensed Practical Nurses

b) Six (6) months after end of the FY 2007 budget period, each State must expand its electronic registration system to include the remaining priority professions identified in the *ESAR-VHP Guidelines* to be released in the summer of 2007.

c) States must add additional professions to their systems as they are added to future versions of the *ESAR-VHP Guidelines.*

3. The ESAR-VHP system must be able to assign volunteers to all four ESAR-VHP credential levels. Assignment will be based on the credentials and qualifications that the State has collected and verified with the issuing entity or appropriate authority.

4. Each electronic system must be able to record ALL volunteer health professional/emergency preparedness affiliations of an individual, including local, State, and Federal entities.

   The purpose of this requirement is to avoid the potential confusion that may arise from having a volunteer appear in multiple registration systems (e.g., Medical Reserve Corps (MRC), National Disaster Medical System (NDMS), State emergency response, and etc.).

5. Each electronic system must be able to identify volunteers willing to participate in a Federally coordinated emergency response.

   a) Each electronic system must query volunteers upon initial registration and/or re-verification of credentials about their willingness to participate in emergency responses coordinated by the Federal government**.** Responses to this question, posed in advance of an emergency, will provide the Federal government with a rough count of the potential volunteer pool that may be available from the States upon request.

   b) If a volunteer responds “Yes” to the Federal question, additional information (e.g., training, physical and medical status, and criminal background history) may be required of the volunteer.

6. Each State must be able to update volunteer information and re-verify credentials every 6 months.

   Note: ASPR will review this requirement regularly for possible adjustments based on the experience of the States.

II. ESAR-VHP Operational Requirements

7. Upon receipt of a request for volunteers from any governmental agency or recognized emergency response entity, all States must: 1) identify qualified volunteers; 2) contact potential volunteers; 3) within 2 hours provide the requester an initial list that includes the names, qualifications, credentials, and credential levels of volunteers; and 4) within 8 hours provide the requester with a verified list of volunteers who have indicated a willingness to respond.

8. All States are required to develop and implement a plan to recruit and retain volunteers.

   ASPR will assist States in meeting this requirement by providing professional assistance to develop a National public education campaign, tools for accessing State enrollment sites, and customized State recruitment and retention plans. This will be carried out in conjunction with existing recruitment and retention practices utilized by States.

9. Each State must develop a plan for coordinating with all volunteer health professional/emergency preparedness entities to ensure an efficient response to an emergency, including but not limited to Medical Reserve Corps (MRC) units and the National Disaster Medical Systems (NDMS) teams.

10. Each State must develop protocols for deploying volunteers (Mobilization Protocols):

    a) Each State is required to develop written protocols that govern the internal activation, operation, and timeframes of the ESAR-VHP system in response to an emergency. ASPR may ask for copies of these protocols as a means of documenting compliance. ASPR will include protocol models in future versions of the *ESAR-VHP Guidelines*.

    b) Each State ESAR-VHP program is required to establish a working relationship with external partners, such as the local and/or State Emergency Management agency and develop protocols outlining the required actions for deploying volunteers during an emergency. These protocols must ensure 24 hour/7 days-a-week accessibility to the ESAR-VHP system. Major areas of focus include:

       1) Intrastate deployment: States must develop protocols that coordinate the use of ESAR-VHP volunteers with those from other volunteer organizations, such as the Medical Reserve Corps (MRC).

2) **Interstate deployment: States must develop protocols outlining the steps needed to respond to requests for volunteers received from another State. States that have provisions for making volunteers employees or agents of the State must also develop protocols for deployment of volunteers to other States through the State Emergency Management agency via the Emergency Management Assistance Compact (EMAC).**

   Each State must have a process for receiving and maintaining the security of volunteers' personal information sent to them from another State and procedures for destroying the information when it is no longer needed.

3) Federal deployment: Each State must develop protocols necessary to respond to requests for volunteers that are received from the Federal Government. Further, each State must adhere to the protocol developed by the Federal Government that governs the process for receiving requests for volunteers, identifying willing and available volunteers, and providing each volunteer's credentials to the Federal Government.

III. ESAR-VHP Evaluation and Reporting Requirements

11. Each State must develop a plan for regular testing of its ESAR-VHP system through drills and exercises. Each State is required to test the activation and operation of the ESAR-VHP system in preparation for response in local, State, and National emergencies.

12. Each State must develop a plan for reporting system performance and capabilities. Each State will be required to report system performance and capabilities data as specified in HPP Guidance and/or *ESAR-VHP Guidelines*. States will report the number of enrolled volunteers by profession and credential level as well as the addition of system capabilities as they are implemented and system activity during responses to actual events.

Appendix C

National Incident Management System (NIMS) Compliance Activities for Hospitals (public and private) [3]

*FY 2006 funding cycle - all participating hospitals were asked to adopt and implement elements 7, 9, 10 and 11.
**FY 2007 funding cycle -all elements are eligible for funding AND the remaining activities must be undertaken and finished during the budget and project period.

Organizational Adoption

Element 1
Adopt NIMS at the organizational level for all departments and business units, as well as promote and encourage NIMS adoption by associations, utilities, partners and suppliers.
Example of compliance:

- *The seventeen elements included in this document are addressed in the organization's emergency management program documentation.*

Command and Management

Element 2
Incident Command System (ICS)
Manage all emergency incidents and preplanned (recurring/special events) in accordance with ICS organizational structures, doctrine, and procedures, as defined in NIMS. ICS implementation must include consistent application of Incident Action Planning and Common Communications Plans.
Example of compliance:

- *The organization's Emergency Operations Plan explains the use of ICS, particularly incident action planning and a common communications plan.*

Element 3
Multi-agency Coordination System
Coordinate and support emergency incident and event management through the development and use of integrated multi-agency coordination systems. That is, develop and coordinate connectivity capability with Hospital EOC and local Incident Command Posts (ICPs), local 911 centers, local Emergency Operations Centers (EOCs) and the state EOC as applicable.

[3] Draft developed for discussion by the HICS National Working Group and consideration by the NIMS Integration Center to address the question of "what types of activities should health care organizations engage in to ensure NIMS compliance?" The draft was developed from the NIMS National Standard Curriculum Training Development Guidance. Adaptations of the language for each element for health care organizations follow legislative format, with underlined items (additions) and strikethroughs (deletions). Examples of compliance were added to provide additional specificity to a health care organization.

Example of compliance:

- *The organization's Emergency Operations Plan explains the management and coordination linkage between the organization's emergency operations center and other, similar, external centers(multi-agency coordination system entities)*

Element 4
Public Information System (PIS)
Implement processes and/or plans to communicate timely, accurate information including through a Joint Information System and Joint Information Center.
Example of compliance:

- *The organization's Emergency Operations Plan explains the management and coordination of public information with health care partners and jurisdictional authorities, such as local public health, emergency management, and so on.*

Preparedness Planning

Element 5
Health care organizations will track NIMS implementation on a yearly basis as part of the organization's emergency management program.
Example of compliance: NIMS organizational adoption, command and management, preparedness/planning, preparedness/training, preparedness/exercises, resource management, and communication and information management activities will be tracked from year-to-year with a goal of improving overall emergency management capability.

Element 6
Develop and implement a system to coordinate appropriate hospital preparedness funding to employ NIMS across the organization.
Example of compliance:

- *The organization's emergency management program documentation includes information on local, state and federal preparedness grants that have been received and work progress.*

Element 7
Revise and update plans and SOPs to incorporate NIMS components, principles and policies, to include planning, training, response, exercises, equipment, evaluation and corrective action.
Example of compliance:

- *The organization's emergency management program work plan reflects status of any revisions to the Emergency Operations Plan, training materials, response procedures, exercise procedures, equipment changes and/or purchases, evaluation and corrective action processes.*

Element 8
Participate in and promote interagency mutual aid agreements, to include agreements with the public and private sector and non-governmental organizations.

Example of compliance:

- *The organization's emergency management program documentation includes information on mutual aid agreements.*

Preparedness Training

Element 9
Complete IS-700: NIMS: An Introduction.
Example of compliance:

- *The organization's emergency management program training records track completion of IS 700 or equivalent by personnel who are likely to assume an incident command position described in the hospital's emergency management plan.*

Element 10
Complete IS-800: NRP: An Introduction.
Example of compliance:

- *The organization's emergency preparedness program training records track completion of IS 800 or equivalent by individual(s) responsible for the hospital's emergency management program.*

Element 11
Complete ICS 100 and ICS 200 training.
Examples of compliance:

- *The organization's emergency preparedness program training records track completion of ICS 100 or equivalent by personnel who are likely to assume an incident command position described in the hospital's emergency management plan.*
- *The organization's emergency management program training records track completion of ICS 200 or equivalent by personnel who are likely to assume an incident command position described in the hospital's emergency management plan.*

Preparedness Exercises

Element 12
Incorporate NIMS/ICS into internal and external, local and regional emergency management training and exercises.
Example of compliance:

- *The organization's emergency management program training and exercise documentation reflects use of NIMS/ICS.*

Element 13
Participate in an all-hazard exercise program based on NIMS that involves responders from multiple disciplines, multiple agencies and organizations.
Example of compliance:

- *The organization's emergency management program training and exercise documentation reflects the organization's participation in exercises with various external entities.*

Element 14
Incorporate corrective actions into preparedness and response plans and procedures.
Example of compliance:

- *The organization's emergency management program documentation reflects a corrective action process.*

Resource Management

Element 15
Maintain an inventory of organizational response assets.
Example of compliance:

- *The organization's emergency management program documentation includes a resource inventory (e.g. medical/surgical supplies, pharmaceuticals, personal protective equipment, staffing, etc.).*

Element 16
To the extent permissible by law, ensure that relevant national standards and guidance to achieve equipment, communication, and data interoperability are incorporated into acquisition programs.
Example of compliance:

- *The organization's emergency management program documentation includes emphasis on the interoperability of response equipment, communications and data systems with external entities.*

Communications and Information Management

Element 17
Apply standardized and consistent terminology, including the establishment of plain English communications standards across the public safety sector.
Example of compliance:

- *The organization's emergency management program documentation reflects an emphasis on the use of plain English by staff during emergencies.*

Appendix D

FY 2007 Funding Table

State	Total funding
Alabama	$6,330,289
Alaska	$1,349,441
Arizona	$8,317,173
Arkansas	$4,063,403
California	$34,106,620
Chicago	**$4,103,521**
Colorado	$6,525,958
Connecticut	$4,943,121
Delaware	$1,581,970
District of Columbia	**$1,737,218**
Florida	$23,432,938
Georgia	$12,370,869
Hawaii	$2,129,653
Idaho	$2,359,069
Illinois	$13,163,842
Indiana	$8,503,785
Iowa	$4,280,453
Kansas	$4,004,077
Kentucky	$5,832,130
LA County	**$13,111,395**
Louisiana	$5,935,695
Maine	$2,175,388
Maryland	$7,619,177
Massachusetts	$8,660,567
Michigan	$13,298,463
Minnesota	$7,050,445
Mississippi	$4,189,754
Missouri	$7,906,932
Montana	$1,697,530
Nebraska	$2,741,751
Nevada	$3,663,636
New Hampshire	$2,166,921
New Jersey	$11,560,312
New Mexico	$2,977,887
New York	$14,561,258
New York City	**$10,913,604**
North Carolina	$11,727,581
North Dakota	$1,306,102
Ohio	$15,050,914
Oklahoma	$5,037,444

Oregon	$5,191,530
Pennsylvania	$16,271,242
Puerto Rico	$5,479,326
Rhode Island	$1,853,432
South Carolina	$5,978,140
South Dakota	$1,491,255
Tennessee	$8,155,520
Texas	$30,301,320
Utah	$3,732,769
Vermont	$1,290,942
Virginia	$10,189,048
Washington	$8,608,090
West Virginia	$2,805,313
Wisconsin	$7,544,102
Wyoming	$1,152,882
Guam (US)	$457,390
Virgin Islands (US)	$387,946
Federated States of Micronesia	$387,095
Northern Marianas Islands (US)	$346,510
American Samoa (US)	$323,330
Marshall Islands	$321,536
Palau	$274,996
Grand Total	**$415,032,000.00**