U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

**Agency:** 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 Healthcare Facilities Partnership Program

**Announcement Type:** Initial Competitive Cooperative Agreement for Partnerships

**Funding Opportunity Number:** n/a

**Catalog of Federal Domestic Assistance (CFDA) Number: 93.889**

**Key Dates:** To receive consideration, applications **must be received** no later than 5:00 p.m. Eastern Time on August 1, 2007 through one of the three application mechanisms specified in Section IV. **Intergovernmental Review (E.O. 12372):** Letters from State Single Point of Contact (SPOC) are due no later than 60 days after application deadline.

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

## I. Funding Opportunity Description

### Purpose

The Pandemic and All-Hazards Preparedness Act of 2006 (Public Law 109-417) amended section 319C-2 of the Public Health Service (PHS) Act 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).

This guidance is the first provided as competitive funding for healthcare partnerships under Section 319C-2 of the Public Health Service Act.

The mission of the Healthcare Facilities Partnership Program is to improve surge capacity and enhance community and hospital preparedness for public health emergencies in defined geographic areas. This will be accomplished through innovative and creative projects that can be replicated across the country that further the concepts surrounding:

- Enhanced situational awareness of capabilities and assets that partnership entities possess and can bring to bear during a response.
- Advanced planning and exercising of plans that address common risks and vulnerabilities and consequences in a defined geographic area.

- Fostering the development of Medical Mutual Aid agreements among partnership entities insuring the inclusion of public health, emergency management and private sector partners.
- Developing and strengthening relationships between and among partnership entities, traditional first response agencies, public health and other response partners prior to disasters and emergencies so that during and after these kinds of events, response and recovery activities happen in an expedited coordinated manner.

Political leaders, health officials, hospital CEOs and emergency management officials have a vested interest in maintaining public confidence in their respective institutions before, during, and after an extreme event. Regional partnerships can help this to be realized through brokering of relationship building, engendering trust among otherwise traditionally competitive entities and maximizing coordination and cooperative planning among healthcare entities and other partners.

The terms partnerships and coalitions are synonymous and used interchangeably throughout this document though the predominant term of partnership mirrors language in section 319C-2 of the Public Health Service (PHS) Act.

At the proposed level of funding and given the budget period (September 1, 2007 – August 8, 2008), it is suggested that some level of capacity and infrastructure of partnerships currently exists. This means that partnerships should be able to demonstrate and submit supporting documentation of at least 2 of the following characteristics:

- Have conducted an assessment and possess an inventory of the assets and resources of the partnership entities.
- Have established mutual aid agreements between the partnership organizations and with outside organizations that can bring additional assets to bear (this may include private industry, adjoining regions or adjoining States)
- Have jointly developed and exercised emergency management plans among entities in the partnership that take into account the sharing of "staff and stuff" with each other and other emergency response partners.
- Have established communications plans that ideally utilize a Multi-Agency Coordination Center (MACC) that functions as a "clearing house" to track resource requests and allocations and when needed interface with the appropriate local and or State emergency operations center (EOC) and other response partners.

## Background

Regional coordination among healthcare entities, public health and other response partners will be central to mounting an effective medical response to a major public health emergency such as a bioterrorist attack, hurricane, or influenza pandemic. The importance of regional coordination of healthcare systems has been illustrated by recent events over the past several years.

As stated in the Medical Surge Capacity and Capability (MSCC) Handbook[1], "*healthcare coalitions are composed of healthcare organizations (HCOs) and other healthcare assets that form a single functional entity to maximize MSCC in a defined geographic area coordinating the mitigation, preparedness, response, and recovery actions of medical and healthcare providers, facilitates mutual aid support, and serves as a unified platform for medical input to jurisdictional authorities.*

*The healthcare coalition emphasizes coordination and cooperative planning rather than truly "unified command" of all public and private medical and health assets. This is because public health and medical assets retain their individual management autonomy during incident response. However, they participate in information sharing and incident planning to promote consistent management strategies. An integral component of the coalition response is medical mutual aid—the redistribution of personnel, facilities, equipment, or supplies to HCOs in need during times of crisis. Mutual aid provides surge capacity and capability that is immediately operational, reliable, and cost-effective. The coalition provides a mechanism to formally establish processes for requesting and receiving mutual aid during preparedness planning. It also allows such issues as staff credentialing, liability, reimbursement, and transfer of patient responsibility to be addressed in preparedness planning, thus ensuring a rapid distribution of aid when it is needed."*

**Role of Critical Infrastructure Protection and Partnerships** *(Successful 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)*

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 National Infrastructure Protection Plan (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 National Preparedness Goal (NPG), National Response Plan (NRP), and National Incident Management System (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.

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[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.

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

This program will provide funding during Federal fiscal year (FY) 2007. The budget period and project period will be from September 1, 2007 – August 8, 2008. Approximately $15 million dollars is expected to be available through a competitive process that will result in approximately 6-30 cooperative agreement awards ranging from $500,000 - $2,500,000.

Cooperative agreements are 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 actions 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 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. Monitoring 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 handicapped.

The measured success and impact of these healthcare partnership demonstration projects will be used to inform future decisions regarding funding and expectations of partnerships. Additional demonstration projects may be supported in the future. Applicants who are successful in obtaining awards under this solicitation will be eligible to compete for additional demonstration project awards, should funding be available. As with all federal grants future offerings are dependent on the availability of appropriated funds in subsequent fiscal years and a decision that funding is in the best interest of the Federal government.

## III. Eligibility Information

### Eligible Applicants

To be eligible for an award through this announcement an entity shall be a partnership consisting of:

- one or more hospitals, at least one of which shall be a designated trauma center[2];
- one or more other local health care 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 subdivisions.

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 **(for the purpose of this announcement the defined geographic area must be the same as the pre-defined sub-state regions for the Hospital Preparedness Program)**

The following chart must be filled out reflecting the names and affiliations of all entities in the partnership and attached as an appendix to the application.

| Facility Name | Parent Organization | Address | Facility Classification | Facility Type | Facility has signed and established an MOA with the Partnership |
|---|---|---|---|---|---|
| | *(Identify facility parent organization, e.g. Tenet, HCA, Kaiser, other, etc.)* | *(Physical and Mailing Address)* | *(Classify the facility as public, private, non-profit, private non-profit, other, etc.)* | *(Identify facility as hospital, designated NDMS facility; trauma center, community health center, clinic, mental health facility, other, etc.)* | |
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[2] For States that do not have Trauma centers, partnerships may include Trauma centers in neighboring States that are willing to become partners. The application must clearly demonstrate how funds will be shared with the Trauma center despite the fact it is in different State from the partnership. The American College of Surgeons sets the standards for Trauma Center Designation. These standards/processes are found at http://www.facs.org/trauma/ntdbacst.html. Simply put, a Trauma Center (TC) is designated in one of 2 ways: (1) TC directly contacts the American College of Surgeons (ACS) Verification Program or (2) The State has passed laws for its own designation process and the designations are done at the State level. In this latter case, States must use the same standards as required by the ACS's Verification Program.

**Cost Sharing or Matching**

Cost sharing is not required for this cooperative agreement for FY 2007.

**Maintenance of Funding**

Partnerships 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 Partnership as a whole for health care preparedness regardless of the source of funds. To be eligible for funding under this announcement, the partnership as a whole must demonstrate in the budget narrative that they intend to budget at least, and not less than, the average of their FY 05 and FY 06 total spending for health care preparedness. See the example below:

MAINTENANCE OF FUNDING: EXAMPLE

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

**Other**

**Guidance to Partnerships**

A political subdivision shall not participate in more than one partnership described in this announcement.

Any application that fails to clearly involve State, Territorial or directly funded metropolitan area public health authorities in the development and administration of this project and submit a letter of assurance from the State Health Official and Hospital Preparedness Coordinator that ensures this application, work plan and budget are in agreement with the State, Territorial and local emergency response plan will be considered non-responsive and will not be considered for funding under this announcement.

Any application that fails to satisfy the submission deadline requirements referenced in this guidance will be considered non-responsive and will not be considered for funding under this announcement.

Any application that fails to adequately address the required activities referenced in this guidance will be considered non-responsive and will not be considered for funding under this announcement.

Any application that fails to provide Specific, Measurable, Realistic and Time-phased objectives with associated activities to achieve those objectives within the designated budget and project period will be considered for funding under this announcement only after those applications that have included these objectives and activities. (See Appendix 3 for a fuller explanation of the SMART principles)

Any application that fails to certify hospitals participating in the partnership have met NIMS compliance activities as described in the FY 2006 National Bioterrorism Hospital Preparedness Guidance **and** as part of the terms and conditions for accepting these funds agrees that all hospitals participating in the partnership will adopt the remaining NIMS compliance activities during this budget period as referenced in this guidance, will be considered non-responsive and will not be considered for funding under this announcement.

## IV. Application and Submission Information

### 1. Address to Request Application Package

Application kits may be obtained by accessing Grants.gov at http://www.grants.gov or the Grant Solutions system 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. Form and Content of Application Submission

**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 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.

Electronic applications are encouraged to be submitted via the GrantSolutions system or the Grants.gov Website Portal (see 3. Submission Dates and Times for more information). For paper applications, the program narrative must be printed on 8½ by 11 inch white paper, with one-inch margins, single-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 75 single-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. Use rubber bands or clips.

Budget forms must be accompanied by a line item narrative justification. For the purposes of this announcement administrative costs (salary, fringe, supplies, travel etc) are to be kept to a minimum (ideally under 15% of direct costs) and clearly justified. Proposed personnel to be supported through these funds must submit CV's or resumes.

Indirect costs should be provided consistent with negotiated indirect cost rate agreements, and copy of that agreement must be submitted with the application. For additional information regarding indirect cost rates, please contact HHS's Division of Cost Allocation (DCA) at: http://rates.psc.gov/ to learn more about rate agreements, the process for applying for them, and the regional offices which negotiate them.

Any proposed equipment purchases with these funds must be consistent with that of the State or local jurisdiction.

This is a non-construction program and as such no construction or major renovation costs may be requested. Minor alterations and renovations (A&R) are allowable on all grants, without HHS prior approval provided minor A&R costs do not exceed $150,000 or 25% of the total budget.

Successfully funded applications will be required to submit additional post-award information that will be transmitted with the Notice of Grant Award (NGA) and can be found in the Performance Measures section of this announcement.

**Content**

The **narrative description** of the project should be able to stand alone in terms of depth of information. These applications are competitive and as such will be reviewed by objective review panels that may or may not necessarily understand the concepts of all hazards planning and preparedness work or healthcare partnerships. Additionally these applications serve as rich sources of information for initial data collection and inquiries on successfully funded programs. The information should be presented in a clear and logical manner to aid in the objective review process and additional uses of information contained herein. To aid in the review and abstraction of this application applicants must utilize the following outline:

**Project Abstract (up to 5 pages- single spaced)**

The project abstract provides a summary of the application. Because the abstract is often distributed to provide information to the public and Congress, please prepare a narrative that

is clear, accurate, concise, and without reference to other parts of the application. It must include a brief description of the proposed project including:

- the defined geographic area being served by the partnership **(for the purpose of this announcement the defined geographic area must be the same as the pre-defined sub-state regions for the Hospital Preparedness Program)**,
- gaps to be addressed,
- the partners being represented, and
- summary of the workplan that addresses proposed activities, timelines and deliverables.

**Purpose of the Project**
This section should describe the purpose of the proposed project keeping in mind the purpose of partnerships found on pages 1 and 2 and the broad preparedness goals listed below. This section should clearly describe and help reviewers understand:

- the geographic area where the partnerships exists and the number and types of healthcare entities in that area (include hospitals (trauma, children's, burn), clinics, health centers, long term care facilities etc) **(for the purpose of this announcement the defined geographic area must be the pre-defined sub-state regions for the Hospital Preparedness Program);**
- unique risks and consequences of the geographic area, based on previously conducted Hazard and Vulnerability Assessment's (HVA) ( e.g. nuclear power plant, chemical refinery, international port of entry such as an airport etc);
- unique challenges posed by vulnerable populations with medical needs in the defined geographic area;
- whether assessments have been conducted and inventories currently exist that detail what the partnership currently posses in terms of facilities (to include number and types of beds as defined in the HAvBED standards attached to this guidance) specialty services, staff and other response assets (mobile medical assets, state based medical response teams etc);
- current mechanisms for coordinating resource requests across the partnership and for relating those needs, when applicable, to local and State emergency operations centers through the use of Multi Agency Coordination Centers (MACC); and
- gaps in the above mentioned areas and other gaps, based on HVA, to be addressed through this project.

This section must demonstrate how planned activities and funding is coordinated and consistent with the State and local All-Hazards Public Health Emergency Preparedness and Response Plan and relevant local plans. This section must also demonstrate how planned activities and funding is coordinated with activities of relevant local Metropolitan Medical Response Systems (MMRS), local Medical Reserve Corps (MRC) and the Cities Readiness Initiative (CRI).

**Work Plan**
The work plan must provide specific, measurable, and time-phased objectives and specific activities proposed to achieve the objectives in the budget period (September 1, 2007 – August 8, 2008). The work plan should include a projected timetable for completion that

includes dates for the accomplishment of task and identifies responsible parties. For each objective, specify how achievement will be measured and documented.
For purposes of this announcement there are two mandated activities that all partnerships will be expected to conduct and allocate funding to in order to accomplish. These mandated activities are:

1. **NIMS Compliance**

   In accordance with Homeland Security Presidential Directive (HSPD) -5, the National Incident Management System (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.

   To be eligible to receive FY 2007 Federal preparedness funding hospitals must meet NIMS compliance requirements. Hospitals are considered to be NIMS compliant if they have adopted and/or implemented the FY 2006 compliance activities as outlined in the FY 2006 National Bioterrorism Hospital Preparedness Program Cooperative Agreement guidance specifically activities 7, 9, 10 and 11 (see Appendix 1 of this guidance.)

   **<u>During the FY 2007 budget period hospitals in the partnership will need to finish the remaining activities by August 8, 2008.</u>**
   These NIMS compliance activities can be found in Appendix 1 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

2. **Emergency Systems for Advance Registration of Volunteer Health Professionals (ESAR VHP)**

   Volunteers will be essential to ensuring an adequate supply of healthcare personnel to meet medical surge capacity and capability needs. In the complex environment of State-based health professional licensure, and with each hospital and healthcare facility establishing its own credentialing procedures to ensure the competence of clinical professionals, there is no single effective and efficient system to quickly confirm the professional credentials of potential health professional volunteers.

   The purpose of the ESAR-VHP program is to establish a national network of State-based programs to effectively facilitate the use of health professional volunteers in local, State, and Federal emergency response. The experiences gained through the development of the ESAR-VHP program and in responding to Hurricane Katrina have shown that State ESAR-VHP programs must be more than a database 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 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.

**Each State (Territory) is expected have a fully operational ESAR-VHP system by August 8, 2008.** 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 2. 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.

1. Submit a **concept of operation** to serve as guidance in planning for and managing ESAR-VHP volunteers during all phases of emergency management across all members in the partnership.
2. Develop a **plan** for the use and function of ESAR-VHP volunteers in hospitals and healthcare facilities in the partnership and with facilities in adjacent regions during an emergency.

Partnerships may propose additional activities with an associated budget and narrative justification that are consistent with the following goals outlined in section 2802(b) of the PHS Act:

- **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

**Evaluation Plan**
The evaluation plan should: a) describe how prior partnership/coalition activities have been evaluated; b) describe how past evaluation impacts have been incorporated into the current evaluation plan; c) demonstrate a well developed and comprehensive understanding of the various levels of potential impact/influence of the proposed partnership/coalition program goals, benchmarks, and performance indicators; d) describe appropriate evaluation methods used to monitor and track changes in partnership/coalition structure, activities, partner activities, and emergency response activities proposed with these grant funds within the defined geographic region.

**Assurances to be included**

(i) A letter of assurance from the State, Territory or directly funded metropolitan area public health agency(ies) participating in the partnership that certifies the hospital entities have adopted the NIMS compliance activities described in the FY 2006 Hospital Preparedness Guidance and as required through Homeland Security presidential Directive (HSPD) – 5. The letter of assurance should clearly state that as part of the terms and conditions for accepting these funds that participating hospitals will ensure that the remaining 14 NIMS

compliance activities as laid out in this announcement will be adopted during this budget period.

(ii) A letter of assurance from the State, Territory or directly funded metropolitan area public health agency(ies) participating in the partnership attesting to the fact that:

i. This application, work plan and budget were prepared in consultation with the lead health officials of the State, Territory or directly funded metropolitan area public health agency(ies).
ii. That this application is coordinated and consistent with the State All-Hazards Public Health Emergency Preparedness and Response Plan and relevant local plans.

(iii) A letter of assurance from the State, Territory or directly funded metropolitan area public health agency(ies) participating in the partnership stating that to the extent practicable, the activities carried out under this award are coordinated with activities of relevant local Metropolitan Medical Response Systems (MMRS), local Medical Reserve Corps (MRC), and the Cities Readiness Initiative (CRI).

### 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 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 supercedes 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 August 1, 2007 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.

*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, 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.

Applications that are mailed should be sent to the following address:
Office of Grants Management, Office of Public Health and Science (OPHS)
Department of Health and Human Services (DHHS)
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 SPOC's 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 Web Site http://www.whitehouse.gov/omb/grants/spoc/html. 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, fund raising activities, and 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

Procedures for assessing the technical merit of grant applications have been instituted to provide for an objective review of applications and to assist the applicant in understanding the standards against which each application will be judged. Critical indicators have been developed for each review criterion to assist the applicant in presenting pertinent information related to that criterion and to provide the reviewer with a standard for evaluation. Review criteria are outlined below with specific detail and scoring points.

Review Criteria are used to review and rank applications. The Healthcare Facility Partnerships Program has 4 review criteria:

- **NEED (30 points)** - The extent to which the application describes the vulnerabilities and gaps identified through HVA, how the partnership can help to address the vulnerabilities and gaps and how federal funding will either fully address or start to address gaps resulting from those vulnerabilities.

- **WORKPLAN (30 points)** – The extent to which the applicant provides specific, measurable, time-phased objectives, and specific activities to be achieved during the budget period; the extent to which the applicant describes specific objectives of the program that are consistent with the purpose and goals of this announcement; the extent to which the applicant provides a time table and identifies responsible parties for achievement of specific activities to accomplish proposed objectives during the budget period.

- **EVALUATION PLAN (25 points)** – The extent to which the applicant describes methods and strategies to assess, monitor, and improve the quality, effectiveness, and efficiency of the project and progress towards meeting proposed goals and objectives; the extent to which the applicant describes indicators to measure program success; the extent to which the applicant describes evaluation methods and strategies that are reasonable and feasible for the scope of activities proposed; the extent to which the applicant describes a clear process to capture and describe process outcomes and overall impact of the project in terms of its contribution to the evidence base for the

role of regional healthcare coalitions in emergency preparedness, response and recovery; the extent to which the applicant describes methods for sharing and disseminating best practices and lessons learned as a result of federal funding.

- **RESOURCES/CAPABILITIES (5 points)** - The extent to which project personnel are qualified by training and/or experience to implement and carry out the projects. The capabilities of the applicant organization, and quality and availability of facilities and personnel to fulfill the needs and requirements of the proposed project.

- **SUPPORT REQUESTED (10 points)** - The reasonableness of the proposed budget in relation to the objectives, the complexity of the activities, and the anticipated results.

2. **Review and Selection process**

**Statutory Funding Preferences**

Statutory funding preferences are available to applicants in the Healthcare Facilities Partnership Program. A funding preference is defined as the funding of a specific category or group of approved applications ahead of other categories or groups of approved application that do not carry a preference. ***Note that these preferences will be applied to only those applications that rank above the 25$^{th}$ percentile of applications recommended for approval.***

**Qualification 1: Regional Coordination**
The partnership demonstrates how it will enhance coordination **among** the hospitals and designated trauma center and **between** other local health care facilities, including clinics, health centers, primary care facilities, mental health centers, mobile medical assets, or nursing homes **and** includes a significant percentage (greater than 51%) of the hospitals and health care facilities within the geographic area served by such partnership

**Qualification 2: National Disaster Medical System (NDMS)**
The partnership includes facilities participating in the National Disaster Medical System. These hospitals must be clearly identified as NDMS participating facilities in the application.

**Qualification 3: Degree of Risk**
Partnerships are located in a geographic area that faces a high degree of risk. This should be based on the Hazard and Vulnerability Assessment conducted by States during the FY 2005 and FY 2006 funding cycle.

**Qualification 4: Significant Need**
Application clearly demonstrates a significant need for funds to achieve the medical preparedness goals described in this guidance. Applications should clearly delineate whether the partnership receives funds from the Hospital Preparedness Program (formerly the National Bioterrorism Hospital Preparedness Program) CDC Public Health Preparedness grants or other Department of Homeland Security (DHS) grants (to include UASI, SHSGP and MMRS)

and how these funds will be used to compliment and/or leverage other preparedness funding for partnership activities.

The Objective Review Committee shall evaluate information to determine if the applicant has met the statutory funding preference(s).

# VI. Award Administration Information

## 1. Award Notices

The HHS does not release information about individual applications during the review process until final funding decisions have been made. 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 in 45 CFR parts 74 and 92 are the 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 downloaded from 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 grantees 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.

## 3. Reporting

### a) Audit Requirements

Every 2 years award recipients shall conduct an audit of expenditures from amounts received under this award 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**

Applicants funded under this announcement will be required to electronically submit a Mid-Year Progress Report and an End-of-Year Progress report, and a financial report that are due 90 days after the budget period ends.

c) **Performance Measures**

HHS is currently in the process of obtaining OMB approval to request the following performance measures and additional supporting data elements under the Paperwork Reduction Act (PRA). Templates for data collection and submission will be released to awardees as soon as they are approved. Successfully funded partnerships should start data collection on the following measures as soon as possible and be ready to report baseline status as soon as the template is released. In addition to the baseline collection and reporting, partnerships/coalitions will also report on progress made on achieving performance measures at mid-year and 90 days after the end of the budget period.

1. The partnership/coalition has completed both a Hazards and Vulnerability Assessment (HVA) and a gap analysis of capabilities and resources among its healthcare coalition partners within the defined substate region. The partnership/coalition has developed a strategic plan to address and correct findings from the completed gap analysis of resources and capabilities and the HVA.

2. The partnership/coalition has developed a comprehensive situational awareness (SA) capability that integrates public health and medical resources in order to improve early detection of, response to, and management of all public health and medical emergencies. The SA capability enables an accurate medical and public health common operating picture and the maintenance of the program includes a continuous improvement process among its healthcare coalition partners within the defined substate region.

3. The partnership/coalition leadership demonstrates clearly defined, cooperative, and ongoing relationships to accomplish its mission with the coalition partners and with local, regional, and/or state public health agencies and emergency management agencies as well as key stakeholders within the defined substate region by: a) actively participating in emergency preparedness planning meetings, activities, and other venues to develop and foster integrative and collaborative relationships engaging private and public capabilities to improve preparedness ; b) managing and mobilizing coalition membership to identify issues related to medical emergency preparedness; c) managing, developing , and establishing cooperative linkages through Memorandum of Agreements (MOAs), Memorandum of Understandings (MOUs), and/or Compact Agreements; and d) participating in drills, table tops, and full scale exercises.

4. The partnership/coalition has an established process to address the media, the public, and develop health communication messages concerning the RHC and its activities within the defined substate region.

5. The partnership/coalition has established a comprehensive written emergency response and recovery plan that clearly describes the goals, objectives, activities, and standard operating procedures. The partnership/coalition emergency response and recovery plan is based on:

   a) National Preparedness Goal and/or state and local plans;
   b) Completed HVA for the defined region;
   c) Completed resource and capabilities assessment;
   d) Completed gap analysis of RHCP coalition members based on the HVA assessment; and
   e) Evidence based emergency preparedness goals that are time-specific and measurable for the accomplishment of its mission.

   The plan clearly identifies points of linkage, integration, and coordination across the coalition and with and key stakeholders during public health emergencies within the defined substate region. The plan includes an established process to review and assess written standard operating procedures that shape partnership/coalition strategic planning and define coalition partners' roles and responsibilities. The partnership/coalition encourages an evidence-based approach to emergency preparedness, researching and adopting best practices, capitalizing and building upon successes demonstrated in literature, and developing accurate metrics to assess preparedness of the partnership/coalition.

6. The partnership/coalition has participated in drills and full scale exercises in coordination with local and/or state emergency management agency and that have included at- risk populations with medical needs (the term 'at-risk individuals' means children, pregnant women, senior citizens and other individuals who have special needs) to validate plans, improve integration and coordination, and enhance emergency response performance. The partnership/coalition has incorporated findings from corrective action reports into a corrective action plan to improve preparedness capabilities and emergency response performance. The partnership/coalition has demonstrated compliance with the Homeland Security Exercise and Evaluation Program (HSEEP)

7. The partnership/coalition in cooperation with the local and/or state emergency management agency and coalition partners have:
   a. Demonstrated knowledge of the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) and the Medical Reserve Corps (MRC);
   b. Developed plans, established protocols, and demonstrated the ability to use ESAR-VHP and MRC volunteers during all phases of emergency management;
   c. Demonstrated the use of the Emergency Management Assistance Compact (EMAC) during an incident and/or exercise; and

   d. Established a process to address barriers and/or limitations for the use of ESAR-VHP, MRC, and EMAC for the sharing of public health and medical resources during and incident or exercise.

8. The partnership/coalition has submitted timely and complete data for the midyear report, the end-of-year report, and the final FSR. *(The measure will be scored by ASPR staff. A "yes" requires two conditions to be met)*
   i. 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.
   ii. 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.

**Partnerships 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.**

## VII. Agency Contacts

***Administrative and Budgetary Contacts Requirements***
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.

***Program Requirements***
CDR Melissa Sanders
Team Leader
Healthcare Systems Preparedness
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 5616
Washington DC 20201
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***Data and Evaluation Requirements***
Dr. Janet Schiller, Ed.D.
Section Chief for Evaluation
State and Local Initiatives Team
US Department of Health and Human Services (HHS)

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***ESAR-VHP Requirements***

Jennifer Hannah
Acting Team Leader
Emergency Systems for Advance Registration
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**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 upcoming 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.

*Example of compliance:*

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[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.

- *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)*

<u>Element 4</u>
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**

<u>Element 5</u>
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.*

<u>Element 6</u>
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.*

<u>Element 7</u>
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.*

<u>Element 8</u>

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**

<u>Element 9</u>
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.*

<u>Element 10</u>
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.*

<u>Element 11</u>
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 2**

**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[4] 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.

        1) Physicians

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

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 3

## Writing Objectives using the SMART Principles

**Specific:** 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.

**Measurable:** An objective should be able to describe in realistic terms the expected results and specify how such results will be measured.

**Achievable:** The accomplishment specified in the objective should be achievable within the proposed time line and as a direct result of program activities and services.

**Realistic:** The objective should be reasonable in nature. The specified outcomes, expected results, should be described in realistic terms.

**Time-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.