DEPARTMENT OF HEALTH AND HUMAN SERVICES

AGENCY: U.S. Department of Health and Human Services (HHS), Office of the 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 (HPP)

ANNOUNCEMENT TYPE: New Cooperative Agreement

Funding Opportunity Number: Not Applicable

Catalog of Federal Domestic Assistance (CFDA) Number 93.889

Key Dates: To receive consideration, **electronic grant application** submissions must be submitted **no later than 11:30 PM on June 20, 2008** through the application mechanism specified in Section IV.

I. FUNDING OPPORTUNITY DESCRIPTION

Purpose

The Office of the Assistant Secretary for Preparedness and Response (ASPR), 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 319C-2 of the Public Health Service (PHS) Act, as amended by the Pandemic and All-Hazards Preparedness Act (PAHPA) (P.L. 109-417). This authorizes 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. The Consolidated Appropriations Act, 2008, provides funding for these awards (P.L. 110-161).

Surge capacity is defined as the ability of a healthcare system to adequately care for increased numbers of patients.

In 2003, as a planning target HPP defined surge capacity for beds as 500 beds/million population. In 2006, the HPP also defined surge capability as the ability of healthcare systems to treat the unusual or highly specialized medical needs produced as a result of surge capacity. The HPP started to lay out a series of capabilities that all healthcare organizations participating in this program must possess and this funding opportunity announcement continues to clarify those capabilities.

The majority of federal funds (ideally seventy-five percent or more) should be distributed to healthcare facilities.

Healthcare facilities are defined broadly as any combination of the following: outpatient facilities and centers (e.g., behavioral health, substance abuse, urgent care), inpatient facilities and centers (e.g., trauma, state and federal veterans, long-term, children's, tribal), and other entities (e.g., poison control, emergency medical services, nursing).

The activities and funding provided through the CA are for the purposes of exercising and improving preparedness plans for all hazards including pandemic influenza.

The awardee should work with all potential sub-awardees to develop activities that clearly integrate and enhance preparedness activities with the overall effect of making healthcare systems function in more efficient, resilient, and coordinated manners.

Awardees are reminded that these funds are to be used to supplement and develop not supplant current resources supporting healthcare preparedness.

Background

The Public Health Service (PHS) Act, as amended by PAHPA

Pursuant to section 319C-2(c) activities supported through funds under this announcement must help awardees to meet the following goals as outlined in section 2802(b):

Integration: Ensure the integration of public and private medical capabilities with public health and other first responder systems, including -

i. The periodic evaluation of preparedness and response capabilities through drills and exercises; and
ii. Integrating public and private sector public health and medical donations and volunteers.

Medical: Increasing the preparedness, response capabilities, and surge capacities of hospitals, other healthcare 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:

i. Strengthening public health emergency medical management and treatment capabilities;
ii. Medical evacuation and fatality management;
iii. Rapid distribution and administration of medical countermeasures, specifically to hospital-based healthcare workers and their family members or partnership entities;
iv. Effective utilization of any available public and private mobile medical assets and integration of other Federal assets;
v. Protecting healthcare workers and healthcare first responders from workplace exposures during a public health emergency.

At-risk populations: Taking into account the public health and medical needs of at-risk individuals in the event of a public health emergency.

Coordination: Minimizing duplication of, and ensuring coordination among, 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 Framework, or any successor plan, the 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.

National Response Framework

HPP funded activities must help awardees integrate response plans into the broader National Response Framework (Framework) published by the US Department of Homeland Security (DHS).

The Framework presents the guiding principles that enable all response partners to prepare for and provide a unified national response to disasters and emergencies – from the smallest incident to the largest catastrophe. This important document establishes a comprehensive, national, all-hazards approach to domestic incident response. The Framework defines the key principles, roles, and structures that organize the way we respond as a Nation. It describes how communities, tribes, States, the Federal Government, and private-sector and nongovernmental partners apply these principles for a coordinated, effective national response. It also identifies special circumstances where the Federal Government exercises a larger role, including incidents where Federal interests are involved and catastrophic incidents where a State would require significant support. The Framework enables first responders, decision makers, and supporting entities to provide a unified national response.

More information may be found at: http://www.fema.gov/emergency/nrf/mainindex.htm

Medical Surge Capacity and Capability (MSCC) Handbook

The handbook provides a blueprint for a systematic approach for managing medical and public health response to emergencies and disasters through the use of a tiered response, from the Management of Individual Healthcare Assets (Tier 1) through the level of Federal Support to State, Tribal, and Jurisdiction Management (Tier 6). This manual guides the HPP and, as such, activities may be proposed that support all Tiers in the MSCC but especially those that focus on the Tier 1, 2 and 3 levels.

An updated version of the MSCC handbook was published by HHS in September 2007 that expands on several of the concepts included in the first edition. In addition, the new version describes recent changes to the Federal emergency response structure, particularly related to public health and medical response.

Awardees are expected to develop increasingly robust capability and capacity working within the tiered framework.

A summary of the key updates to the MSCC framework is provided in the appendices of this funding opportunity.

Integrating Preparedness Activities across Federal Agencies

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 awardees are strongly encouraged to take advantage of them.

Project Description

Overarching Requirements and ASPR Expectations

The following four sub-capabilities must be incorporated into the development and maintenance of all capabilities:

1. **National Incident Management System (NIMS)**
2. **Education and Preparedness Training**
3. **Exercises, Evaluation and Corrective Actions**
4. **Needs of At-Risk Populations**

1. 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, awardees shall assure sub-awardees continue adopting and implementing NIMS compliance activities. NIMS activities for FY 2008 have been streamlined and adjusted.

ASPR Expectation:

Awardees: Awardees will assess and report which participating hospitals (healthcare organizations) currently have adopted all NIMS elements as outlined in the NIMS Implementation Activities for Healthcare Organizations and which facilities are still in the process of adopting activities. For any participating hospitals that are still working to adopt activities, funds must be prioritized and made available to ensure full compliance of those facilities during the funding cycle.

Further information can be found in the appendices of this funding opportunity and at: http://www.fema.gov/pdf/emergency/nims/imp_hos.pdf

Healthcare Organizations: All participating healthcare organizations must comprehensively track facility compliance with NIMS activities and report on those activities annually as part of the reporting requirements of this cooperative agreement.

The following issues must be addressed in the FY 2008 application:

1. A comprehensive inventory that lists participating healthcare organizations; identifies each of the 14 NIMS activities (described in the appendices of the funding opportunity) that have been achieved; and identifies each activity still in progress.
2. A detailed description of activities with associated budget allocations that ensure all facilities are striving to reach full NIMS compliance by July 2008.

2. Education and Preparedness Training

ASPR Expectations of Awardees and Sub-awardees:
Awardees shall ensure that education and training opportunities or programs exist for adult and pediatric pre-hospital, hospital, and outpatient healthcare personnel who respond to terrorist incidents or other public health emergencies. Those opportunities or programs must encompass the sub-capabilities described herein. Also, awardees shall undertake activities to ensure all education and training opportunities or programs (including those in local health departments, major community healthcare institutions, emergency response agencies, public safety agencies, mental health and substance abuse facilities, etc.) collectively enhance the abilities of workers to respond in a coordinated, non-overlapping manner that minimizes duplication and fills gaps in the event of a public health emergency. FY 2008 funds may be used to offset the cost of hospital personnel participation in training centered around sub-capability development; to prepare staff with the necessary knowledge, skills and abilities to perform/enhance the capability; and to participate in drills and exercises. System capabilities may be enhanced as well. The HPP fully expects that awardees will work closely with their sub-awardees in determining cost-sharing arrangements that will facilitate the maximum number of personnel participating in drills and exercises.

The following issues must be addressed in the FY 2008 application:

1. Describe how the education and training activities proposed in the work plan are linked to facility level or community level Hazard and Vulnerability Assessments (HVA).
2. Describe how the knowledge, skills and abilities acquired as a result of education and training activities proposed in the work plan will be incorporated into exercises/drills.

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.

3. Exercises, Evaluations and Corrective Actions

To meet the applicable goals described in section 2802(b) of the PHS Act, all applications must address the evaluation of State and local preparedness and response capabilities through drills and exercises.

In FY 2008, awardees shall continue to use the DHS 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. At-risk populations and/or those who represent them must also be engaged in preparedness planning and exercise activities.

Awardees are reminded that response to real world events that may arise during the course of the project period (12 months) **may** count towards the exercise requirements if the following conditions are met as outlined under "ASPR Expectation." There is no minimum requirement on the length of the event as long as an AAR and corrective action plan are put into place after the event.

ASPR Expectation: Exercise programs funded all or in part by HPP cooperative agreement funds should be built on the Homeland Security Exercise and Evaluation Program (HSEEP). Further information on HSEEP may be found in Appendix C of this funding opportunity.

Awardees must ensure at least one exercise is conducted in each Cities Readiness Initiative (CRI) city and an equal number of exercises in other locations during the FY 2008 budget period and ensure that participating healthcare organizations in those areas participate in these exercises. Further, ASPR expects that each exercise tests the operational capability of the following medical surge components:

1. Interoperable communications and Emergency Systems for Advance Registration of Volunteer Health Professionals (ESAR VHP);

2. A tabletop component to test the MOUs that are in place in partnerships/coalitions within the areas selected (further information on what these MOUs should contain is described below in the Partnership/Coalition description below); and

3. Fatality Management, Medical Evacuation, Tracking of Bed Availability (at least 2 of these other Level-One capabilities).

Whenever possible, exercises should be combined with exercises scheduled by public health, Homeland Security, emergency management or other responders, to minimize burden on exercise planners and participants.

As with all other activities discussed in this funding opportunity, exercise plans must demonstrate coordination with relevant local entities such as local healthcare partnerships, Metropolitan Medical Response System (MMRS) facilities, local Medical Reserve Corps (MRC), and the CRI jurisdictions, to the extent possible. Awardees are expected to work with relevant State and local officials to provide information for the National Exercise Schedule (NEXS) so that exercises can be coordinated across levels of government.

Awardees shall develop and submit an exercise plan. The exercise plan must include a proposed exercise schedule; a discussion of the plans for development, conduct, and evaluation; and improvement planning.

Awardees must:

1. Clearly delineate the CRI and non-CRI cities in which exercises are being developed and conducted, the dates of those exercises and the exercise objectives (to include those listed above);

2. Describe the role of healthcare organizations in exercise development, participation, evaluation, development of after action reports, and participation in evaluation and improvement plans;

3. Describe how the awardee will ensure that lessons learned from after action reports are shared with the healthcare facilities and how the emergency operations plans of those facilities are then modified; and

4. Describe how plans for training are integrated with the exercise program.

5. Track all HPP funded training, drills and exercises. The system shall detail the subject matter of trainings and the number trained by healthcare specialty. The awardee is required to track the level of exercise, the sub-capabilities being targeted, and the participating organizations, i.e., hospitals and other healthcare entities, EMS, Department of Public Health, or other participants. **This information will be submitted with the end-of-year progress reports.**
6. Awardees shall submit all AARs, improvement plans, and corrective actions that are developed for the aforementioned exercises. Additionally, an executive summary of the 3 corrective action items and the timeline for fixing those deficiencies must be **submitted with the end-of-year progress reports**.

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. (Note: Salaries for back filling are not allowable costs under the cooperative agreement);

- Costs associated with planning, developing, executing and evaluating exercises and drills.

4. Needs of At-Risk Populations

ASPR Expectations:
Applications must clearly articulate which at-risk populations with medical needs are being served and the activities that will be undertaken with respect to the needs of these individuals. Medical needs include and are not limited to behavioral health consisting of both mental health and substance abuse considerations. Awardees should work with community-based organizations serving these groups to ensure plans are appropriate, involve the necessary partners, and include representation from the at-risk populations.

HHS has developed a broader definition of "at-risk" populations that is used to supplement the legislative language above. Before, during, and after an incident, at-risk populations are those who may have additional needs in one or more of the following functional areas:

a. independence
b. communication
c. transportation
d. supervision
e. medical care

In addition to those individuals specifically recognized as at-risk in section 2802(b)(4)(B) of the PHS Act (i.e., children, senior citizens, and pregnant women), individuals who may need additional response assistance should include those who: have disabilities; live in institutionalized settings; are from diverse cultures; have limited English proficiency or are non-English speaking; are transportation disadvantaged; have chronic medical disorders; and/or have pharmacological dependency. In simple terms, at-risk populations are those who have, in addition to their medical needs, other needs that may interfere with their ability to access or receive medical care.

Project Activities

Level One Sub-capabilities

FY 2008 HPP cooperative agreement funds will be used to continue building medical surge capacity and capability at the State and local level through associated planning, personnel, equipment, training and exercises. Awardees are expected to continue the work initiated during the FY 2007 program year, and are required to address the following priority sub-capabilities within their FY 2008 work plans**:**

- Interoperable Communication Systems
- Tracking of Bed Availability (HAvBED)
- ESAR VHP

- Fatality Management
- Medical Evacuation/Shelter in Place
- Partnership/Coalition Development

Interoperable Communication Systems

ASPR Expectation: All awardees are required to equip participating hospitals and other healthcare entities, to the extent possible, with communication devices which allow them to communicate horizontally and vertically with EMS, fire, law enforcement, local and state public health agencies, nearby community health centers, long term care facilities, nursing homes and other medical and referral centers. In addition, ASPR expects awardees to identify a minimum of 3 hospitals or healthcare entities per sub-state region for participation in the Federal Communications Commission's (FCC) Telecommunications Service Priority Program (TSP).

Since FY 2003, the Hospital Preparedness Program (HPP) has required that hospitals and health departments establish communications redundancy, ensuring that if one communications system fails, other technologies can be implemented in order to maintain communications. HHS strongly encourages all participating hospitals, healthcare partnerships, and State Departments of Health to develop communications redundancy composed of the following:

- Landline and Cellular Telephones
- Two-Way VHF/UHF Radio
- Satellite Telephone
- Amateur (HAM) Radio

During FY 2008, awardees shall develop operational, redundant communication systems that are capable of communicating both horizontally, between healthcare providers, and vertically, within the jurisdiction incident command structure as described in the tiered response framework outlined in the MSCC Handbook. The systems shall link all health related organizations that participate in the HPP program, as well as those that are deemed necessary by the State for both state and local jurisdiction health and medical response operations, including the integration of plans with those of law enforcement, public works and others. Systems should provide 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. These systems should promote information and real time data integration intra - and extramurally among healthcare systems. For the purpose of meeting the intent of this funded program and to provide a clear and informative aid to the officials and personnel implementing measures to meet these objectives, any use of the term "real time" is described as an application in which information or data are immediately collected and received without any or virtually no time delay.
Events that occur in real time (i.e., occurring virtually at that particular moment) are dynamic -- not static -- and available immediately and continuously.

Not all tiers are meant to be implemented equally across all organizations. HHS recognizes there is more than one way to implement each communication tier and that each State faces its own unique circumstances, such as geographic considerations. Each organization will also need to consider the operational and financial impact of these various recommendations as they develop their plans; but this activity must be viewed as a priority for this funding cycle and be addressed accordingly.

Telecommunications Service Priority (TSP) Program

ASPR Expectation: Awardees are required to identify hospitals or healthcare entities for participation in the FCC TSP. Participating facilities must be those that the awardee recognizes as high priority medical surge points, and that possibly risk the loss/interruption of communication capability. Participation in this program allows for communications with first responders (i.e., police, fire and ambulance), as well as to State and local health departments. This includes lines that allow for data transfer of patient case specific information, telemedicine, bed availability and other resources and medical equipment needs such as ventilators.

Awardees will provide a list of facilities currently participating in TSP (noting whether federal funds were used to achieve this purpose) and a list of those being considered for participation through this funding opportunity. Awardees should be very cognizant that facilities currently participating in TSP and supporting the costs on their own are not eligible for federal funds to support these costs moving forward. This may be construed as supplanting funds.

The Federal Communications Commission's (FCC), Public Safety and Homeland Security Bureau (PSHSB) works with various stakeholders to improve emergency response capabilities and the ability of the nation's hospitals and healthcare community to communicate effectively. One of the top priorities of the Bureau is to work with Federal partners on issues regarding the restoration of communications services to awardees and their participating entities impacted by a disaster. Under the Federal Emergency Support Function-2 (ESF-2) of the National Response Framework, the FCC and PSHSB support the National Communications System (NCS) and the Federal Emergency Management Agency (FEMA) in the restoration of communications services impacted by a natural disaster or man-made event.

The TSP requires local telecommunications service providers to give restoration (priority applied to new or existing telecommunications services to ensure restoration before any other services) or provisioning service priority to users (priority installation of new telecommunications services), even during disasters, where there is extensive damage to the telecommunications infrastructure and large numbers of other local customers are out of service.

Because telecommunications service providers typically charge for TSP on a per line basis, participating hospitals or healthcare entities should only seek coverage for those

lines essential to keeping operations running. It is important to note that healthcare organizations participating in TSP have the advantage of moving service to alternative care sites should they be forced into situations where evacuation and/or relocation of operations is a factor.

Finally, TSP is designed to ensure that the most critical telecommunications lines work. It **does not** provide for priority completion of calls. This can be done by participation in Government Emergency Telecommunications Service (GETS) or Wireless Priority Service (WPS) for mobile cellular phones. These are emergency telecommunications programs administered by the NCS that provide for priority completion of out-bound calls when the Public Telephone Network (PTN) is congested. GETS does not provide priority completion of in-bound calls.

Because State and local health departments, hospitals and other healthcare facilities originate large numbers of calls during emergencies, the FCC, NCS and HHS recommend that they participate in all three programs: GETS, WPS and TSP. All three programs meet requirements set forth by HPP under Interoperable Communications requirements. For further information about TSP, call or email:

Allan Manuel at allan.manuel@fcc.gov or tspinfo@fcc.gov.

GETS and WPS information can be found on the NCS web-site at: http://gets.ncs.gov/ and http://wps.ncs.gov/ . For further information, call or email:

Deborah.Bea at Deborah.Bea@dhs.gov
866-NCS-CALL (866-627-2255)

National Hospital Available Beds for Emergencies and Disasters (**HAvBED)**

ASPR Expectation: During the FY07 budget period**,** awardees were required to complete development of an operational bed tracking, accountability/availability system compatible with the HAvBED data standards and definitions. During the FY08 budget period, systems must be further developed to submit required data using one of two mechanisms. Depending upon the system the State chooses to use to report the data, the system must adhere to requirements and definitions included in the appendices of this funding opportunity:

1) Awardees may choose to use the HAvBED web-portal to manually enter the required data. Data are 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) Awardees may use existing systems to automatically transfer required data to the HAvBED server using the HAvBED EDXL Communication Schema, which can be found at: http://www.ahrq.gov/prep/havbed/.

During the remainder of the FY07 budget period and throughout the FY08 budget period, information and technical assistance will be provided for awardees planning to utilize

either of the two options. States are strongly encouraged to move toward automation and capabilities for reporting information in real-time. A definition of real-time was described in the CDC's FY 2007 Public Health Emergency Preparedness Grant Guidance.

All technical assistance or system requirement issues should be directed to Mr. Mark Lauda (mark.lauda@hhs.gov), 202-401-2783.

Emergency Systems for Advance Registration of Volunteer Health Professionals (ESAR-VHP)

ASPR Expectation: ASPR expects that all ESAR-VHP electronic system, operational, evaluation and reporting compliance requirements are met by August 8, 2009. For a detailed list of these requirements please see Appendix E of this funding opportunity.

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. In order to successfully support the use of health professional volunteers at all tiers of response, State ESAR-VHP programs must work to ensure program viability and operability through the development of plans to:

- recruit and retain volunteers;
- coordinate with other volunteer health professional/emergency preparedness entities; and
- link State ESAR-VHP programs with State emergency management authorities to ensure effective movement and deployment of volunteers.

The *ESAR-VHP Compliance Requirements* define the capabilities of such a program. As a condition of receiving HPP funds, awardees shall meet the ESAR-VHP compliance requirements and work to continue adopting and implementing the *2008 Interim ESAR-VHP Technical and Policy Guidelines, Standards, and Definitions* (Guidelines). The *ESAR-VHP Guidelines* are intended to be a living document. It is anticipated that sections of the *ESAR-VHP Guidelines* will be continuously refined and updated as new information is available.

In FY 2007, awardees were required to meet the Electronic System Requirements (1-5). Please provide a statement that confirms that the State has met these requirements as described in the FY 2007 HPP funding opportunity. **Note:** The Compliance Requirements document was revised, and requirements 1 and 2 have been combined.

In accordance with the eligibility and allowable use of funds awarded through this announcement, awardees shall direct FY 2008 funding towards meeting the remaining compliance requirements by **August 8, 2009.**

Fatality Management

ASPR Expectation: All awardees must work closely with participating hospitals and other appropriate healthcare entities to ensure that facility level fatality management plans are integrated into local, jurisdictional and State plans for disposition of the deceased. These plans must clearly account for the proper identification, handling and storage of remains.

In FY 2007, awardees were directed to begin development of disaster and mass fatality management plans and concepts of operation with participating healthcare entities, local health departments, emergency management and State/jurisdictional Chief Medical Examiner/Coroner. During FY 2008, awardees must continue to work with the entities above, and others as appropriate, to continue building robust plans that integrate mass fatality planning within the MSCC tiered response framework, with a focus on:

Tier 2 – Management of the Healthcare Coalition
Tier 3 – Jurisdiction Incident Management
Tier 4 – Management of State Response and Coordination of Intrastate Jurisdictions

Awardees should base planning on the estimated number of fatalities expected in the case of the most likely events as identified in the state HVA, or expected during an influenza pandemic. Funds may be used for the development of enhanced plans, as well as the purchase of mortuary equipment and supplies (i.e., face shields, protective covering, gloves, and disaster body bags).

In the funding application, awardees must address:

- the current status of Fatality Management planning, including the need for expanded refrigerated storage capacity, and supplies such as body bags;
- the role of the State/jurisdictional Chief Medical Examiner/Coroner in the fatality management planning process;
- the role of participating hospitals, emergency management, public health and other State/local agencies in the fatality management planning process, and
- the cultural, religious, legal and regulatory issues involved with the respectful retrieval, tracking, transportation, identification of bodies, and death certificate completion.

Medical Evacuation/Shelter in Place (SIP)

ASPR Expectation: ASPR understands that not all scenarios will or should require a full or partial facility evacuation. In some situations it may be safer and more medically responsible for facilities to shelter in place versus evacuating patients and/or facilities.

In FY 2008, the Federal Government through its Regional Emergency Coordinators (RECs) will undertake a collaboration with States to better determine the capabilities and

opportunities for improvement of healthcare system preparedness. They will work with healthcare facilities, EMS, emergency management officials, fire departments, law enforcement and public health officials with the expressed goal of evaluating the advisability of evacuation and sheltering in place of patients in the event of a catastrophe or degraded infrastructure. This evaluation shall consider operational requirements and resources in order to enhance the strategic decision to shelter in place or evacuate. These evaluations should result in processes that are available to all institutions and integrated with other preparedness plans.

Awardees must continue to integrate planning of participating hospitals into Tiers 2, 3, and 4 of the tiered response framework

Proactive planning and preparation will ensure successful operational plans. Awardees should develop plans based on a Hazard and Vulnerability Analysis (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 awardees and healthcare entities plan for the event. Awardees should develop their plans based on the personnel, equipment and systems, planning, and training needs to ensure the safe and respectful movement of patients, and the safety of personnel and family members in the hospital.

The State should encourage all participating hospitals to take the following into account when working on the integration of local/regional plans:

- the personnel of other hospitals in their region and within other regions of the state;
- equipment and systems of other hospitals as well as those offered by State's office of emergency management or designated agency;
- planning and training needed among all participating hospitals to ensure the safe evacuation of patients; and
- the safety of personnel and family members in the hospital.

While it is not practical to exercise evacuation plans on a large scale, the awardee may want to consider conducting tabletop or feasibly scaled exercises around this issue to highlight vulnerabilities and solutions.

Partnership/Coalition Development

ASPR Expectation:

1. During this funding cycle, all awardees must ensure operational partnerships/coalitions that encompass all CRI cities in the State plus an equal number of partnerships/coalitions involving non-CRI sub-state regions. For example, if a State possess 2 CRI cities then there needs to be 4 partnerships/coalitions (2 in the CRI cities and 2 in other sub-state regions)

2. Partnerships shall plan and develop memoranda of understanding (MOU) 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. These MOUs shall be tested through tabletop components of exercises conducted in CRI and non-CRI cities as described above in the Exercise section.

3. Awardees will submit the following information with the end-of-year report:
    a. the name of the partnership/coalition;
    b. the location of the partnership/coalition;
    c. the participant healthcare organizations and other partners; and
    d. the number and type of MOUs that exist.

Partnerships/coalitions will consist of:

- one or more hospitals, at least one of which shall be a designated trauma center, if applicable;
- 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 awardees; or
- one or more awardees and one or more political subdivisions.

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 and disaster operations become necessary. Partnerships shall be able to strategically:

- integrate plans and activities of all participating partners into the jurisdictional response plan and the State response plan;
- increase medical response capabilities in the community, region and State;
- prepare for the needs of at-risk populations in their communities in the event of a public health emergency;
- coordinate activities to minimize duplication of effort and ensure coordination among, 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); and
- maintain continuity of operations in the community vertically with the local jurisdictional emergency management organizations.

Partnerships are not expected to replace or relieve healthcare facilities of their institutional responsibilities during an emergency or to subvert the authority and responsibility of the State or directly funded city.

Level Two Sub-capabilities

HHS recognizes that maintenance of current systems, equipment and capabilities is critical for the sustainability of State preparedness efforts. These Level-Two sub-capability activities remain allowable costs under the FY 2008 cooperative agreement provided the Level–One Capabilities are being adequately addressed in the work plan. Once that determination has been made, awardees may suggest activities and proposed funding for the activities listed below.

To the extent possible, equipment purchases should be considered through the DHS Homeland Security Grant Program (HSGP) Standardized Equipment List (SEL) for first responders. This list is accessible through the DHS Responder Knowledge Base at: https://www.rkb.us/mel.cfm.

Alternate Care Sites (ACS)

ASPR Expectation: ASPR expects all awardees to continue developing and improving their ACS plans and concept of operations for providing supplemental surge capacity to the healthcare system. ACS plans should include issues on providing care and allocating scarce equipment, supplies, and personnel by the state at such sites. ACS planning must be conducted by closely working with HHS Regional Emergency Coordinators (RECs), local health departments, State public health agencies, State Medicaid Agencies, State Survey Agencies, provider associations, community partners, State mental health and substance abuse authorities and neighboring and regional healthcare facilities.

Many awardees have been developing ACS plans as an option for providing disaster and mass casualty medical care in the event that hospitals are overrun or rendered unusable by a disaster. Awardees shall use FY 2008 HPP cooperative agreement funds to continue building robust plans for the use of such facilities.

Establishment of ACS (e.g., schools, hotels, airport hangars, gymnasiums, stadiums, convention centers) are critical to providing supplemental facility 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 and other healthcare service quality 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.

Use of existing buildings and infrastructure as ACS is the most probable though not the only solution should a surge medical care facility need to be opened. When identifying sites, awardees should consider how the ACS would interface with other local, regional, State, EMAC and Federal assets. Federal assets may require an “environment of opportunity” for set up and operation and may not be available for 72 hours or more. 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.

Planning for the use of an ACS as part of the medical response system is a complicated undertaking. The Agency for Healthcare Research and Quality (AHRQ) has developed a tool that serves to identify a facility within a region suitable for the purpose of an ACS. This tool can be found at http://www.ahrq.gov/research/altsites/index.html#Contents. In addition, plans must take into account many other issues including, but not limited to, ownership, command and control, staffing, scope of care to be provided, criteria for admission, standard operating procedures, safety and security, housekeeping, and many other complex considerations.

Awardees will submit the following information with the end-of-year progress report:

- location of ACS ;
- number of beds;
- level of care to be provided or types of patients that can be taken care of; and
- summary of plans for staffing, supply and re-supply of sites.

Mobile Medical Assets

Awardees may need the ability to provide care outside of the hospital or healthcare system. Use of mobile medical assets (tents, trailers or medical facilities that can be easily transported from one place to another) may be an option for some jurisdictions until patients in large population centers can be evacuated to less affected outlying areas with intact healthcare delivery systems. Awardees 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 who may function interchangeably as surge augmentation or evacuation facilitators.

Pharmaceutical Caches

Each awardee must develop an operational plan that assures storage, rotation and distribution of critical medications through the supply chain during an emergency for healthcare providers and their families in a timely manner. Although many awardees should already have caches in place due to the multiple years of funding for this activity, awardees 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. During FY 2008, awardees may undertake analysis of and propose funding for the purchase of caches to care for **patients in medical facilities**, if this has not already occurred. FY 2008 funding can be used to purchase, replace and rotate pharmaceuticals only if the purchases are linked to a Hazard and Vulnerability Analysis (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 ensure 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 ensure the integrity of the supply line and how it will be managed in an event. Mutual aid agreements may need to be developed to ensure that access to the caches is timely for all healthcare centers.

Awardees 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 in planning to provide access to all healthcare partners during an event. Awardees should also work with these stakeholders to develop training and education for healthcare providers on the available assets and identify how those assets would be utilized to maximize response efforts.

Allowable purchases

The following are allowable purchases and both pediatric doses and adult doses shall be considered. Awardees may consider a phased approach for pharmaceutical purchases in the following order of precedence:

a) antibiotic drugs for prophylaxis and post-exposure prophylaxis to biological agents for at least three days.;

b) nerve agent antidotes.

   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. HPP funds may be used (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. 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.);

c) antiviral drugs - in general, the purchase of antivirals is allowed through the HPP; however, purchases are <u>limited</u> to treatment purposes only for patients, medical and ancillary staff and their family members. <u>Purchases for prophylaxes are unallowable</u>. Plans should consider the following: cost, dispensing prioritization, storage location, and rotation of stock and dispensing mechanisms.

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

d) medications and vaccines needed for exposure to other threats (e.g., radiological events).

Personal Protective Equipment

Each awardee must ensure adequate types and amounts of personal protective equipment (PPE) to protect current and additional trained healthcare personnel expected in support of the events of highest risk and identified through a State-based HVA or assessment. The amount should be tied directly to the number of healthcare personnel needed to support bed surge capacity during an MCI that requires PPE.

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.

Decontamination

Each recipient should ensure that 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 all hazards and health and medical disaster events. 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. 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.

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.

Additional Considerations

Medical Reserve Corps (MRC)

The Medical Reserve Corps (MRC) program is administered by the HHS Office of the Surgeon General. MRC units are organized locally to meet the health and safety needs of their communities. MRC members are identified, credentialed, trained and organized in advance of an emergency, and may be also be utilized throughout the year to improve the public health system.

In order to promote and ensure the integration of public and private medical capabilities with public health and other first responder systems, awardees may consider using HPP cooperative agreement funds to support the integration of MRC units with local, regional and statewide infrastructure. Awardees are also encouraged to use multiple sources of funding to establish/maintain the MRC program**.** HPP grant funds may be used to:

- support MRC personnel/coordinators for the primary purpose of integrating the MRC structure with the State ESAR-VHP program;
- include MRC volunteers in trainings that are integrated with that of other local, State, and regional assets such as hospitals, Community Health Centers, Long-Term Care Facilities, or volunteers through the ESAR-VHP program; and/or
- include MRC volunteers in exercises that integrate the MRC volunteers with other local, State, and regional assets such as personnel who work in hospitals, Community Health Centers, Long-Term Care Facilities, or volunteer through the ESAR-VHP program.

For more information on what HPP grant funds may be used for, please contact your project officer with the Hospital Preparedness Program. More information about the MRC program can be found at: www.medicalreservecorps.gov or MRCcontact@hhs.gov, (301) 443-4951.

Critical Infrastructure Protection (CIP)

Protecting and ensuring the resiliency of the critical infrastructure and key resources (CI/KR) of the United States is essential to the Nation's security, economic vitality and public health. In *The National Infrastructure Protection Plan* (NIPP) Base Plan, the Department of Homeland Security sets forth the national model to protect critical assets, systems, networks, and functions for each of the 17 national CI/KR sectors identified in Homeland Security Presidential Directive #7 (HSPD-7) , *Critical Infrastructure Identification, Prioritization and Protection.*

The infrastructure protection concepts in the risk management framework highlighted in the NIPP represent a vital component within the "continuum of readiness" and are integrated with the principles and guidance promulgated in the NRF and the NIMS. The NIPP designates HHS as the Sector Specific Agency (SSA) for the Healthcare and Public Health (HPH) Sector. HHS, as SSA, is responsible for facilitating a public/private partnership in support of efforts to identify, prioritize, protect, and ensure resiliency of the nation's healthcare and public health CI/KR. The partnership is important in that many of the assets critical at the national, regional, State, and local levels are owned and/or operated by private sector organizations. HHS is also responsible for reporting annually on the progress made in the sector.

For HPP-related activities, the following definitions will be applied:

- *Critical Infrastructure Protection (CIP)* - the strategies, policies, and preparedness needed to protect, prevent, and when necessary, respond to threats to critical infrastructures and key resources.
- *Critical Infrastructure (CI) and Key Resources (KR)* – the assets, systems, networks, and functions, whether physical or organizational, whose destruction or incapacity would have a debilitating impact on the Nation's security, public health and safety, and/or economic vitality.
- *Resilience* - the ability of an asset, system, network or function, to maintain its capabilities and function during and in the aftermath of an All-Hazards incident.

During the FY 2008 funding cycle, HHS would like to foster stronger regional, State and local cooperation in CIP activities such as asset identification, asset protection, facility and system resilience, and sector continuity of operations.

Several of the sections above have described efforts that relate to CIP. HHS encourages applicants to propose projects that relate directly to resilience and protection of critical facilities and services. Suggestions should be based on a need identified in a risk assessment**.** Some examples may include: upgrading of security systems; movement of switching rooms and generators; ensuring adequate back up generators for key facilities in the region; expanding the functions/services that have back-up power (HVAC, elevators, security systems, etc.).
HHS recognizes that facility level needs will likely be high for these kinds of activities but *still urges* awardees to consider activities and purchases that support REGIONAL approaches to planning and response due to limited funding and competing demands.

Awardees will report progress on these activities through semi-annual progress reporting.

For further information on the documents referenced above please refer to the following links:

- NIPP – National Infrastructure Protection Plan - http://www.dhs.gov/nipp

- HSPD-7 – Homeland Security Presidential Directive #7 - http://www.whitehouse.gov/news/releases/2003/12/20031217-5.html
- CIP Program for the Healthcare and Public Health Sector – http://www.hhs.gov/aspr/opeo/cip/index.html
- FEMA ICS free online course on the NIPP (IS-860) - http://www.training.fema.gov/EMIWEB/is/is860.asp

II. AWARD INFORMATION

Type of Award: Cooperative Agreement
Approximate Award Period Funding: $398,095,000 (Includes direct and indirect costs.)
Approximate Number of Awards: 62
Approximate Average Award: Not Applicable
Floor of Individual Award Range: Not Applicable
Ceiling of Individual Award Range: Not Applicable
Anticipated Award Date: August 9, 2008
Budget Period Length: 12 months
Project Period Length: 12 months

Throughout the project period, HHS' commitment to continuation of awards will be conditioned on the availability of funds, evidence of satisfactory progress by the recipient (as documented in required reports), and the determination that continued funding is in the best interest of the Federal government.

This is a new cooperative agreement. ASPR will be substantially involved in the recipient activities by reviewing and approving technical assistance products and participating in planning and training activities, which will be determined by the needs and priorities of the recipient and the ASPR. The cooperative agreement will include the following and any additional elements which may be agreed upon between the ASPR and the recipient when the agreement is funded:

1) The recipient will
- Provide work plans, assessment plan, budgets, applicable work products, etc. that support the goals of the National Health Security Strategy.
- Ensure program activities are consistent with the Department of Homeland Security National Preparedness Framework.
- Submit program performance and financial status reports on a quarterly basis.

2) ASPR will
- Monitor program performance and take corrective action as necessary if detailed performance specifications are not met.
- Provide Technical Assistance, including but not limited to:
    - Integration/Coordination of federal funding for preparedness
    - Subject matter expertise on preparedness activities
    - Identification of promising practices
    - Development of performance goals and standards
    - Assistance with exercise planning and execution

- Review and approve work plans, budgets, and proposed contracts.

III. ELIGIBILITY INFORMATION

1. Eligible Applicants

Eligible applicants for this announcement are limited to those previously funded under the Hospital Preparedness Program:

- 50 States, the District of Columbia, the three metropolitan areas of New York City, Los Angeles County, and Chicago; the Commonwealth of Puerto Rico and the Northern Mariana Islands, the territories of American Samoa, Guam and the U.S. Virgin Islands; the Federated States of Micronesia; and the Republic of Palau and the Marshall Islands.

Applicants are encouraged to reach out to a broad range of healthcare partners to participate in the program. Healthcare partners include and are not limited to hospitals, outpatient facilities, community health centers, poison control centers, nursing homes, urgent care centers, tribal health facilities, EMS and other healthcare partners. These entities 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 funding opportunity, 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

No cost sharing or match is required.

3. Other

Maintenance of Effort (MOE)

Awardees must demonstrate that they intend to 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 healthcare preparedness.

To be eligible for funding under this announcement, the recipient must demonstrate in the budget narrative that they intend to budget not less than the average of their FY 2006 and FY 2007 total spending for healthcare preparedness.
For the purposes of calculating MOE for healthcare preparedness spending, the following applies:

1. State contributions only, not Federal dollars

2. Surge Capacity investments to be considered:

    a. Beds
    b. Isolation
    c. Decontamination
    d. PPE
    e. Pharmaceuticals
    f. Mobile Medical Assets
    g. Interoperable communications equipment and capability
    h. Laboratory equipment, trainings

The following table must be submitted with the application:

MAINTENANCE OF FUNDING: EXAMPLE

STATE EXPENDITURES - HEALTHCARE PREPAREDNESS

	STATE Funds	TOTAL	
FY 06	$1,000,000	$1,000,000	
FY 07	$1,200,000	$1,200,000	
		AVERAGE	$1,100,000

FOR FY 08, STATE SHALL MAINTAIN EXPENDITURES FOR HEALTHCARE PREPAREDNESS OF AT LEAST $1,100,000.

Other

PAHPA amended section 319C-1 and 319C-2 of the PHS Act to add certain accountability and compliance requirements that grantees must meet, including achievement of evidence-based benchmarks, audit requirements, and maximum carryover amounts. Please see Appendix F, Enforcement Actions and Disputes, for more details about these requirements. Beginning with the distribution of FY 2009 funding, awardees that fail substantially to meet for FY 2008, the State Level performance measures described in this announcement in Section VI (Award Administration Information), Performance Measures and Data Elements or who fail to submit a pandemic influenza plan to CDC as part of their application for PHEP funds, may have funds withheld from their FY 2009 and subsequent award amounts as described in Appendix F.

IV. APPLICATION AND SUBMISSION INFORMATION

1. Address to Request Application Package

Given the technical capabilities necessary to carryout and document the activities required under this program, HHS is limiting applications to electronic submission only by accessing the Grants.gov website at: http://www.Grants.gov.

Dun and Bradstreet Data Universal Number System

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. Organizations can receive a DUNS number at no cost by calling the dedicated toll-free DUNS Number request line at 1-866-705-5711 or by using this link: https://www.whitehouse.gov/omb/grants/duns_num_guide.pdf**.**

2. Content and Form of Application Submission

Program Narrative

Applicants must electronically submit a program narrative with the application forms, in the following format:

- Document size: 8.5 by 11 inches white background, with one-inch margins;
- Font size: Be single-spaced with an easily readable12-point font;
- Maximum number of pages: **85 single-spaced** pages not including appendices and required forms. (If the narrative exceeds the page limit, ASPR will only review the first pages that are within the page limit.);
- Number all pages of the application sequentially from page one (Application Face Page) to the end of the application, including charts, figures, tables, and appendices.

Additional requirements that may require you to submit additional documentation with your application are listed in section "VI.2. Administrative and National Policy Requirements."

The components counted as part of the 85 page limit include:

- Summary
- Description of Applicant Organization
- Program Description
- Needs Statement
- Program Outcome Objectives
- Workplan and Timetable
- Evaluation Plan

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 awardees 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:

- *Summary:* 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:* 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. Awardees 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.

- *Program description:* For each sub-capability, provide the current status of planning, a needs statement, the outcome objectives, and proposed funding. A detailed description of each area is provided below. *Current Status:* In this section, describe the current status of each sub-capability that will be addressed with this funding. If using HPP funds to support any Level Two sub-capabilities, the awardee should provide a statement that all FY 2008 Level-One Capabilities have either already been met or are prioritized in such a way that they will be completed by August 8, 2009 prior to addressing any funding that will be applied to the Level-Two Capabilities. This section should describe each sub-capability 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.

- *Needs Statement:* Describe the need for further work to develop each sub-capability being funded. 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:* Describe the overall goal of the project, outline the objectives to be accomplished and the activities that will occur to achieve the capability 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.

  Awardees 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 funding opportunity). All outcome objectives should be described in terms that are specific, measurable, achievable, realistic, and time-framed (S.M.A.R.T.).

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.

- *Workplan and Timetable:* In this section outline the objectives and activities that will occur to accomplish the overall project 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 during a 12-month 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 strongly encourages Awardees to limit the amount of direct costs (ideally less than or equal to fifteen-percent) that collectively include personnel, fringe, travel, supplies and equipment.

- *Evaluation Plan:* 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.

3. Submission Dates and Times

The deadline for the submission of applications under this program announcement is June 20, 2008. **Applications must be submitted electronically via Grants.gov by 11:30 P.M. Eastern Daylight Time.**

Applications that fail to meet the application due date will **not** be reviewed and will receive **no** further consideration. Grants.gov will automatically send applicants a tracking number and date of receipt verification electronically once the application has been successfully received and validated in Grants.gov.

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 that 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.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

Restrictions, which applicants must take into account while writing the budget, are as follows:

- Recipients may not use funds for construction or major renovations;
- Recipients may not use funds for fund raising activities or political education and/or lobbying;
- Recipients may not use funds for research;
- Recipients may only expend funds for reasonable program purposes, including personnel, travel, supplies, and services, such as contractual; and
- Reimbursement of pre-award cost is not allowed.

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.

6. Other Requirements

ASPR Data Conference

Grantees are strongly encouraged to budget for attendance at an ASPR Data Conference, which

is expected to be scheduled for Spring 2009. The conference will be approximately 2 and one half days in length, and will take place in the greater Washington D.C. metro area. The conference will feature research presentations and a discussion of performance measures. Additional information will be provided by Mr. Torrance Brown.

V. APPLICATION REVIEW INFORMATION

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 at-risk populations are addressed in the plan
- Clarity of which the budget justification reflects the costs associated with the activities to be completed

Review and Selection Process

These applications will be reviewed internally within ASPR using a standardized review format and process. If the application fulfills the review criteria and meets the program requirements, awards will be targeted for August 9, 2008.

If recommendations from these reviews result in conditions of award, the conditions shall be addressed as instructed in the Notice of Award (NoA).

Anticipated Announcement and Award

The ASPR anticipates announcing and awarding by August 9, 2008 for a 12-month period ending August 8, 2009.

VI. AWARD ADMINISTRATION INFORMATION

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 NoA, signed by the Grants Management Officer (GMO), which specifies to the awardee 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 awardee to project costs.

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 awardees 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 awardees 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.

Awardees 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 awardee's ability to draw down funds from the Payment Management System until the awardee has taken corrective action.

Reporting Requirements

Audit Requirements

Each entity receiving HPP funds shall, not less often than once every 2 years, audit its expenditures from amounts received under their HPP award. Such audits shall be conducted by an entity independent of the agency administering a program funded under by the HPP 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, the entity shall submit a copy of that audit report to the following office:

National External Audit Review Center
HHS Office of Audit Services
323 West 8th Street
Lucas Place

Room 514
Kansas City, MO 64105.

The audit requirement does not alter the annual audit requirements attached to other HHS program funding.

Progress Reports and Financial Reports

Applicants funded under this announcement will be required to electronically submit a Mid-Year Report at six months, 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 that apply under 45 CFR parts 74 and 92.

In light of the increased emphasis on performance measurement and accountability in the PAHPA, awardees are advised that 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 awardee for corrections.

The mid-year report will consist of 3 sections: 1. a narrative Program Progress Report, 2. a report on progress with Performance Measures and 3. Data Elements.

Evidence-based Performance Measures and Program Data Elements

As soon as templates for data collection and submission are approved through OMB, they will be released to awardees. These performance measures and data elements will be reported twice annually and are listed below. Calculation of results based on numerator and denominator information submitted by awardees will be conducted by staff in the State and Local Initiatives Team, Evaluation Section at ASPR.

Awardees 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. Documentation should contain information on both the method awardees used for collecting particular information as well as the data set prepared from the hospitals' reports.

For clarification in reporting, it is important to note that the HPP funds hospital preparedness for public health emergencies through cooperative agreements with eligible states and other jurisdictions. Eligible entitles include: the 50 States; 8 territories and Freely Associated States of the Pacific; the metropolitan areas of New York City, Chicago, and Los Angeles; and the District of Columbia.

There are various levels of engagement and activities due to the various eligible entities. As a result, some performance measures focus at the State level, while other performance measures focus at the Hospital level for individual hospitals (participating hospital) supported by HPP funds through the State during the current project period.

State Level Performance Measures are measures that require a response of reported achievement from the State. For the purposes of this Guidance, State includes: 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 Samoa, Guam and the U.S. Virgin Islands; the Federated States of Micronesia; and the Republics of Palau and the Marshall Islands.

The ASPR Targets are program management benchmarks established to track overall achievement of program performance.

State Level Performance Measures:

S1.1. The State EOC can report available beds for at least 75% of participating hospitals, according to HAvBED definitions, to the HHS SOC within 4 hours or less of a request, during an incident or exercise at least once during the current project period.

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

S1.2. Please report in number of hours how much time it took to report available beds according to HAvBED definitions for at least 75% of participating hospitals, to the HHS SOC.

ASPR FY08 Targets (Measure S1.1.):

Mid-Year:	50% of Awardees reported available beds for at least 75% of their participating hospitals.
End-of-Year:	100% of Awardees reported available beds for at least 75% of their participating hospitals.

S2.1. The State/Territory demonstrates the ability to query their ESAR-VHP System during a functional drill, exercise, or actual event to generate a list of potential volunteer health professionals, by discipline and credential level, within 2 hours or less of a request being issued by a requesting body or HHS SOC during the current project period.

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

S2.2. Please report in hours the amount of time it took to query the ESAR-VHP System to generate a list of potential volunteer health professionals, by discipline and credential level.

ASPR FY08 Targets (Measure S2.1.):

Mid-Year: 30% of Awardees demonstrated the ability to query their ESAR-VHP System during a functional drill, exercises, or actual event to generate a list of potential volunteer health professionals by discipline and credential level, within 2 hours or less of a request being issued by a requesting body.

End-of-Year: 60% of Awardees demonstrated the ability to query their ESAR-VHP System during a functional drill, exercises, or actual event to generate a list of potential volunteer health professionals by discipline and credential level, within 2 hours or less of a request being issued by a requesting body.

S3.1. The State/Territory can compile an initial list of volunteer health professionals, by discipline and credential level, within 12 hours or less of a request being issued by a requesting body or HHS SOC during the current project period.

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

S3.2. Please report in hours the amount of time it took to compile an initial list of willing volunteer health professionals, by discipline and credential level after a request being issued.

ASPR FY08 Targets (Measure S3.1.):

Mid-Year: 30% of Awardees can compile an initial list of volunteer health professionals, by discipline and credential level, within 12 hours or less of a request being issued by a requesting body or HHS SOC during the current project period.

End-of-Year: 60% of Awardees can compile an initial list of volunteer health professionals, by discipline and credential level, within 12 hours or less of a request being issued by a requesting body or HHS SOC during the current project period.

S4.1. The State/Territory can report a verified list of available volunteer health professionals, by discipline and credential level, within 24 hours or less of a request being issued by a requesting body or HHS SOC during the current project period.

Note: Each State is asked to report "Yes" or "No." Individual responses will be

aggregated into a national measure.

S4.2. Please report in hours how much time it took the State/Territory to report a verified list of available volunteer health professionals, by discipline and credential level to a requesting body or HHS SOC during the current project period.

ASPR FY08 Targets (S4.1.):

Mid-Year: 30% of Awardees can report a verified list of available volunteer health professionals, by discipline and credential level, within 24 hours or less of a request being issued by a requesting body.

End-of-Year: 60% of Awardees can report a verified list of available volunteer health professionals, by discipline and credential level, within 24 hours or less of a request being issued by a requesting body.

S5.1. The State/Territories conduct statewide and regional exercises that incorporate NIMS concepts and principles and include hospitals during the current project period.

- Numerator: The number of State/Territories that conducts statewide and regional exercises that incorporate NIMS concepts and principles and include hospitals during the current project period.
- Denominator: The number of statewide and regional exercises conducted during the current project period.

ASPR FY08 Targets (Measure S5.1.):

Mid-Year: 50% of Awardees conduct statewide and regional exercises that incorporate NIMS concepts and principles and include hospitals during the current project period.

End-of-Year: 100% of Awardees conduct statewide and regional exercises that incorporate NIMS concepts and principles and include hospitals during the current project period.

S6.1. The Awardee submits timely and complete data for the midyear report, the end-of-year report, and the final financial status report (FSR).

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

Hospital Level Performance Measures:

H1.1. According to HAvBED definitions the number of participating hospitals that can report available beds, to the State EOC within 60 minutes or less of a State request at least once during the current project period.

- Numerator: The number of participating hospitals that can report available beds, according to HAvBED definitions, to the State EOC within 60 minutes or less of a State request at least once during the current project period.
- Denominator: The total number of participating hospitals in the State.

ASPR FY08 Targets (H1.1.):

Mid-Year: 50% of participating hospitals reported available beds, according to HAvBED definitions, to the State EOC within 60 minutes or less of a State request at least once during the current project period.

End-of-Year: 100% of participating hospitals reported available beds, according to HAvBED definitions, to the State EOC within 60 minutes or less of a State request at least once during the current project period.

H2.1. The number of participating hospitals that demonstrate dedicated, redundant communications capability during an exercise or incident, as evidenced by exercise evaluations or after action reports at least once during the current project period.

Note: To demonstrate efficacy of a back-up communications system, the usual primary system needs to be compromised, requiring that a different communications system actually be put to use.

- Numerator: The number of participating hospitals that demonstrated communications capability.
- Denominator: The total number of participating hospitals

ASPR FY08 Targets (Measure H2.1.):

Mid-Year: 50% of participating hospitals demonstrated dedicated, redundant communications capability during an exercise or

incident, as evidenced by exercise evaluations or after action reports at least once during the current project period.

End-of-Year: 100% of participating hospitals demonstrated dedicated, redundant communications capability during an exercise or incident, as evidenced by exercise evaluations or after action reports at least once during the current project period.

H3.1. The number of participating hospitals that demonstrate sustained two-way communications capability with the local EOC and Tier 2 partners during an exercise or incident, as evidenced by exercise evaluations or after action reports at least once during the current project period.

Note: For the purposes of this measure, sustained two-way communications is the ability to send and receive information and messages from the same location for an extended period of time.

- Numerator: The number of participating hospitals that demonstrated the sustained two-way communications capability with the Local EOC and Tier 2 partners during an exercise or incident.
- Denominator: The total number of participating hospitals.

H3.2. Please report in hours the average amount of time that participating hospitals tested sustained-two way communications with the local EOC or Tier 2 Partners.

H3.3. Please list at least two Tier 2 partners with which you were able to sustain two way communications.

ASPR FY08 Targets (Measure H3.1.):

Mid-Year: 50% of participating hospitals that demonstrate sustained two-way communications capability with the local EOC and Tier 2 partners during an exercise or incident, as evidenced by exercise evaluations or after action reports at least once during the current project period.

End-of-Year: 100% of participating hospitals that demonstrate sustained two-way communications capability with the local EOC and Tier 2 partners during an exercise or incident, as evidenced by exercise evaluations or after action reports at least once during the current project period.

H4.1. The number of participating hospitals that have written plans to address mass fatality

management.

Note: Mass Fatality Plans should include at minimum current information on: (a) trained and available personnel; (b) equipment, supplies, facilities, and other material resources, and, (c) the operational structure and standard operating procedures for disposition of the deceased.

Note: A completed draft is a plan that has not been submitted for senior management approval.

A finalized written plan is a plan that has received senior management approval.

- Numerator: The number of participating hospitals that that have written plans to address mass fatality management.
- Denominator: The total number of participating hospitals.

ASPR FY08 Targets (Measure H4.1.):

Mid-Year: 100% of Awardees have a completed draft plan for mass fatality management.

End- of- Year: 100% of Awardees have a finalized written plan for mass fatality management.

H5.1. The number of participating hospitals that have written plans to address medical evacuation.

Note: Medical Evacuation Plans should include at minimum current information on: (a) personnel training in evacuation procedures; (b) transportation means, equipment, supplies, and alternative facilities, and, (c) the operational structure and standard operating procedures for moving patients as appropriate.

Note: A completed draft is a plan that has not been submitted for senior management approval.

A finalized written plan is a plan that has received senior management approval.

- Numerator: The number of participating hospitals that that have written plans to address medical evacuation.
- Denominator: The total number of participating hospitals.

ASPR FY08 Targets (Measure H5.1.):

Mid-Year: 100% of Awardees have a completed draft plan for medical evacuation.
End-of-Year: 100% of Awardees have a finalized written plan for medical evacuation

H6.1. The number of participating hospitals that incorporate the National Incident Management System (NIMS) concepts and principles for handling emergency events.

ASPR FY08 Targets (Measure H6.1.):

Mid-Year: 50% of participating hospitals have incorporated the National Incident Management System (NIMS) concepts and principles for handling emergency events.

End-of-Year: 100% of participating hospitals have incorporated the National Incident Management System (NIMS) concepts and principles for handling emergency events.

H7.1. The number of participating hospitals that have identified appropriate hospital personnel for training and have verified their completion of the following courses or their equivalent - IS 100, IS 200, IS 700, IS 800B.

- Numerator: The number of appropriate hospital personnel that have completed the following courses or their equivalent - IS 100, IS 200, IS 700, IS 800B.
- Denominator: The number of hospital personnel appropriate for this training.

ASPR FY08 Targets (Measure H7.1.):

Mid-Year: 50% of participating hospitals ensured that appropriate hospital personnel have completed the following courses or their equivalent - IS 100, IS 200, IS 700, IS 800B.

End-of-Year: 100% of participating hospitals ensured that appropriate hospital personnel have completed the following courses or their equivalent - IS 100, IS 200, IS 700, IS 800B.

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 may be used to evaluate awardees performance.
The template will include definitions, response choices, due dates and instructions for completing the template.

VII. AGENCY CONTACTS

Administrative and Budgetary Contacts

For application kits, submission of applications, and information on budget and business aspects of the application, please contact:

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APPENDIX A

Key updates to the *Medical Surge Capacity and Capability: A Management System for Integrating Medical and Health Resources During Large- Scale Emergencies*[1]

- Tier 6 – Federal Support to State, Tribal and Jurisdiction Management – has been rewritten to highlight changes to the Federal emergency response structure. The chapter focuses on the information that medical and public health planners need to know regarding the request, receipt, and integration of Federal public health and medical support under Emergency Support Function #8 of the NRP.
- The handbook now emphasizes how MSCC concepts can be applied not only to medical surge, but also to maintain normal healthcare services and operations during a crisis (i.e. medical system resiliency).
- Newly added section 1.4.1 clarifies the role of Incident Command versus the regular administration of an organization during response and recovery operations. Included in this section is a description of the "Agency Executive" role in ICS.
- In accordance with NIMS, the handbook describes the role of a Multiagency Coordination Center (MACC), and Multiagency Coordination Group (MAC Group) in providing emergency operations support to incident command. The application of these concepts at Tiers 2 and 3 is particularly important.
- Section 1.3.1 draws distinctions between the processes and structures that are used in preparedness planning and those used during incident response and recovery.
- An important lesson learned from Hurricane Katrina and included in this update is the need at all levels of government to plan for the health services support needs of medically fragile populations.
- The structure of the Emergency Operations Plan (EOP) has become increasingly standardized. Section 2.3 of the handbook provides a more detailed description of the requirements of an effective EOP for healthcare organizations.
- The term "healthcare organization" has been substituted for "healthcare facility" to reflect the fact that many medical assets that may be brought to bear in an emergency or disaster are not facility-based.

Further information on the handbook can be found at
http://www.hhs.gov/disasters/discussion/planners/mscc/

[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, 2007.

APPENDIX B

FY08 NIMS Implementation for Healthcare Organizations

FY 2008 NIMS implementation will continue to align healthcare organizations with their State, territory, tribal and local partners through the use of compliance metrics. In FY07 the concept of metrics was introduced to State, territory, tribal and local entities as a method to assess NIMS implementation.

In August 2007, a healthcare working group assembled to review and clarify the existing NIMS implementation activities and compliance metrics for healthcare organizations first established in September 2006.

During the FY 2008 funding cycle HPP awardees will be required to insure that participating healthcare organizations are in a position to report full compliance with the following implementation activities:

Adoption

1. Adopt NIMS throughout the healthcare organization including all appropriate departments and business units.
2. Ensure Federal Preparedness awards support NIMS Implementation (in accordance with the eligibility and allowable uses of the awards).

Preparedness: Planning

3. Revise and update emergency operations plans (EOPs), standard operating procedures (SOPs), and standard operating guidelines (SOGs) to incorporate NIMS and National Response Framework (NRF) components, principles and policies, to include planning, training, response, exercises, equipment, evaluation, and corrective actions.
4. Participate in interagency mutual aid and/or assistance agreements, to include agreements with public and private sector and nongovernmental organizations.

Preparedness: Training

5. Identify the appropriate personnel to complete ICS-100, ICS-200, and IS-700, or equivalent courses.
6. Identify the appropriate personnel to complete IS-800 or an equivalent course.
7. Promote NIMS concepts and principles into all organization-related training and exercises. Demonstrate the use of NIMS principles and ICS Management structure in training and exercises.

Communication and Information Management

8. Promote and ensure that equipment, communication, and data interoperability are incorporated into the healthcare organization's acquisition programs.
9. Apply common and consistent terminology as promoted in NIMS, including the establishment of plain language communications standards.

10. Utilize systems, tools, and processes that facilitate the collection and distribution of consistent and accurate information during an incident or event.

Resource Management

No implementation objective

Command and Management

11. Manage all emergency incidents, exercises, and preplanned (recurring/special) events in accordance with ICS organizational structures, doctrine, and procedures, as defined in NIMS.
12. ICS implementation must include the consistent application of Incident Action Planning (IAP) and common communications plans, as appropriate.
13. Adopt the principle of Public Information, facilitated by the use of the Joint Information System (JIS) and Joint Information Center (JIC) during an incident or event.
14. Ensure that Public Information procedures and processes gather, verify, coordinate, and disseminate information during an incident or event.

APPENDIX C

The Homeland Security Exercise and Evaluation Program (HSEEP)

The Department of Homeland Security (DHS) Homeland Security Exercise and Evaluation Program (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.

Starting this year exercise programs funded all or in part by HPP cooperative agreement funds must meet the intent of the HSEEP practices for exercise program management, design, development, conduct, evaluation and improvement planning. This means if a hospital or healthcare entity **participates** in an exercise sponsored by another agency, they must ensure the exercise is HSEEP compliant. If the healthcare facility **sponsors** the exercise the following four distinct performance requirements must be evidenced:

1. **Participating facilities are required to conduct annual Training and Exercise Plan Workshop (T&EPW) and maintain a Multi-year Training and Exercise Plan.** This includes:
    - Training and exercise priorities based on overarching strategy and previous improvement plans.
    - Capabilities from the Target Capabilities List (TCL) that the facility will train for and exercise against.
    - A multi-year training and exercise schedule which:
        - Reflects the training activities which will take place prior to an exercise, allowing exercises to serve as a true validation of previous training.
        - Reflects all exercises in which the facility participates.
        - Employs a "building-block approach" in which training and exercise activities gradually escalate in complexity.
    - A new or updated Multi-year Training and Exercise plan must be formalized and implemented within **60 days** of the T&EPW.
    - The Multi-year Training and Exercise Plan must be updated on an annual basis (or as necessary) to reflect schedule changes.

2. **Participating facilities should plan and conduct exercises that are:**
    - Consistent with the entity's Multi-year Training and Exercise Plan.
    - Based on capabilities and their associated critical tasks, which are contained within the Exercise Evaluation Guides (EEGs). For Example, if an entity, based on its risk/vulnerability analysis, determines that it is prone to hurricanes, it may want to validate its evacuation capabilities. In order to validate this capability it would first refer to the "Citizen Protection: Evacuation and/or In-Place Protection" EEG. Tasks associated with this capability include: *"make the decision to evacuate or shelter in place;" "identify and mobilize appropriate personnel;"*

- *and activate approved traffic control plan."* Facilities may wish to create their own Simple, Measurable, Achievable, Realistic, and Task—oriented (S.M.A.R.T.) objectives based on its specific plans/procedures associated with these capabilities and tasks, such as: 1) "Examine the ability of local response agencies to conduct mass evacuation procedures in accordance with Standard Operating Procedures; and 2) Evaluate the ability of local response agencies to issue public notification of an evacuation order within the timeframe prescribed in local Standard Operating Procedures.
- Tailored toward validating the capabilities, and based on the facility's risk/vulnerability assessment.
- Exercise planners should develop the following documents to support exercise planning, conduct, evaluation, and improvement planning:
    - For Discussion-based Exercises:
        - Situation Manual (SITMAN)
    - For Operations-based Exercises this requires:
        - Exercise Plan (EXPLAN)
        - Player Handout
        - Master Scenario Events List (MSEL)
        - Controller/Evaluator Handbook (C/E Handbook)

  Templates and samples of these documents can be found in HSEEP Volume VI: Sample Templates and Formats, available on the HSEEP website (http://hseep.dhs.gov).
- Reflective of the principles of the National Incident Management System (NIMS).

3. **Developing and submitting a properly formatted After-Action Report/Improvement Plan (AAR/IP). Format is found in HSEEP Volume III.**
    - AAR/IPs created for exercise must conform to the templates provided in *HSEEP Volume III: Exercise Evaluation and Improvement Planning.*
    - Following each exercise, a draft AAR/IP must be developed based on the information gathered through the use of EEGs.
    - Following every exercise, an After-Action Conference (AAC) must be conducted, in which:
        - Key personnel and the exercise planning team are presented with findings and recommendations from the draft AAR/IP.
        - Corrective actions addressing a draft AAR/IP's recommendation are developed and assigned to responsible parties with due dates for completion.
    - A final AAR/IP with recommendations and corrective actions derived from discussion at the AAC must be completed **within 60 days** after the completion of each exercise.

4. **Tracking and implementing corrective actions identified in the AAR/IP.**
    - An improvement plan will include broad recommendations from the AAR/IP organized by target capability as defined in the TCL.

- Corrective actions derived from ACC are associated with the recommendations and must be linked to a capability element as defined in the TCL.
- Corrective actions included in the improvement plan must:
    - Be measurable.
    - Designate a projected state date and completion date.
    - Be assigned to an organization and a point of contact (POC) within that organization.
- Corrective actions must be continually monitored and reviewed as a part of an organizational Corrective Action Program. An individual should be responsible for managing a Corrective action program to ensure corrective actions resulting from exercises, policy discussions and real-world events are resolve and support the scheduling and development of subsequent training and exercises.

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

APPENDIX D

HAvBED Operational Requirements and Definitions

Requirements

a) Report aggregate State level data to the HHS SOC not more 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:

1. Intensive Care Unit (ICU)
2. Medical and Surgical (Med/Surge)
3. Burn Care
4. Peds ICU
5. Pediatrics (Peds)
6. Psychiatric (Psych)
7. Negative Pressure Isolation
8. Emergency Department Divert Status
9. Decontamination Facility Available
10. Ventilators Available

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.

Awardees are reminded that bed availability data are to be reported directly through the HAvBED web portal, or through data exchange with existing systems that have been adapted to track according to the standards and definitions above.

It is expected that during this funding cycle HHS will release the data exchange information to all awardees as well as provided technical assistance and support in the application of this technology to existing systems.

Further information on the HAvBED system can be found at
http://www.ahrq.gov/prep/havbed/

APPENDIX E

Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP)

Draft Compliance Requirements

*In FY 2007, Awardees were required to meet the Electronic System requirements 1-5 by August 8, 2008. **Note:** The Compliance Requirements document was revised, and requirements 1 and 2 have been combined.

**In FY 2008, Awardees are required to meet the remaining compliance requirements by August 8, 2009.

The 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. Each State must meet all of the compliance requirements. All Awardees must report progress toward meeting these compliance requirements on Mid-Year and End-of-Year Progress Reports for the Hospital Preparedness Program (HPP).

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 presented in the *2008 Interim ESAR-VHP Technical and Policy Guidelines, Standards and Definitions* (*Guidelines).*

   These systems must:

   a) Offer Internet-based registration. Information must be controlled and managed by authorized personnel who are responsible for the data.
   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 variables as defined by requestor.
   d) Ensure that each State ESAR-VHP System is both backed up on a regular basis and that the back up is not co-located.

   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 *2008 Interim ESAR-VHP Guidelines*

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

a) Each State must collect and verify the credentials and qualifications of the following health professionals. Beyond this list of occupations, a State may register volunteers from any other occupation it chooses. The standards and requirements for including additional occupations are left to the Awardees.

1) Physicians (Allopathic and Osteopathic)
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 and Technicians
8) Respiratory Therapists
9) Medical and Clinical Laboratory Technologists and Technicians
10) Licensed Practical Nurses and Licensed Vocational 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 professions identified in the *2008 ESAR-VHP Guidelines*.

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

2. Each electronic 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.

3. 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), etc.).

4. 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 an estimate of the potential volunteer pool that may be available from the Awardees upon request.

b) If a volunteer responds "Yes" to the Federal question, Awardees may be required to collect additional information (e.g., training, physical and medical status, etc.).

5. 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 Awardees.

ESAR-VHP Operational Requirements

6. Upon receipt of a request for volunteers from any governmental agency or recognized emergency response entity, all Awardees must: 1) within 2 hours query the electronic system to generate a list of potential volunteer health professionals to contact; 2) contact potential volunteers; 3) within 12 hours provide the requester an initial list of willing volunteer health professionals that includes the names, qualifications, credentials, and credential levels of volunteers; and 4) within 24 hours provide the requester with a verified list of available volunteer health professionals.

7. All Awardees are required to develop and implement a plan to recruit and retain volunteers.

   ASPR will assist Awardees 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 Awardees.

8. 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.

9. Each State must develop protocols for deploying and tracking volunteers during an emergency (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. Included in these protocols must be plans to track volunteers during an emergency and for maintaining a history of volunteer deployments. 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: Awardees 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: Awardees must develop protocols outlining the steps needed to respond to requests for volunteers received from another State. Awardees that have provisions for making volunteers employees or agents of the State must also develop protocols for deployment of volunteers to other Awardees 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.

ESAR-VHP Evaluation and Reporting Requirements

10. Each State must develop a plan for regular testing of its ESAR-VHP system through drills and exercises. These exercises must be consistent with the requirement for drills and exercises as outlined in the Hospital Preparedness Program (HPP) funding opportunity.

11. Each State must develop a plan for reporting program performance and capabilities.

    Each State will be required to report program performance and capabilities data as specified in the HPP funding opportunity and/or *ESAR-VHP Guidelines*. Awardees will report the number of enrolled volunteers by profession and credential level, the addition of program capabilities as they are implemented, and program activity during responses to actual events.

APPENDIX F

ASPR Hospital Preparedness Program (HPP) Cooperative Agreement Enforcement Actions and Disputes

I. PURPOSE

Sections 319C-1 and C-2 of the Public Health Service (PHS), as amended by the Pandemic and All-Hazards Preparedness Act (PAHPA), include certain accountability and compliance requirements that grantees must meet, including achievement of evidence-based benchmarks, audit requirements, and maximum carryover amounts. This document provides information about enforcement actions associated with these requirements, and appeal processes in the event there is a dispute. This document addresses requirements and enforcement actions specifically outlined in section 319C-1 and C-2 of the PHS. It is not intended to cover all requirements that grantees must meet pursuant to grant laws, regulations, Departmental grants policy, and terms and conditions of the award. Grant laws, regulations, and Departmental grants policies apply to these grants to the extent they are consistent with section 319C-1 and C-2 of the PHS Act.

II. ABBREVIATIONS, ACRONYMS AND DEFINITIONS

A. For the purpose of this document, the following abbreviations and acronyms apply:

1. **ARC –** Agency Review Committee
2. **ASPR** – Assistant Secretary for Preparedness and Response
3. **CGMO** – Chief Grants Management Officer
4. **DAB** – Departmental Appeals Board
5. **GMO** – Grants Management Officer
6. **GMS** – Grants Management Specialist
7. **HHS** – Department of Health and Human Services
8. **HPP** – Hospital Preparedness Program
9. **IDDA** – Intra-Departmental Delegation of Authority (IDDA)
10. **NoA –** Notice of Award
11. **OPHS** – Office of Public Health and Science
12. **PHEP** – Public Health Emergency Preparedness
13. **PO** – Project Officer

B. For the purpose of this document, the following definitions apply:

1. **HHS Department Appeals Board (DAB) -** The administrative board responsible for resolving certain disputes arising under HHS assistance programs. The DAB provides an impartial adjudicatory hearing process for appealing certain final written decisions by GMOs. The DAB's jurisdiction is specified in 45 CFR Part 16, "Procedures for HHS Grant Appeals Board."

2. **Agency Review Committee (ARC)** – Committee composed of awarding agency members who review awardee appeals to adverse determinations made by grant

officials. A minimum of three appointed core members, one of whom will be designated a chairperson by the ASPR. Others may be designated as determined by the chairperson. Members of the ARC may not be from the branch or program whose adverse determination is being appealed.

3. **Recipient** - The organization that receives a grant or cooperative agreement award from an awarding agency, and is responsible and accountable for using the funds provided, and for the performance of the grant-supported project or activity. The recipient is the entire legal entity, even if a particular component is designated in the NoA. The term includes "awardee/grantee."

4. **Corrective action** - Action taken by the awardee that corrects identified deficiencies or produces recommended improvements.

5. **Enforcement** – Actions taken to compel the observance of policies, regulations, and laws governing the administration of an assistance program. Such actions are generally the result of a recipient's failure to comply with the terms and conditions of an award. These failures may cause an awarding agency to take one or more actions, depending on the severity and duration of the non-compliance. The awarding agency generally will afford the recipient an opportunity to correct the deficiencies before taking enforcement action, unless public health or welfare concerns require immediate action. However, even if an awardee is taking corrective action, the awarding agency may take proactive steps to protect the Federal government's interests, including placing special conditions on awards, or may take action designed to prevent future non-compliance, such as closer monitoring.

6. **Termination** – The permanent withdrawal by the awarding agency of an awardee's authority to obligate previously awarded grant funds before that authority would otherwise expire, including the voluntary relinquishment of that authority by the recipient.

7. **Disallowance** – A determination denying payment of an amount claimed under an award, or requiring return of funds or off-set of funds already received.

8. **Void** – A determination that an award is invalid because the award was not authorized by statute or regulation, or because it was fraudulently obtained.

9. **Withholding of funds** – An action taken by an awarding agency to withhold or reduce support within a previously approved or subsequent budget period. Withholding may occur for the following justifiable reasons: (1) an awardee is delinquent in submitting required reports; (2) adequate Federal funds are not available to support the project; (3) an awardee fails to show satisfactory progress in achieving the objectives of the project, e.g., performance measures/benchmarks and/or excessive carryover; (4) an awardee fails to meet the terms of a previous award; (5) an awardee's management practices fail to provide adequate stewardship of Federal funds; (6) any reason which would indicate that continued funding would not be in

the best interests of the Government.

10. **Offset** – The withholding of funds from an award recipient in order to compensate for costs owed the awarding agency.

11. **Repayment of funds** – Funds for payment of a debt determined to be owed to the Federal Government. Repayment of funds cannot come from other Federally-sponsored programs.

12. **Terms and conditions of award -** all requirements imposed on a recipient by the Federal awarding agency, whether by statute, regulation, or within the grant award document itself. The terms of award may include both standard and special provisions, appearing on each NoA that are considered necessary to attain the objectives of the grant; facilitate post award administration of the grant, conserve grant funds, or otherwise protect the Federal government's interests.

13. **Performance measures/benchmarks** – The use of statistical evidence to determine progress toward specific defined objectives. These are leading indicators that will allow a national "snapshot" to show how preparedness and response activities, and the associated resources, aid in improving the public health system.

14. **Excessive Carryover** – Unobligated funds of a recipient that exceed the established maximum percentage of 15% of the award**,** as reported on a Financial Status Report (SF-269) at the time a carryover request is made, approximately 10 months into the 12 month budget cycle. The threshold amount includes direct and indirect costs.

15. **Outlays or Expenditures** – The charges made to the Federally-sponsored project or program. They may be reported on a cash or accrual basis. For reports prepared on a cash basis, outlays are the sum of cash disbursements for direct charges for goods and services, the amount of indirect expense charged, the value of third party in-kind contributions applied and the amount of cash advances and payments made to sub-awardees. For reports prepared on an accrual basis, outlays are the sum of cash reimbursements for direct charges for goods and services, the amount of indirect expense incurred, the value of in-kind contributions applied, and the net increase (or decrease) in the amounts owed by the recipient for goods and other property received, for services performed by employees, contractors, sub-awardees and other payees and other amounts becoming owed under programs for which no current services or performance are required.

16. **Audits** – A systematic review or appraisal made to determine whether internal accounting and other control systems provide reasonable assurance of financial operations are properly conducted; financial reports are timely, fair, and accurate;

    the entity has complied with applicable laws, regulations, and terms and conditions of award; resources are managed and used economically and efficiently; desired

results and objectives are being achieved effectively.

17. **Failure** – Noncompliance with any or all of the provisions of the NoA. which include but not limited to various laws, regulations, assurances, terms, or conditions applicable to the grant or cooperative agreement.

18. **Matching or Cost Sharing** - The value of third-party in-kind contributions and the portion of the costs of a federally assisted project or program not borne by the Federal Government. Costs used to satisfy matching or cost-sharing requirements are subject to the same policies governing allowability as other costs under the approved budget.

III. BACKGROUND

PAHPA amended section 319C-2 of the PHS Act, and authorizes the Assistant Secretary for Preparedness and Response (ASPR) to award 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 Consolidated Appropriations Act of 2008 (Public Law 110-161).

Grantees must meet certain statutory accountability and compliance requirements. Sections 319C-1 and C-2 of the PHS Act require the Department to take certain enforcement actions if grantees fail to meet these requirements. More specifically, this document addresses the following enforcement actions required by the statute: 1) beginning in fiscal year 2009, withholding a statutorily-mandated percentage of the award if an awardee fails substantially to meet established benchmarks and performance measures for the immediately preceeding fiscal year or fails to submit a satisfactory pandemic flu plan to the Department; 2) repayment of any funds that exceed the maximum percentage of an award that an entity may carryover to the succeeding fiscal year; and 3) repayment or future withholding or offset as a result of a disallowance decision if an audit shows that funds have not been spent in accordance with section 319C-2 of the PHS Act .

IV. Enforcement Actions and Disputes

A. Withholding for failure to meet established benchmarks and performance measures or to submit a satisfactory pandemic influenza plan.

1. Beginning with the distribution of FY 2009 funding, awardees that fail substantially to meet performance measures/benchmarks for the immediately preceding fiscal year and/or who fail to submit a pandemic influenza plan to CDC as part of their application for PHEP funds, may have funds withheld from their FY 2009 and subsequent award amounts. An awardee that fails to correct such noncompliance shall be subject to withholding in the following amounts:

- For the fiscal year immediately following a fiscal year in which the awardee has failed substantially to meet performance measures/benchmarks

or who has failed to submit a satisfactory pandemic influenza plan; an amount equal to 10 percent of funding the awardee was eligible to receive.

- For the fiscal year immediately following two consecutive fiscal years in which an awardee experienced such a failure, an amount equal to 15 percent of funding the awardee was eligible to receive, taking into account the withholding of funds for the immediately preceding fiscal year.
- For the fiscal year immediately following three consecutive fiscal years in which an awardee experienced such a failure, an amount equal to 20 percent of funding the awardee was eligible to receive, taking into account the withholding of funds for the immediately preceding fiscal years.
- For the fiscal year immediately following four consecutive fiscal years in which an entity experienced such a failure, an amount equal to 25 percent of funding the awardee was eligible to receive for such a fiscal year, taking into account the withholding of funds for the immediately preceding fiscal year.

Please note that HHS is required to treat each failure to substantially meet all the benchmarks and each failure to submit a satisfactory pandemic influenza plan as a separate withholding action. For example, an awardee failing substantially to meet benchmarks/performance measures AND who fails to submit a satisfactory pandemic influenza plan could have 10% withheld for each failure for a total of 20% for the first year this happens. If this situation remained unchanged, HHS would then be required to assess 15% for each failure for a total of 30% for the second year this happens. Alternatively, if one of the two failures are corrected in the second year but one remained, HHS is required to withhold 15% of the second year funding.

2. Technical assistance and notification of failures

ASPR may, in coordination with the CGMO and in accordance with established Departmental grants policy, provide to an awardee, upon request, technical assistance in meeting benchmarks/performance measures and submitting a satisfactory pandemic influenza plan. In addition, as described below, ASPR will notify awardees that are determined to have failed substantially to meet benchmarks/performance measures and/or who have failed to submit a satisfactory pandemic influenza plan and give them an opportunity to correct such noncompliance. Entities who fail to correct such noncompliance will be subject to withholding as described in the paragraph above.

The awardee shall submit the required progress report on or before the specified due date according to the terms and conditions of the NoA. The Project Officer shall, within 15 days of receipt of the required progress report, assess performance, provide technical assistance to the awardee as required, and issue a written letter acknowledging completion of assessment and that the assessment has been forwarded to the GMO.

Upon determination that the awardee has failed to comply with the terms and conditions of a grant or cooperative agreement, the Project Officer (PO) shall issue a written

recommendation and provide a complete documentation package to the Grants Management Officer (GMO) based on the review and monitoring of the awardee.

Within 15 days of receipt of the recommendation from the PO, the GMO shall issue an initial failure notification to the awardee in writing. This document will provide compliance requirements as submitted by the PO and will include the total amount of Federal funds which will be withheld or reduced in the subsequent fiscal year due to noncompliance, absent corrective action by the awardee that is satisfactory to the GMO. The document will specify that the GMO will take such other remedies as may be legally available and appropriate in the circumstances, such as withholding of Federal funds.

The awardee must provide a proposed Corrective Action Plan (CAP) in writing to the GMO, within 15 days of receipt of the initial failure notification.. The GMO will forward a copy to the PO. The awardee may request technical assistance at this time.

Within 15 days of receipt of the proposed CAP, the PO will assess the remedies and provide a recommendation to the GMO. If the GMO finds the corrective action measures satisfactory, the GMO shall, **within 15 days** of receipt of the PO's assessment, provide notification to the awardee of the awarding agency's intent to rescind the initial failure notification. If in the GMO's judgment the awardee has still failed to comply with the terms and conditions of a grant or cooperative agreement, the GMO shall issue a final failure notification and provide information about the appeal process to include applicable timelines in writing. The GMO will concurrently issue his/her decision to the awardee and the Agency Review Committee (ARC).

3. Dispute process

The ASPR has established an ARC for the purpose of providing awardees a fair and flexible process to appeal certain enforcement actions such as a final decision to withhold funds due to a failure to meet benchmarks/performance measures and/or to submit a satisfactory pandemic influenza plan. The ARC consists of three regular members: ASPR Principal Deputy (Director); OPEO (Director); and Resource Planning and Evaluation (Director). The ASPR Principal Deputy, Director, or designee, shall be the chairperson for the ARC. The ARC may consult with subject matter experts within the Department as necessary (i.e., attorneys, Branch Chiefs, Team Leaders, Project Officer/Public Health Advisors, etc.) Members of the ARC may not be from the branch or program whose adverse determination is being appealed.

If the awardee chooses to appeal the GMO decision, the awardee must do so directly to the ARC **within ten days** of receipt of the GMO's final failure notification. The Notice of Appeal shall include: 1) a detailed description of the reason for appeal including supporting documentation and 2) a description of how the enforcement action impacts the affected organization. The awardee should be aware that they bear the burden of proof to the extent of the type of modification or reversal of the GMO's decision they seek and the necessity for modification or reversal.

Within ten days of receipt of the awardee's notice of appeal, the GMO will 1) brief the

ARC on the issues of the case, 2) submit any relevant documentation supporting the decision, and 3) provide a written statement responding to the notice of appeal.

Within ten days of receipt of the brief and documentation submitted by the GMO, the ARC will acknowledge, in writing, the notice of appeal to the awardee and the GMO. The ARC will review the relevant information, **within seven days of providing written notification to awardee and GMO** , and use one or a combination of the following methods for dispute resolution:

(a) Documentation Review – an independent evaluation of documents to verify compliance with laws, regulations, or policies;

(b) Conference – allow parties an opportunity to make an oral presentation to clarify issues, question both parties to obtain a clear understanding of the facts, and provide recommendations for resolution. Telephone conferences are acceptable.

Based on the outcome of the review or conference, the ARC will decide on the resolution of an issue **within seven days**. The ARC may decide that the Department should waive or reduce the withholding as described above for a single entity or for all entities in a fiscal year, if the ARC reviews and determines that mitigating conditions exist that justify the waiver or reduction. The ARC will notify the GMO, PO, and the awardee, in writing, of their final decision that the Department should waive or withhold federal funds.

If the ARC's final decision is to for the Department to waive the federal funds to be withheld or withhold Federal funds for the subsequent fiscal year, the GMO shall issue, in writing, a final decision to the awardee **within ten days** from the receipt of the ARC's final decision.

Funds that are withheld for failure to substantially meet benchmarks/performance measures and/or to submit a satisfactory pandemic influenza plan will be reallocated so that the Secretary may make awards under section 319C-2 to entities described in subsection (b)(1) of that section (i.e., Healthcare Facility Partnership grants).

4. Responsibilities

A. PO/Public Health Advisor shall:

1. During the corrective action phase, provide technical assistance to the awardee to meet the requirement.
2. If determined the awardee will not meet the requirement, the PO shall issue a written recommendation to the GMO based on the review and monitoring of awardee progress.
3. Provide a timely documentation package to the GMO regarding a decision to withhold or reduce cooperative agreement funds.

B. GMO shall:

1. Rescind initial failure notification or issue a final failure notification and provide the awarding agency's process for appeal to include applicable timelines, in writing, to the awardee and provide a copy to ARC.
2. Brief ARC on issues pertaining to disputes.
3. Prepare and submit a complete documentation package to the ARC regarding a decision to withhold or reduce cooperative agreement funds.

C. ARC shall:

1. Establish regular committee members and consult with subject matter experts in the Department as necessary.
2. Receive initial Notice of Appeal.
3. Send acknowledgements to the awardee and GMO.
4. Review disputes by documentation or conference.
5. Provide recommendations and facilitate disputes to preclude further action.
6. Provide the ARC decisions on appeals.

D. Awardee or Complainant shall:

1. Remedy non-compliance issues during the corrective action phase. If the GMO determines that corrective actions have not been adequate, the awardee may submit a written request for review.
2. If awardee disputes the GMO's final decision, submit dispute to ARC after Failure Notification is received from the agency awarding office. The dispute must contain the following:

A. a detailed description of the reason for dispute including supporting documentation and

B. a description of how the enforcement action impacts the affected organization.

B. Repayment of any funds that exceed the maximum percentage of an award that an entity may carryover to the succeeding fiscal year.

1. For each fiscal year, ASPR, in consultation with the States and political subdivisions, will determine the maximum percentage amount of an award that an awardee may carryover to the succeeding fiscal year. This percentage amount will be listed in the funding opportunity announcement (FOA). For fiscal year 2008 awards, this maximum percentage amount that an awardee may carryover is 15%. For each fiscal year, if the percentage amount of an award unobligated by an awardee exceeds the maximum percentage permitted (i.e., 15% for FY 2008 awards), the awardee shall repay the portion of the unobligated amount that exceeds the maximum amount permitted to be carried over to the succeeding fiscal year.

2. Notification of failure

Upon determination that the awardee has exceeded the maximum percentage permitted, the GMO shall issue an initial failure notification to the awardee in writing. Such documentation will specify that the GMO will take such remedies as may be legally available and appropriate in the circumstances, such as requiring repayment of the portion of the unobligated amount that exceeds the maximum amount permitted to be carried over to the succeeding fiscal year.

The awardee must provide a proposed Corrective Action Plan (CAP) in writing to the GMO, within 15 days of receipt of the initial failure notification.. The GMO will provide a copy to the PO. The awardee may request technical assistance at this time.

Within 15 days of receipt of the proposed CAP, the PO will assess the remedies and provide a recommendation to the GMO. The GMO shall, **within 15 days** of receipt of the PO's assessment, provide notification to the awardee of the awarding agency's intent to rescind the initial failure notification. If the awardee has still failed to comply with the terms and conditions of a grant or cooperative agreement, the GMO shall issue a final failure notification in writing and provide information about the appeal process and application for waiver of repayment to include applicable timelines. The GMO will concurrently issue his/her decision to the awardee and the Agency Review Committee (ARC).

3. Dispute process

If the awardee chooses to appeal the GMO decision, the awardee must do so directly to the ARC **within ten days** of receipt of the GMO's final failure notification. The Notice of Appeal shall include: 1) a detailed description of the reason for appeal including supporting documentation; 2) a description of how the enforcement action impacts the affected organization; and 3) request for a waiver of repayment that includes an explanation why such requirement (for maximum percentage of carryover amount) should not apply to the awardee and the steps taken by the awardee to ensure that all HPP funds will be expended appropriately. The awardee should be aware that they bear the burden of proof to the extent of the type of modification or reversal of the GMO's decision they seek and the modification or reversal.

Within ten days of receipt of the awardee's notice of appeal, the GMO will 1) brief the ARC on the issues of the case, 2) submit any relevant documentation supporting the decision, and 3) provide a written statement responding to the notice of appeal.

Within ten days of receipt of the brief and documentation submitted by the GMO, the ARC will acknowledge, in writing, the notice of appeal to the awardee and the GMO.

The ARC will review the relevant information, **within seven days**, and use one or a combination of the following methods for dispute resolution:

(a) Documentation Review – an independent evaluation of documents to verify compliance with laws, regulations, or policies;

(b) Conference – allow parties an opportunity to make an oral presentation to clarify issues, question both parties to obtain a clear understanding of the facts, and provide recommendations for resolution. Telephone conferences are acceptable.

The ARC may decide that the Department should waive or reduce the amount to be repaid for a single entity or for all entities in a fiscal year, if the ARC reviews and determines that mitigating conditions exist that justify the waiver or reduction. The ARC will notify the GMO, PO, and the awardee, in writing, of their final decision that the Department should waive or require repayment of the portion of the unobligated amount of HPP funds that exceeds the maximum amount permitted to be carried over to the succeeding fiscal year.

If the ARC's final decision is to waive or to require repayment of the portion of the unobligated amount of HPP funds that exceeds the maximum amount permitted to be carried over to the succeeding fiscal year, the GMO shall issue a final decision in writing to the awardee **within ten days** from the receipt of the ARC's final decision.

Funds that are repaid to ASPR will be reallocated so that the Secretary may make awards under section 319C-2 to entities described in subsection (b)(1) of that section (i.e., Healthcare Facility Partnership grants).

4. Responsibilities

A. PO/Public Health Advisor shall:

1. If determined the awardee has exceeded the maximum carryover percentage, the PO shall issue a written recommendation to the GMO based on the review and monitoring of awardee progress.
2. Provide a timely documentation package to the GMO regarding a decision to repay unobligated HPP funds that exceed the maximum carryover percentage.

B. GMO shall:

1. Rescind initial failure notification or issue a final failure notification and provide the awarding agency's process for appeal to include applicable timelines, in writing, to the awardee and provide a copy to ARC.
2. Brief ARC on issues pertaining to disputes.
3. Prepare and submit a complete documentation package to the ARC regarding a decision to repay.

C. ARC shall:

1. Establish regular committee members and consult with subject matter experts in the Department, as necessary.
2. Receive initial Notice of Appeals.
3. Send acknowledgements to the awardee and GMO.

4. Review disputes by documentation or conference.
5. Provide recommendations and facilitate disputes to preclude further action.
6. Provide the ARC decisions on appeals.

D. Awardee or Complainant shall:

1. Remedy non-compliance issues during the corrective action phase. If the GMO determines that corrective actions have not been adequate, the awardee may submit a written request for review.
2. If awardee disputes the GMO's final decisions, submit dispute to ARC after Failure Notification is received from the agency awarding office as described in the NoA. The dispute must contain the following:

A. a detailed description of the reason for dispute including supporting documentation ;

B. a description of how the enforcement action impacts the affected organization; and

C. request for a waiver of repayment that includes an explanation why such requirement (for maximum percentage of carryover amount) should not apply to the awardee and the steps taken by the awardee to ensure that all HPP funds will be expended appropriately

C. Repayment or future withholding or offset as a result of a disallowance decision if an audit shows that funds have not been spent in accordance with section 319C-2 of the PHS Act.

1. Awardees shall, not less often than once every 2 years, audit their expenditures from HPP funds received. Such audits shall be conducted by an entity independent of the agency administering the HPP program 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 completion of each audit report, awardees should submit a copy of that audit report to ASPR.

Awardees shall repay to the United States amounts found not to have been expended in accordance with section 319C-2 of the PHS Act. If such repayment is not made, ASPR may offset such amounts against the amount of any allotment to which the awardee is or may become entitled under section 319C-2 or may otherwise recover such amount. ASPR may withhold payment of funds to any awardee which is not using its allotment under section 319C-2 in accordance with such section. ASPR may withhold such funds until it finds that the reason for the withholding has been removed and there is reasonable assurance that it will not recur.

2. Disallowance notification
Upon determination as a result of audit findings that the awardee has not expended funds in accordance with section 319C-2, the GMO shall issue a disallowance notification to the awardee for the portion of funds not expended in accordance with section 319C-2 and

require repayment of those funds to the United States.

3. Dispute process

HHS has established a DAB for the purpose of providing awardees a fair and flexible process to appeal certain written final decisions involving grant and cooperative agreement programs administered by agencies of HHS. This document notifies HPP awardees that an opportunity exists to appeal a **disallowance** enforcement action to the DAB. If the awardee chooses to appeal a final disallowance decision by the GMO, the awardee must do so directly to the DAB **within thirty days** of receipt of the GMO's final disallowance notification. The Notice of Appeal shall include: 1) a copy of the final decision, 2) a statement of the amount in dispute in the appeal, and 3) a brief statement of why the decision is wrong. More details about the DAB's procedures may be found at 45 C.F.R. part 16.

V. REFERENCES

A. Code of Federal Regulations (CFR)

* 45 CFR Part 16 and Appendix A, Procedures of the Departmental Grants Appeal Board

* 45 CFR Part 74 and Appendix E, Uniform Administrative Requirements for Awards and Sub-awards to Institutions of Higher Education, Hospitals, Other Nonprofit organizations, and commercial organizations

* 45 CFR Part 92, Uniform Administrative Requirements for Grants and Cooperative Agreements to State, Local, and Tribal Governments

B. OMB Circulars

* A-87, Cost Principles for State, Local and Indian Tribal Governments
* A-102, Grants and Cooperative Agreements with State and Local Governments
* A-110, Uniform Administrative Requirements for Grants and Other Agreements with Institutions of Higher Education, Hospitals, and Other Non-Profit Organizations.
* A-133, Audits of States, Local Governments, and Non-Profit Organizations Requirements

C. HHS Grants Policy Statement, January 1, 2007