DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Assistant Secretary for Preparedness and Response
Office of Preparedness and Emergency Operations
Division of National Healthcare Preparedness Programs

FY09 Hospital Preparedness Program
Funding Opportunity Announcement

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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 (NHPP)

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

ANNOUNCEMENT TYPE: New Cooperative Agreement (CA)

Catalog of Federal Domestic Assistance (CFDA) Number: 93.889

Application Due Date: To receive consideration, **electronic CA applications** must be submitted **no later than 11:30 PM on June 30, 2009** through the application mechanism specified in Section IV.

Anticipated Award Date: August 9, 2009

Project Period: Three-years

Executive Summary:

The ASPR, OPEO, NHPP, HPP requests applications for State and jurisdictional hospital preparedness CAs, 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 grants in the form of a CA to eligible entities, to enable such entities to improve surge capacity and enhance community and hospital preparedness for public health emergencies. The Omnibus Appropriations Act, 2009, provides funding for these awards (P.L. 111-8).

The funding provided through the HPP is for activities that include, but are not limited to, exercising and improving preparedness plans for all-hazards including pandemic influenza, increasing the ability of healthcare systems to provide needed beds, engage with other responders through interoperable communication systems, track bed and resource availability using electronic systems, develop ESAR-VHP systems, protect their healthcare workers with proper equipment, decontaminate patients, enable partnerships/coalitions, educate and train their healthcare workers, enhance fatality management and healthcare system evacuation/shelter in place plans, and coordinate regional exercises.

1.0 FUNDING OPPORTUNITY DESCRIPTION

1.1 Purpose

The HPP goal is to ensure awardees uses these CA funds to maintain, refine, and to the extent achievable, enhance the capacities and capabilities of their healthcare systems, and for exercising and improving preparedness plans for all-hazards including pandemic influenza. For the purposes of this CA, healthcare systems (E.g., sub-awardees) are composed of hospitals and other healthcare facilities which 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, CHCs, nursing, etc.).

1.1.1 Surge Capacity – Surge Capability

Surge capacity is broadly defined as the ability of a healthcare system to adequately care for increased numbers of patients. In 2003, as a planning target, HPP further defined surge capacity for beds as 500 beds/million population. In 2006, the HPP 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. At that time, the HPP started to lay out a series of sub-capabilities that all healthcare systems participating in the HPP must possess, and this funding opportunity announcement (FOA) continues to clarify those sub-capabilities.

In an effort to assist awardees with long-term strategic planning, the HPP will implement a **three-year project period for this CA starting with FY09 awards. Applicants will be required to submit a program narrative, including all appropriate components identified under the "Content and Form of Application Submission" section of this FOA, describing how the project will progressively unfold during the FY09, FY10 and FY11 budget periods, using their FY09 award as a budget planning target for FY10 and FY11.*

**The majority of Federal funds (ideally seventy-five percent or more) should be distributed to benefit eligible healthcare systems. Awardees should work with sub-awardees to develop deliverables that clearly integrate and enhance their healthcare system preparedness activities, with the overall effect of making the systems function in a more efficient, resilient, and coordinated manner.*

**Awardees are reminded these funds are to be used to supplement, not supplant current resources supporting healthcare preparedness.*

**Award of a continuation grant in FY10 and FY11 will be based on the availability of funds, evidence of satisfactory progress by the awardee and the determination that continued funding is in the best interest of the Federal government.*

1.2 Background

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

Pursuant to section 319C-2(c) activities supported through funds under this FOA 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, and trauma care and emergency medical service systems, with respect to public health emergencies. This shall include developing plans for the following:

iii. Strengthening public health emergency medical management and treatment capabilities;
iv. Medical evacuation and fatality management;
v. Rapid distribution and administration of medical countermeasures, specifically to hospital-based healthcare workers and their family members, or partnership entities;
vi. Effective utilization of any available public and private mobile medical assets, and integration of other Federal assets;
vii. 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 (NRF), or any successor plan, the National Incident Management System (NIMS), and the National Preparedness Goal (NPG), 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.

1.2.2 National Response Framework (NRF)

HPP funded activities must be used to assist awardees with integrating response plans into the broader NRF or "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. It 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.

NRF information is available at www.fema.gov/emergency/nrf/mainindex.htm

1.2.3 Medical Surge Capacity and Capability (MSCC) Handbook

This handbook provides a blueprint for a systematic approach to managing medical and public health responses 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). An updated version of the MSCC handbook was published by HHS in September 2007, which expands on several concepts included in the first edition. Also, the new version describes recent changes to the Federal emergency response structure, particularly related to the public health and medical response.

This handbook 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. While the HPP does not require awardees to directly fund each tier, awardees are expected to develop increasingly robust capacity and capability, and work within the tiered framework to ensure integration of the healthcare system response from the local up through the State level.

A summary of the key updates to the MSCC framework is provided in **APPENDIX A** of this FOA, and further information on the MSCC handbook can be found at www.hhs.gov/disasters/discussion/planners/mscc/

1.2.4 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 sub-capabilities at the State and local levels. Various opportunities for collaboration exist among the distinct yet related grant/CA programs at DHS and HHS, and awardees are strongly encouraged to take advantage of them.

1.3 Project Description

1.3.1 Capabilities-Based Planning

Capabilities-based planning is "planning under uncertainty to provide sub-capabilities suitable for a wide range of threats and hazards, while working within an economic framework that necessitates prioritization and choice." This planning approach assists leaders at all levels to allocate resources systematically to close gaps, thereby enhancing the effectiveness of preparedness efforts.

Capabilities-based planning will provide a means for healthcare systems, States and ultimately the Nation to achieve a heightened state of preparedness by answering three fundamental questions: "How prepared do we need to be?", "How prepared are we?", and "How do we prioritize efforts to close the gap?"

1.3.2 Gap Analysis

For the purpose of this application, the latest State, regional, and/or community-based HVAs completed should be utilized to determine gaps in sub-capabilities. A gap analysis will drive the rationale to fund sub-capabilities needed by local, regional and State healthcare systems (E.g., a region with a toxic chemical manufacturer must utilize a State, regional, and/or community-based HVAs, measure the potential health consequences of a chemical release, and develop/acquire the sub-capabilities needed for the healthcare system response to the specific consequences). In addition to developing sub-capabilities for vulnerabilities identified in their HVAs, States must continue to build their sub-capabilities to respond to a pandemic influenza. *This will require close coordination with others including their State/local Public Health Preparedness Directors and State Department of Homeland Security, and associated activities funded through the CDC Public Health Emergency Preparedness and Department of Homeland Security grant/CA programs.*

Two products have been developed and released to assist awardee Capability-Based Planning. Funding and leadership to support the Hospital Surge Model and the Emergency Preparedness Resource Inventory (EPRI) tool was provided by the U.S. Department of Health and Human Services' Office of the Assistant Secretary for Preparedness and Response, through an Agency for Healthcare Research and Quality (AHRQ) contract.

The Hospital Surge Model estimates the hospital resources needed to treat casualties arising from biological (anthrax, smallpox, pandemic flu), chemical (chlorine, sulfur mustard, or sarin) nuclear (1 KT or 10 KT explosion) or radiological (dispersion device or point source) attacks, and is available at www.hospitalsurgemodel.ahrq.gov

The EPRI tool enables States, counties, or regional entities to compile an inventory of resources and capabilities for responding to emergencies and disasters. Originally released in 2005, EPRI has been updated with improved usability and additional features, and is available at www.ahrq.gov/research/epri/

1.3.2.1 Application Requirements

In the FY09 HPP CA application, all awardees must:

- Describe how all *Overarching Requirements and ASPR Expectations*, and FY08 Level 1 Sub-Capabilities will be maintained and refined during the three-year project period. Delineate how funds will be applied, and describe the activities to be conducted, in order to meet the Overarching Requirements and ASPR Expectations.

Awardees may then:

- Describe the two highest ranked scenarios from the latest State, regional, and/or community-based HVAs, include the rationale for ranking these selections highest, and add Pandemic Flu as a third scenario.
- Describe in detail what Level 2 Sub-Capabilities currently exist to address each of the three scenarios (E.g., Scenario 1, 2 and Pandemic Flu) and what is needed.
- Describe what additional Level 2 Sub-Capabilities need funding over the three-year project period to fill gaps for the two highest ranked scenarios, and Pandemic Flu.
- Describe how chosen Level 2 Sub-Capabilities will be prioritized in terms of applying funds over the three-year project period, and describe the activities required to accomplish.

1.4 Overarching Requirements and ASPR Expectations

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

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

1.4.1 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 ensure appropriate participating healthcare systems continue implementing and maintaining NIMS activities during FY09, and throughout the three-year project period.

1.4.1.1 ASPR Expectation

Awardees: Awardees will assess and report annually which participating healthcare systems currently have adopted all NIMS implementation activities, and which are still in

the process of implementing the 14 activities. For any participating healthcare system still working to implement NIMS activities, funds must be prioritized and made available during each budget period to ensure the full implementation and maintenance of all activities during the three-year project period.

Healthcare Systems: All participating healthcare systems must comprehensively track all NIMS implementation activities, and report on those activities annually as part of the reporting requirements for this CA.

1.4.1.2 Application Requirements

The following must be addressed in the FY09 application, and with each End-of-Year Progress Report:

1. A comprehensive inventory that lists participating healthcare systems; identifies each of the 14 NIMS implementation activities that have been achieved; and identifies each activity still in progress.

2. Detailed descriptions of all implementation activities with associated budget allocations, that ensure all healthcare systems achieve and maintain all activities during the three-year project period.

Further information on NIMS for healthcare systems can be found in **APPENDIX B** of this FOA, and at www.fema.gov/pdf/emergency/nims/imp_hos.pdf

1.4.2 Needs of At-Risk Populations

1.4.2.1 ASPR Expectation

FY09 HPP applications must clearly describe 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, but 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. Additional At-Risk information can be found in **APPENDIX J**

In addition to those individuals specifically recognized as at-risk in section 2802(b)(4)(B) of the PHS Act (E.g., 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. Such needs could include additional needs in one or more of the following functional areas:

- independence
- communication

- transportation
- supervision
- medical care

1.4.3 Education and Preparedness Training

1.4.3.1 ASPR Expectation

Awardees shall ensure that education and training opportunities/programs exist for healthcare workers who respond to terrorist incidents or other public health emergencies during each budget period within the three-year project period, and ensure those opportunities or programs encompass the sub-capabilities described herein.

Awardees shall undertake activities that ensure all education and training opportunities/programs enhance the ability of healthcare workers (including not only healthcare system workers, but those from local health departments, community healthcare systems, emergency response agencies, public safety agencies, and others) to respond in a coordinated and non-overlapping manner. In order to reduce costs and build relationships, joint training of all healthcare system workers is strongly encouraged.

**Funds may be used to offset the cost of healthcare system worker participation in training centered on sub-capability development; to prepare workers with the necessary knowledge, skills and abilities to perform/enhance the sub-capability; and to participate in drills and exercises around those sub-capabilities or related systems.*

**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 workers participating in training, drills and exercises.*

1.4.3.2 Application Requirements

The following issues must be addressed in the FY09 application:

1. Describe how the education and training activities proposed in the awardee's program narrative support sub-capability development, and are linked to healthcare system, community-based, regional and/or State HVAs.

2. Describe how the knowledge, skills and abilities acquired as a result of education and training activities proposed in the program narrative will be incorporated into exercises/drills.

** As in previous years, release time for healthcare workers to attend trainings, drills and exercises is an allowable cost under the CA.*

** Salaries for back filling of personnel are **not** allowed.*

1.4.4 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 FY09, and throughout the three-year project period, awardees are strongly encouraged to continue to use the DHS Senior Advisory Committees, established to coordinate Federal preparedness programs and encourage collaboration at the State and local level among homeland security, emergency management, public safety, public health, the health and medical community, and other responders, to develop an exercise plan for conducting joint exercises to meet multiple requirements from various grant/CA programs, and minimize the burden on exercise planners and participants.

Exercise plans must demonstrate coordination with relevant entities such as local healthcare system partnerships/coalitions, Metropolitan Medical Response System (MMRS) entities, the local Medical Reserve Corps (MRC), and the Cities Readiness Initiative (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.*

**At-risk populations and/or those who represent them must also be engaged in preparedness planning and exercise activities.*

1.4.4.1 ASPR Expectation

Exercise programs funded all or in part by HPP CA funds should be built on the Homeland Security Exercise and Evaluation Program (HSEEP). Further information on HPP related HSEEP guidelines, and exercise policy can be found in **APPENDIX C** of this FOA.

Awardees must ensure during each budget period within the three-year project period at least one exercise is conducted in each CRI city, and an equal number of exercises are conducted in other locations, and ensure participating healthcare systems in those areas participate in these exercises.

Further, HPP expects that each exercise tests the operational capability of the following medical surge components:

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

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

3. Fatality Management, Medical Evacuation/Shelter in Place, and Tracking of Bed Availability;

1.4.4.2 Application Requirements

Awardees shall develop and submit an exercise plan with their FY09 application, and proposed plans for the FY10, FY11 budget periods).

The exercise plan must include a proposed exercise schedule, and a discussion of the plans for exercise development, conduct, evaluation, and improvement planning.

Awardees must:

- 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);
- Describe the role of healthcare systems in exercise development, participation, evaluation, development of after action reports, and participation in evaluation and improvement plans;
- Describe how the awardee will ensure that lessons learned from after action reports are shared with the healthcare systems, and how the emergency operations plans of those healthcare systems are then modified; and
- Describe how plans for training are integrated with the exercise program.

The following information must be submitted with each HPP End-of-Year Progress Report for FY09, FY10, FY11:

- Comprehensive information on all HPP funded training, drills and exercises. The system shall detail the subject matter of trainings, and the number of healthcare workers trained by specialty. The awardee is required to track the level of exercise, the sub-capabilities being targeted, and the participating/exercising healthcare systems (E.g., those identified on page 2 of this FOA, as well as other relevant exercise participants).
- Awardees must submit all AAR summaries, improvement plans, and corrective actions that are developed for the aforementioned exercises, an executive summary of the priority 3 corrective action items, and a timeline for fixing those deficiencies.

Additional activities for funding consideration under this sub-capability include:

- Enhancement and upgrade of emergency operations plans based on exercise evaluation and improvement plans;
- Release time for healthcare workers to attend drills and exercises. (Note: Salaries for back filling are not allowable costs under this CA);
- Costs associated with planning, developing, executing and evaluating exercises and drills.

The abridged Tools for Evaluating Core Elements of Hospital Disaster Drills, at www.ahrq.gov/prep/drillelements/index.html provides healthcare systems with an

instrument designed to capture the most critical aspects of disaster drill activities.

Efficient use of the tools modules will assist in identifying the most important strengths and weaknesses in healthcare system disaster drills. Evaluation results can be applied to further training and drill planning.

Awardees are reminded that responses to real world events that may arise during the course of the three-year project period **may count towards the exercise requirements if the conditions outlined under "ASPR Expectation" of the Exercises, Evaluation and Corrective Actions section are met. There is no minimum requirement on the length of the event, as long as the AAR and corrective action plan are put into place after the event.*

1.5 Project Activities

1.5.1 Level 1 Sub-Capabilities

FY09 HPP CA funds will be used to continue maintaining and refining medical surge capacity and capability at the State and local level through associated planning, personnel, equipment, training and exercises. The ASPR recognizes that maintenance and refinement of current Level 1 Sub-Capabilities is critical for the sustainability of State preparedness efforts. Therefore, awardees are expected to maintain and refine all Level 1 Sub-Capabilities that were developed during FY08, and must address, in their FY09 program narrative how they will accomplish this **during each budget period within the three-year project period.**

1. Interoperable Communication Systems
2. Tracking of Bed Availability (HAvBED)
3. ESAR-VHP
4. Fatality Management
5. Medical Evacuation/Shelter in Place
6. Partnership/Coalition Development

1.5.2 Level 2 Sub-Capabilities

While the ASPR recognizes the challenge to maintain and refine current systems, awardees are strongly encouraged to expand their State preparedness efforts through the development of Level 2 Sub-Capabilities. The funding of Level 2 Sub-Capabilities should be addressed by each awardee, to the extent achievable, during the three-year project period only after Level 1 Sub-Capability maintenance and refinement is described.

Using Capabilities-Based Planning and the HVA/Gap Analysis requirements described in this FOA, the program narrative developed by awardees should ensure the need or gap will be addressed to the fullest extent achievable. The HPP strongly suggests that each awardee propose Level 2 Sub-Capability projects that progressively unfold during each budget period to close gaps over the length of the three-year project period.

1. Alternate Care Sites (ACS)
2. Mobile Medical Assets
3. Pharmaceutical Caches
4. Personal Protective Equipment
5. Decontamination
6. Medical Reserve Corps (MRC)
7. Critical Infrastructure Protection (CIP)

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 www.rkb.us/mel.cfm

1.5.3 Interoperable Communication Systems

1.5.3.1 ASPR Expectation

All awardees are required to equip participating healthcare systems, to the extent achievable, with communication devices which allow them to communicate horizontally (with each other), and vertically with EMS, fire, law enforcement, local and State public health agencies, etc.

Since FY03, the HPP has required that healthcare systems and health departments establish communications redundancy, ensuring that if one communications system fails, other technologies can be implemented in order to maintain communications. HHS encourages all participating healthcare systems, and State Departments of Public Health to develop communications redundancy composed of the following:

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

During each budget period within the three-year project period, awardees shall maintain and refine operational, redundant communication systems that are capable of communicating both horizontally, between healthcare systems, and vertically, within the jurisdiction's incident command structure, as described in the tiered response framework outlined in the MSCC Handbook.

The systems shall link all healthcare systems that participate in the HPP, 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 continue to 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.

Not all tiers are meant to be implemented equally across all organizations. The ASPR 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 healthcare system will also need to consider the operational and financial impact of these various recommendations as they update their plans; but this activity must be viewed as a continued priority to maintain and refine during the three-year project period, and be addressed accordingly.

1.5.3.2 Telecommunications Service Priority (TSP) Program

ASPR Expectation: Awardees are encouraged to fund at least one dedicated line for a minimum of 3 healthcare systems per sub-State region as part of HPP participation in the Federal Communications Commission TSP program. The TSP requires local telecommunications service providers to give restoration, or provisioning service priority to users even during disasters, where there is extensive damage to the telecommunications infrastructure and large numbers of other local customers are out of service. Participation in this program will enable healthcare system communications with first responders (E.g., police, fire and ambulance), as well as with State and local health departments during critical times. 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 should be cognizant that healthcare systems currently participating in TSP and supporting the costs on their own are not eligible for Federal funds to support these costs moving forward, as this may be construed as supplanting funds.*

TSP 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 DHS, National Communications Service (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, and healthcare systems 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.

Further information about HPP TSP implementation for healthcare systems can be found in **APPENDIX D of this FOA.*

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

1.5.4.1 ASPR Expectation

During each budget period within the three-year project period, awardees are required to maintain and refine an operational bed tracking, accountability/availability systems

compatible with the HAvBED data standards and definitions.

Systems must be maintained, refined, and adhere to all requirements and definitions included in **APPENDIX E** of this FOA, with the ongoing ability to submit required data using one of two following mechanisms:

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 healthcare systems, **OR**
Awardees may use existing systems to automatically transfer required data to the HAvBED server using the HAvBED EDXL Communication Schema, found at: www.havbed.hhs.gov

**Information and technical assistance will continue being provided to awardees on both options. States are strongly encouraged to move toward automation, and the capability to report information in real-time.*

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

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

1.5.5.1 ASPR Expectation

The ASPR expects that all ESAR-VHP electronic system, operational, evaluation and reporting compliance requirements are met by August 8, 2012. For a detailed list of these requirements please see **APPENDIX F** 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.

1.5.5.2 Application Requirements

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 *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 FY08, awardees were required to meet all of the compliance requirements.

In accordance with the eligibility and allowable use of funds awarded through this announcement, awardees shall direct funding towards meeting or refining all of the compliance requirements by **August 8, 2012.**

The following must be included in the FY09 application and during each budget period update:

1. A detailed description of the ESAR-VHP program.
2. The current status of each item and sub-item in the compliance requirements.
3. A list of the occupations (health professional and non-health professional) included in the ESAR-VHP system.
4. The total number of volunteers registered in the ESAR-VHP system.

All States must report progress toward meeting these compliance requirements in Mid-Year and End-of-Year Progress Reports for the HPP.

1.5.6 Fatality Management

1.5.6.1 ASPR Expectation

All awardees must work closely with participating healthcare systems and other appropriate 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 FY08, awardees were directed to develop disaster and mass fatality management plans and concepts of operation with participating healthcare systems, local health departments, emergency management and State/jurisdictional Chief Medical Examiner/Coroner.

During each budget period within the three-year project period, awardees must continue to work with the entities above, and others as appropriate, to maintain and refine 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 continue to base planning on the estimated number of fatalities expected in the case of the most likely events as identified in their State, regional, and/or community-based HVAs, or expected during an influenza pandemic.*

Funds may be used for the continued maintenance and refinement of plans, as well as the

purchase of mortuary equipment and supplies (E.g., face shields, protective covering, gloves, and disaster body bags).

1.5.6.2 Application Requirements

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 healthcare systems, 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.

1.5.7 Medical Evacuation/Shelter in Place (SIP)

1.5.7.1 ASPR Expectation

The 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 healthcare systems to shelter in place versus evacuating patients and/or facilities.

The Federal Government through its Regional Emergency Coordinators (RECs) will continue to work in collaboration with States to better determine the capabilities and opportunities for improvement of healthcare system preparedness. They will continue to work with healthcare systems, 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 healthcare systems and integrated with other preparedness plans.

**Awardees must continue to integrate the evacuation planning of participating healthcare systems into Tiers 2, 3, and 4 of the MSCC framework.*

Proactive planning and preparation will ensure successful operational plans. Awardees should continue to maintain and refine plans, based on their State, regional, and/or community-based HVAs, to identify the imminent threat to life in the area. The nature of the vulnerability and the hazards posed should help the awardees and healthcare systems plan for the event. Awardees should continue to maintain and refine 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 facility healthcare workers and family members.

The State should encourage all participating healthcare systems to take the following into

account while continuing to work on the integration of local/regional plans:

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

**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.*

The Mass Evacuation Transportation Planning Model estimates the time required to evacuate and transport patients from one healthcare system to another. Healthcare system planners can also use this model to estimate the transportation resources needed to evacuate patients within a certain time period. Funding and leadership to support this model was provided by the Department of Homeland Security's Federal Emergency Management Agency, and the U.S. Department of Health and Human Services' Office of the Assistant Secretary for Preparedness and Response, through an AHRQ contract. This project was co-led by AHRQ and the U.S. Department of Defense, and will be made available in 2009 at www.massevacmodel.ahrq.gov

1.5.8 Partnership/Coalition Development

1.5.8.1 ASPR Expectation

1. During each budget period within the three-year project period, all awardees shall continue to 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.

2. For example, if a State possess 2 CRI cities, then 4 partnerships/coalitions must be maintained and refined (2 in the CRI cities and 2 in other sub-State regions).

3. Partnerships/coalitions are strongly encouraged to continue to plan and develop memoranda of understanding (MOU) to share assets, personnel and information. These MOUs shall be tested through tabletop components of exercises conducted in CRI and non-CRI cities as described above in the Exercises, Evaluations and Corrective Actions section.

4. Partnerships/coalitions shall develop plans to unify ESF-8 management of healthcare during a public health emergency, and integrate communication with jurisdictional command in the area.

1.5.8.2 Application Requirements

The following information must be submitted with each HPP End-of-Year Progress Report for FY09, FY10, FY11:

1. the name of the partnership/coalition;
2. the location of the partnership/coalition;
3. the participant healthcare systems and other partners; and
4. the number and type of MOUs that exist.
5. the funding directed to the partnership/coalition and activities associated with these funds.

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/coalitions 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/coalitions shall be able to strategically:

- integrate plans and activities of all participating healthcare systems 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/coalitions are not expected to replace or relieve healthcare systems of their institutional responsibilities during an emergency, or to subvert the authority and responsibility of the State or directly funded city.*

1.5.9 Alternate Care Sites (ACS)

1.5.9.1 ASPR Expectation

During any budget period within the three-year project period, the ASPR expects 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 should 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 systems.

**Many awardees have been developing ACS plans as an option for providing disaster and mass casualty medical care in the event that healthcare systems are overrun or rendered unusable by a disaster. Awardees may use HPP CA 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 systems.

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 and public health systems, and emergency management agencies, work with other response partners when choosing a facility to use as an ACS.

In addition, plans should 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.

1.5.9.2 Application Requirements

If ACS activities are funded during the project period, the following information must be submitted with each HPP End-of-Year Progress Report for FY09, FY10, FY11.

- 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.

1.5.10 Mobile Medical Assets

During any budget period within the three-year project period, awardees may need the ability to provide care outside of their healthcare systems. 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.

If Mobile Medical Asset related activities are funded during the project period, it must be reported on with each HPP End-of-Year Progress Report for FY09, FY10, FY11.

1.5.11 Pharmaceutical Caches

During any budget period within the three-year project period, each awardee may develop an operational plan that assures storage, rotation and timely distribution of critical antibiotic medications through the supply chain during an emergency, for healthcare workers and their families. Although many awardees should already have caches in place due to the multiple years of HPP funding for this activity, awardees may continue to establish, maintain or enhance event accessible caches of specific categories of pharmaceuticals, and ensure availability in facilities/on-site, cached within regions, or at the State level.

Awardees may undertake analysis of and propose funding for the purchase of antiviral caches to care for **patients in healthcare systems, if this has not already occurred. HPP funding may be used to purchase, replace and rotate pharmaceuticals only if the purchases are linked to State, regional, and/or community-based HVAs, 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 system would ensure immediate access to the medications. It is understood that facility 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 systems.

Awardees are encouraged to work with stakeholders (Schools of Pharmacy, State Boards of Pharmacy, healthcare systems, 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 systems 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.

1.5.11.1 Allowable purchases

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

1. **Antibiotic drugs** for prophylaxis and post-exposure prophylaxis to biological agents for at least three days;

2. **Nerve agent antidotes;** Funding for the initial cost of the CHEMPACK cache site modification and maintenance over time 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.);

3. **Antiviral drugs** - In general, the purchase of antiviral drugs for use during an influenza pandemic is allowed through the HPP; however, purchases must be made consistent with U.S. government antiviral drug use guidance published on pandemicflu.gov: www.pandemicflu.gov/vaccine/antiviral_use.pdf and www.pandemicflu.gov/vaccine/antiviral_employers.pdf. Plans should consider the following: prescribing, storage, and dispensing. *Public sector purchases can be coordinated with the HHS Subsidy Program.*

4. Medications needed for exposure to other threats (**E.g., radiological events**).

If pharmaceutical cache related activities are funded during the project period, it must be reported on with each HPP End-of-Year Progress Report for FY09, FY10, FY11.

1.5.12 Personal Protective Equipment

During any budget period within the three-year project period, awardees should ensure adequate types and amounts of personal protective equipment (PPE) to protect current and additional trained healthcare workers expected in support of the events of highest risk, and identified through State, regional, and/or community-based HVAs or assessments. The amount should be tied directly to the number of healthcare workers 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 healthcare systems

that have identified probable high-risk scenarios (E.g., the facility functions near an organophosphate production plant with a history of employee contamination incidents) should have higher levels of PPE, and more stringent decontamination processes.

If PPE related activities are funded during the project period, it must be reported on with each HPP End-of-Year Progress Report for FY09, FY10, FY11.

1.5.13 Decontamination

During any budget period within the three-year project period, each awardee should ensure that adequate portable or fixed decontamination system capability exists Statewide for managing adult and pediatric patients, as well as healthcare workers, who have been exposed during all-hazards 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 State, regional, and/or community-based HVAs or assessments. All decontamination assets shall be based on how many patients/providers can be decontaminated on an hourly basis.

If decontamination related activities are funded during the project period, it must be reported on with each HPP End-of-Year Progress Report for FY09, FY10, FY11.

1.5.13.1 Relevant Resources

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 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.

The ASTM website is available at www.astm.org

1.5.14 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 as described in section 2802(b) of the PHS Act, awardees may consider using HPP CA funds to support the integration of MRC units with local, regional and statewide infrastructure, during any budget period within the three-year project period. Awardees are also encouraged to use multiple sources of funding to establish/maintain the MRC program**.** HPP CA 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, healthcare systems, 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 healthcare system workers or volunteers that participate in the ESAR-VHP program.

For more information on what HPP CA funds may be used for, please contact your HPP Project Officer. More information about the MRC program can be found at www.medicalreservecorps.gov or MRCcontact@hhs.gov

If MRC related activities are funded during the project period, it must be reported on with each HPP End-of-Year Progress Report for FY09, FY10, FY11.

1.5.15 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 (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.

**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.*

During any budget period within the three-year project period, awardees may propose projects that relate directly to resilience and protection of critical healthcare systems and services. Suggestions should be based on a need identified in State, regional, and/or community-based HVAs, or other assessments**.** Some examples may include: *upgrading of security systems; movement of switching rooms and generators; ensuring adequate back up generators or other power sources for key facilities in the region; expanding the functions/services that have back-up power* (HVAC, elevators, security systems, etc.).

HHS recognizes that healthcare system 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.

1.5.15.1 Relevant Resources

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

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

If CIP related activities are funded during the project period, it must be reported on with each HPP End-of-Year Progress Report for FY09, FY10, FY11.

2.0 AWARD INFORMATION

Type of Award: CA
Approximate Award Period Funding: Approximately $360M (Includes direct and indirect costs.)
Approximate Number of Awards: 62
Approximate Average Award: $6M
Anticipated Award Date: August 9, 2009
Budget Period Length: 9-Months 3-Weeks
Project Period Length: Three-years

Throughout the three-year project period, HHS' commitment to continuation awards will be conditioned on the availability of funds, evidence of satisfactory progress by the awardee (as documented in required reports), and the determination that continued funding is in the best interest of the Federal government. If additional HPP funds become available, funding amounts may be adjusted prior to making awards

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

1. The awardee will:
- **a.** Provide a program narrative (including work-plans, an assessment plan, budgets, applicable work products, etc.) that support the applicable goals in section 2802(b) of the PHS Act.
- **b.** Ensure program activities are consistent with the Department of Homeland Security, NRF.
- **c.** Submit program performance and financial status reports on a semi-annual basis.

2. The ASPR will:
- **a.** Monitor program performance and take corrective action as necessary if detailed performance specifications are not met.
- **b.** Provide technical assistance, including but not limited to:
- **c.** Integration/Coordination of Federal funding for preparedness.
- **d.** Subject matter expertise on preparedness activities.
- **e.** Identification of promising practices.
- **f.** Development of performance goals and standards.
- **g.** Assistance with exercise planning and execution.
- **h.** Review and approve work-plans, budgets, and proposed contracts.

3.0 ELIGIBILITY INFORMATION

3.1 Eligible Applicants

Eligible applicants for this funding opportunity are limited to those previously funded under the HPP: 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 systems (including but not limited to those identified on page 2 of this FOA) to participate in the HPP; these facilities should work directly with the appropriate State health department programs. 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 FOA, the use of the term "State" may include the State, municipality, or associated Territory for which a CA is received).

3.2 Cost Sharing or Matching

HPP CA funding must be matched by nonfederal contributions beginning with the distribution of FY09 funds. Nonfederal contributions (match) may be provided directly or through donations from public or private entities and may be in cash or in-kind donations, fairly evaluated, including plant, equipment, or services. Amounts provided by the federal government, or services assisted or subsidized to any significant extent by the federal government, may not be included in determining the amount of such nonfederal contributions. Awardees will be required to provide matching funds as described:

- For FY09, not less than 5% of such costs ($1 for each $20 of federal funds provided in the CA; and
- For any subsequent fiscal year of such CA, not less than 10% of such costs ($1 for each $10 of federal funds provided in the CA).

Please refer to 45 CFR § 92.24 for match requirements, including descriptions of acceptable match resources. Documentation of match (including methods and sources) must be included in the FY09 application for funds, follow procedures for generally accepted accounting practices and meet audit requirements. Beginning with FY09, the HHS Secretary may not make an award to an entity eligible for HPP funds unless the eligible entity agrees to make available nonfederal contributions in full as described above.

3.3 Other

3.3.1 Maintenance of Funding (MOF)

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 an award under this funding opportunity, the awardee must demonstrate in the budget narrative, that they intend to budget not less than the average of their FY07 and FY08 total spending for healthcare preparedness.

For the purposes of calculating MOF for healthcare preparedness spending, the following applies:

1. State contributions only, not Federal dollars
2. Surge Capacity investments to be considered:
3. Beds
4. Isolation
5. Decontamination
6. PPE
7. Pharmaceuticals
8. Mobile Medical Assets
9. Interoperable communications equipment and capability
10. Laboratory equipment, and trainings

The following example table describes awardee MOF – it must be submitted with the FY09 application:

MAINTENANCE OF FUNDING: EXAMPLE

STATE EXPENDITURES - HEALTHCARE PREPAREDNESS

	STATE Funds	TOTAL	
FY07	$1,000,000	$1,000,000	
FY08	$1,200,000	$1,200,000	
		AVERAGE	$1,100,000

FOR FY09, THE STATE SHALL MAINTAIN EXPENDITURES FOR HEALTHCARE PREPAREDNESS OF AT LEAST $1,100,000.

3.3.2 Other

PAHPA amended section 319C-1 and 319C-2 of the PHS Act to add certain accountability and compliance requirements that awardees must meet, including the achievement of evidence-based benchmarks, audit requirements, and maximum carryover amounts.

Continuing with the distribution of FY09 funding, awardees that fail substantially to meet for FY09, the State Level Performance Measures described in **APPENDIX G** of this announcement or who fail to submit an effective pandemic influenza plan to CDC as part of their application for PHEP funds, may have funds withheld from their FY10 and subsequent award amounts. Additional information regarding HPP pandemic influenza plan evaluation criteria will be forthcoming.

4.0 APPLICATION AND SUBMISSION INFORMATION

4.1 Address to Request Application Package

Given the technical capabilities necessary to carryout and document the activities required for the HPP, HHS is limiting applications to electronic submission only, accessible at www.Grants.gov or www.GrantSolutions.gov

Application kits may be obtained by accessing Grants.gov at www.grants.gov or the Grant Solutions system at www.GrantSolutions.gov. To obtain a hard copy of the application kit, contact the OPHS Office of Grants Management at (240) 453-8822. Applicants may fax a written request to the Office of Grants Management as well at (240) 453-8823.

4.1.1 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 (866) 705-5711 or at www.whitehouse.gov/omb/grants/duns_num_guide.pdf

4.2 Content and Form of Application Submission

The application kit includes the following documents. You must use all of the above documents in completing your application:

- *OPHS-1 – Includes the face page, budget forms, assurances, certification, and checklist. Applicants must use the OPHS-1; applications that are not submitted on the required application form will be screened out and will not be reviewed.

- The FOA – Provides specific information about the availability of funds along with instructions for completing the CA application. This document is the FOA. The FOA will be available on the GrantSolutions Web site at www.GrantSolutions.gov and a synopsis of the FOA is available on the Federal grants Web site at www.Grants.gov

- 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 readable 12-point font;

- Maximum number of pages: **85 single-spaced** pages *not including appendices and required forms*. (If the narrative exceeds the page limit, the 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."*

4.2.1 Program Narrative Requirements

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

- Summary
- Description of Applicant Organization
- Program Description
- Needs Statement
- Program Outcome Objectives
- Work-plan 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. Awardees must follow the outline below when writing the program narrative, and it should be written as if the reviewer knows nothing or very little about State preparedness planning.

The program narrative of the project must contain the following sections:

1. *Summary:* This section should be an abstract of the program narrative sections of the organization's capacity to provide the rapid and effective use of resources needed to conduct the project, collect necessary data, and evaluate the project. 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.

2. *Program description:* For each Level 1 Sub-Capability to be maintained and refined and any proposed Level 2 Sub-Capabilities, provide the current status of planning, a needs statement, the outcome objectives, and proposed funding for each of the application. It should be succinct, self-explanatory and well organized so that reviewers can understand the proposed project.

3. *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 budget period within the three-year project

period. A detailed description of each area is provided below.

a. *Current Status:* In this section, describe the current status of each Level 1 Sub-Capability that will be maintained and refined with this funding. If using HPP funds to support any Level 2 Sub-Capabilities, the awardee must provide a statement that all Level 1 Sub-Capabilities are met, and will be maintained and/or refined in FY09, or are prioritized through a Corrective Action Plan (CAP) to assure all Level 1 Sub-Capabilities will be completed by August 8, 2009.

(1) All Level 1 Sub-Capabilities must be fully met prior to addressing any funding that will be applied to Level 2 Sub-Capabilities.

(2) Any request for Level 2 Sub-Capability funding must meet the requirements outlined under the "Project Description" section of this FOA (E.g., the Capability-Based Planning and Gap Analysis section – pages 4/5).

(3) This section should describe each Level 2 Sub-Capability in terms of development to date, by explaining how the sub-capability can currently support healthcare system medical surge capacity and capability, how the healthcare system partners have been a part of the process, and their role in further development of each Level 2 Sub-Capability.

4. *Needs Statement:* Describe the need for further work to maintain and/or refine each Level 1 Sub-Capability, and proposed Level 2 Sub-Capabilities. Describe the envisioned final product in terms of personnel, training, equipment or systems, organizational, or planning needs that will be addressed with this funding during each budget period within the three-year project period. Descriptions should be detailed enough to provide sufficient information to allow the reviewer to understand the depth and breadth of the activities - **budget narratives which are not outlined by sub-capability will not be accepted.**

5. *Program Outcome Objectives:* Describe the overall goal of the project **by sub-capability**, outline the objectives to be accomplished and the activities that will occur to achieve the sub-capability and ultimately support achievement of the goal. The goal(s), objectives and activities should describe the steps that will be taken to ultimately achieve, in a progressive fashion, development of the sub-capabilities during each budget period within the three-year project 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 HPP goals during each budget period within the three-year project period.*

When writing the outcome objectives they should be written as a "statement" which defines measurable results the project expects to accomplish (E.g., operational ESAR-VHP system that meets the requirements set forth in the ESAR-VHP section of this FOA). All outcome objectives should be described in terms that are specific,

measurable, achievable, realistic, and time-framed (S.M.A.R.T.) for each budget period within the three-year project period.

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.

6. *Work-plan and Timetable:* In this section, outline the objectives and activities that will occur to accomplish the overall project goal (**by sub-capability** during each budget period within the three-year project period). The work-plan 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 each budget period within the three-year project period,** and 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 during each budget period within the three-year project period. Consistent with prior years, the HPP strongly encourages awardees to limit the amount of administrative costs (ideally less than or equal to 15%) that collectively include personnel, fringe, travel, supplies and equipment.

7. *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 for all activities during each budget period within the three-year project period.

4.3 Submission Dates and Times

The deadline for the submission of applications under this program announcement is June 30, 2009. Applications must be submitted electronically via **GrantsSolutions** by 11:30 PM Eastern Daylight Time.

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

4.4 Intergovernmental Review

Applications under this announcement are not subject to the review requirements of E.O. 12372.

4.5 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;
- Reimbursement of pre-award cost is not allowed;
- It is recommended awardee administrative costs remain capped at 15%; and
- Backfilling costs for staff are 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.

4.6 Other Requirements

4.6.1 HPP Awardee Conference

Awardees must budget for attendance at an ASPR Awardee Conference, which is anticipated for spring 2010. The conference will be approximately 3 days in length, and will take place in the greater Washington D.C. metro area. The conference will feature research presentations, promising practices, and a discussion of performance measures. Additional information will be provided by HPP Team leader closer to the conference date.

5.0 APPLICATION REVIEW INFORMATION

5.1 Criteria

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

- Clarity of the needs in terms of personnel, organizational/leadership, equipment and systems, planning and how well applications describe how training and exercises will support developing 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.
- Extent to which the budget justification reflects the costs.

5.2 Review and Selection Process

These applications will be reviewed internally within the 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 a start date of **August 9, 2008**.

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

5.3 Anticipated Announcement and Award

*The ASPR *expects to announce awards in **July 2009** for a 9-Month 3-Week budget period beginning* **August 9, 2009.**

6.0 AWARD ADMINISTRATION INFORMATION

6.1 Award Notices

When funding 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 CA, the length of the project and budget periods, terms and conditions of the award, and the amount of funding to be contributed by the awardee to project costs.

6.2 Administrative and National Policy Requirements

The regulations set in 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, local, and Tribal governments. Applicants funded under this announcement must be aware of and comply with these regulations. The CFR volume that includes parts 74 and 92 is found at 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 CA, including responsiveness to HPP guidance, measured progress in meeting the performance measures, 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 an awardees ability to draw down funds from the Payment Management System until the awardee has taken corrective action.*

6.3 Reporting Requirements

6.3.1 Audit Requirements

The successful applicant under this FOA is required to comply with audit requirements from the Office of Management and Budget (OMB) Circular A-133. Awardees that expend $500,000 or more in Federal funds per year are required to complete an audit under this requirement. Information on the scope, frequency, and other aspects of the audits can be found at www.whitehouse.gov/omb/circulars

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 the HPP in accordance with the Comptroller General's standards for auditing governmental organizations, programs, activities, and functions and using 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:

> Federal Audit Clearinghouse, Bureau of the Census, 1201 E. 10th Street, Jeffersonville, IN 47132. Reporting packages for Fiscal Years 2008 and later must be submitted electronically online at the following website: www.harvester.census.gov/fac/collect/ddeindex.html

**Grantees that satisfy OMB Circular A-133 audit requirements will also satisfy HPP audit requirements.*

6.3.2 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 (E.g., progress reports), and **bi-annual** Financial Status Report (FSR) SF-269, with the Mid-Year Report and 90 days after the CA 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 (Mid-Year 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-based progress report, 2. a report on progress with Performance Measures and 3. Data Elements.

6.4 Evidence-based Performance Measures and Program Data Elements

6.4.1 Benchmarks, Performance Measures and Program Data Elements

The ASPR expects that all awardees must continue to achieve, maintain, and report Benchmarks, Performance Measures and Program Data Elements for FY09. The ASPR reserves the right to modify performances measures and data elements on an annual basis as needed and in accordance with directives, goals, and objectives of the ASPR.

For the purposes of this FOA, the reporting entity is the State. 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 State is responsible for the collection of information from participating local healthcare systems directly supported by HPP funds during the budget period.

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 healthcare system reports.

Benchmarks, performance measures and data elements will be reported twice annually. 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 the ASPR. The ASPR will provide required reporting instructions, templates, forms, and formats, on an annual basis for reporting requirements. The template will include definitions, response choices, due dates and instructions for completing the template.

6.4.2 Benchmarks

While the ASPR is interested, in all benchmarks, performance measures, and program data elements, the ASPR has identified five benchmarks to be used as a basis for withholding funding for HPP awardees during FY10 and subsequent budget periods. In line with provisions of the PAHPA, awardees that fail to "substantially meet" the benchmarks described in APPENDIX G for FY09 are subject to withholding of funds penalties. The ASPR defines awardees that provide complete and accurate information/ responses for all five benchmarks as having "substantially met" reporting requirements. In addition, to having "substantially met" benchmarks, awardees are expected to meet the ASPR expectations articulated in sections 1.3, 1.4, and 1.5 of the FY09 FOA. Awardees that demonstrate achievement of these requirements are not subject to withholding of funds for FY10 and subsequent budget periods.

6.4.3 Performance Measures

Performance measures serve as indicators for program performance and achievement. They reflect progress in the field and help to inform, guide, and direct programmatic performance. While the ASPR directly funds States, the impact and result are also reflective at the local healthcare system level. As a result of the varying levels of impact, some performance measures focus at the State level, while other performance measures focus at the healthcare system level (for individual participating sub-awardee facilities supported by HPP funds) at any point during the current budget period. The ASPR reserves the right to reclassify performance measures as benchmarks standards subject to withholding provisions on an annual basis as needed and in accordance with directives, goals, and objectives of the ASPR.

6.4.4 Data Elements

In addition to benchmarks and performance measures, data elements will be requested for HPP monitoring purposes. Data elements may be used to: provide supporting information; establish, track, and monitor healthcare preparedness capabilities; inform the development of new targets and performance measures; and respond to routine requests for information about the program.

7.0 AGENCY CONTACTS

7.1 Administrative and Budgetary Contacts

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

Office of Grants Management, Office of Public Health and Science
1101 Wootton Parkway, Suite 550
Rockville, MD 20852
O: (240) 453-8822
Fax: (240) 453-8823

For grants management assistance, contact:

Mr. Roscoe Brunson
Grants Management Specialist
Office of Grants Management
Office of Public Health and Science
1101 Wootton Parkway
Suite 550
Rockville, MD 20852
O: (240) 453-8832
Roscoe.Brunson@hhs.gov

7.2 Program Contacts

For HPP assistance, contact:

Mr. Robert Dugas

Team Leader, Hospital Preparedness Program
US Department of Health and Human Services (HHS)
Office of the Assistant Secretary for Preparedness and Response (ASPR)
Office of Preparedness and Emergency Operations (OPEO)
395 E ST., SW, 10th Fl, Suite 1075
Washington DC 20201
O: (202) 245-0732
Robert.Dugas@hhs.gov

For Data and Evaluation assistance, contact:

Mr. Torrance Brown
Interim Section Chief, Program Evaluation Section
State and Local Initiatives Team
US Department of Health and Human Services (HHS)
Office of the Assistant Secretary for Preparedness and Response (ASPR)
Office of Preparedness and Emergency Operations (OPEO)
395 E ST., SW, 10th Floor, Suite 1075
Washington DC 20201
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Torrance.Brown@hhs.gov

For ESAR-VHP assistance, contact:

Ms. Jennifer Hannah
Team Leader
Emergency System for Advance Registration
of Volunteer Health Professionals (ESAR-VHP)
US Department of Health and Human Services (HHS)
Office of the Assistant Secretary for Preparedness and Response (ASPR)
Office of Preparedness and Emergency Operations (OPEO)
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APPENDIX A: Key updates to the Medical Surge Capacity and Capability Handbook: 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 (E.g., 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 Multi-agency Coordination Center (MACC), and Multi-agency 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.

[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.

- 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 MSCC handbook information is at
www.hhs.gov/disasters/discussion/planners/mscc/

APPENDIX B: FY09 HPP NIMS Implementation for Healthcare Systems

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

In FY08 the concept of metrics was introduced to State, territory, tribal and local entities as a method to assess NIMS implementation.

FY09 HPP NIMS implementation will continue to align healthcare systems with their State, territory, tribal and local partners. During the FY09 funding cycle, HPP awardees will be required to maintain and refine existing implementation activities, and insure that participating healthcare systems are in a position to report fully with regard to implementing the following activities:

1. **Adoption**
   - **a.** Adopt NIMS throughout the healthcare system including all appropriate departments and business units.
   - **b.** Ensure Federal Preparedness awards support NIMS Implementation (in accordance with the eligibility and allowable uses of the awards).

2. **Preparedness: Planning**
   - **a.** 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.
   - **b.** Participate in interagency mutual aid and/or assistance agreements, to include agreements with public and private sector and nongovernmental organizations.

3. **Preparedness: Training**
   - **a.** Identify the appropriate personnel to complete ICS-100, ICS-200, and IS-700, or equivalent courses.
   - **b.** Identify the appropriate personnel to complete IS-800 or an equivalent course.
   - **c.** 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.

4. **Communication and Information Management**
   - **a.** Promote and ensure that equipment, communication, and data interoperability are incorporated into the healthcare systems acquisition programs.
   - **b.** Apply common and consistent terminology as promoted in NIMS,

including the establishment of plain language communications standards.

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

5. Resource Management - No implementation objective

6. Command and Management

a. Manage all emergency incidents, exercises, and preplanned (recurring/special) events in accordance with ICS organizational structures, doctrine, and procedures, as defined in NIMS.

b. ICS implementation must include the consistent application of Incident Action Planning (IAP) and common communications plans, as appropriate.

c. 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.

d. Ensure that Public Information procedures and processes gather, verify, coordinate, and disseminate information during an incident or event.

APPENDIX C: FY09 Hospital Preparedness Program (HPP) Homeland Security Exercise and Evaluation Program (HSEEP) Guidelines

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 a 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 CA funds must meet the intent of the HSEEP practices for exercise program management, design, development, conduct, evaluation and improvement planning. This means if a healthcare system **participates** in an exercise sponsored by another agency, they must ensure the exercise is HSEEP compliant. If the healthcare system **sponsors** the exercise the following four distinct performance requirements must be evidenced:

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

2. **Participating healthcare systems should plan and conduct exercises that are:**
    - **a.** Consistent with the entity's Multi-year Training and Exercise Plan.
    - **b.** Based on capabilities and their associated critical tasks, which are contained within the Exercise Evaluation Guides (EEGs). For Example, if a facility, 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.

c. Tasks associated with this capability include: "*make the decision to evacuate or shelter in place;" "identify and mobilize appropriate healthcare workers;" and activate approved traffic control plan."*

d. 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.

e. Tailored toward validating the capabilities, and based on the facility's risk/vulnerability assessment.

f. Exercise planners should develop the following documents to support exercise planning, conduct, evaluation, and improvement planning:

(1) For Discussion-based Exercises:
- Situation Manual (SITMAN)

(2) 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, are available on the HSEEP website at www.hseep.dhs.gov

g. Reflective of the principles of the NIMS.

3. Developing and submitting a properly formatted After-Action Report/Improvement Plan (AAR/IP). Format is found in HSEEP Volume III.

a. AAR/IPs created for exercise must conform to the templates provided in *HSEEP Volume III: Exercise Evaluation and Improvement Planning.*

b. Following each exercise, a draft AAR/IP must be developed based on the information gathered through the use of EEGs.

c. Following every exercise, an After-Action Conference (AAC) must be conducted, in which:

(1) Key healthcare workers, and the exercise planning team are presented with findings and recommendations from the draft AAR/IP.

(2) Corrective actions addressing a draft AAR/IP's recommendation are developed and assigned to responsible parties with due dates for completion.

d. 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.

a. An improvement plan will include broad recommendations from the AAR/IP organized by target capability as defined in the TCL.

b. Corrective actions derived from ACC are associated with the recommendations and must be linked to a capability element as defined in the TCL.

c. Corrective actions included in the improvement plan must:

(1) Be measurable.

(2) Designate a projected start and completion date.

(3) Be assigned to a facility and a point of contact (POC) within that facility.

d. Corrective actions must be continually monitored and reviewed as a part of an 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.

APPENDIX C2: FY09 Hospital Preparedness Program (HPP) Exercise Policy

Introduction:

The purpose of this HPP policy document is to clarify the Office of the Assistant Secretary of Preparedness and Response (ASPR), HPP exercise requirements for grant awardees (state/territories) and their sub-awardees (local and/or regional) regarding the Homeland Security Exercise and Evaluation Program (HSEEP).

ASPR strongly encourages awardees and/or sub-awardees to jointly participate in exercises with local, regional and state healthcare, public health, public safety, and emergency management partners and stakeholders to fulfill HPP exercise requirements involving multiple agencies, multiple disciplines and multi-jurisdictional community exercises. ASPR recognizes, however, that other exercises, such as facility (E.g., healthcare system/hospital, clinic, other facility, etc.) exercises, may not require the involvement of other local, regional or state agencies and disciplines. For example, a facility testing its internal interoperable communication systems may not involve partners external to their facility.

At this time, the HPP does not require full HSEEP compliance for ASPR-funded exercises; however, all exercises conducted using HPP funds must follow the HSEEP framework and program guidelines. Since State Homeland Security grant awardees are required to meeting HSEEP compliance requirements, ASPR strongly encourages HPP-funded entities to work with these partners utilizing HSEEP guidelines.

HSEEP Background Information:

The Homeland Security Exercise and Evaluation Program (HSEEP) (https://hseep.dhs.gov/pages/1001_HSEEP7.aspx) is a capabilities and performance-based exercise program that provides a standardized methodology and terminology for exercise design, development, conduct, evaluation, and improvement planning.

The HSEEP Policy and Guidance is presented in detail in HSEEP Volumes I-III. Adherence to the policy and guidance presented in the HSEEP Volumes ensures that exercise programs conform to established best practices and helps provide unity and consistency of effort for exercises at all levels of government. An excellent, concise explanation of HSEEP Terminology, Methodology, and Compliance Guidelines is found at https://hseep.dhs.gov/support/HSEEP_101.pdf.

HSEEP methodology can be applied to all levels of exercises – Federal, State, or local. However, only those jurisdictions or entities that receive grant funds to conduct exercises through the Homeland Security Grant Program (HSGP) are required to follow the guidance found in HSEEP Volume I-III. Federal exercises conducted as part of the Homeland Security Council's National Exercise Program (NEP) are also required to follow these HSEEP guidelines.

Examples of an entity complying with *HSEEP guidelines* include:

- The exercise utilizes a "building block approach" in which a cycle of exercises gradually escalate in complexity.
- The design, conduct, and evaluation are based on a capabilities-based approach.
- The project adheres to exercise planning timelines.
- Scenarios are based on the entity's risk/vulnerability assessment and tailored toward validating capabilities, tasks, and objectives contained within the Exercise Evaluation Guides (EEGs).
- Created documents conform to the guidelines and templates provided in the HSEEP volumes.
- Exercise conduct reflects the principles of the National Incident Management System (NIMS).
- Findings and recommendations from the draft After Action Report/Improvement Plan (AAR/IP) are presented to key personnel and the exercise planning team at an After Action Conference (AAC)
- Corrective Actions included in the improvement plan are measurable.

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

1. *Training and Exercise Plan Workshop:* All HSEEP compliant entities must conduct a Training and Exercise Plan Workshop (T&EPW) each calendar year in which they develop a Multi-Year Training and Exercise Plan which includes the entities' training and exercise priorities. The plan must also include a multi-year training and exercise schedule.
2. *Exercise Planning and Conduct:* The type of exercise selected should be consistent with the entity's Multi-year Training and Exercise Plan.
3. *After-Action Reporting:* Following each exercise, an AAR/IP must be developed and submitted in a proper report format (as found in HSEEP Volume III).
4. *Improvement Planning:* Corrective Actions identified in the AAR/IP must be tracked and implemented (e.g. designated start date and completion date and a point of contract and organization assigned to the action).

HPP Awardee and Sub-Awardee Responsibilities:

Awardees and/or sub-awardees should participate in the state Training and Exercise Plan Workshop (T&EPW) process to promote the inclusion of healthcare and public health requirements, objectives and partners at all levels of exercise. HPP awardees and/or sub-

awardees should work closely with their State Homeland Security agency, as well as with other local, regional and state partners/stakeholders, in the design, development, conduct, and evaluation of drills and exercises. This collaboration can integrate the exercise requirements and objectives for many different agencies, partners and stakeholders through joint exercises.

HPP awardees and/or sub-awardees should assure that local, regional and/or statewide exercises incorporate the following HPP overarching and Level 1 Sub-Capabilities:

1. Interoperable Communications;
2. Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP);
3. Partnerships/coalitions within areas selected for exercise (MSCC Tier 2); and
4. Fatality Management, Medical Evacuation, and/or Tracking of Bed Availability (two of these three areas).

At least one exercise in each Cities Readiness Initiative (CRI) city/Metropolitan Statistical Area (MSA) and an equal number of exercises in other locations must be conducted. Participating healthcare systems (sub-awardees) in those areas must participate in these exercises.

Participation in a Homeland Security HSEEP compliant exercise implies that awardees and/or sub-awardees are represented in all of the planning meeting; include their objectives in the exercise design; and complete an AAR/IP, regardless of agency sponsorship. HPP encourages use of the HSEEP Toolkit (https://hseep.dhs.gov/pages/1001_Toolk.aspx) to prepare these documents, as appropriate. Additional exercise information and support documents can be found in the AHRQ Toolkit (http://www.ahrq.gov/prep/). The AHRQ tools provide greater detail specific to healthcare not found in the HSEEP Exercise Evaluation Guide (EEG), and can provide useful information to incorporate into the AAR/IP.

HPP awardees and sub-awardees must participate in the After Action Conference for their exercise and contribute to the AAR/IP development. If an exercise is not sponsored by emergency management or another state agency, the awardee or sub-awardee should follow the alternate instructions included in the FY08/09 HPP FOA, and HSEEP guidelines listed earlier. Awardees and/or sub-awardees may use an alternative AAR/IP template as long as the HSEEP format is followed. Improvement Plans must include input from partners and stakeholders and can be captured at the After-Action Conference or in another appropriate format. The final After Action Report with the Improvement Plan in the appendix (AAR/IP) should be preserved and available for audit during site visits by regional/state coordinators and/or ASPR project officers. The awardees and sub-awardees must track the completion of their assigned corrective actions.

ASPR requires awardees to create an executive summary from the AAR/IPs of each

CRI/MSA related exercise and an equal number of exercises in other locations, to submit with the FY08 End-Of-Year Report. For example, if a state has one CRI/MSA, it is required to submit an executive summary for two exercises.

APPENDIX D: FY09 Hospital Preparedness Program (HPP) Telecommunications Service Priority (TSP) Restoration Program Policy

TSP is a Federal Communications Commission (FCC) program that directs telecommunications service providers to give preferential treatment to users enrolled in the program, when they need to add new lines or have their lines restored following a disruption of service, regardless of the cause. The FCC sets the rules and policies for the TSP program; the National Communications System (NCS), a part of the U.S. Department of Homeland Security, manages the TSP program. Federal sponsorship is required to enroll in the TSP program. Enrollment and monthly fees for the TSP program are generally set at the state level by public utility or public service commissions. Typically, one-time per line enrollment fees are approximately $100, and monthly fees per line average $3. Additionally, if the line requires repair during the period of service, a repair fee will be incurred.

The U.S. Department of Health and Human Services (HHS), Hospital Preparedness Program (HPP) supports, thus sponsors the use of HPP funds in establishing and maintaining TSP services in area healthcare systems. However, TSP is not a requirement of the Hospital Preparedness Program.

Healthcare Systems and Telecommunication Service Providers Instructions

1. Healthcare systems should first decide which circuits or lines they want to add TSP restoration priority (RP) to. ***This may require assistance from their telecom or IT manager, or the person that actually places the orders and pays the bill for phone service with the carrier. Here are some tips to help with that determination as well:

- Circuits used for emergency communications with first responders.
- Circuits used for emergency communications with state and local health departments.
- Circuits used for telemedicine applications and data transfer.
- Circuits used to transfer patient information, availability of beds and other resources, and medical equipment needs.

2. Once they've identified the lines;

Healthcare systems should contact their respective carriers to explain what they want to do. They should ask the carrier representative about any additional changes to their account (some carriers charge and some do not).

Also, a healthcare system should determine how TSP codes must be conveyed to the carrier. For example - a spreadsheet via email or via a change service order.

If the carrier representative requires additional information, please refer them to Mrs. Deborah Bea of the Department of Homeland Security's National Communications

System (NCS) at (703) 235-5359 or Deborah.Bea@dhs.gov.

3. Once the healthcare system is ready to move forward, they should request the restoration priorities from the TSP Program Office (TSPPO). There are two ways to do this:

   - Option 1 - The "eforms" module that is accessible at the TSP website. (Instructions below) or;
   - Option 2 - An email w/ spreadsheet sent to tsp@dhs.gov.

4. Option 2 is recommended because it is quick and easy. In the body of the email, the healthcare system should include the following:
   - Name of facility
   - Point of Contact name (POC)
   - POC title
   - POC address
   - POC phone number
   - POC email address

5. A spreadsheet should be attached to the email that includes two columns. Column A should have the circuit IDs or line numbers that they want the RP for, and Column B should have the carrier name that is providing the service.

6. The information requested in items (4) and (5) should be emailed to the TSPPO, with an email copy to your respective State/territory Hospital Preparedness Program Coordinator or designee as record of the request.

7. Once the TSPPO receives the email, it will be processed and an email will be sent back to the POC. The spreadsheet will be attached with an additional column that lists the TSP code that has been assigned to each line.

8. The POC should immediately send the TSP codes to their carrier using the procedures they discussed with them (item 2 above).

E-forms Module Instructions

1. The healthcare system will access the NCS web-site at (www.tsp.ncs.gov) to establish a TSP account. [Select **"E-forms"**, then **"Register to use e-forms."**]

2. The NCS will email the healthcare system, and provide a login ID and password back to them via an email.

3. The healthcare system will re-enter the NCS web-site (using the provided login ID and password) and will fill out the application form. [**Select "E-forms"**, then **"Access to e-forms application"**, then **"TSP request for service users (Form 315)"**].

4. The NCS will approve TSP coverage, and will provide the healthcare system administrator with TSP authorization codes for each circuit. (E.g., TSP02H682-03). This information is accessed by logging into the eforms module.

For help with this process, call **1-866-NCS-CALL; *Option 3***.

APPENDIX E: FY09 HAvBED Operational Requirements and Definitions

Requirements

1. 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. Possess the following Hospital Identification Information:
    - **a.** Hospital Name
    - **b.** Contact Name
    - **c.** Street Address
    - **d.** City
    - **e.** State
    - **f.** Zip Code
    - **g.** Area Code
    - **h.** Local Telephone Number
    - **i.** County

2. Report on the following categories as defined in the HHS HAvBed system Vacant/ Available Bed Counts:
    - **a.** Intensive Care Unit (ICU)
    - **b.** Medical and Surgical (Med/Surge)
    - **c.** Burn Care
    - **d.** Peds ICU
    - **e.** Pediatrics (Peds)
    - **f.** Psychiatric (Psych)
    - **g.** Negative Pressure Isolation
    - **h.** Emergency Department Divert Status
    - **i.** Decontamination Facility Available
    - **j.** Ventilators Available

Bed Definitions

1. 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.
2. Adult Intensive Care (ICU): Can support critically ill/injured patients, including ventilator support.
3. Medical/Surgical: Also thought of as “Ward” beds.
4. 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.)
5. Pediatric ICU: The same as adult ICU, but for patients 17 years and younger

6. Pediatrics: Ward medical/surgical beds for patients 17 and younger
7. Psychiatric: Ward beds on a closed/locked psychiatric unit or ward beds where a patient will be attended by a sitter.
8. 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.
9. 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 www.ahrq.gov/prep/havbed/

APPENDIX F: Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) Draft Compliance Requirements (Revised February 2009)

*In FY08, Awardees were required to meet all of the compliance requirements by August 8, 2009.

****In FY09, Awardees are required to direct funding towards meeting or refining all of the compliance requirements by August 8, 2012.**

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 *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.

[2] For purpose of this document, State refers to States, Territories, Cities, Counties, the District of Columbia, Commonwealths, or the sovereign nations of Palau, Marshall Islands, and Federated States of Micronesia.

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

e. 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,
(3) Advanced Practice Registered Nurses (APRNs) including Nurse Practitioners, Certified Nurse Anesthetists, Certified Nurse Midwives, and Clinical Nurse Specialists
(4) Pharmacists
(5) Psychologists
(6) Clinical Social Workers
(7) Mental Health Counselors
(8) Radiologic Technologists and Technicians
(9) Respiratory Therapists
(10) Medical and Clinical Laboratory Technologists and Technicians
(11) Licensed Practical Nurses and Licensed Vocational Nurses
(12) Dentists
(13) Marriage and Family Therapists
(14) Physician Assistants
(15) Veterinarians
(16) Cardiovascular Technologists and Technicians
(17) Diagnostic Medical Sonographers
(18) Emergency Medical Technicians and Paramedics
(19) Radiologic Technologists and Technicians
(20) Medical Records and Health Information Technicians

f. 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: The ASPR is reviewing 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.

The 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. The 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 FOA 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 G: FY09 Hospital Preparedness Program (HPP) Evidence-based Benchmarks Subject to Withholdings

State Benchmarks	
S1.1	The State EOC can report available beds for at least 75% of participating healthcare systems, 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.
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 healthcare systems, to the HHS SOC.
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.
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.
S3.1	The State/Territories conduct statewide and regional exercises that incorporate NIMS concepts and principles and includes healthcare systems during the current project period.
S3.2	Please report the total number of statewide and regional exercises conducted that incorporate NIMS concepts and principles during the current project period.
S3.3	Please report the total number of statewide and regional exercises conducted that incorporate NIMS concepts and principles and includes healthcare systems during the current project period. – Numerator: The number of statewide and regional exercises conducted by the State/Territories that incorporate NIMS concepts and principles and include healthcare systems during the current project period. – Denominator: The number of statewide and regional exercises conducted during the current project period.
S4.1	The Awardees submits timely and complete data for the midyear report, the end-of-year report, and the final financial status report (FSR).

APPENDIX H: HPP State Level Performance Measures/ASPR Expectations and Level 1 Sub-Capabilities Crosswalk

			National incident Management System (NIMS)	Education and Preparedness Training	Exercises, Evaluation and Corrective Actions	Needs of At-Risk Populations	Interoperable Communications	Bed Tracking (HAvBED)	ESAR-VHP	Fatality Management	Medical Evacuation/ Shelter in Place	Partnership/Coalitions Development
	S1.1	The State EOC can report available beds for at least 75% of participating healthcare systems, 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 peri						X				
	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 healthcare systems, to the HHS SOC.						X				
	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 for less of							X			
	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.							X			
	S3.1	The State/Territories conduct statewide and regional exercises that incorporate NIMS concepts and principles and includes healthcare systems during the current project period.			X							
	S3.2	Please report the total number of statewide and regional exercises conducted that incorporate NIMS concepts and principles during the current project period.	X		X							
	S3.3	Please report the total number of statewide and regional exercises conducted that incorporate NIMS concepts and principles during the current project period. - Numerator: The number of statewide and regional exercises conducted by the State/Territories t	X		X							
	S4.1	The Awardees submits timely and complete data for the midyear report, the end-of-year report, and the funal financial status report (FSR).										

APPENDIX I: The FY09 ASPR Hospital Preparedness Program (HPP) Cooperative Agreement (CA) Enforcement Actions and Disputes Document

1.0 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.

2.0 Abbreviations, Acronyms and Definitions

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

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 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.

3.0 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.

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 preceding 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 .

4.0 Enforcement Actions and Disputes

4.1 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 is 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

The 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, the 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: The 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.

4.2 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, the 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 the 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

(3) 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

4.3 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.

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 the 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, the 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. The ASPR may withhold payment of funds to any awardee which is not using its allotment under section 319C-2 in accordance with such section. The 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.

5.0 References

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

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

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Appendix J: At Risk Individuals

The US Department of Health and Human Services (HHS) has developed the following definition of at-risk individuals:

> Before, during, and after an incident, members of at-risk populations may have additional needs in one or more of the following functional areas: communication, medical care, maintaining independence, supervision, and transportation. In addition to those individuals specifically recognized as at-risk in the Pandemic and All-Hazards Preparedness Act (i.e., children, senior citizens, and pregnant women), individuals who may need additional response assistance 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 have pharmacological dependency.

This HHS definition of *at-risk individuals* is designed to be compatible with the National Response Framework (NRF) definition of *special needs populations*. The difference between the illustrative list of at-risk individuals in the HHS definition and the NRF definition of special needs is that the NRF definition does not include pregnant women, those who have chronic medical disorders, or those who have pharmacological dependency. The HHS definition includes these three other groups because pregnant women are specifically designated as at-risk in the Pandemic and All-Hazards Preparedness Act and those who have chronic medical disorders or pharmacological dependency are two other populations that HHS has a specific mandate to serve.

At-risk individuals are those who have, in addition to their medical needs, other needs that may interfere with their ability to access or receive medical care. They may have additional needs before, during, and after an incident in one or more of the following functional areas (C-MIST):

Communication – Individuals who have limitations that interfere with the receipt of and response to information will need that information provided in methods they can understand and use. They may not be able to hear verbal announcements, see directional signs, or understand how to get assistance due to hearing, vision, speech, cognitive, or intellectual limitations, and/or limited English proficiency.

Medical Care – Individuals who are not self-sufficient or who do not have adequate support from caregivers, family, or friends may need assistance with: managing unstable, terminal or contagious conditions that require observation and ongoing treatment; managing intravenous therapy, tube feeding, and vital signs; receiving dialysis, oxygen, and suction administration; managing wounds; and operating power-dependent equipment to sustain life. These individuals require support of trained medical professionals.

Independence – Individuals requiring support to be independent in daily activities may lose this support during an emergency or a disaster. Such support may include

consumable medical supplies (diapers, formula, bandages, ostomy supplies, etc.), durable medical equipment (wheelchairs, walkers, scooters, etc.), service animals, and/or attendants or caregivers. Supplying needed support to these individuals will enable them to maintain their pre-disaster level of independence.

Supervision – Before, during, and after an emergency individuals may lose the support of caregivers, family, or friends or may be unable to cope in a new environment (particularly if they have dementia, Alzheimer's or psychiatric conditions such as schizophrenia or intense anxiety). If separated from their caregivers, young children may be unable to identify themselves; and when in danger, they may lack the cognitive ability to assess the situation and react appropriately.

Transportation – Individuals who cannot drive or who do not have a vehicle may require transportation support for successful evacuation. This support may include accessible vehicles (e.g., lift-equipped or vehicles suitable for transporting individuals who use oxygen) or information about how and where to access mass transportation during an evacuation.

This approach to defining at-risk individuals establishes a flexible framework that addresses a broad set of common function-based needs irrespective of specific diagnoses, statuses, or labels (e.g., those with HIV, children, the elderly). At-risk individuals, along with their needs and concerns, must be addressed in all Federal, Territorial, Tribal, State, and local emergency plans.

The following examples may assist with the understanding and identification of who may be considered at-risk.

Example #1

An individual with HIV/AIDS who does not speak English and who contracts influenza could easily find herself in a precarious situation. In addition to treatment for influenza, her functional needs would be *medical care* (for the HIV/AIDS) and *communication* (her lack of English may keep her from hearing about where and how to access services). Without addressing those functional needs, she cannot get healthcare services.

Example #2

During an influenza pandemic, the health status of an individual who receives home dialysis treatment and who relies on a local Para-transit system to attend medical appointments and food shopping could quickly become critical if 40% of the workforce is ill and transportation is suspended. In addition to treatment for influenza, his functional needs would be *medical care* (for dialysis) and *transportation*. Without addressing those functional needs, he cannot get healthcare services.

APPENDIX K: FY09 Hospital Preparedness Program (HPP) Acronyms/Glossary

After Action Report / Improvement Plan AAR/IP: the main product of the Evaluation and Improvement Planning process is the AAR/IP. The AAR/IP has two components: an AAR, which captures observations of an exercise and makes recommendations for post-exercise improvements; and an IP, which identifies specific corrective actions, assigns them to responsible parties, and establishes targets for their completion. The final AAR/IP should be disseminated to participants no more than 60 days after exercise conduct. Even though the AAR and IP are developed through different processes and perform distinct functions, the final AAR and IP should always be printed and distributed jointly as a single AAR/IP following an exercise.

Corrective Action: Corrective actions are the concrete, actionable steps outlined in Improvement Plans (IPs) that are intended to resolve preparedness gaps and shortcomings experienced in exercises or real-world events.

Coordination: The process of systematically analyzing a situation, developing relevant information, and the synchronization of the activities of all relevant stakeholders to achieve a common purpose.

Collaboration: The development and sustainment of broad relationships among individuals and organizations to encourage trust, advocate a team atmosphere, build consensus, and facilitate communication.

Competency-Based Training (CBT): CBT is an approach to vocational education and training that places emphasis on what a person can do in the workplace as a result of completing a program of training. Competency-based training programs are often comprised of modules broken into segments called learning outcomes, which are based on standards set by industry, and assessment is designed to ensure each student has achieved all the outcomes (skills and knowledge) required by each module.

Drill: a drill is a type of operations-based exercise. It is a coordinated, supervised activity usually employed to test a single specific operation or function in a single agency. Drills are commonly used to provide training on new equipment, develop or test new policies or procedures, or practice and maintain current skills.

Emergency Operations Center (EOC): The EOC is the physical location at which the coordination of information and resources to support domestic incident management activities take place. An EOC may be a temporary facility or may be located in a more central or permanently established facility, perhaps at a higher level of organization within a jurisdiction. An EOC may be organized by major functional disciplines (E.g., fire, law enforcement, and medical services), by jurisdiction (E.g., Federal, State, regional, county, city, tribal), or by some combination thereof**.**

Emergency Operations Plan (EOP): An EOP is the "steady-state" plan maintained by various jurisdictional levels for managing a wide variety of potential hazards.

Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP): ESAR-VHP is a national network of state-based systems designed to assist medical professionals in volunteering for disasters by providing verifiable, up-to-date information regarding the health volunteer's identity and licensing, credentialing, privileging and certification to hospitals and other medical facilities that request their services.

Full-Scale Exercises (FSE): A full-scale exercise is a multi-agency, multi-jurisdictional, multi-discipline exercise involving functional (E.g., joint field office, emergency operation centers, etc.) and "boots on the ground" response (E.g., firefighters decontaminating mock victims).

Functional Exercise (FE): A functional exercise is a single or multi-agency activity designed to evaluate capabilities and multiple functions using a simulated response. An FE is typically used to: evaluate the management of Emergency Operations Centers, command posts, and headquarters; and assess the adequacy of response plans and resources.

Hospital Available Beds for Emergencies and Disasters (HAvBED) System: HAvBED is a system of hospital bed definitions that provide uniform terminology for organizations tracking the availability of beds in the aftermath of a public health emergency or bioterrorist event. Definitions were vetted by members from Federal and State governments, hospitals around the Nation, and the private sector for the following: Licensed Beds, Physically Available Beds, Staffed Beds, Unstaffed Beds, Occupied Bed, and Vacant/Available Beds. Beds also can be categorized according to the type of patient they serve: Adult Intensive Care (ICU), Medical/Surgical, Burn or Burn ICU, Pediatric ICU, Pediatrics, Psychiatric, Negative Pressure/Isolation, and Operating Rooms. For purposes of estimating institutional surge capability in dealing with patient disposition during a large mass casualty incident, the following bed availability estimates also may be reported: 24-hour Beds Available and 72-hour Beds Available.

Hospital Preparedness Program (HPP) Participating Hospitals: HPP participating hospitals are hospitals that receive funding, benefits, and/or services through the State/Recipient's Cooperative Agreement with HPP during the specified funding/reporting period.

Improvement Plan (IP): An IP lists the corrective actions that will be taken, the responsible party or agency, and the expected completion date. The IP is included at the end of the AAR.

Incident Commander (IC). The IC is the individual responsible for all incident activities, including the development of strategies and tactics and the ordering and release of resources. The IC has overall authority and responsibility for conducting incident

operations and is responsible for the management of all incident operations at the incident site.

Incident Command System (ICS). The ICS is a standardized on scene emergency management construct specifically designed to provide for the adoption of an integrated organizational structure that reflects the complexity and demands of single or multiple incidents, without being hindered by jurisdictional boundaries. ICS is the combination of facilities, equipment, personnel, procedures, and communications operating with a common organizational structure, designed to aid in the management of resources during incidents. ICS is used for all kinds of emergencies and is applicable to small as well as large and complex incidents.

Integration: Integration is ensuring unity of effort among all levels of government and all elements of a community.

Mass Immunization: An immunization is the introduction of antigens into the body in order to stimulate the development of antibodies against a particular disease. Mass immunization is the prophylaxis of large numbers of individuals (certain populations) against a specific disease agent, usually within a prescribed period of time.

Mass Prophylaxis: Particular action(s) that lead to the prevention of disease or of the processes that can lead to disease. Mass prophylaxis refers to the distribution of materiel to large numbers of individuals (certain populations) to prevent them from contracting a particular disease. A mass vaccination or prophylaxis plan or clinic can be implemented for a variety of public health emergencies. Local health departments provide vaccination or prophylaxis services for the general public in their jurisdiction, whereas hospitals provide these services for their staff and families.

National Incident Management System (NIMS): The NIMS standard was designed to enhance the ability of the United States to manage domestic incidents by establishing a single, comprehensive system for incident management. It is a system mandated by HSPD-5 that provides a consistent, nationwide approach for Federal, State, local, and tribal governments, the private sector, and non-governmental organizations to work effectively and efficiently together to prepare for, respond to, and recover from domestic incidents, regardless of cause, size, or complexity.

National Preparedness Goal: The National Preparedness Goal was set to achieve and sustain capabilities that enable the Nation to successfully prevent terrorist attacks on the homeland and rapidly and effectively respond to and recover from any terrorist attack, major disaster, or other emergency that does occur in order to minimize the impact on lives, property, and the economy.

Negative Pressure/Isolation: Beds provided with negative airflow, providing respiratory isolation.

Operations-Based Exercises: Operations-based exercises are a category of exercises

characterized by actual response, mobilization of apparatus and resources, and commitment of personnel, usually held over an extended period of time. Operations-based exercises can be used to validate plans, policies, agreements, and procedures. They include drills, functional exercises, and full scale exercises. They can clarify roles and responsibilities, identify gaps in resources needed to implement plans and procedures, and improve individual and team performance.

Personal Protective Equipment (PPE): PPE is specialized clothing or equipment worn by employees for protection against health and safety hazards. PPE is designed to protect many parts of the body (E.g., eyes, head, face, hands, feet, and ears).

Pharmaceutical Cache: Pharmaceutical Caches are established to provide emergency medical support in the event of a natural disaster, emergency, or terrorist attack. The cache is a stockpile of medications, treatment kits, intravenous solutions, and other medical supplies.

Prophylaxis: Prophylaxis refers to any medical or public health procedure whose purpose is to prevent, rather than treat or cure, disease. Vaccines and antibiotics are prophylactic: they are used before illness develop, either being administered to large numbers of people in order to prevent infection, or in some cases (such as the smallpox vaccine) to people who have been exposed to a disease but have not yet become ill.

Public Information Officer (PIO): The PIO is a member of the Command Staff responsible for interfacing with the public, media, or with other agencies with incident related information requirements. The responsibility of the Public Information Officer is to ensure the rapid dissemination of accurate instructions and information to the public and to the State using available public information systems.

Redundant Communication: Redundant communications is the use of multiple communications capabilities to sustain business operations and eliminate single points of failure that could disrupt primary services. Redundancy solutions include having multiple sites where a function is performed, multiple communications offices serving sites, and multiple routes between each site and the serving central offices.

Secretary's Operation Center (SOC): is the focal point for synthesis of critical public health and medical information on behalf of the United States Government. During emergency situations or exigent circumstances, the Secretary's Operations Center coordinates incident management system responses for the Department of the Health and Human Services (HHS).

Tabletop Exercises (TTX): TTX are intended to stimulate discussion of various issues regarding a hypothetical situation. They can be used to assess plans, policies, and procedures or to assess types of systems needed to guide the prevention of, response to, or recovery from a defined incident. During a TTX, senior staff, elected or appointed officials, or other key personnel meet in an informal setting to discuss simulated situations. TTXs are typically aimed at facilitating understanding of concepts, identifying

strengths and shortfalls, and/or achieving a change in attitude. Participants are encouraged to discuss issues in depth and develop decisions through slow-paced problem-solving rather than the rapid, spontaneous decision-making that occurs under actual or simulated emergency conditions.

APPENDIX L: FY09 Hospital Preparedness Program (HPP)/AHRQ Awardee Resources

1. Model for Health Professional's Cross Training for Mass Casualty Respiratory Needs at www.ahrq.gov/prep/projxtreme/

2. Emergency Preparedness Atlas: U.S. Nursing Home and Hospital Facilities at www.ahrq.gov/prep/nursinghomes/atlas.htm

3. Exploring the Special Needs and Potential Role of Nursing Homes in Surge Capacity at www.ahrq.gov/prep/nursinghomes/report.htm

4. AHRQ Report Recommends Use of Existing Call Centers at www.ahrq.gov/prep/callcenters

5. Mass Casualty Response: Alternate Care Site Selector at www.ahrq.gov/research/altsites.htm

6. Community Planning Guide at www.ahrq.gov/research/mce/

7. Re-opening Shuttered Hospitals to Expand Surge Capacity at www.ahrq.gov/research/shuttered/

8. Hospital Surge Model at www.hospitalsurgemodel.ahrq.gov

9. Mass Evacuation Transportation Model at www.massevacmodel.ahrq.gov

10. Emergency Preparedness Resource Inventory (EPRI) at www.ahrq.gov/research/epri/

11. Tools for Evaluating Core Elements of Hospital Disaster Drills at www.ahrq.gov/prep/drillelements/index.html

12. HAvBED EDXL Communication Schema at www.havbed.hhs.gov

FY09 Hospital Preparedness Program Funding by State, Selected Cities and Territories	
State	**FY 2009**
Alabama	$5,528,753
Alaska	$1,232,661
Arizona	$7,242,486
Arkansas	$3,573,514
California	$29,486,456
LA County	$11,377,608
Colorado	$5,697,522
Connecticut	$4,332,291
Delaware	$1,433,223
District of Columbia	$1,589,577
Florida	$20,280,168
Georgia	$10,738,888
Hawaii	$1,905,612
Idaho	$2,103,488
Illinois	$11,422,845
Chicago	$3,608,117
Indiana	$7,403,442
Iowa	$3,760,725
Kansas	$3,522,344
Kentucky	$5,099,081
Louisiana	$5,188,408
Maine	$1,945,059
Maryland	$6,640,448
Massachusetts	$7,538,670
Michigan	$11,538,958
Minnesota	$6,149,904
Mississippi	$3,682,495
Missouri	$6,888,644
Montana	$1,532,896
Nebraska	$2,433,560
Nevada	$3,228,706
New Hampshire	$1,937,756
New Jersey	$10,039,764
New Mexico	$2,637,233
New York	$12,628,147

New York City	$9,481,964
North Carolina	$10,184,038
North Dakota	$1,195,281
Ohio	$13,050,486
Oklahoma	$4,413,646
Oregon	$4,546,549
Pennsylvania	$14,103,046
Rhode Island	$1,667,365
South Carolina	$5,225,017
South Dakota	$1,354,980
Tennessee	$7,103,056
Texas	$26,204,300
Utah	$3,288,335
Vermont	$1,182,205
Virginia	$8,857,019
Washington	$7,493,408
West Virginia	$2,488,384
Wisconsin	$6,575,694
Wyoming	$1,063,125
US Territory	
American Samoa	$313,249
Guam	$428,879
Northern Marianas Islands	$333,242
Virgin Islands (US)	$368,981
Puerto Rico	$4,794,779
Freely Associated States	
Micronesia	$368,248
Marshall Islands	$311,702
Palau	$271,559
Grand Total	$362,017,984

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