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

FY11 Hospital Preparedness Program (HPP)
Guidance

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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 (DNHPP)

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

FUNDING OPPORTUNITY NUMBER: Not Applicable

ANNOUNCEMENT TYPE: Continuation (CONT) 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 EDT on May 27, 2011** through the application mechanism specified in Section 4.0.

Anticipated Award Date: July 1, 2011

Project Period: Year three of three

Executive Summary:

The ASPR, OPEO, DNHPP, HPP requests CONT 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 Department of Defense and Full Year Continuing Appropriations Act, 2011 (P.L. 112-10) provides funding for these awards.

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 entities to provide needed beds, engaging with other responders through interoperable communication systems, tracking and sharing bed and resource availability using electronic systems, developing ESAR-VHP systems, protecting their healthcare workers with proper equipment, decontaminating patients, enabling healthcare partnerships/coalitions, educating and training their healthcare workers, enhancing fatality management and healthcare entity evacuation/shelter in place plans, and coordinating regional exercises.

The upcoming FY12 grant cycle will expand the concept of healthcare preparedness from

the facility level to the community level, through greater emphasis on operational, regional Healthcare Coalitions across the country. This emphasis is consistent with the National Health Security Strategy's strategic goals, the PHEP capabilities and risk-based funding strategies, and through the HPP vision of communities prepared to meet the healthcare needs of their citizens in response to and recovery from disasters.

1.0 FUNDING OPPORTUNITY DESCRIPTION

1.1 Purpose

The HPP goal is to ensure awardees use these CA funds to maintain, refine, and to the extent achievable, enhance the capacities and capabilities of their healthcare entities, and for exercising and improving all-hazards preparedness plans, including for pandemic influenza. For the purposes of this CA, healthcare entities (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, community health centers (CHCs), nursing, and etc.).

1.1.1 Surge Capacity – Surge Capability

Surge capacity is broadly defined as the ability of a healthcare entity to adequately care for increased numbers of patients. In 2003, as a planning target, the HPP further defined a community-wide goal for bed surge capacity as 500 beds/million population. In 2006, the HPP defined surge capability as the ability of healthcare entities 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 awardees and their sub-recipients share in building and maintaining, and this guidance continues to clarify those sub-capabilities.

In an effort to assist awardees with continued execution of long-term strategic planning, this FY11 CONT guidance provides assistance for **"year 3" of a **three-year project period**. Applicants will be required to submit an updated program narrative, including all appropriate components identified under the "Content and Form of Application Submission" section of this guidance, describing how the project will progressively unfold during the FY11 budget period.*

**The majority of Federal funds (ideally seventy-five percent or more) should be distributed to facilitate maintenance of the Overarching Requirements and Level 1 Sub-Capabilities, to build state and community preparedness and benefit eligible healthcare entities. Awardees should work with sub-awardees to develop deliverables that clearly integrate and enhance their healthcare entity 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 entity preparedness.*

**Award of a CONT grant in FY11 will be based on the availability of funds, evidence of compliance to the criteria stated below 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

* PAHPA Link: http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=109_cong_public_laws&docid=f:publ417.109.pdf.

Pursuant to section 319C-2(c) activities supported through funds under this guidance 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. Please see Appendix F regarding the ESAR-VHP Compliance Requirements, which detail current and future volunteer coordination strategies across departments and agencies.

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:

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

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

Coordination: Minimizing duplication of, and ensuring coordination among, Federal, State, local, and Tribal planning, preparedness, response and recovery activities (including the State Emergency Management Assistance Compact). Planning shall be consistent with the National Response Framework (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 U.S. 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.

The Framework 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.

Additional information is available at the NRF Resource Center at http://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 entity response from the local through the State level.

A summary of the key updates to the MSCC framework is provided in **APPENDIX A** of this guidance, and further information on the MSCC handbook can be found at http://www.phe.gov/Preparedness/planning/mscc/handbook/.

In addition, a new handbook specifically expanding upon Tier 2 concepts and principles has been developed through the ASPR, OPEO. This handbook titled "Medical Surge Capacity and Capability: The Healthcare Coalition in Emergency Response and Recovery", is also available as a resource and guide to assist with awardee healthcare partnership/coalition development.

* Please see Appendix O of this guidance titled "HPP a New Mission and Vision for FY12" for additional information on how the program plans to assist enhancing Healthcare Coalition development in the future.

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. Please reference the links below for access to all DHS Homeland Security Grant Program including MMRS, and the new CDC PHEP preparedness capabilities including medical surge.

Relevant Program Links:

2011 CDC Public Health Preparedness Capabilities:
National Standards for State and Local Planning -
http://www.cdc.gov/phpr/capabilities/.

2010 CDC Public Health Emergency Preparedness Cooperative Agreement Program -
http://www.bt.cdc.gov/cdcpreparedness/coopagreement/.

2010 DHS Homeland Security Grant/Other DHS Preparedness Programs -
http://www.fema.gov/government/grant/hsgp/index.shtm.

*National Health Security Strategy
The Nation's first comprehensive strategy focused on protecting people's health during a large-scale emergency. The strategy sets priorities for government and non-government activities over the next four years and is a call to action for every individual in our Nation to help every community become truly resilient. Additional information is available at http://www.phe.gov/preparedness/planning/authority/nhss/.

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 entities, 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 continuation application, the latest State, regional, and/or community-based Hazard Vulnerability Analysis (HVAs) completed should be utilized to update information on gaps in sub-capabilities. A gap analysis will drive the rationale to continue funding sub-capabilities needed by local, Tribal, regional and State healthcare entities (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 entity 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, State Department of Homeland Security (SDHS), Emergency Management and associated activities funded through the CDC Public Health Emergency Preparedness (and pandemic influenza supplemental funding opportunities) and Department of Homeland Security grant/CA programs.*

Two products have been developed and released to continue assisting awardees with 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 http://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 http://www.ahrq.gov/research/epri/.

1.3.2.1 Application Requirement

In the FY11 HPP CONT CA application, all awardees must:

- Describe how all *Overarching and Application Requirements* and Level 1 Sub-Capabilities will be maintained and refined during the FY11 budget period. Delineate how funds will be applied, and describe the activities to be conducted, in order to meet the Overarching and Application Requirements listed in Section 1.4.

Awardees will then (funds permitting):

- 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 detail existing gaps.
- Describe what Level 2 Sub-Capabilities require funding during the FY11 budget 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 during the FY11 budget period, and describe the activities required to accomplish.

***** *In addition to Capabilities-Based planning/funding Level 2 Sub-Capabilities, awardees may allocate funding to projects that fill gaps identified through assessment work performed by the ASPR Regional Emergency Coordinators (RECs).*

1.4 Overarching and Application Requirements

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

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

1.4.1 National Incident Management System (NIMS)

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 that appropriate participating healthcare entities continue implementing and maintaining NIMS activities during the FY11 budget period.

1.4.1.1 Application Requirement

Awardees: Awardees will assess and report annually which participating healthcare entities currently have adopted all NIMS implementation activities, and which are still in the process of implementing the 14 activities. For any participating healthcare entity still working to implement NIMS activities, funds must be prioritized and made available during the FY11 budget period to ensure the full implementation and maintenance of all activities during the three-year project period.

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

The following must be addressed in the FY11 CONT application, and within each End-of-Year Progress Report:

1. A comprehensive inventory that lists participating healthcare entities; 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 entities achieve and maintain all activities during the FY11 budget period.

Further information on NIMS for healthcare entities can be found in **APPENDIX B** of this guidance, and at www.fema.gov/pdf/emergency/nims/imp_hos.pdf - this document is currently being updated to reflect revised implementation activities and examples, and will be released during the FY11 budget period.

1.4.2 Needs of At-Risk Populations

1.4.2.1 Application Requirement

FY11 HPP CONT 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 during the FY11 budget period. 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

**Awardees should work to ensure mechanisms are in place to include Tribal organizations, serving the American Indian/Alaska Native/Native American communities,*

as an eligible sub-recipient partner in regional surge capability and response planning.

1.4.3 Education and Preparedness Training

1.4.3.1 Application Requirement

Awardees shall ensure that education and training opportunities/programs exist for healthcare workers who respond to terrorist incidents or other public health emergencies during the FY11 budget 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 entity workers, but those from local health departments, community healthcare entities, 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 entity workers is strongly encouraged.

**Funds may be used to offset the cost of healthcare entity 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 exercise activities.*

The following must be addressed in the FY11 CONT application, and within each End-of-Year Progress Report:

1. Describe how the education and training activities proposed in the awardees' program narrative support sub-capability development, and are linked to healthcare entity, 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 the organizational exercises program.

** 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 FY11 CONT applications must address the evaluation of State and local preparedness and response capabilities through drills and exercises.*

During the FY11 budget 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 and refine a multi-year 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 partnerships/coalitions, Metropolitan Medical Response System (MMRS) entities, the local Medical Reserve Corps (MRC), Urban Area Working Groups (UAWG), the Cities Readiness Initiative (CRI) jurisdictions, local health departments, and should also include methods to leverage resources 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, and healthcare entity components identified.*

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

The Homeland Security Exercise and Evaluation Program (HSEEP) 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 constitutes a national standard for all exercises. Through exercises, the National Exercise Program (NEP) supports organizations to achieve objective assessments of their capabilities so that strengths and areas for improvement are identified, corrected, and shared as appropriate prior to a real incident.

** HPP strongly encourages putting after action reports (AAR) to include healthcare entity related information on the FEMA Lessons Learned Information Site (LLIS) at https://www.llis.dhs.gov/.*

1.4.4.1 ASPR Requirements

Exercise programs funded all or in part by HPP CA funding, or conducted to address the exercise requirements reflected in this CA, should be built on the guidance and concepts of 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 guidance, and on the HSEEP website at https://hseep.dhs.gov/pages/1001_HSEEP7.aspx.

Awardees must ensure during the FY11 budget 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 (not necessarily all) healthcare entities in those areas participate in these exercises.

*During the FY11 Budget Period, Awardees are to plan for all HPP participating Healthcare Organizations (HCOs) to be included in at least one Statewide or Regional exercises to test HPP funded sub-capabilities. This may require implementation of rotation strategies across future budget periods if needed.

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 (that may be done prior) to test the MOUs that are in place for healthcare partnerships/coalitions within the areas selected (further information on what these MOUs should contain is detailed below in the healthcare partnership/coalition description);
3. Fatality Management, Medical Evacuation/Shelter in Place, and Tracking of Bed Availability (2 of these 3 sub-capabilities);

Awardees shall develop and submit an exercise plan with their FY11 CONT application.

The exercise plan must include a proposed exercise schedule, and a discussion of the plans for healthcare entity exercise development, conduct, evaluation, and improvement planning. This multi-year exercise plan needs to be updated annually and include the HPP requirement of showing how the healthcare entity is incorporated, and how required sub-capabilities will be tested.

Awardees must:

- Clearly delineate the CRI cities and other locations in which exercises are being developed and conducted, the dates of those exercises, and the healthcare entity exercise objectives (to include those listed above);
- Describe the role of healthcare entities 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 entities, and how the emergency operations plans of those healthcare entities are then modified; and
- Describe how plans for training are integrated in to the exercise program.

The following must be addressed in the FY11 CONT application, and within each End-of-Year Progress Report:

1. Comprehensive information on all HPP funded training, drills and exercises. The system shall detail the subject matter of all 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 entities (e.g., those identified on page 6 of this guidance, as well as other relevant exercise participants).

2. Awardees must submit all after action 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 requirement include:

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

The abridged Tools for Evaluating Core Elements of Hospital Disaster Drills, at http://www.ahrq.gov/prep/drillelements/ provides healthcare entities 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 entity disaster drills. Evaluation results can be applied to further training and drill planning.

Additional exercise evaluation guides can be found and specifically crafted in the Homeland Security Exercise Evaluation Toolkit under Design and Development System (DDS).

Awardees are reminded that responses to real world events that may arise during the FY11 budget period which **may count towards the exercise requirements if the conditions outlined under "Application Requirement" of the Exercises, Evaluation and Corrective Actions section are met. There is no minimum requirement on the length of the event, as long as all required CONT guidance sub-capabilities are exercised, and all HPP exercise related progress report information (as described above) is completed in full.*

1.5 Project Activities

1.5.1 Level 1 Sub-Capabilities

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, and must address, in their program narrative how they will accomplish this **during the FY11 budget period.**

1. Interoperable Communication Systems
2. Tracking of Bed Availability (HAvBED)
3. Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP)
4. Fatality Management
5. Medical Evacuation/Shelter in Place (SIP)
6. Partnership/Coalition Development – please see Appendix O of this grant guidance for additional information on future Healthcare Coalition development through HPP in FY12.

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 and progress reported by each awardee, to the extent achievable, during the FY11 budget period if funds permitted, and only after Level 1 Sub-Capability maintenance and refinement is achieved.

Using Capabilities-Based Planning and the HVA/Gap Analysis requirements described in this guidance, 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 the FY11 budget period to close gaps.

1. Alternate Care Sites (ACS)
2. Mobile Medical Assets
3. Pharmaceutical Caches
4. Personal Protective Equipment (PPE)
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 https://www.rkb.us/mel.cfm.

1.5.3 Interoperable Communication Systems

1.5.3.1 Application Requirement

All awardees are required to equip participating healthcare entities, to the extent achievable, with communication devices which allow them to communicate horizontally (with each other and healthcare coalitions), and vertically with EMS, fire, law

enforcement, local and State public health agencies, etc.

Since FY03, the HPP has required that healthcare entities 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 entities 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

*Additional communication considerations may need to be implemented to ensure compliance with specific State interoperability communications guidance/requirements.

During the FY11 budget period, awardees shall maintain and refine operational, redundant communication systems that are capable of communicating both horizontally, between healthcare entities, 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 entities 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 entities.

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 entity 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 FY11 budget period, and be addressed accordingly.

1.5.3.2 Telecommunications Service Priority (TSP) Program

Application Requirement: Awardees are encouraged to fund at least one dedicated line for a minimum of 3 healthcare entities 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 entity 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 entities 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), providing 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 entities 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 entities can be found in **APPENDIX D of this guidance.*

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

1.5.4.1 Application Requirement

During the FY11 budget 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 guidance, 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 a sub-state regional/delineated aggregate format by the State, therefore the State must have a system that collects the data from the participating healthcare entities, **OR**
Awardees may use existing systems to automatically transfer required data a sub-state regional/delineated to the HAvBED server using the HAvBED EDXL Communication Schema, found at https://havbedws.hhs.gov/.

**Information and technical assistance will continue being provided to awardees on both options. States are expected to report required data electronically, and sustain the*

capability to report hospital-level information in real-time.

**Awardees are required to:*

- *Continuously update reporting systems to include all data elements developed through ASPR in FY10, and be amenable to include the addition/removal of data elements.*
- *Participate in online webinars/trainings twice annually. These trainings will be made available on the homepage of the HAvBED website.*
- *Participate in the assessments of Situational Awareness tools, gaps in situational awareness data, and emerging needs. Awardees are encouraged to share situational awareness data elements, captured in their State, with neighboring States and the HAvBED Program.*
- *Participate in a minimum of one annual HAvBED drill/exercise, designed to test awardees' ability to meet the associated performance measures (see APPENDIX G and H). Awardees will be notified of logistical details, by the HAvBED Systems Manager, prior to the drill/exercise. A report summary will be disseminated to awardees following the completion of the drill/exercise.*

HAvBED Web Portal Link: https://havbed.hhs.gov/.

All questions, regarding technological assistance on electronic data reporting or automated data transfers, account help, log-in credentialing needs, and/or other technical assistance, should be directed to the HAvBED helpdesk email at HAvBEDhelpdesk@hhs.gov.

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

1.5.5.1 Application Requirement

All awardees are required to meet and maintain all ESAR-VHP electronic system, operational, evaluation and reporting compliance requirements. 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 single national interoperable 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 and implementation of plans to:

- Recruit, register, verify the credentials, and retain volunteers; and
- Coordinate with other volunteer health professional entities and emergency management authorities to ensure effective movement and deployment of volunteers.

The *ESAR-VHP Compliance Requirements* define the capabilities of such a program. As a condition of receiving HPP funds, awardees shall meet the ESAR-VHP compliance

requirements and work to continue adopting and implementing the *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 continuously be refined and updated as new information and experience dictate.

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.

The following must be addressed in the FY11 CONT application, and within each End-of-Year Progress Report:

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 detailed list and description of activities planned to address unmet compliance requirements.
4. List and brief description of proposed ESAR-VHP activities in the work plan and timetable.
5. A list of the occupations (health professional and non-health professional) included in the ESAR-VHP system and the number of volunteers registered in each occupation.
6. The total number of volunteers registered in the ESAR-VHP system.
7. The name of other volunteer affiliations (e.g., MRC, DMAT) included in the ESAR-VHP system and the number of volunteers affiliated with each entity.
8. Description of volunteer activation and response activities during the previous project period.

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

All technical assistance and ESAR-VHP requirement issues should be directed to the ASPR ESAR-VHP program at ESARVHP@hhs.gov.

1.5.6 Fatality Management

1.5.6.1 Application Requirement

All awardees must work closely with participating healthcare entities 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 FY09, awardees were directed to develop disaster and mass fatality management plans and concepts of operation with participating healthcare entities, local health departments, emergency management and State/jurisdictional Chief Medical Examiner/Coroner.

During the FY11 budget 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.*

Awardees should also review the Fatality Management capability as detailed in the 2011 CDC Public Health Preparedness Capabilities document, and ensure any funded activities specific to including hospital plans into larger planning is coordinated with CDC PHEP activities.

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).

The following must be addressed in the FY11 CONT application, and within each End-of-Year Progress Report:

1. The current status of fatality management planning, including the need for expanded refrigerated storage capacity, and supplies such as body bags;
2. The role of the State/jurisdictional Chief Medical Examiner/Coroner in the fatality management planning process;
3. The role of participating healthcare entities, emergency management, public health and other State/local agencies in the fatality management planning process; and
4. 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 Application Requirement

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 entities to shelter in place versus evacuating patients and/or facilities.

**Awardees must continue to integrate the evacuation planning of participating healthcare entities 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 entities 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 entities to take the following into account while continuing to work on the integration of local/regional plans:

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

The Mass Evacuation Transportation Planning Model estimates the time required to evacuate and transport patients from one healthcare entity to another. Healthcare entity 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 is available at: http://massevacmodel.ahrq.gov/.

1.5.8 Partnership and Healthcare Coalition Development

1.5.8.1 Definitions (for the purposes of this FOA)

Healthcare Coalitions will consist of:

1. One or more hospitals, at least one of which shall be a designated trauma center, if applicable;
2. One or more other local healthcare facilities, including clinics, health centers, primary care facilities, mental health centers, mobile medical assets, or nursing homes; **and**
3. One or more political subdivisions;
4. One or more awardees; or one or more awardees and one or more political subdivisions.

Partnerships will consist of:

1. A formalized coordination with any partner for emergency preparedness and response purpose. These partnerships are vital to coordinate medical and public health activities with the structure of the emergency management system. These partnerships should occur vertically and develop a hierarchy of response and

preparedness activities and should also occur horizontally to integrate a network of emergency preparedness agencies.

2. Partnerships within the State may include other healthcare entities but Healthcare Coalition organization is encouraged at the Tier 2 level for Healthcare Organizations (HCOs).
3. Partnerships with non-healthcare related organizations such as public health, emergency management, public safety, public works, etc. are essential at the Tier 3 level. These established partnerships will assist with achieving success at Tiers 4, 5, and 6 and will ensure capacity for medical surge planning at the local, regional, and State levels. In order to establish successful partnerships, it is highly recommended that partners formalize their involvement through actions such as regular attendance at partnership meetings, establishment of MOU/MOAs, by-laws, etc., for partnership development.
4. Non-formalized partnerships are highly encouraged for purposes of exchange of services, resource sharing and other forms of assistance that benefit the State, regional or local program, the healthcare coalition or the individual Healthcare Organization (HCO).

The development and integration of partnerships and healthcare coalitions should unify the management capability of the healthcare entity 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 and healthcare coalitions shall:

1. Integrate plans and activities of all participating healthcare entities into the jurisdictional response plan, and the State response plan;
2. Increase medical response capabilities in the community, region and State;
3. Prepare for the needs of at-risk populations in their communities in the event of a public health emergency;
4. 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, State Administrative Agency and Emergency Management Assistance Compact); and
5. Maintain continuity of operations in the community vertically with the local jurisdictional emergency management organizations.

**Neither partnership nor healthcare coalitions are expected to replace or relieve healthcare entities of their institutional responsibilities during an emergency, or to subvert the authority and responsibility of the State or directly funded city* – please see Appendix O of this grant guidance for additional information on future Healthcare Coalition development through HPP in FY12.

1.5.8.2 Application Requirement

During the FY11 budget period and in the future, all awardees shall make it a priority to ensure operational partnerships and healthcare coalitions that encompass all CRI cities in the State plus an equal number of partnerships and healthcare coalitions involving non-CRI sub-State regions. **For example, if a State possesses 2 CRI cities, then 4 partnerships and healthcare coalitions must be maintained and refined (one in each CRI city and 2 in other sub-state regions).* In addition, consideration should be given to the development of partnerships and healthcare coalitions within other sub-state planning regions of a State.

Partnerships and healthcare coalitions shall continue to plan and develop memoranda of understanding (MOU) to share assets, personnel and information. These MOUs shall be tested through tabletops or other exercises conducted in CRI and non-CRI cities as described above in the Exercises, Evaluations and Corrective Actions section as well as in sub-state planning regions of a State where additional partnerships and healthcare coalitions may exist. Partnerships and healthcare 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. (see Note 1 and Definition B.1). The ASPR HPP will require increased emphasis on building required partnerships and healthcare coalitions during the FY11 budget period and beyond. This work should build upon the "Comprehensive Coalition Strategies for Optimization of Healthcare" promoted through the FY09 Pandemic Influenza Healthcare Preparedness Improvements for States FOA and the new "Medical Surge Capacity and Capability: The Healthcare Coalition in Emergency Response and Recovery" (MSCC) handbook concepts, to develop broad reaching healthcare entity partnerships and healthcare coalitions that build community resiliency. Awardees should specifically focus on developing Tiers 1, 2 and 3 as discussed in the MSCC handbook during the FY11 budget period. Please see Figure 1:1 page 1-12 for a diagram on the recommended "MSCC Management Organization Strategy" for medical surge and how healthcare facilities and partners can integrate into the preparedness and response structure of their communities (see Note 2).

The Medical Surge Capacity and Capability: The Healthcare Coalition in Emergency Response and Recovery handbook is now available electronically at http://www.phe.gov/Preparedness/planning/mscc/healthcarecoalition/.

The latest version of The Medical Surge Capacity and Capability: A Management System for Integrating Medical and Health Resources During Large-Scale Emergencies is also available at http://www.phe.gov/Preparedness/planning/mscc/handbook/Pages/default.aspx.

The following must be addressed in the FY11 CONT application, and within each End-of-Year Progress Report:

1. The name of the partnership(s) and healthcare coalition(s);
2. The location of the partnership(s) and healthcare coalition(s);
3. The participant healthcare entities and other partners; and

4. The number and type of MOUs that exist.
5. The funding directed to the partnership(s) and healthcare coalition(s) and activities associated with these funds.

*Prior to release of the FY12 HPP FOA, ASPR, in coordination with grantees, will be developing and piloting new measures of strength and functionality of the Healthcare Coalition.

1.5.8.3 Notes

1. For healthcare planners and participants in a Healthcare Coalition, it is important to distinguish the Coalition's "preparedness organization" from the "response organization" that is needed for emergency response and recovery (See Exhibit 1-5 on page 1-15 of the "Medical Surge Capacity and Capability: The Healthcare Coalition in Emergency Response and Recovery").

2. The authors of the MSCC handbook recognize that some jurisdictions have established organizational structures for emergency preparedness and response that incorporate elements of MSCC Tiers 1, 2, and 3. This approach is perfectly valid as long as the critical Tier 2 response issues presented in this handbook are addressed. It is important to note, however, that these multi-tier organizational structures almost always incorporate an element of command and control of medical and public health assets during response. In contrast, Tier 2 Healthcare Coalitions, as defined in this handbook, do not have command and control authorities and provide only support to healthcare organizations (Tier 1) and jurisdictional authorities (Tier 3). While Healthcare Coalitions must coordinate and integrate closely with governmental agencies, they are not composed of organizations with statutory command authority. It is beyond the scope of the MSCC handbook to describe the full range of emergency response models that incorporate public sector organizations that conduct command and control or area command. This handbook focuses on the key MSCC Tier 2 issues and the organizational structure, processes, and procedures that address these issues through a Tier 2 Healthcare Coalition. The reader may find utility in adopting the tenets proposed in this handbook regardless of the organizational structures used in their home jurisdiction(s).

1.5.9 Alternate Care Sites (ACS)

1.5.9.1 Application Requirement

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 entity. ACS plans should include planning to provide care and allocate scarce equipment, supplies, and personnel by the State at such sites.

**Many awardees have been developing ACS plans as an option for providing disaster and mass casualty medical care in the event that healthcare entities 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 entity, 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 entities.

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 Requirement

If ACS activities are funded during the FY11 budget period, the following must be reported in each HPP End-of-Year Progress Report:

1. Location of ACS;
2. Number of beds;
3. Level of care to be provided or types of patients that can be taken care of; and
4. 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 entities. 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 FY11 budget period, it must be reported in each HPP End-of-Year Progress Report.

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 antimicrobial 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 entities, 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 entity 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 entities.

Awardees are encouraged to work with stakeholders (Schools of Pharmacy, State Boards of Pharmacy, healthcare entities, 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 entities 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 http://www.pandemicflu.gov/. 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 FY11 budget period, it must be reported in each HPP End-of-Year Progress Report.

1.5.12 Personal Protective Equipment (PPE)

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 a mass casualty incident (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 entities 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 FY11 budget period, it must be reported in each HPP End-of-Year Progress Report.

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 FY11 budget period, it must be reported in each HPP End-of-Year Progress Report.

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 http://www.osha.gov/dts/osta/bestpractices/firstreceivers_hospital.pdf.

In addition, the American Society for Testing and Materials (ASTM) International Subcommittee Decontamination (E54.03) has established task 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 http://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 entities, 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 entity 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 FY11 budget period, it must be reported in each HPP End-of-Year Progress Report.

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 entities 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 backup 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.); or implementing strategies for managing hazardous medical waste.*

HHS recognizes that healthcare entity 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 http://www.dhs.gov/nipp.
- HSPD-7 - Homeland Security Presidential Directive 7 at http://www.dhs.gov/xabout/laws/gc_1214597989952.shtm.
- CIP Program for the Healthcare and Public Health Sector at http://www.phe.gov/Preparedness/planning/cip/.
- FEMA ICS free online course on the NIPP (IS-860) at http://www.training.fema.gov/EMIWEB/is/is860.asp.

If CIP related activities are funded during the FY11 budget period, it must be reported in each HPP End-of-Year Progress Report.

2.0 AWARD INFORMATION

Type of Award: CA
Approximate Award Period Funding: Approximately $384,500,000 (Includes direct and indirect costs.)
Approximate Number of Awards: 62
Approximate Average Award: $6M
Anticipated Award Date: July 1, 2011
Budget Period Length: 12-Months
Project Period Length: Year three of three

Award of a continuation grant in 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.

This is a CONT 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 supports 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 Federal Financial Report SF-425 (expenditure portion) reports on a semi-annual basis.
    d) Submit Federal Financial Report SF-425 cash transaction report quarterly.

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:
        (1) Integration/Coordination of Federal funding for preparedness (e.g. including PHEP and FEMA funding streams).
        (2) Subject matter expertise on preparedness activities.
        (3) Identification of promising practices.
        (4) Development of performance goals and standards.
        (5) Assistance with exercise planning and execution.
        (6) Review work-plans and budgets.

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 entities (including but not limited to those identified on page 6 of this guidance) 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 guidance, 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 may not be included in determining the amount of such nonfederal contributions. Awardees will be required to provide matching funds as described:

- For FY11, 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 FY11 application for funds, follow procedures for generally accepted accounting practices and meet audit requirements.

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. The awardee must 'certify with a sentence' that they have maintained the average level of expenditures required.

To be eligible for an award under this funding opportunity, the awardee must demonstrate, in the budget narrative, they intend to budget not less than the average of their FY09 and FY10 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

3.4 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 FY11 funding, awardees that fail substantially to meet for FY11, the State Level Performance Measures described in **APPENDIX G** of this announcement or the application requirements in 1.3, 1.4 and 1.5 as discussed in Section 6.4.2, 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 subsequent award amounts. Additional information regarding HPP pandemic influenza plan evaluation criteria will be forthcoming. In addition, the maximum percentage amount of the FY11 award an entity may carryover to the succeeding fiscal year is 15%.

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 GrantSolutions.gov. Application kits may be obtained by accessing your current FY10 HPP grant award in 'My Grants List' at https://www.GrantSolutions.gov.

4.1.1 Central Contractor Registration (CCR) and Dun and Bradstreet Data Universal Number System (DUNS)

Except for those entities exempt from requirements listed at 2 CFR Part 25 (e.g., individuals), effective October 1, 2010, HHS requires all entities that plan to apply for and ultimately receive Federal grant funds from any HHS Operating/Staff Division (OPDIV) or receive subawards directly from recipients of those grant funds to:

- Be registered in the CCR prior to submitting an application of plan;
- Maintain an active CCR registration with current information at all times during which it has an active award or an application or plan under consideration by an OPDIV; and
- Provide its DUNS number in each application or plan it submits to the OPDIV.

An award cannot be made until an applicant has complied with these requirements. At the time an award is ready to be made, if the intended recipient has not complied with these requirements, the OPDIV:

- May determine that the applicant is no qualified to receive an award; and
- May use that determination as a basis for making an award to another applicant.

Additionally, all first-tier subaward recipients (e.g., direct subrecipient) must have a DUNS number at the time the subaward is made.

CCR registration may be made online at http://www.ccr.gov or by phone at 1-877-252-2700.

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 http://www.whitehouse.gov/sites/default/files/omb/grants/duns_num_guide.pdf.

4.2 Content and Form of Application Submission

The application kit includes the following documents, which includes the SF-424 family including the face page, budget forms, certifications and assurances.

- The guidance - Provides specific information about the availability of funds along with instructions for completing the Continuation application. This document is the guidance. The guidance will be available on the GrantSolutions website at https://www.GrantSolutions.gov.

- Program Narrative - Applicants must electronically submit a *program narrative* with the application kit, 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 6 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 internal 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 healthcare 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, Tribal, regional and local level. It is recommended that applicants place an organizational chart in the Appendices of the application.

2. *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, and time and facilities for FY11, within this three-year project period.
3. *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. It should be succinct, self-explanatory and well organized so that reviewers can understand the proposed project.

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 FY11.
    (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 guidance (e.g., the Capability-Based Planning and Gap Analysis section – pages 9).
    (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 entity medical surge capacity and capability, how the healthcare entity 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 the FY11 budget period, within this 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**. It is suggested that the awardee includes the budget justification template that is used by the Office of Grants Management (OGM), which breaks costs out in the same manner as the Notice of Grant Award (NGA), personnel, fringe, travel, etc. The budget justification template can be found in appendix M.
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 all funded sub-capabilities during the FY11 budget period, within this 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 the FY11 budget period, within this 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 guidance). All outcome objectives should be described in terms that are specific, measurable, achievable, realistic, and time-framed (S.M.A.R.T.) for the FY11 budget period, within this 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 the FY11 budget period, within this 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 the FY11 budget period.**

The budget justification must clearly describe each cost element and explain how each cost contributes to meeting the project's objectives/goals during the FY11 budget period, within this 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.

*Suggested budget narrative templates are included as APPENDIX M, and will be emailed to awardees through the HPP listserv.

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 the FY11 budget period, within this three-year project period.

4.3 Submission Dates and Times

The deadline for the submission of applications under this program announcement is May 27, 2011. Applications must be submitted electronically via https://www.GrantSolutions.gov by 11:30 PM Eastern Daylight Time.

After submitting the non-competing application, GrantSolutions will show a confirmation screen providing the applicant with their application number and date of submission.

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 ASPR at ASPRgrants@hhs.gov for further information.

4.6 Other Requirements

4.6.1 HPP Awardee Conference/2011 Integrated Training Summit

In addition to anticipated regional meeting travel, awardees must budget for attendance at an ASPR Awardee Conference/2011 Integrated Training Summit, which is anticipated for spring 2012. The conference will be approximately 3 days in length. Additional information will be provided by the HPP Team leader closer to the conference date.

5.0 APPLICATION REVIEW INFORMATION

5.1 Criteria

CONT Applications will be reviewed for compliance 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 **July 1, 2011**.

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

5.3 Anticipated Announcement and Award

*The ASPR *expects to announce CONT awards in **June 2011** for a 12 month budget period beginning **July 1, 2011*.**

6.0 AWARD ADMINISTRATION INFORMATION

6.1 Award Notices

After reviews for compliance of the criteria listed in 5.1 have been completed, the applicant's authorized representative will be notified by an electronic NGA issued through GrantSolutions.

The official document notifying an applicant that the application has been approved for funding is the NGA, electronically 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 http://www.access.gpo.gov/nara/cfr/waisidx_03/45cfrv1_03.html.

Subaward and Executive Compensation Reporting: Currently HHS does not apply the sub-award and executive compensation reporting requirements found at 2 CFR Part 170 to awardees receiving continuation funding. Awardees are advised that this policy may change based on a final OMB ruling. Awardees will be notified if such a change should occur.

**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 guidance 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 http://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: http://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 semi-annual progress and Federal Financial Reports or SF-425s. The mid-year progress reports are due 30 days after the first 6 months of the budget period, and year-end reports are due 90 days after the 12 month budget period end date. Reporting formats are established in accordance with provisions of the general regulations that apply under 45 CFR parts 74 and 92. The mid-year FFR will be due 30 days after the first 6 months of the budget period, and annual FFR will be due 120 days after the budget period end date.

- 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.
- Incomplete or inconsistent reports will be returned to the awardee for corrections.
- The progress reports will consist of 3 sections: (1) a narrative-based progress report, (2) a report on progress with Performance Measures and (3) Data Elements.

Grantees should submit the mid-year and end-of-year progress reports to the ASPR, Program Evaluation Section On-Line Data Collection (OLDC) link: https://extranet.acf.hhs.gov/ssi/.

Federal Financial Report: SF-425

Recipients must report cash transaction data via the Payment Management System (PMS) using the cash transaction data elements captured on the Federal Financial Report (FFR), Standard Form (SF) 425. Recipients will utilize the SF425 lines 10.a through 10.c in lieu of the SF272. The FFR SF425 (lines 10.a through 10.c) is due 30 days after the end of each calendar quarter. The FFR SF425 electronic submission and dates for the new quarters will be announced through the Payment Management/SmartLink Payment System's bulletin board.

The FFR SF425 was designed to replace the Financial Status Report SF269 and the Federal Cash Transactions Report SF272 with one comprehensive financial reporting form. The SF425 will also be used for reporting of expenditure data to meet ASPR's semi-annual and annual financial reporting requirement (replacing the SF269). All other lines except 10.a through 10.c should be completed. The FFR SF425 may be found at http://www.whitehouse.gov/omb/grants/grants_forms.aspx.

Please submit the quarterly SF425 (lines 10.a through 10.c) electronically to the Division of Payment Management and the semi-annual/annual SF425 (all other lines) to ASPRgrants@hhs.gov.

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 FY11. The ASPR reserves the right to modify performance 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 guidance, 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 entities 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 entity reports.*

Benchmarks, performance measures and data elements will be reported annually (except

for State-level benchmarks collected with the MYR). Calculation of results based on numerator and denominator information submitted by awardees will be conducted by staff in the State and Local Initiatives Team, Program Evaluation Section at the ASPR.

6.4.2 Benchmarks

While the ASPR is interested, in all benchmarks, performance measures, and program data elements, the ASPR has identified benchmarks to be used as a basis for withholding funding for HPP awardees during FY11 and subsequent budget periods. In line with provisions of the PAHPA, awardees that fail to "substantially meet" the benchmarks described in APPENDIX G for FY11 are subject to withholding of funds penalties. The ASPR defines awardees that provide complete and accurate information/responses for all benchmarks as having "substantially met" reporting requirements. In addition to the benchmarks listed in Appendix G, the Application Requirements articulated in Sections 1.3, 1.4, and 1.5 of the FY11 HPP guidance are also benchmarks that awardees must "substantially meet" to avoid withholding of funds penalties. Awardees that demonstrate achievement of these Application Requirements and the benchmarks in Appendix G are not subject to withholding of funds for FY11 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 entity 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 entity 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 and submission of applications please visit GrantSolutions.gov. Search for your FY11 HPP award in "My Grants List" to access and apply for the continuation funding opportunity. For information on budget and business aspects of the application, and grants management assistance, please contact:

Ms. Jennifer Richards
ASPR, Office of Grants Management
O: (202) 245-0969
ASPRgrants@hhs.gov

7.2 Program Contacts

For HPP assistance, contact:

Mr. Robert Dugas
Team Leader, Hospital Preparedness Program
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)
395 E ST., SW, 10th Floor, Suite 1075
Washington, D.C. 20201
O: (202) 245-0732
Robert.Dugas@hhs.gov

For Data and Evaluation assistance, contact:

Ms. Margaret Sparr
Team Leader, Program Evaluation Section (PES)
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)
395 E ST., SW, 10th Floor, Suite 1075
Washington, D.C. 20201
O: (202) 245-0771
Margaret.Sparr@hhs.gov

For ESAR-VHP assistance, contact:

Ms. Jennifer Hannah
Team Leader, Emergency System for Advance Registration
of Volunteer Health Professionals (ESAR-VHP)
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)
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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.

- 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.

[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 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 http://www.phe.gov/Preparedness/planning/mscc/handbook/.

APPENDIX B: FY11 HPP NIMS Implementation for Healthcare Entities

In FY09, a NIMS working group was put together to update and refine the definitions of the 14 NIMS hospital implementation activities and provide examples. In the near future the results of this working group will be released.

FY11 HPP NIMS implementation will continue to align healthcare entities with their State, territory, Tribal and local partners. During the FY11 funding cycle, HPP awardees will be required to maintain and refine existing implementation activities, and insure that participating healthcare entities are in a position to report fully with regard to implementing the following activities:

1. **Adoption**
    a) Adopt NIMS throughout the healthcare entity 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 entities 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: FY11 Hospital Preparedness Program (HPP) Homeland Security Exercise and Evaluation Program (HSEEP) Guidelines

Homeland Security Exercise and Evaluation Program (HSEEP)

HSEEP was created to provide a consistent methodology for exercise planning, design, development, conduct, evaluation, and improvement planning processes. HSEEP provides the tools and resources such as policy, guidance, training, technology, sample materials, and direct support to promote regional, State, and local exercise expertise, while advancing a standardized means of assessing and improving preparedness across the nation.

Capabilities-Based Planning

The National Planning Scenarios and the establishment of the national priorities steered the focus of homeland security toward a capabilities-based planning approach. Capabilities-based planning focuses on uncertainty. Because it can never be determined with 100 percent accuracy what threat or hazard will occur, it is important to build capabilities that can be applied to a wide variety of incidents. The Target Capabilities List (TCL) defines capabilities-based planning as "planning, under uncertainty, to build capabilities suitable for a wide range of threats and hazards while working within an economic framework that necessitates prioritization and choice." As such, capabilities-based planning is all-hazards planning that identifies a baseline assessment of State or urban area homeland security efforts. An assessment of this kind is necessary to begin any long-term exercise strategy. This determines where current capabilities stand against the Universal Task List (UTL) and TCL and identifies gaps in capabilities. The approach focuses efforts on identifying and developing the capabilities from the TCL to perform the critical tasks from the UTL.

Evolution of Capabilities-Based Planning

Homeland Security Presidential Directive 8 (HSPD-8)

On December 17, 2003, the President issued Homeland Security Presidential Directive 8 (HSPD-8): National Preparedness. Among other actions, HSPD-8 required establishment of a National Preparedness Goal, which establishes measurable priorities, targets, and a common approach to developing capabilities needed to better prepare the Nation as a whole. The National Preparedness Goal uses a capabilities-based planning approach to help answer the following questions:

1. How prepared are we?

2. How prepared do we need to be?
3. How do we prioritize efforts to close the gap?
4. As a result of HSPD-8 and the National Preparedness Goal, a set of National Planning Scenarios was developed to illustrate the effects and conditions of incidents of national significance for which the Nation should prepare.

Presidential Policy Directive / PPD-8: National Preparedness – March 30, 2011

This directive is aimed at strengthening the security and resilience of the United States through systematic preparation for the threats that pose the greatest risk to the security of the Nation, including acts of terrorism, cyber attacks, pandemics, and catastrophic natural disasters. Our national preparedness is the shared responsibility of all levels of government, the private and nonprofit sectors, and individual citizens. Everyone can contribute to safeguarding the Nation from harm. As such, while this directive is intended to galvanize action by the Federal Government, it is also aimed at facilitating an integrated, all-of-Nation, capabilities-based approach to preparedness.
*For more information on PPD-8 and its impact on the current National Preparedness Goal, please visit http://www.dhs.gov/xabout/laws/gc_1215444247124.shtm.

National Preparedness Goal

The National Preparedness Goal is designed to guide Federal departments and agencies; State, territorial, Tribal, and local officials; the private sector; nongovernmental organizations (NGOs); and the public in determining how most effectively and efficiently to strengthen preparedness for terrorist attacks, major disasters, and other emergencies.

The following eight national priorities were established by the DHS National Preparedness Goal:

1. Implement the National Incident Management System (NIMS) and National Response Framework (NRF).
2. Expand regional collaboration.
3. Implement the National Infrastructure Preparedness Plan.
4. Strengthen information sharing and collaboration capabilities.
5. Strengthen chemical, biological, radiological, nuclear, and high-yield explosives (CBRNE) weapons detection, response, and decontamination capabilities.
6. Strengthen interoperable communications capabilities.
7. Strengthen medical surge and mass prophylaxis capabilities.
8. Strengthen emergency operations planning and citizen protection capabilities.

National Planning Scenarios

The 15 National Planning Scenarios address all-hazards incidents, which include terrorism, natural disasters, and health emergencies. They represent the minimum number of scenarios necessary to illustrate the range of potential incidents, rather than every possible threat or hazard. The 15 National Planning Scenarios are:

1. Improvised Nuclear Device (IND)
2. Aerosolized Anthrax
3. Pandemic Influenza
4. Plague
5. Blister Agent
6. Toxic Industrial Chemical
7. Nerve Agent
8. Chlorine Tank Explosion
9. Major Earthquake
10. Major Hurricane
11. Radiological Dispersal Device (RDD)
12. Improvised Explosive Device (IED)
13. Food Contamination
14. Foreign Animal Disease (FAD)
15. Cyber

The National Planning Scenarios serve as the basis for identifying tasks that must be performed to prevent, protect against, respond to, and recover from these incidents, as well as the capabilities required to perform the tasks. The 15 scenarios provide for common planning factors in terms of the potential scope, magnitude, and complexity of major events that will help to determine the target levels of capability required and apportion responsibility among all potential partners. Developing appropriate capabilities to address this range of scenarios will best prepare the Nation for terrorist attacks, major disasters, and other emergencies.

Target Capabilities List (TCL)

The TCL includes 37 goals that will balance the potential threat and magnitude of terrorist attacks, major disasters, and other emergencies with the resources required for prevention, response, and recovery. This list is designed to help jurisdictions understand what their preparedness roles and responsibilities are during a major incident and includes everything from all-hazards planning to worker health and safety.

Universal Task List (UTL)

The UTL is a list of every unique task that was identified from the list of National Planning Scenarios developed under the leadership of the Homeland Security Council. The UTL is a reference to help plan, organize, equip, train, exercise, and evaluate personnel for the tasks they may need to perform during a major incident.

Exercise Types:

Discussion-Based Exercises

Discussion-based exercises are normally used as starting points in the building-block approach to the cycle, mix, and range of exercises. Discussion-based exercises include

seminars, workshops, tabletop exercises (TTXs), and games. These types of exercises typically highlight existing plans, policies, mutual aid agreements (MAAs), and procedures. Thus, they are exceptional tools for familiarizing agencies and personnel with current or expected jurisdictional capabilities. Discussion-based exercises typically focus on strategic policy-oriented issues; operations-based exercises focus more on tactical response-related issues. Facilitators and/or presenters usually lead the discussion, keeping participants on track while meeting the objectives of the exercise.

Seminars - are generally used to orient participants to, or provide an overview of, authorities, strategies, plans, policies, procedures, protocols, response resources, or concepts and ideas. Seminars provide a good starting point for jurisdictions that are developing or making major changes to their plans and procedures. They offer the following attributes:

1. Informal discussions led by a seminar leader.
2. Lack of time constraints caused by real-time portrayal of events.
3. Low-stress environment that uses a number of instruction techniques such as lectures, multimedia presentations, panel discussions, case study discussions, expert testimony, and decision support tools.
4. Proven effectiveness with both small and large groups.

Workshops - represent the second tier of exercises in the Homeland Security Exercise and Evaluation Program (HSEEP) building-block approach. Although similar to seminars, workshops differ in two important aspects: participant interaction is increased, and the focus is on achieving or building a product (such as a plan or a policy).

<u>Workshops provide an ideal forum for the following</u>:

1. Building teams.
2. Collecting or sharing information.
3. Obtaining consensus.
4. Obtaining new or different perspectives.
5. Problem solving of complex issues.
6. Testing new ideas, processes, or procedures.
7. Training groups in coordinated activities.

<u>In conjunction with exercise development, workshops are most useful in achieving specific aspects of exercise design such as the following</u>:

1. Determining evaluation elements and standards of performance.
2. Determining program or exercise objectives.
3. Developing exercise scenario and key events listings.

A workshop may be used to produce new standard operating procedures (SOPs), emergency operations plans (EOPs), MAAs, Multi-Year Training and Exercise Plans (output of the TEPW), and improvement plans (IPs). To be effective, workshops must be

highly focused on a specific issue, and the desired outcome or goal must be clearly defined.

Potential topics and goals are numerous, but all workshops share the following attributes:

1. Effective with both small and large groups.
2. Facilitated, working breakout sessions.
3. Goals oriented toward an identifiable product.
4. Information conveyed through different instructional techniques.
5. Lack of time constraint from real-time portrayal of events.
6. Low-stress environment.
7. No-fault forum.
8. Plenary discussions led by a workshop leader.

Tabletop Exercises (TTXs) - involve senior staff members, elected or appointed officials, or other key personnel in an informal setting discussing simulated situations. This type of exercise is intended to stimulate discussion of various issues regarding a hypothetical situation. It can be used to assess plans, policies, and procedures or to assess types of systems needed to guide the prevention of, response to, and recovery from a defined incident. 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. In contrast to the scale and cost of operations-based exercises and games, TTXs can be cost-effective tools when used in conjunction with more complex exercises. The effectiveness of a TTX is derived from the energetic involvement of participants and their assessment of recommended revisions to current policies, procedures, and plans.

TTX methods are divided into two categories: basic and advanced. In a basic TTX, the scene set by the scenario materials remains constant. It describes an event or emergency incident and brings discussion participants up to the simulated present time. Players apply their knowledge and skills to a list of problems presented by the facilitator, problems are discussed as a group, and resolution is generally agreed upon and summarized by the leader. In an advanced TTX, play focuses on delivery of pre-scripted messages to players that alter the original scenario. The exercise facilitator usually introduces problems one at a time in the form of a written message, simulated telephone call, videotape, or other means. Participants discuss the issues raised by the problem, using appropriate plans and procedures.

TTX attributes may include the following:

1. Achieving limited or specific objectives.
2. Assessing interagency coordination.
3. Conducting a specific case study.
4. Examining personnel contingencies.

5. Familiarizing senior officials with a situation.
6. Participating in information sharing.
7. Practicing group problem solving.
8. Testing group message interpretation.

Operations-Based Exercises

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

Drills – are a coordinated, supervised activity usually used 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. Typical attributes include the following:

1. A narrow focus, measured against established standards.
2. Instant feedback.
3. Performance in isolation.
4. Realistic environment.

Functional Exercises (FEs) - are also known as a Command Post Exercise (CPX), is designed to test and evaluate individual capabilities, multiple functions or activities within a function, or interdependent groups of functions. FEs generally focus on exercising the plans, policies, procedures, and staffs of the direction and control nodes of the Incident Command System (ICS), Unified Command, and Emergency Operations Centers (EOCs). Generally, incidents are projected through an exercise scenario with event updates that drive activity at the management level. Movement of personnel and equipment is simulated.

The objective of an FE is to execute specific plans and procedures and apply established policies, plans, and procedures under crisis conditions, within or by particular function teams. An FE simulates the reality of operations in a functional area by presenting complex and realistic problems that require rapid and effective responses by trained personnel in a highly stressful environment. Attributes of an FE include the following:

1. Evaluating the EOC, headquarters, and staff.
2. Evaluating functions.
3. Examining interjurisdictional relationships.
4. Measuring resource adequacy.
5. Reinforcing established policies and procedures.

Full-Scale Exercises (FSEs) - are multiagency, multijurisdictional exercises that test many facets of emergency response and recovery. They include many first responders

operating under the ICS or Unified Command to effectively and efficiently respond to, and recover from, an incident. An FSE focuses on implementing and analyzing the plans, policies, and procedures developed in discussion-based exercises and honed in previous, smaller, operations-based exercises. The events are projected through a scripted exercise scenario with built-in flexibility to allow updates to drive activity. It is conducted in a real-time, stressful environment that closely mirrors a real incident. First responders and resources are mobilized and deployed to the scene where they conduct their actions as if a real incident had occurred (with minor exceptions). An FSE simulates the reality of operations in multiple functional areas by presenting complex and realistic problems that require critical thinking, rapid problem solving, and effective responses by trained personnel in a highly stressful environment. Other entities that are not involved in the exercise, but that would be involved in an actual incident, should be instructed not to respond.

An FSE provides an opportunity to execute plans, procedures, and MAAs in response to a simulated live incident in a highly stressful environment. Typical FSE attributes include the following:

1. Activating personnel and equipment.
2. Allocating resources and personnel.
3. Analyzing memorandums of understanding (MOUs), SOPs, plans, policies, and procedures.
4. Assessing equipment capabilities.
5. Assessing interjurisdictional cooperation.
6. Assessing organizational and individual performance.
7. Demonstrating interagency cooperation.
8. Exercising public information systems.
9. Testing communications systems and procedures.

HSEEP - HPP Connectivity

The Homeland Security Exercise and Evaluation Program (HSEEP) 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 Homeland Security Exercise and Evaluation Program (HSEEP) constitute a national standard for all exercises. Through exercises, the National Exercise Program supports organizations to achieve objective assessments of their capabilities so that strengths and areas for improvement are identified, corrected, and shared as appropriate prior to a real incident.

Continuing for FY11, 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 entity **participates** in an exercise sponsored by another agency, they must ensure the

exercise is HSEEP compliant. If the healthcare entity **sponsors** the exercise the following four distinct performance requirements must be evidenced:

1. **Participating healthcare entities are required to conduct annual Training and Exercise Plan Workshops (T& EPW), and maintain a Multi-year Training and Exercise Plan (MYT&EP). 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) Validates planning from previous training and exercises conducted.
        (4) 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.

*The Homeland Security's Exercise and Evaluation Program website contains several job aids that can be of assistance in conducting and completing a MYT&EP workshop and plan, and is available at: https://hseep.dhs.gov/pages/1001_HSEEP7.aspx.

*HHS' ASPR, through a partnership with the Agency for Healthcare Research and Quality has published an emergency-preparedness pocket guide (http://www.ahrq.gov/prep/hospex.htm) that provides resources to help hospitals design, conduct and evaluate their own emergency-preparedness exercises, with the aim of improving response capabilities. The guide also contains a searchable atlas of resources and tools.

The guidebook addresses preparedness exercise related requirements for Federal funding and hospital accreditation. It is intended for use in planning, conducting, and evaluating such exercises, with the goal of improving hospital emergency preparedness programs. It also can serve as a resource for senior leadership to help increase institutional commitment to provide the necessary resources for successful preparedness exercises.

The Hospital Preparedness Exercises Guidebook is available at: http://www.ahrq.gov/prep/hospexguide/.

2. **Participating healthcare entities 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 Evacuation and Shelter-In-Place" 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 https://hseep.dhs.gov/pages/1001_HSEEP7.aspx.

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 each exercise conducted 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** following 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.

(4) Identify any supporting entity or agency whose participation or involvement is essential to achieving full implementation and identify an individual point of contact to assist in the implementation process**.**

d) Corrective actions are acted upon and tracked to ensure corrective actions from exercises, policy discussions and real-world events are effectively implemented and incorporated in future planning, training and exercise schedules, and individual exercises, as part of a Corrective Action Program.

e) An individual should be responsible for managing the overall Corrective Action Program to ensure corrective actions resulting from exercises, policy discussions and real-world events are effectively implemented, and incorporated into the subsequent planning, training and exercise activities.

APPENDIX C2: FY11 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.

At this time, the HPP does not require full HSEEP compliance for ASPR-funded exercises; however, all healthcare entity exercises conducted using HPP funds must follow the HSEEP framework and program guidelines. Since State Homeland Security grant awardees are required to meet 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) is a capabilities-based exercise program that provides common exercise policy and program guidance that constitutes a national standard for exercises. The purpose of the program is to build self-sustaining exercise programs and provide a standardized methodology for designing, developing, conducting, and evaluating all exercises. The HSEEP methodology contains exercise program management methodology: the building-block approach to training and exercises.

Exercise program management assists a jurisdiction or agency in sustaining a variety of preparedness activities and includes multi-year planning, budgeting, grant management, and funding allocation. Program management is cyclical: a Multi-Year Training and Exercise Plan (TEP) developed at the Training and Exercise Planning Workshop (TEPW) and is in accordance with the jurisdiction or agency's preparedness priorities. Exercise activities are then planned and conducted according to the TEP schedule.

The HSEEP Policy and Guidance is presented in detail in HSEEP Volumes I, II and III (https://hseep.dhs.gov/pages/1001_HSEEP7.aspx). 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:* In-line with the HSEEP guidelines, all 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 to include each Cities Readiness Initiative (CRI) city/Metropolitan Statistical Area (MSA) and an equal number of exercises in other locations must be conducted. Participating healthcare entities (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 exercise planning conferences/meetings; to include incorporating their specific exercise objectives in the exercise design; After Action Conference; and completion of an AAR/IP, regardless of agency sponsorship. HPP encourages the use of the HSEEP Toolkit, which can be found at 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 participating in exercises must take part 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 FY11 HPP FOA, and HSEEP guidelines detailed 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, and submit annually starting with the FY08 HPP 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: FY11 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 and thus sponsors the use of HPP funds in establishing and maintaining TSP services in area healthcare entities. However, TSP is not a requirement of the Hospital Preparedness Program.

Healthcare Entities and Telecommunication Service Providers Instructions

1. Healthcare entities 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 have identified the lines:

Healthcare entities 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 entity 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 entity 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 with 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 entity 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 entity will access the NCS web-site at http://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 entity, and provide a login ID and password back to them via an email.

3. The healthcare entity 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 entity

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: FY11 HAvBED Operational Requirements and Definitions

Requirements

1. Report sub-state regional/delineated aggregate data to the HHS SOC not more than twice daily during emergencies, within 4 hours of request. 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 Current Available and Staffed Bed Counts:
    a) Adult Intensive Care Unit (ICU)
    b) Adult Medical and Surgical (Med/Surge)
    c) Burn Care
    d) Pediatrics Intensive Care Unit (ICU)
    e) Pediatrics Medical and Surgical (Med/Surge)
    f) Psychiatric (Psych)
    g) Airborne Infection Isolation
    h) Operating Rooms

Bed Definitions:

1. Current 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. Adult 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 Medical/Surgical: 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. Airborne Infection Isolation/Negative Pressure: 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. Facsimile of data does not meet this reporting requirement.

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 https://havbed.hhs.gov/.

APPENDIX F: Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) Compliance Requirements (Revised April 2011)

The ESAR-VHP compliance requirements identify capabilities and procedures that State[1] ESAR-VHP programs must have in place to ensure effective management and inter-jurisdictional movement of volunteer health personnel in emergencies.

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 backup is not co-located.

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

   a) Each State must collect and verify the credentials and qualifications of the following health professionals. Beyond this list of occupations, a State may

[1] For purpose of this document, State refers to States, Territories, New York City, Chicago, Los Angeles County, the District of Columbia, Commonwealths, or the sovereign nations of Palau, Marshall Islands, and Federated States of Micronesia.

register volunteers from any other occupation it chooses. The standards and requirements for including additional occupations are left to the States.

(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
(11) Medical and Clinical Laboratory Technicians
(12) Licensed Practical Nurses and Licensed Vocational Nurses
(13) Dentists
(14) Marriage and Family Therapists
(15) Physician Assistants
(16) Veterinarians
(17) Cardiovascular Technologists and Technicians
(18) Diagnostic Medical Sonographers
(19) Emergency Medical Technicians and Paramedics
(20) Medical Records and Health Information Technicians

b) States 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 States upon request.

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

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

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

ESAR-VHP Operational Requirements

6. Upon receipt of a request for volunteers from any governmental agency or recognized emergency response entity, all States 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 States are required to develop and implement a plan to recruit and retain volunteers.

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

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, National Disaster Medical Systems (NDMS) teams, and the Federal Emergency Management Agency (FEMA) Citizen Corps.

9. Each State must develop protocols for deploying and tracking volunteers during an emergency (Mobilization Protocols):

   a) Each State is required to develop written protocols that govern the internal activation, operation, and timeframes of the ESAR-VHP system in response to an emergency. Included in these protocols must be plans to track volunteers

during an emergency and for maintaining a history of volunteer deployments. ASPR may ask for copies of these protocols as a means of documenting compliance. ASPR will include protocol models in future versions of the *ESAR-VHP Guidelines*.

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

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

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

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

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

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 ASPR Hospital Preparedness Program (HPP), Centers for Disease Control and Prevention (CDC) Public Health Emergency Preparedness (PHEP) Program, and ASPR ESAR-VHP Program requirements for drills and exercises.

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 by the ASPR Hospital Preparedness Program (HPP), CDC Public Health Emergency Preparedness (PHEP) Program, and/or the ASPR ESAR-VHP Program. States 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.

All technical assistance and ESAR-VHP requirement issues should be directed to the ASPR ESAR-VHP program at ESARVHP@hhs.gov.

APPENDIX G: FY11 Hospital Preparedness Program (HPP) Evidence-based Benchmarks Subject to Withholdings

State Benchmarks	
S1.1	The State EOC can electronically report available beds for at least 75% of participating healthcare entities, 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 electronically report available beds according to HAvBED definitions for at least 75% of participating healthcare entities, 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 entities 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 entities 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 entities 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 Federal Financial Report (FFR).

APPENDIX H: Hospital Preparedness Program (HPP) State Level Performance Measures/Application Requirements and Level 1 Sub-Capabilities Crosswalk

	HPP State Benchmarks	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/Coalition Development
S1.1	The State EOC can electronically report available beds for at least 75% of participating healthcare entities, 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 electronically report available beds according to HAvBED definitions for at least 75% of participating healthcare entities, 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 entities 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 entities 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 entities 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 I: The FY11 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) Act, 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. **NGA –** Notice of Grant 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 NGA. 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 NGA 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 Federal Financial Report (SF-425) 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 NGA. 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 State 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:
    a) 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.

b) 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.
c) 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.
d) 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 NGA. 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:
i. A detailed description of the reason for dispute including supporting documentation and
ii. 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 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 NGA. The dispute must contain the following:

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

ii. A description of how the enforcement action impacts the affected organization; and

iii. 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

HHS Grants Policy Statement, January 1, 2007

Appendix J: At Risk Individuals Resources

The U.S. 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.

<u>Hospital Preparedness Program At-Risk/Pediatric Resources</u>:

- EMSC National Resource Center - http://www.childrensnational.org/EMSC/PubRes/PDPreparedness.aspx.

- Pediatric Disaster Resource and Training Center - http://www.chladisastercenter.org/.

- National Commission on Children and Disasters Interim Report, October 14, 2009 - http://www.childrenanddisasters.acf.hhs.gov/20091014_508IR_partII.pdf.

- Pediatric Terrorism and Disaster Preparedness Resource (PTDPR) - http://www.ahrq.gov/RESEARCH/PEDPREP/resource.htm.

- National Advisory Committee on Children and Terrorism (NACCT) - http://www.bt.cdc.gov/children/.

- Pediatric Terrorism and Disaster Preparedness: A Resource for Pediatricians (AHRQ) - http://www.ahrq.gov/research/pedprep/pedresource.pdf.

- Children in Disasters: Hospitals Guidelines for Pediatrics Preparedness, 3rd ed. 2008 (NYC DOHMH) - http://www.nyc.gov/html/doh/downloads/pdf/bhpp/hepp-peds-childrenindisasters-010709.pdf.

- Pediatric Disaster Hospital Tabletop Exercise Toolkit - http://www.nyc.gov/html/doh/html/bhpp/bhpp-focus-ped.shtml#1.

- Pediatric Terrorism Awareness Level Training, University of Kentucky Terrorism and Response Program - http://www.kiprc.uky.edu/trap/peds.html.

EXAMPLE PRACTICES:

Children's Hospital Boston

Center for Biopreparedness. The Center for Biopreparedness, a national Center of Excellence, focuses on biological, chemical or radiation disasters affecting children and their caregivers as well as all pediatric aspects of public health preparedness and consequence management after acts of terrorism and other disasters. The Center works to establish response guidelines for emergency medical responders, schools, neighborhood health centers, parents and hospitals; develop training protocols for Emergency Department physicians and staff; and develop syndromic surveillance and reporting tools to identify significant patterns in emergency cases and catch potential outbreaks early. (Accessed September 2008).

Illinois Emergency Medical Services for Children (EMSC)

Disaster Preparedness Exercises Addressing the Pediatric Population. This document serves as a resource for organizations on how to conduct disaster drills and tabletop exercises and offers tools to assist groups in how to manage critically ill or injured pediatric patients during disaster or mass casualty incidents. (2006).

Miami Children's Hospital

JumpSTART Pediatric Multicasualty Triage Tool. The START rapid triage system is one of the most widely recognized formal triage systems and is built around the premise that rapid primary triage, based on assessment of respirations, perfusion, and mental status (RPM) is effective in maximizing limited resources. In an effort to compose a rapid triage system for children, JumpSTART has taken the same basic RPM approach and created an algorithm modeled after the START system. (1995).

National Association of School Psychologists

PREPaRE Training Curriculum. The PREPaRE curriculum, developed by the National Association of School Psychologists (NASP), is designed to provide leadership in evidence-based resources and consultation related to school crisis prevention and response. PREPaRE is a model emphasizes that, as members of a school crisis team, school mental health professionals must be involved in the following specific hierarchical and sequential set of activities: prevent, reaffirm, evaluate, provide and respond and examine. (Accessed September 2008).

New York City Department of Health and Mental Hygiene

Pediatric Disaster Toolkit: Hospital Guidelines for Pediatrics during Disasters, 2nd Edition. This toolkit provides hospitals, especially those that do not normally admit children and hospitals that do admit children but do not have pediatric intensive care services, with useful planning strategies and tools for providing protection, treatment and acute care for pediatric patients during a disaster. (2006).

FAMILY AND CAREGIVER RESOURCES:

American Academy of Pediatrics

Family Readiness Kit: Preparing to Handle Disasters, 2nd Edition. This kit is for parents to use at home to help prepare for most kinds of disasters. It includes information on understanding disasters; steps to take to prepare for a disaster involving your family; family disaster supplies list; disaster fact sheets addressing hurricanes, earthquakes, floods, tornadoes, tsunamis, winter storms, and terrorism, and is also available in Spanish. (Accessed September 2008).

Children and Disasters. This section of the American Academy of Pediatrics' website includes information about disaster preparedness for children, families, teachers and others and offers a wide variety of resources including planning kits and reference materials. (Accessed September 2008).

American Red Cross

Masters of Disasters. This online resource is divided into educational areas for teachers and children and includes a family readiness kit, games and other informational resources to assist children in learning how to prepare for disasters. (Accessed September 2008).

Children and Disasters. This section of the American Red Cross' website offers resources for families and caregivers relating to disaster preparedness and children including the collaborative American Red Cross and Federal Emergency Management Agency (FEMA) document, Preparing for Disasters. (Accessed September 2008).

Pediatric Disaster Preparedness Coloring Books. Be Ready 1-2-3 helps children ages 5 to 8 learn about home fires, earthquakes, and winter storms through activities and demonstrations led by "experts" Cool Cat (Home Fires), Ready Rabbit (Winter Storms), and Disaster Dog (Earthquakes). A second coloring book is also available for children ages 3-10. (1993).

Florida Institute for Family Involvement

Disaster Preparedness for Families of Children with Special Needs. Planning is critical in minimizing the effects of disasters and emergencies. Emergencies or disasters are difficult for most families, but for those with special needs, the ability to manage can become more difficult. This publication, also available in Spanish, includes some resources and links to assist families in preparing and reacting to disasters and emergencies. (Accessed September 2008).

National Association of Child Care Resource and Referral Agencies

What's the Plan: Ask Your Child Care Provider Before A Disaster. To help parents ensure the safety and well-being of their children, this brochure walks them through questions they should ask about the what, when, where and how of their child care provider's disaster plan. (2006).

NYU Child Study Center

Bioterrorism: Talking with Kids About Threats They Can't See. This online resource answers a variety of questions parents might have regarding how to explain bioterrorism to children, including how children might react, what children are most worried about, how to make a family safety plan and how to reassure children and help them deal with their worry and concern. (Accessed September 2008).

Texas Department of State Health Services

Emergency and Disaster Planning for Children with Special Health Care Needs. The Children with Special Health Care Needs (CSHCN) Services Program of the Texas Department of State Health Services offers this bilingual booklet on disaster preparedness for children with special health care needs and their families. (2008).

APPENDIX K: FY11 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: FY11 Hospital Preparedness Program (HPP)/AHRQ Awardee Resources

Training

- Project XTREME - Cross-Training Respiratory Extenders for Medical Emergencies - http://www.ahrq.gov/prep/projxtreme/.

Hospital Exercise Evaluation

- Evaluation of Hospital Disaster Drills: A Module-Based Approach - http://www.ahrq.gov/research/hospdrills/hospdrill.htm.
- Tools for Evaluating Core Elements of Hospital Disaster Drills - http://www.ahrq.gov/prep/drillelements/index.html.
- Hospital Preparedness Exercises Guidebook - http://www.ahrq.gov/prep/hospexguide/.

Scarce Resource Management

- Mass Medical Care with Scarce Resources: A Community Planning Guide - http://www.ahrq.gov/research/mce/.
- HAvBED EDXL Communication Schema - https://havbed.hhs.gov.
- AHRQ Report Recommends Use of Existing Call Centers - http://www.ahrq.gov/prep/callcenters/.

Medical Surge Strategy Tools

- Rocky Mountain Regional Care Model for Bioterrorist Events (Alternate Care Site Selection Tool) - http://www.ahrq.gov/research/altsites.htm.
- Disaster Alternate Care Facilities - http://www.ahrq.gov/prep/acfselection/.
- Reopening Shuttered Hospitals to Expand Surge Capacity (with Tool and Checklist) - http://www.ahrq.gov/research/shuttered/.
- Computer Staffing Model for Bioterrorism Response: Version 2 BERM - http://www.ahrq.gov/research/biomodel.htm.
- Emergency Preparedness Atlas: U.S. Nursing Home and Hospital Facilities - http://www.ahrq.gov/prep/nursinghomes/atlas.htm.
- Emergency Preparedness Resource Inventory (EPRI) - http://www.ahrq.gov/research/epri/.
- Hospital Surge Model - http://www.ahrq.gov/prep/hospsurgemodel/.
- Health Emergency Assistance Line and Triage Hub (HEALTH) Model - http://www.ahrq.gov/research/health/.
- Nursing Homes in Public Health Emergencies - http://www.ahrq.gov/prep/nursinghomes/report.htm.
- Mass Casualty Response: Alternate Care Site Selector at http://www.ahrq.gov/research/altsites.htm.

- Mass Evacuation Transportation Model - http://massevacmodel.ahrq.gov/.

At-Risk/Pediatrics Resources

- Decontamination of Children – Preparedness and Response for Hospital Emergency Departments: Video - http://www.ahrq.gov/research/decontam.htm.
- Pediatric Hospital Surge Capacity in Public Health Emergencies - http://www.ahrq.gov/prep/pedhospital/.
- Pediatric Terrorism and Disaster Preparedness: A Resource for Pediatricians - http://www.ahrq.gov/research/pedprep/resource.htm.
- Planning and Preparedness for Children's Needs in Public Health Emergencies: Webcast - http://www.ahrq.gov/prep/childneeds/.
- School-Based Emergency Preparedness: A National Analysis and Recommended Protocol - http://www.ahrq.gov/prep/schoolprep/.

Pandemic Influenza

- Community-Based Mass Prophylaxis: A Planning Guide for Public Health Preparedness - http://www.ahrq.gov/research/cbmprophyl/cbmpro.htm.
- Home Health Care During an Influenza Pandemic: Issues and Resources - http://www.flu.gov/professional/hospital/homehealth.html.

APPENDIX M: ASPR OGM Budget Narrative Templates

* Excel templates will be emailed to awardees through the HPP listserv.

Object Class Category	Federal Funds	Non-Federal (Cash)	Non-Federal (in-kind)	TOTAL	Justification (Text only)
Personnel					
Fringe Benefits					
Travel					
Equipment					
Supplies					
Contractual					
Other					
Indirect Charges					
TOTAL	$ -	$ -	$ -	$ -	

ASPR Hospital Preparedness Program - State Name Here	Non-Federal (Cash)	Non-Federal (in-kind)	TOTAL
A. Personnel	$ -	$ -	$ -
B. Fringe Benefits	$ -	$ -	$ -
C. Travel	$ -	$ -	$ -
D. Equipment	$ -	$ -	$ -
E. Supplies	$ -	$ -	$ -
F. Contractual (By capability) Total	$ -	$ -	$ -
Overarching Requirements			
NIMS	$ -	$ -	$ -
Needs of At-Risk Populations	$ -	$ -	$ -
Education and Preparedness Training	$ -	$ -	$ -
Exercises, Evaluations and Corrective Actions	$ -	$ -	$ -
Level 1 Sub-Capabilities			
Interoperable Communication Systems	$ -	$ -	$ -
Tracking of Bed Availability (HAvBED)	$ -	$ -	$ -
ESAR-VHP	$ -	$ -	$ -
Fatality Management	$ -	$ -	$ -
Medical Evacuation/Shelter in Place	$ -	$ -	$ -
Partnership/Coalition Development	$ -	$ -	$ -
Level 2 Sub-Capabilities			
Alternate Care Sites (ACS)	$ -	$ -	$ -
Mobile Medical Assets	$ -	$ -	$ -
Pharmaceutical Caches	$ -	$ -	$ -
Personal Protective Equipment	$ -	$ -	$ -
Decontamination	$ -	$ -	$ -
Medical Reserve Corps (MRC)	$ -	$ -	$ -
Critical Infrastructure Protection (CIP)	$ -	$ -	$ -
G.Other	$ -	$ -	$ -
G. TOTAL DIRECT COSTS (Total A through G above)	$ -	$ -	$ -
H. TOTAL INDIRECT COSTS: (Federally Negotiated Indirect Cost Rate)	$ -	$ -	$ -
I. TOTAL COST (Must equal award amount)	$ -	$ -	$ -

APPENDIX N: FY11 Hospital Preparedness Program (HPP) Funding by State, Selected Cities, and Territories*

ASPR Hospital Preparedness Funding by State, Selected Cities and Territories		
State	**Abbrev**	**FY 11**
Alabama	AL	$5,868,499
Alaska	AK	$1,282,160
Arizona	AZ	$7,698,012
Arkansas	AR	$3,781,162
California	CA	$31,444,799
LA County		$12,112,506
Colorado	CO	$6,048,670
Connecticut	CT	$4,591,203
Delaware	DE	$1,496,272
District of Columbia	DC	$1,663,189
Florida	FL	$21,616,529
Georgia	GA	$11,430,633
Hawaii	HI	$2,000,576
Idaho	ID	$2,211,821
Illinois	IL	$12,160,799
Chicago		$3,818,103
Indiana	IN	$7,869,843
Iowa	IA	$3,981,021
Kansas	KS	$3,726,536
Kentucky	KY	$5,409,797
Louisiana	LA	$5,505,160
Maine	ME	$2,042,688
Maryland	MD	$7,055,301
Massachusetts	MA	$8,014,208
Michigan	MI	$12,284,757
Minnesota	MN	$6,531,615
Mississippi	MS	$3,897,506
Missouri	MO	$7,320,264
Montana	MT	$1,602,680
Nebraska	NE	$2,564,193
Nevada	NV	$3,413,059
New Hampshire	NH	$2,034,892
New Jersey	NJ	$10,684,277
New Mexico	NM	$2,781,625
New York	NY	$13,447,532
New York City		$10,088,792
North Carolina	NC	$10,838,298
North Dakota	ND	$1,242,255
Ohio	OH	$13,898,405
Oklahoma	OK	$4,678,054
Oregon	OR	$4,819,936

Pennsylvania	PA	$15,022,076
Rhode Island	RI	$1,746,233
South Carolina	SC	$5,554,242
South Dakota	SD	$1,412,743
Tennessee	TN	$7,549,162
Texas	TX	$27,940,899
Utah	UT	$3,476,717
Vermont	VT	$1,228,295
Virginia	VA	$9,421,624
Washington	WA	$7,965,887
West Virginia	WV	$2,622,720
Wisconsin	WI	$6,986,172
Wyoming	WY	$1,101,170
U.S. Territory		
Puerto Rico	PR	$5,084,937
American Samoa	AS	$317,522
Guam	GU	$440,964
Northern Marianas Islands	CNMI	$338,866
Virgin Islands (U.S.)	USVI	$377,020
Freely Associated State		
Federated States of Micronesia	FSM	$376,237
Republic of the Marshall Islands	RMI	$315,870
Palau		$273,017
Grand Total		**$384,500,000**

*Funding levels are contingent upon current appropriations.

APPENDIX O: HPP - A New Mission and Vision for FY12

FY12 will continue the evolution of HPP in two important ways. First, it will align and be integrated with the PHEP grants, assuring the integration of public health and health care capabilities to achieve health preparedness in States, territories and communities throughout the US. Second, it will provide Federal leadership and grant funding to move from preparedness at the facility level to healthcare preparedness at the community level, through further development and operation of Healthcare Coalitions nationally.

A *health care coalition* is a group of healthcare organizations located in a specified geographic area, that agree to work together to enhance the efficiency and effectiveness of all of its member organizations' collective preparedness and response in its community, and that appropriately interface with jurisdictional authorities. The HPP defines a *healthcare organization* (HCO) as follows: inpatient facilities and centers (e.g., trauma, State and Federal veterans, long-term, children's, Tribal), outpatient facilities and centers (e.g., behavioral health, substance abuse, urgent care), and other entities (e.g., poison control, emergency medical services, community health centers (CHCs), nursing, and etc.).

The Medical Surge Capacity and Capability (MSCC) handbook defines the role of a healthcare coalition as:

"…Organizing individual healthcare assets into a single functional unit. Its goal is to maximize MSCC across the coalition through *cooperative planning, information sharing, and management coordination*. The coalition ensures that health and medical assets have the information and data they need at a level of detail that will enable them to optimally provide MSCC. In addition to hospitals, the healthcare coalition may include long-term care or alternative treatment facilities, private physician offices, clinics, and any other health or medical asset that may be brought to bear during a major medical response. Its reach may extend beyond the geographic area of the primary responding jurisdiction (Tier 3), especially in rural settings…"

In overarching concert with the National Health Security Strategy's (NHSS) two strategic goals:

- **Build Community Resilience**;
- **Strengthen and sustain health and emergency response systems**;

and through the new HPP vision of "communities prepared to meet the healthcare needs of their citizens in response to and recovery from disasters", the future HPP will utilize existing MSCC architecture and other expert research, to create and refine program components to execute its national healthcare coalition-based mission, and ultimately enable operational healthcare coalitions nationwide.

Vision of a Community Prepared to Meet its Healthcare Needs

A community prepared to meet its healthcare needs in response to an emergency or disaster would be informed, empowered, and resilient through implementation of citizen education and training, heightened community involvement and decision-making strategies, as well as a sound medical response from the Healthcare Coalition.

A Community Prepared to Meet its Healthcare Needs – The Essential Healthcare Coalition

The fundamental cornerstone of a community prepared to meet its healthcare needs is the healthcare coalition. When linked to other partners through a tiered relationship, the Healthcare Coalition becomes the hub for healthcare-response in a community.

This response delivered through the healthcare coalition must provide safe and appropriate care to the sick and/or injured, protect the well, and facilitate the maintenance of essential healthcare services for the community it serves, including vulnerable populations with special medical, ethnic, and cultural needs. The coalition-response would be flexible and scalable, enabling it to adapt to rapidly changing risks and response and recovery requirements during an emergency or disaster. The coalition would have an equitable and legal process for managing, maximizing, and allocating critical resources, including those in scarce supply. Finally, the healthcare coalition would be able to return to normal business functions and pre-event operations as soon as possible after an emergency or disaster.

The healthcare coalition will function as an integrated and coordinated entity across all phases of emergency management. Transparency and trust will enable the coalition to provide a common operating picture capable of collecting, synthesizing, and sharing relevant information not only among the members, but with appropriate jurisdictional and other external partners. Joint planning, training, and exercising are essential to ensure interoperability and resiliency across the healthcare coalition. Each member will have clearly defined roles and capabilities that will be demonstrated, measured, and continuously improved through exercises/actual events, objective after action reporting, and structured process improvement efforts.

Attributes of a Successful Healthcare Coalition

- Well-established core membership representing key sectors helps to ensure broad perspective on coalition operations.
- Collaborative governance structure, contributing to coalition planning and accountability.
- Commitment that enables self-sustainment.
- Common “third space” that facilitates transparency and development of a common operating picture.
- Active engagement, preferably on a daily basis, that strengthens and reinforces communications, relationship building, and decision making.

- Communications and linkages between other coalitions and entities, which are essential to enable regional response efforts.
- Scalability and flexibility that enables an effective surge response.

Measures of a Successful Healthcare Coalition

Coalitions vary based on their level of maturity and the geographical/geopolitical environments in which they exist. For example, rural coalitions will have different challenges than urban coalitions. These differences, whether based on maturity or environment, will influence the measurement process and the inferences drawn from measurement. Measurement should contribute to a formative process that provides guidance tailored to the coalition's state of evolution as well the unique challenges it may face based on location and other factors. Some of those factors may include:

- Defined leadership
- Clear vision and mission
- Established Memoranda of Understanding (to include strong state 'buy-in')
- Strategy for allocation of scarce resource
- Established communication
- Documented decision making process
- Method to document and circulate successes

Three coalition assessment strategies could include:

1. Self-reported information – both quantitative and qualitative.
2. Independent review of specific data sources (e.g., meeting minutes, after action reports, action plans).
3. Site visits in which third party reviewers collect data and qualitatively assess the effectiveness of a coalition

Stakeholder Engagement

During the coming year, prior to release of the FY12 HPP Funding Opportunity Announcement or FOA, the HPP looks forward to engaging in constructive dialogue with our State and local partners on all Federal program and awardee-based aspects of the new HPP, including mission, vision, execution, and a thoughtful discussion regarding successful measurement.