

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

FY10 Hospital Preparedness Program
Guidance

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45

TABLE OF CONTENTS

1

2 **1.0 FUNDING OPPORTUNITY DESCRIPTION..... 6**

3 1.1 PURPOSE 6

4 1.1.1 Surge Capacity – Surge Capability 6

5 1.2 BACKGROUND..... 7

6 1.2.1 The Public Health Service (PHS) Act, as amended by PAHPA..... 7

7 1.2.2 National Response Framework (NRF)..... 8

8 1.2.3 Medical Surge Capacity and Capability (MSCC) Handbook..... 8

9 1.2.4 Integrating Preparedness Activities across Federal Agencies 9

10 1.3 PROJECT DESCRIPTION..... 9

11 1.3.1 Capabilities-Based Planning 9

12 1.3.2 Gap Analysis..... 9

13 1.4 OVERARCHING AND APPLICATION REQUIREMENTS 11

14 1.4.1 National Incident Management System 11

15 1.4.2 Needs of At-Risk Populations..... 12

16 1.4.3 Education and Preparedness Training..... 12

17 1.4.4 Exercises, Evaluations and Corrective Actions 13

18 1.5 PROJECT ACTIVITIES..... 16

19 1.5.1 Level 1 Sub-Capabilities..... 16

20 1.5.2 Level 2 Sub-Capabilities..... 16

21 1.5.3 Interoperable Communication Systems 17

22 1.5.4 National Hospital Available Beds for Emergencies and Disasters

23 (HAVBED)..... 19

24 1.5.5 Emergency System for Advance Registration of Volunteer Health

25 Professionals (ESAR-VHP)..... 19

26 1.5.6 Fatality Management 21

27 1.5.7 Medical Evacuation/Shelter in Place (SIP)..... 21

28 1.5.8 Partnership/Coalition Development..... 23

29 1.5.9 Alternate Care Sites (ACS)..... 24

30 1.5.10 Mobile Medical Assets 25

31 1.5.11 Pharmaceutical Caches 26

32 1.5.12 Personal Protective Equipment..... 27

33 1.5.13 Decontamination 27

34 1.5.14 Medical Reserve Corps (MRC) 28

35 1.5.15 Critical Infrastructure Protection (CIP) 29

36 **2.0 AWARD INFORMATION 31**

37 **3.0 ELIGIBILITY INFORMATION 32**

38 3.1 ELIGIBLE APPLICANTS 32

39 3.2 COST SHARING OR MATCHING..... 32

40 3.3 OTHER 32

41 3.3.1 Maintenance of Funding (MOF)..... 32

42 3.3.2 Other 33

43 **4.0 APPLICATION AND SUBMISSION INFORMATION 34**

1	4.1	ADDRESS TO REQUEST APPLICATION PACKAGE.....	34
2	4.1.1	Dun and Bradstreet Data Universal Number System	34
3	4.2	CONTENT AND FORM OF APPLICATION SUBMISSION.....	34
4	4.2.1	Program Narrative Requirements	34
5	4.3	SUBMISSION DATES AND TIMES.....	37
6	4.4	INTERGOVERNMENTAL REVIEW.....	37
7	4.5	FUNDING RESTRICTIONS	37
8	4.6	OTHER REQUIREMENTS.....	38
9	4.6.1	HPP Awardee Conference/ESF-8 Summit	38
10	4.6.2	Tax Certifications.....	38
11	5.0	APPLICATION REVIEW INFORMATION	39
12	5.1	CRITERIA	39
13	5.2	REVIEW AND SELECTION PROCESS	39
14	5.3	ANTICIPATED ANNOUNCEMENT AND AWARD.....	39
15	6.0	AWARD ADMINISTRATION INFORMATION.....	40
16	6.1	AWARD NOTICES	40
17	6.2	ADMINISTRATIVE AND NATIONAL POLICY REQUIREMENTS.....	40
18	6.3	REPORTING REQUIREMENTS	40
19	6.3.1	Audit Requirements	40
20	6.3.2	Progress Reports and Financial Reports	41
21	6.4	EVIDENCE-BASED PERFORMANCE MEASURES AND PROGRAM DATA ELEMENTS.....	42
22	7.0	AGENCY CONTACTS.....	44
23	7.1	ADMINISTRATIVE AND BUDGETARY CONTACTS	44
24	7.2	PROGRAM CONTACTS	44
25	APPENDIX A: KEY UPDATES TO THE MEDICAL SURGE CAPACITY AND		
26	CAPABILITY HANDBOOK: A MANAGEMENT SYSTEM FOR INTEGRATING		
27	MEDICAL AND HEALTH RESOURCES DURING LARGE-SCALE		
28	EMERGENCIES.....		46
29	APPENDIX B: FY10 HPP NIMS IMPLEMENTATION FOR HEALTHCARE		
30	SYSTEMS.....		48
31	APPENDIX C: FY10 HOSPITAL PREPAREDNESS PROGRAM (HPP)		
32	HOMELAND SECURITY EXERCISE AND EVALUATION PROGRAM (HSEEP)		
33	GUIDELINES		50
34		HOMELAND SECURITY EXERCISE AND EVALUATION PROGRAM (HSEEP)	50
35		CAPABILITIES-BASED PLANNING.....	50
36		HOMELAND SECURITY PRESIDENTIAL DIRECTIVE 8 (HSPD-8)	50
37		NATIONAL PREPAREDNESS GOAL	51
38		NATIONAL PLANNING SCENARIOS	51
39		TARGET CAPABILITIES LIST (TCL).....	52

1	UNIVERSAL TASK LIST (UTL).....	52
2	EXERCISE TYPES:.....	52
3	Discussion-Based Exercises.....	52
4	Operations-Based Exercises.....	54
5	APPENDIX C2: FY10 HOSPITAL PREPAREDNESS PROGRAM (HPP)	
6	EXERCISE POLICY	59
7	APPENDIX D: FY10 HOSPITAL PREPAREDNESS PROGRAM (HPP)	
8	TELECOMMUNICATIONS SERVICE PRIORITY (TSP) RESTORATION	
9	PROGRAM POLICY.....	63
10	APPENDIX E: FY10 HAVBED OPERATIONAL REQUIREMENTS AND	
11	DEFINITIONS	66
12	APPENDIX F: EMERGENCY SYSTEM FOR ADVANCE REGISTRATION OF	
13	VOLUNTEER HEALTH PROFESSIONALS (ESAR-VHP) COMPLIANCE	
14	REQUIREMENTS (REVISED JANUARY 2010).....	68
15	APPENDIX G: FY10 HOSPITAL PREPAREDNESS PROGRAM (HPP)	
16	EVIDENCE-BASED BENCHMARKS SUBJECT TO WITHHOLDINGS.....	73
17	APPENDIX H: HPP STATE LEVEL PERFORMANCE	
18	MEASURES/APPLICATION REQUIREMENTS AND LEVEL 1 SUB-	
19	CAPABILITIES CROSSWALK.....	74
20	APPENDIX I: THE FY10 ASPR HOSPITAL PREPAREDNESS PROGRAM	
21	(HPP) COOPERATIVE AGREEMENT (CA) ENFORCEMENT ACTIONS AND	
22	DISPUTES DOCUMENT	75
23	1.0 PURPOSE	75
24	2.0 ABBREVIATIONS, ACRONYMS AND DEFINITIONS	75
25	3.0 BACKGROUND.....	78
26	4.0 ENFORCEMENT ACTIONS AND DISPUTES.....	78
27	4.1 Withholding for failure to meet established benchmarks and performance	
28	measures or to submit a satisfactory pandemic influenza plan.....	78
29	4.2 Repayment of any funds that exceed the maximum percentage of an award	
30	that an entity may carryover to the succeeding fiscal year.	82
31	4.3 Repayment or future withholding or offset as a result of a disallowance	
32	decision if an audit shows that funds have not been spent in accordance with	
33	section 319C-2 of the PHS Act.	85
34	5.0 REFERENCES	86
35	APPENDIX J: AT RISK INDIVIDUALS	87
36	APPENDIX K: FY10 HOSPITAL PREPAREDNESS PROGRAM (HPP)	
37	ACRONYMS/GLOSSARY	92
38	APPENDIX L: FY10 HOSPITAL PREPAREDNESS PROGRAM (HPP)/AHRQ	
39	AWARDEE RESOURCES	97
40	APPENDIX M: ASPR OGM BUDGET NARRATIVE TEMPLATES.....	99

1	APPENDIX N: FY10 HOSPITAL PREPAREDNESS PROGRAM FUNDING BY	
2	STATE, SELECTED CITIES, AND TERRITORIES	100
3	APPENDIX O: FY10 ASPR HPP - CDC PHEP COOPERATIVE AGREEMENT	
4	CROSSCUTTING INITIATIVES PROJECT.....	102
5	APPENDIX P: FY10 HPP EXPERT PANEL: CA GUIDANCE	
6	RECOMMENDATIONS.....	106

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 21, 2010** through the application mechanism specified in Section 4.0.

Anticipated Award Date: July 1, 2010

Project Period: Year two 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 Consolidated Appropriations Act, 2010 (P.L. 111-117) 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 systems to provide needed beds, engaging with other responders through interoperable communication systems, tracking bed and resource availability using electronic systems, developing ESAR-VHP systems, protecting their healthcare workers with proper equipment, decontaminating patients, enabling partnerships/coalitions, educating and training their healthcare workers, enhancing fatality management and healthcare system evacuation/shelter in place plans, and coordinating regional exercises.

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 systems, and for exercising and improving preparedness plans for all-hazards including pandemic influenza. For the purposes of this CA, healthcare systems (e.g., sub-awardees) are composed of hospitals and other healthcare facilities which are defined broadly as any combination of the following: outpatient facilities and centers (e.g., behavioral health, substance abuse, urgent care), inpatient facilities and centers (e.g., trauma, State and Federal veterans, long-term, children's, Tribal), and other entities (e.g., poison control, emergency medical services, 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 system to adequately care for increased numbers of patients. In 2003, as a planning target, the HPP further defined surge capacity for beds as 500 beds/million population. In 2006, the HPP defined surge capability as the ability of healthcare systems to treat the unusual or highly specialized medical needs produced as a result of surge capacity. At that time, the HPP started to lay out a series of sub-capabilities that all healthcare systems participating in the HPP must possess, and this funding opportunity announcement (FOA) continues to clarify those sub-capabilities.

**In an effort to assist awardees with continued execution of long-term strategic planning, this FY10 cont FOA provides assistance for “year 2” 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 FOA, describing how the project will progressively unfold during the FY10 and FY11 budget periods using their FY10 award as a budget planning target for FY11.*

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

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

**Award of a continuation 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 **1.2 Background**

2 **1.2.1 The Public Health Service (PHS) Act, as amended by PAHPA**

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

5
6 Pursuant to section 319C-2(c) activities supported through funds under this FOA must
7 help awardees to meet the following goals as outlined in section 2802(b):

8
9 **Integration:** Ensure the integration of public and private medical capabilities with public
10 health and other first responder systems, including:

- 11
12 i. The periodic evaluation of preparedness and response capabilities through drills
13 and exercises; and
14 ii. Integrating public and private sector public health and medical donations and
15 volunteers.

16
17 **Medical:** Increasing the preparedness, response capabilities, and surge capacities of
18 hospitals, other healthcare facilities, and trauma care and emergency medical service
19 systems, with respect to public health emergencies. This shall include developing plans
20 for the following:

- 21
22 i. Strengthening public health emergency medical management and treatment
23 capabilities;
24 ii. Medical evacuation and fatality management;
25 iii. Rapid distribution and administration of medical countermeasures, specifically to
26 hospital-based healthcare workers and their family members, or partnership
27 entities;
28 iv. Effective utilization of any available public and private mobile medical assets, and
29 integration of other Federal assets;
30 v. Protecting healthcare workers and healthcare first responders from workplace
31 exposures during a public health emergency.

32
33 **At-risk populations:** Taking into account the public health and medical needs of at-risk
34 individuals in the event of a public health emergency.

35
36 **Coordination:** Minimizing duplication of, and ensuring coordination among, Federal,
37 State, local, and Tribal planning, preparedness, response and recovery activities
38 (including the State Emergency Management Assistance Compact). Planning shall be
39 consistent with the National Response Framework (NRF), or any successor plan, the
40 National Incident Management System (NIMS), and the National Preparedness Goal
41 (NPG), as well as any State and local plans.

42
43 **Continuity of Operations:** Maintaining vital public health and medical services to allow
44 for optimal Federal, State, local, and Tribal operations in the event of a public health
45 emergency.

1
2 **1.2.2 National Response Framework (NRF)**

3 HPP funded activities must be used to assist awardees with integrating response plans
4 into the broader NRF or “Framework” published by the US Department of Homeland
5 Security (DHS). The Framework presents the guiding principles that enable all response
6 partners to prepare for, and provide a unified national response to disasters and
7 emergencies – from the smallest incident to the largest catastrophe. It establishes a
8 comprehensive, national, all-hazards approach to domestic incident response. The
9 Framework defines the key principles, roles, and structures that organize the way we
10 respond as a Nation. It describes how communities, Tribes, States, the Federal
11 Government, and private-sector and nongovernmental partners apply these principles for
12 a coordinated, effective national response.

13
14 It also identifies special circumstances where the Federal Government exercises a larger
15 role, including incidents where Federal interests are involved and catastrophic incidents
16 where a State would require significant support. The Framework enables first
17 responders, decision makers, and supporting entities to provide a unified national
18 response.

19
20 Additional information is available at the NRF Resource Center at
21 www.fema.gov/emergency/nrf/mainindex.htm

22
23 **1.2.3 Medical Surge Capacity and Capability (MSCC) Handbook**

24 This handbook provides a blueprint for a systematic approach to managing medical and
25 public health responses to emergencies and disasters, through the use of a tiered response,
26 from the Management of Individual Healthcare Assets (Tier 1) through the level of
27 Federal Support to State, Tribal, and Jurisdiction Management (Tier 6). An updated
28 version of the MSCC handbook was published by HHS in September 2007, which
29 expands on several concepts included in the first edition. Also, the new version describes
30 recent changes to the Federal emergency response structure, particularly related to the
31 public health and medical response.

32 This handbook guides the HPP, and as such, activities may be proposed that support all
33 Tiers in the MSCC, but especially those that focus on the Tier 1, 2 and 3 levels. While
34 the HPP does not require awardees to directly fund each tier, awardees are expected to
35 develop increasingly robust capacity and capability, and work within the tiered
36 framework to ensure integration of the healthcare system response from the local up
37 through the State level.

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

41
42 In addition, a new handbook specifically expanding upon Tier 2 concepts and principles
43 has been developed through the ASPR, OPEO. This handbook titled “Medical Surge
44 Capacity and Capability: The Healthcare Coalition in Emergency Response and

1 Recovery”, is available as a resource and guide to assist with awardee
2 partnership/coalition development. This handbook will be emailed to awardees through
3 the HPP listserv.
4

5 **1.2.4 Integrating Preparedness Activities across Federal Agencies**

6 DHS and HHS will continue to take steps to increase collaboration and coordination at
7 the Federal level while supporting the enhancement of sub-capabilities at the State and
8 local levels. Various opportunities for collaboration exist among the distinct yet related
9 grant/CA programs at DHS and HHS, and awardees are strongly encouraged to take
10 advantage of them.
11

12 Relevant Program Links:

13
14 CDC Public Health Emergency Preparedness Cooperative Agreement Program –
15 www.bt.cdc.gov/cotper/coopagreement/
16

17 DHS Homeland Security Grant/Other Programs -
18 www.fema.gov/government/grant/hsgp/index.shtm
19

20 ***National Health Security Strategy**

21
22 The nation's first comprehensive strategy focused on protecting people's health during a
23 large-scale emergency. The strategy sets priorities for government and non-government
24 activities over the next four years and is a call to action for every individual in our nation
25 to help every community become truly resilient. Additional information is available at
26 www.hhs.gov/aspr/osp/nhss/strategy.html
27

28 **1.3 Project Description**

29 **1.3.1 Capabilities-Based Planning**

30 Capabilities-based planning is “planning under uncertainty to provide sub-capabilities
31 suitable for a wide range of threats and hazards, while working within an economic
32 framework that necessitates prioritization and choice.” This planning approach assists
33 leaders at all levels to allocate resources systematically to close gaps, thereby enhancing
34 the effectiveness of preparedness efforts.
35

36 Capabilities-based planning will provide a means for healthcare systems, States and
37 ultimately the Nation to achieve a heightened state of preparedness by answering three
38 fundamental questions: “How prepared do we need to be?”; “How prepared are we?”;
39 and “How do we prioritize efforts to close the gap?”
40

41 **1.3.2 Gap Analysis**

42 For the purpose of this CONT application, the latest State, regional, and/or community-
43 based Hazard Vulnerability Analysis (HVAs) completed should be utilized to update
44 information on gaps in sub-capabilities. A gap analysis will drive the rationale to
45 continue funding sub-capabilities needed by local, Tribal, regional and State healthcare

1 systems (e.g., a region with a toxic chemical manufacturer must utilize a State, regional,
2 and/or community-based HVAs, measure the potential health consequences of a chemical
3 release, and develop/acquire the sub-capabilities needed for the healthcare system
4 response to the specific consequences). In addition to developing sub-capabilities for
5 vulnerabilities identified in their HVAs, States must continue to build their sub-
6 capabilities to respond to a pandemic influenza. *This will require close coordination with*
7 *others including their State/local Public Health Preparedness Directors, State*
8 *Department of Homeland Security (SDHS), Emergency Management and associated*
9 *activities funded through the CDC Public Health Emergency Preparedness (and*
10 *pandemic influenza supplemental funding opportunities) and Department of Homeland*
11 *Security grant/CA programs.*

12
13 Two products have been developed and released to continue assisting awardee with
14 Capability-Based Planning. Funding and leadership to support the Hospital Surge Model
15 and the Emergency Preparedness Resource Inventory (EPRI) tool was provided by the
16 U.S. Department of Health and Human Services' Office of the Assistant Secretary for
17 Preparedness and Response, through an Agency for Healthcare Research and Quality
18 (AHRQ) contract.

19
20 The Hospital Surge Model estimates the hospital resources needed to treat casualties
21 arising from biological (anthrax, smallpox, pandemic flu), chemical (chlorine, sulfur
22 mustard, or sarin) nuclear (1 KT or 10 KT explosion) or radiological (dispersion device
23 or point source) attacks, and is available at <http://hospitalsurgemodel.ahrq.gov>.

24
25 The EPRI tool enables States, counties, or regional entities to compile an inventory of
26 resources and capabilities for responding to emergencies and disasters. Originally
27 released in 2005, EPRI has been updated with improved usability and additional features,
28 and is available at www.ahrq.gov/research/epri/.

29 30 **1.3.2.1 Application Requirements**

31 **In the FY10 HPP CONT CA application, all awardees must:**

- 32
33
- 34 • Describe how all *Overarching and Application Requirements*, and Level 1 Sub-
35 Capabilities will be maintained and refined during the FY10 and FY11 budget
36 periods. Delineate how funds will be applied, and describe the activities to be
37 conducted, in order to meet the Overarching and Application Requirements listed in
38 Section 1.4.

39 **Awardees will then (funds permitting):**

- 40
- 41 • Describe the two highest ranked scenarios from the latest State, regional, and/or
42 community-based HVAs, include the rationale for ranking these selections highest,
43 and add Pandemic Flu as a third scenario.
 - 44 • Describe in detail what Level 2 Sub-Capabilities currently exist to address each of the
45 three scenarios (e.g., Scenario 1, 2 and Pandemic Flu) and detail existing gaps.
- 46

- Describe what Level 2 Sub-Capabilities require funding during the FY10 and FY11 budget periods 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 FY10 and FY11 budget periods, 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

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 systems continue implementing and maintaining NIMS activities during the FY10 and FY11 budget periods.

1.4.1.1 Application Requirement

Awardees: Awardees will assess and report annually which participating healthcare systems currently have adopted all NIMS implementation activities, and which are still in the process of implementing the 14 activities. For any participating healthcare system still working to implement NIMS activities, funds must be prioritized and made available during the FY10 and FY11 budget period to ensure the full implementation and maintenance of all activities during the three-year project period.

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

The following must be addressed in the FY10 CONT application, and within each End-of-Year Progress Report:

1. A comprehensive inventory that lists participating healthcare systems; identifies each

1 of the 14 NIMS implementation activities that have been achieved; and identifies
2 each activity still in progress.

- 3
4 2. Detailed descriptions of all implementation activities with associated budget
5 allocations, that ensure all healthcare systems achieve and maintain all activities
6 during the FY10 and FY11 budget periods.
7

8 Further information on NIMS for healthcare systems can be found in **APPENDIX B** of
9 this FOA, and at www.fema.gov/pdf/emergency/nims/imp_hos.pdf - this document is
10 currently being updated to reflect the 14 implementation activities and examples and will
11 be released early in 2010.
12

13 **1.4.2 Needs of At-Risk Populations**

14 **1.4.2.1 Application Requirement**

15 FY10 HPP CONT applications must clearly describe which at-risk populations with
16 medical needs are being served, and the activities that will be undertaken with respect to
17 the needs of these individuals during the FY10 and FY11 budget periods. Medical needs
18 include, but are not limited to behavioral health consisting of both mental health and
19 substance abuse considerations. Awardees should work with community-based
20 organizations serving these groups to ensure plans are appropriate, involve the necessary
21 partners, and include representation from the at-risk populations. Additional At-Risk
22 information can be found in **APPENDIX J**
23

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

- 33
 - independence
 - 34 • communication
 - 35 • transportation
 - 36 • supervision
 - 37 • medical care

38

39 **1.4.3 Education and Preparedness Training**

40 **1.4.3.1 Application Requirement**

41 Awardees shall ensure that education and training opportunities/programs exist for
42 healthcare workers who respond to terrorist incidents or other public health emergencies
43 during the FY10 and FY11 budget periods, and ensure those opportunities or programs
44 encompass the sub-capabilities described herein.
45

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

7
8 **Funds may be used to offset the cost of healthcare system worker participation in
9 training centered on sub-capability development; to prepare workers with the necessary
10 knowledge, skills and abilities to perform/enhance the sub-capability; and to participate
11 in drills and exercises around those sub-capabilities or related systems.*

12
13 **The HPP fully expects that awardees will work closely with their sub-awardees in
14 determining cost-sharing arrangements that will facilitate the maximum number of
15 workers participating in training, drills and exercise activities.*

16
17 **The following issues must be addressed in the FY10 CONT application:**

- 18
19 1. Describe how the education and training activities proposed in the awardee's program
20 narrative support sub-capability development, and are linked to healthcare system,
21 community-based, regional and/or State HVAs.
22
23 2. Describe how the knowledge, skills and abilities acquired as a result of education and
24 training activities proposed in the program narrative will be incorporated into the
25 organizational exercises program.

26
27 ** As in previous years, release time for healthcare workers to attend trainings, drills and
28 exercises is an allowable cost under the CA.*

29
30 ** Salaries for back filling of personnel are **not** allowed.*

31
32 **1.4.4 Exercises, Evaluations and Corrective Actions**

33 **To meet the applicable goals described in section 2802(b) of the PHS Act, all FY10
34 CONT applications must address the evaluation of State and local preparedness and
35 response capabilities through drills and exercises.*

36
37 During the FY10 and FY11 budget periods, awardees are strongly encouraged to
38 continue to use the DHS Senior Advisory Committees, established to coordinate Federal
39 preparedness programs and encourage collaboration at the State and local level among
40 homeland security, emergency management, public safety, public health, the health and
41 medical community, and other responders, **to develop and refine a multi-year exercise
42 plan for conducting joint exercises to meet multiple requirements from various
43 grant/CA programs, and minimize the burden on exercise planners and
44 participants.**

45
46 Exercise plans must demonstrate coordination with relevant entities such as local

1 healthcare system partnerships/coalitions, Metropolitan Medical Response System
2 (MMRS) entities, the local Medical Reserve Corps (MRC), Urban Area Working Groups
3 (UAWG), and the Cities Readiness Initiative (CRI) jurisdictions, to the extent possible.
4

5 **Awardees are expected to work with relevant State and local officials to provide*
6 *information for the National Exercise Schedule (NEXS), so that exercises can be*
7 *coordinated across levels of government, and healthcare system components identified.*
8

9 **At-risk populations and/or those who represent them must also be engaged in*
10 *preparedness planning and exercise activities.*
11

12 The Homeland Security Exercise and Evaluation Program (HSEEP) is a capabilities and
13 performance-based exercise program that provides a standardized methodology and
14 terminology for exercise design, development, conduct, evaluation, and improvement
15 planning.
16

17 The HSEEP constitutes a national standard for all exercises. Through exercises, the
18 National Exercise Program (NEP) supports organizations to achieve objective
19 assessments of their capabilities so that strengths and areas for improvement are
20 identified, corrected, and shared as appropriate prior to a real incident.
21

22 ** HPP strongly encourages putting after action reports (AAR) to include healthcare*
23 *system related information on the FEMA Lessons Learned Information Site (LLIS) at*
24 *www.llis.gov/index.gov*
25

26 **1.4.4.1 ASPR Requirements**

27 Exercise programs funded all or in part by HPP CA funding, or conducted to address the
28 exercise requirements reflected in this CA, should be built on the guidance and concepts
29 of the Homeland Security Exercise and Evaluation Program (HSEEP). Further
30 information on HPP related HSEEP guidelines, and exercise policy can be found in
31 **APPENDIX C** of this FOA, and on the HSEEP website at
32 https://hseep.dhs.gov/pages/1001_HSEEP7.aspx.
33

34 Awardees must ensure during the FY10 and FY11 budget periods, at least one exercise is
35 conducted in each CRI city, and an equal number of exercises are conducted in other
36 locations, and ensure participating (not necessarily all) healthcare systems in those areas
37 participate in these exercises.
38

39 Further, HPP expects that each exercise tests the operational capability of the following
40 medical surge components:
41

- 42 1. Interoperable communications, and Emergency System for Advance Registration of
43 Volunteer Health Professionals (ESAR-VHP);
44

- 1 2. A tabletop component (that may be done prior) to test the MOUs that are in place for
2 partnerships/coalitions within the areas selected (further information on what these
3 MOUs should contain is detailed below in the partnership/coalition description);
4
- 5 3. Fatality Management, Medical Evacuation/Shelter in Place, and Tracking of Bed
6 Availability (2 of these 3 sub-capabilities);
7

8 **Awardees shall develop and submit an exercise plan with their FY10 CONT**
9 **application, and proposed plan for the FY11 budget period.**

10
11 The exercise plan must include a proposed exercise schedule, and a discussion of the
12 plans for healthcare system exercise development, conduct, evaluation, and improvement
13 planning. This multi-year exercise plan needs to be updated annually and include the
14 HPP requirement of showing how the healthcare system is incorporated and how required
15 sub-capabilities will be tested.
16

17 Awardees must:

- 18
- 19 • Clearly delineate the CRI cities and other locations in which exercises are being
20 developed and conducted, the dates of those exercises, and the healthcare system
21 exercise objectives (to include those listed above);
- 22 • Describe the role of healthcare systems in exercise development, participation,
23 evaluation, development of after action reports, and participation in evaluation and
24 improvement plans;
- 25 • Describe how the awardee will ensure that lessons learned from after action reports
26 are shared with the healthcare systems, and how the emergency operations plans of
27 those healthcare systems are then modified; and
- 28 • Describe how plans for training are integrated in to the exercise program.
29

30 **The following information must be submitted with each HPP End-of-Year Progress**
31 **Report for FY10 and FY11:**
32

- 33 • Comprehensive information on all HPP funded training, drills and exercises. The
34 system shall detail the subject matter of all trainings, and the number of healthcare
35 workers trained by specialty. The awardee is required to track the level of exercise,
36 the sub-capabilities being targeted, and the participating/exercising healthcare
37 systems (e.g., those identified on page 6 of this FOA, as well as other relevant
38 exercise participants).
- 39 • Awardees must submit all after action summaries, improvement plans, and corrective
40 actions that are developed for the aforementioned exercises, an executive summary of
41 the priority 3 corrective action items, and a timeline for fixing those deficiencies.
42

43 Additional activities for funding consideration under this requirement include:

- 44 • Enhancement and upgrade of emergency operations plans based on exercise
45 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 www.ahrq.gov/prep/drillelements/index.html provides healthcare systems with an instrument designed to capture the most critical aspects of disaster drill activities.

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

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 FY10 and FY11 budget periods 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 FOA 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 FY10 and FY11 budget periods.**

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

1.5.2 Level 2 Sub-Capabilities

While the ASPR recognizes the challenge to maintain and refine current systems, awardees are strongly encouraged to expand their State preparedness efforts through the development of Level 2 Sub-Capabilities. The funding of Level 2 Sub-Capabilities

1 should be addressed and progress reported by each awardee, to the extent achievable,
2 during the FY10 and FY11 budget periods if funds permitted, and only after Level 1 Sub-
3 Capability maintenance and refinement is achieved.
4

5 Using Capabilities-Based Planning and the HVA/Gap Analysis requirements described in
6 this FOA, the program narrative developed by awardees should ensure the need or gap
7 will be addressed to the fullest extent achievable. The HPP strongly suggests that each
8 awardee propose Level 2 Sub-Capability projects that progressively unfold during the
9 FY10 and FY11 budget periods to close gaps.
10

- 11 1. Alternate Care Sites (ACS)
 - 12 2. Mobile Medical Assets
 - 13 3. Pharmaceutical Caches
 - 14 4. Personal Protective Equipment
 - 15 5. Decontamination
 - 16 6. Medical Reserve Corps (MRC)
 - 17 7. Critical Infrastructure Protection (CIP)
- 18

19 To the extent possible, equipment purchases should be considered through the DHS
20 Homeland Security Grant Program (HSGP) Standardized Equipment List (SEL) for first
21 responders. This list is accessible through the DHS Responder Knowledge Base at
22 www.rkb.us/mel.cfm.
23

24 **1.5.3 Interoperable Communication Systems**

25 **1.5.3.1 Application Requirement**

26 All awardees are required to equip participating healthcare systems, to the extent
27 achievable, with communication devices which allow them to communicate horizontally
28 (with each other), and vertically with EMS, fire, law enforcement, local and State public
29 health agencies, etc.
30

31 Since FY03, the HPP has required that healthcare systems and health departments
32 establish communications redundancy, ensuring that if one communications system fails,
33 other technologies can be implemented in order to maintain communications. HHS
34 encourages all participating healthcare systems and State Departments of Public Health to
35 develop communications redundancy composed of the following:
36

- 37 • Landline and Cellular Telephones
 - 38 • Two-Way VHF/UHF Radio
 - 39 • Satellite Telephone
 - 40 • Amateur (HAM) Radio
- 41

42 * Additional communication considerations may need to be implemented to ensure
43 compliance with specific state interoperability communications guidance/requirements.
44

45 During the FY10 and FY11 budget periods, awardees shall maintain and refine
46 operational, redundant communication systems that are capable of communicating both

1 horizontally, between healthcare systems, and vertically, within the jurisdiction's incident
2 command structure, as described in the tiered response framework outlined in the MSCC
3 Handbook.

4
5 The systems shall link all healthcare systems that participate in the HPP, as well as those
6 that are deemed necessary by the State, for both State and local jurisdiction health and
7 medical response operations, including the integration of plans with those of law
8 enforcement, public works and others. Systems should continue to provide the ability to
9 exchange voice and/or data with all partners on demand, in real-time, when needed, and
10 as authorized in the operational plans developed by the State and local jurisdictions.
11 These systems should promote information and real-time data integration intra- and
12 extramurally among healthcare systems.

13
14 Not all tiers are meant to be implemented equally across all organizations. The ASPR
15 recognizes there is more than one way to implement each communication tier, and that
16 each State faces its own unique circumstances, such as geographic considerations. Each
17 healthcare system will also need to consider the operational and financial impact of these
18 various recommendations as they update their plans; but this activity must be viewed as a
19 continued priority to maintain and refine during the FY10 and FY11 budget periods, and
20 be addressed accordingly.

21 22 **1.5.3.2 Telecommunications Service Priority (TSP) Program**

23 **Application Requirement:** Awardees are encouraged to fund at least one dedicated line
24 for a minimum of 3 healthcare systems per sub-State region as part of HPP participation
25 in the Federal Communications Commission TSP program. The TSP requires local
26 telecommunications service providers to give restoration, or provisioning service priority
27 to users even during disasters, where there is extensive damage to the
28 telecommunications infrastructure and large numbers of other local customers are out of
29 service. Participation in this program will enable healthcare system communications with
30 first responders (e.g., police, fire and ambulance), as well as with State and local health
31 departments during critical times. This includes lines that allow for data transfer of
32 patient case-specific information, telemedicine, bed availability and other resources and
33 medical equipment needs such as ventilators.

34
35 **Awardees should be cognizant that healthcare systems currently participating in TSP
36 and supporting the costs on their own are not eligible for Federal funds to support these
37 costs moving forward, as this may be construed as supplanting funds.*

38
39 TSP **does not** provide for priority completion of calls. This can be done by participation
40 in Government Emergency Telecommunications Service (GETS) or Wireless Priority
41 Service (WPS) for mobile cellular phones. These are emergency telecommunications
42 programs administered by the DHS National Communications Service (NCS), providing
43 for priority completion of out-bound calls when the Public Telephone Network (PTN) is
44 congested. GETS does not provide priority completion of in-bound calls.

45
46 Because State and local health departments and healthcare systems originate large

1 numbers of calls during emergencies, the FCC, NCS and HHS recommend that they
2 participate in all three programs: GETS, WPS and TSP. All three programs meet
3 requirements set forth by HPP under Interoperable Communications requirements.
4

5 **Further information about HPP TSP implementation for healthcare systems can be*
6 *found in APPENDIX D of this FOA.*
7

8 **1.5.4 National Hospital Available Beds for Emergencies and** 9 **Disasters (HAvBED)**

10 **1.5.4.1 Application Requirement**

11 During the FY10 and FY11 budget periods, awardees are required to maintain and refine
12 an operational bed tracking, accountability/availability systems compatible with the
13 HAvBED data standards and definitions.
14

15 Systems must be maintained, refined, and adhere to all requirements and definitions
16 included in APPENDIX E of this FOA, with the ongoing ability to submit required data
17 using one of two following mechanisms:
18

19 Awardees may choose to use the HAvBED web-portal to manually enter the required
20 data. Data are to be reported in aggregate by the State, therefore the State must have a
21 system that collects the data from the participating healthcare systems, **OR**

22 Awardees may use existing systems to automatically transfer required data to the
23 HAvBED server using the HAvBED EDXL Communication Schema, found at:
24 www.havbed.hhs.gov
25

26 **Information and technical assistance will continue being provided to awardees on both*
27 *options. States are strongly encouraged to continue moving toward full-automation, and*
28 *the capability to report hospital-level information in real-time.*
29

30 **Awardees are required to continue updating their reporting systems to include all*
31 *situational awareness data elements developed through ASPR in FY09, and be*
32 *amenable to include the addition of new elements.*
33

34 **HAvBED Web Portal Link:** <https://havbed.hhs.gov/v2/>
35

36 All technical assistance or system requirement issues should be directed to Mr. Mark
37 Lauda at (202) 401-2783 or Mark.Lauda@hhs.gov
38

39 **1.5.5 Emergency System for Advance Registration of Volunteer** 40 **Health Professionals (ESAR-VHP)**

41 **1.5.5.1 Application Requirement**

42 All awardees are required to meet and maintain all ESAR-VHP electronic system,
43 operational, evaluation and reporting compliance requirements. For a detailed list of
44 these requirements please see APPENDIX F of this funding opportunity.
45

1 The purpose of the ESAR-VHP program is to establish a single national interoperable
2 network of State-based programs to effectively facilitate the use of volunteers in local,
3 territorial, State, and Federal emergency responses. In order to successfully support the
4 use of health professional volunteers at all tiers of response, State ESAR-VHP programs
5 must work to ensure program viability and operability through the development and
6 implementation of plans to:

- 7
- 8 • recruit, register, verify the credentials, and retain volunteers; and
- 9 • coordinate with other volunteer health professional entities and emergency
10 management authorities to ensure effective movement and deployment of volunteers.
- 11

12 The *ESAR-VHP Compliance Requirements* define the capabilities of such a program. As
13 a condition of receiving HPP funds, awardees shall meet the ESAR-VHP compliance
14 requirements and work to continue adopting and implementing the *Interim ESAR-VHP*
15 *Technical and Policy Guidelines, Standards, and Definitions* (Guidelines). The *ESAR-*
16 *VHP Guidelines* are intended to be a living document.

17

18 It is anticipated that sections of the *ESAR-VHP Guidelines* will be continuously be
19 refined and updated as new information and experience dictate.

20

21 In accordance with the eligibility and allowable use of funds awarded through this
22 announcement, awardees shall direct funding towards meeting or refining all of the
23 compliance requirements.

24

25 The following must be submitted in the FY10 application and during each budget period
26 update:

- 27
- 28 1. A detailed description of the ESAR-VHP program.
- 29 2. The current status of each item and sub-item in the compliance requirements.
- 30 3. A detailed list and description of activities planned to address unmet compliance
31 requirements.
- 32 4. List and brief description of proposed ESAR-VHP activities in the work plan and
33 timetable.
- 34 5. A list of the occupations (health professional and non-health professional) included in
35 the ESAR-VHP system and the number of volunteers registered in each occupation.
- 36 6. The total number of volunteers registered in the ESAR-VHP system.
- 37 7. The name of other volunteer affiliations (e.g., MRC, DMAT) included in the ESAR-
38 VHP system and the number of volunteers affiliated with each entity.
- 39 8. Description of volunteer activation and response activities during the previous project
40 period.
- 41

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

44

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

1
2 **1.5.6 Fatality Management**

3 **1.5.6.1 Application Requirement**

4 All awardees must work closely with participating healthcare systems and other
5 appropriate entities, to ensure that facility level fatality management plans are integrated
6 into local, jurisdictional and State plans for disposition of the deceased. These plans must
7 clearly account for the proper identification, handling and storage of remains.
8

9 In FY09, awardees were directed to develop disaster and mass fatality management plans
10 and concepts of operation with participating healthcare systems, local health departments,
11 emergency management and State/jurisdictional Chief Medical Examiner/Coroner.
12

13 During the FY10 and FY11 budget periods, awardees must continue to work with the
14 entities above, and others as appropriate, to maintain and refine robust plans that integrate
15 mass fatality planning within the MSCC tiered response framework, with a focus on:
16

- 17
- 18 • Tier 2 – Management of the Healthcare Coalition
 - 19 • Tier 3 – Jurisdiction Incident Management
 - 20 • Tier 4 – Management of State Response and Coordination of Intrastate Jurisdictions

21 **Awardees should continue to base planning on the estimated number of fatalities*
22 *expected in the case of the most likely events as identified in their State, regional, and/or*
23 *community-based HVAs, or expected during an influenza pandemic.*
24

25 *Funds may be used for the continued maintenance and refinement of plans, as well as the*
26 *purchase of mortuary equipment and supplies (e.g., face shields, protective covering,*
27 *gloves, and disaster body bags).*
28

29 In the funding application, awardees must address:

- 30
- 31 • the current status of fatality management planning, including the need for expanded
32 refrigerated storage capacity, and supplies such as body bags;
 - 33 • the role of the State/jurisdictional Chief Medical Examiner/Coroner in the fatality
34 management planning process;
 - 35 • the role of participating healthcare systems, emergency management, public health
36 and other State/local agencies in the fatality management planning process; and
 - 37 • the cultural, religious, legal and regulatory issues involved with the respectful
38 retrieval, tracking, transportation, identification of bodies, and death certificate
39 completion.

40 **1.5.7 Medical Evacuation/Shelter in Place (SIP)**

41 **1.5.7.1 Application Requirement**

42 The ASPR understands that not all scenarios will (or should) require a full or partial
43 facility evacuation. In some situations it may be safer and more medically responsible
44 for healthcare systems to shelter in place versus evacuating patients and/or facilities.

1
2 The Federal Government through its Regional Emergency Coordinators (RECs) will
3 continue to work in collaboration with States to better determine the capabilities and
4 opportunities for improvement of healthcare system preparedness. They will continue to
5 work with healthcare systems, EMS, homeland security/emergency management, fire
6 service, law enforcement, public health and other officials with the expressed goal of
7 evaluating the advisability of evacuation and sheltering in place of patients in the event of
8 a catastrophe or degraded infrastructure or catastrophic event. This evaluation shall
9 consider operational requirements and resources in order to enhance the strategic decision
10 to shelter in place or evacuate. These evaluations should result in processes that are
11 available to all healthcare systems and integrated with other preparedness plans.
12

13 **Awardees must continue to integrate the evacuation planning of participating*
14 *healthcare systems into Tiers 2, 3, and 4 of the MSCC framework.*
15

16 Proactive planning and preparation will ensure successful operational plans. Awardees
17 should continue to maintain and refine plans, based on their State, regional, and/or
18 community-based HVAs, to identify the imminent threat to life in the area. The nature of
19 the vulnerability and the hazards posed should help the awardees and healthcare systems
20 plan for the event. Awardees should continue to maintain and refine their plans based on
21 the personnel, equipment and systems, planning, and training needs to ensure the safe and
22 respectful movement of patients, and the safety of facility healthcare workers and family
23 members.
24

25 The State should encourage all participating healthcare systems to take the following into
26 account while continuing to work on the integration of local/regional plans:
27

- 28 • the personnel of other healthcare systems in their region, and within other regions of
29 the State;
- 30 • equipment and systems of other healthcare systems as well as those offered by the
31 State's office of emergency management or designated agency;
- 32 • planning and training needed among all participating healthcare systems to ensure the
33 safe evacuation of patients; and
- 34 • the safety of facility healthcare workers and family members.
35

36 The Mass Evacuation Transportation Planning Model estimates the time required to
37 evacuate and transport patients from one healthcare system to another. Healthcare
38 system planners can also use this model to estimate the transportation resources needed to
39 evacuate patients within a certain time period. Funding and leadership to support this
40 model was provided by the Department of Homeland Security's Federal Emergency
41 Management Agency and the U.S. Department of Health and Human Services' Office of
42 the Assistant Secretary for Preparedness and Response, through an AHRQ contract. This
43 project was co-led by AHRQ and the U.S. Department of Defense, and is available at
44 <http://massevacmodel.ahrq.gov/>.
45

1 **1.5.8 Partnership/Coalition Development**

2 **1.5.8.1 Application Requirement**

- 3 1. During the FY10 and FY11 budget periods, all awardees shall make it a priority to
4 ensure operational partnerships/coalitions that encompass all CRI cities in the State
5 plus an equal number of partnerships/coalitions involving non-CRI sub-State regions.
6 **For example, if a State possesses 2 CRI cities, then 4 partnerships/coalitions must be
7 maintained and refined (one in each CRI city and 2 in other sub-State regions).*
8
9 2. Partnerships/coalitions shall continue to plan and develop memoranda of
10 understanding (MOU) to share assets, personnel and information. These MOUs shall
11 be tested through tabletops conducted in CRI and non-CRI cities as described above
12 in the Exercises, Evaluations and Corrective Actions section.
13
14 3. Partnerships/coalitions shall develop plans to unify ESF-8 management of healthcare
15 during a public health emergency, and integrate communication with jurisdictional
16 command in the area.
17
18 4. The ASPR HPP will require increased emphasis on building required
19 partnerships/coalitions during the FY10 and FY11 budget periods. This work should
20 build upon the “Comprehensive Coalition Strategies for Optimization of Healthcare”
21 promoted through the FY09 Pandemic Influenza Healthcare Preparedness
22 Improvements for States FOA and the new “Medical Surge Capacity and Capability:
23 The Healthcare Coalition in Emergency Response and Recovery” handbook concepts,
24 to develop broad reaching healthcare system partnerships/coalitions that build
25 community resiliency. The new handbook is now available through the HPP
26 electronically in .pdf format.
27
28 5. Also for reference is the “Provisional Criteria for the Assessment of Progress toward
29 Healthcare Preparedness” report from the UPMC Center for Biosecurity. It examines
30 essential measurement of healthcare preparedness progress within healthcare
31 coalitions. This report will be emailed to awardees through the HPP listserv.
32

33 **1.5.8.2 Application Requirement**

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

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

42 Partnerships/Coalitions will consist of:

- 43 1. one or more hospitals, at least one of which shall be a designated trauma center, if
44 applicable;
45

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/coalitions should unify the management capability of the healthcare system to a level that will be necessary if the normal day-to-day operations and standard operating procedures of the health system are overwhelmed, and disaster operations become necessary. Partnerships/coalitions shall be able to strategically:

1. integrate plans and activities of all participating healthcare systems 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 State Management Assistance Compact); and
5. maintain continuity of operations in the community vertically with the local jurisdictional emergency management organizations.

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

1.5.9 Alternate Care Sites (ACS)

1.5.9.1 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 system. ACS plans should include issues on providing care and allocating scarce equipment, supplies, and personnel by the State at such sites. ACS planning should be conducted by closely working with HHS Regional Emergency Coordinators (RECs), local health departments, State Public Health Agencies, State Medicaid Agencies, State Survey Agencies, provider associations, community partners, State mental health and substance abuse authorities, Emergency Management, EMS, and neighboring and regional healthcare systems.

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

Establishment of ACS (e.g., schools, hotels, airport hangars, gymnasiums, stadiums,

1 convention centers) are critical to providing supplemental facility surge capacity to the
2 healthcare system, with the goal of providing care and allocating scarce equipment,
3 supplies, and personnel. Planning should therefore include thresholds for altering triage
4 and other healthcare service quality algorithms, and otherwise optimizing the allocation
5 of scarce resources. Effective planning and implementation will depend on close
6 collaboration among State and local health departments (e.g., State Public Health
7 Agencies, State Medicaid Agencies, State Survey Agencies), provider associations,
8 community partners, and neighboring and regional healthcare systems.

9
10 Use of existing buildings and infrastructure as ACS is the most probable, though not the
11 only solution should a surge medical care facility need to be opened. When identifying
12 sites, awardees should consider how the ACS would interface with other local, regional,
13 State, EMAC and Federal assets. Federal assets may require an “environment of
14 opportunity” for set up and operation and may not be available for 72 hours or more.
15 Therefore, it is critical that healthcare and public health systems, and emergency
16 management agencies, work with other response partners when choosing a facility to use
17 as an ACS.

18
19 In addition, plans should take into account many other issues including, but not limited
20 to, ownership, command and control, staffing, scope of care to be provided, criteria for
21 admission, standard operating procedures, safety and security, housekeeping, and many
22 other complex considerations.

23 24 **1.5.9.2 Application Requirement**

25 **If ACS activities are funded during the FY10 or FY11 budget period, the following**
26 **information must be submitted with the HPP End-of-Year Progress Report.**

- 27
- 28 • location of ACS;
 - 29 • number of beds;
 - 30 • level of care to be provided or types of patients that can be taken care of; and
 - 31 • summary of plans for staffing, supply and re-supply of sites.
- 32

33 **1.5.10 Mobile Medical Assets**

34 During any budget period within the three-year project period, awardees may need the
35 ability to provide care outside of their healthcare systems. Use of mobile medical assets
36 (tents, trailers or medical facilities that can be easily transported from one place to
37 another) may be an option for some jurisdictions until patients in large population centers
38 can be evacuated to less affected outlying areas with intact healthcare delivery systems.
39 Awardees may continue to develop or begin to establish plans for a mobile medical
40 capability, working with State and local stakeholders to ensure integration of plans and
41 sharing of resources. Mobile medical plans must address staffing, supply and re-supply,
42 and training of associated personnel, who may function interchangeably as surge
43 augmentation or evacuation facilitators.

44
45 **If Mobile Medical Asset related activities are funded during the FY10 or FY11**
46 **budget period, it must be reported in each HPP End-of-Year Progress Report.**

1
2 **1.5.11 Pharmaceutical Caches**

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

11
12 **Awardees may undertake analysis of and propose funding for the purchase of antiviral*
13 *caches to care for **patients in healthcare systems**, if this has not already occurred. HPP*
14 *funding may be used to purchase, replace and rotate pharmaceuticals only if the*
15 *purchases are linked to State, regional, and/or community-based HVAs, and gaps*
16 *identified that show where and why sufficient quantities do not currently exist.*

17
18 Caches should be placed in strategic locations based on the same HVA, and stored in
19 appropriate conditions to rotate stock and maximize shelf life. Designation of emergency
20 contacts that will have access to the cache in addition to a contingency plan for access
21 should be developed. On-site caches or an increase in stock levels within a healthcare
22 system would ensure immediate access to the medications. It is understood that facility
23 space is limited; therefore, caches may be stored on a regional or State-wide basis. If
24 caches are located regionally or at the State level, a plan should be developed that would
25 ensure the integrity of the supply line and how it will be managed in an event.
26 Mutual aid agreements may need to be developed to ensure that access to the caches is
27 timely for all healthcare systems.

28 Awardees are encouraged to work with stakeholders (Schools of Pharmacy, State Boards
29 of Pharmacy, healthcare systems, pharmacy organizations, public health organizations
30 and academia) for guidance and assistance in identifying medications that may be
31 needed, and in planning to provide access to all healthcare systems during an event.

32 Awardees should also work with these stakeholders to develop training and education for
33 healthcare providers on the available assets, and identify how those assets would be
34 utilized to maximize response efforts.

35
36 **1.5.11.1 Allowable purchases**

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

- 40
41 1. **Antibiotic drugs** for prophylaxis and post-exposure prophylaxis to biological agents
42 for at least three days;
43
44 2. **Nerve agent antidotes** - Funding for the initial cost of the CHEMPACK cache site
45 modification and maintenance over time can be defrayed by a variety of funding
46 sources including local, State, and other Federal agencies or programs including the

1 Metropolitan Medical Response System (MMRS) and private funds. HPP funds may
2 be used (up to \$2500 per CHEMPACK site) to offset reasonable costs associated with
3 the retrofit of CHEMPACK cache storage facilities to meet the Food and Drug
4 Administration's (FDA) Shelf Life Extension Program (SLEP) requirements. For
5 sites that have already been retrofitted, funds can be used to continue the support of
6 maintenance costs (e.g., phone line, security cameras, etc.).
7

8 3. **Antiviral drugs** - In general, the purchase of antiviral drugs for use during an
9 influenza pandemic is allowed through the HPP; however, purchases must be made
10 consistent with U.S. government antiviral drug use guidance published on
11 Pandemicflu.gov. Plans should consider the following: prescribing, storage, and
12 dispensing. *Public sector purchases can be coordinated with the HHS Subsidy
13 Program.*
14

15 4. Medications needed for exposure to other threats (e.g., **radiological events**).
16

17 **If pharmaceutical cache related activities are funded during the FY10 or FY11**
18 **budget periods, it must be reported in each HPP End-of-Year Progress Report.**
19

20 **1.5.12 Personal Protective Equipment**

21 During any budget period within the three-year project period, awardees should ensure
22 adequate types and amounts of personal protective equipment (PPE) to protect current
23 and additional trained healthcare workers expected in support of the events of highest
24 risk, and identified through State, regional, and/or community-based HVAs or
25 assessments. The amount should be tied directly to the number of healthcare workers
26 needed to support bed surge capacity during a mass casualty incident (MCI) that requires
27 PPE. The level of PPE should be established based on the HVA, and the level of
28 decontamination that is planned in each region. For example, those healthcare systems
29 that have identified probable high-risk scenarios (e.g., the facility functions near an
30 organophosphate production plant with a history of employee contamination incidents)
31 should have higher levels of PPE, and more stringent decontamination processes.
32

33 **If PPE related activities are funded during the FY10 or FY11 budget periods, it**
34 **must be reported in each HPP End-of-Year Progress Report.**
35

36 **1.5.13 Decontamination**

37 During any budget period within the three-year project period, each awardee should
38 ensure that adequate portable or fixed decontamination system capability exists Statewide
39 for managing adult and pediatric patients, as well as healthcare workers, who have been
40 exposed during all-hazards health and medical disaster events. The level of capability
41 should be in accordance with the number of required surge capacity beds expected to
42 support the events of highest risk identified through State, regional, and/or community-
43 based HVAs or assessments. All decontamination assets shall be based on how many
44 patients/providers can be decontaminated on an hourly basis.
45

46 **If decontamination related activities are funded during the FY10 or FY11 budget**

1 **periods, it must be reported in each HPP End-of-Year Progress Report.**

2
3 **1.5.13.1 Relevant Resources**

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

7
8 *“All participating hospitals shall be capable of providing decontamination to*
9 *individual(s) with potential or actual hazardous agents in or on their body. It is*
10 *essential that these facilities have the capability to decontaminate more than one*
11 *patient at a time, and be able to decontaminate both ambulatory and stretcher*
12 *bound patients. The decontamination process must be integrated with local,*
13 *regional and State planning.”*

14
15 The OSHA best practices guide can be found at
16 www.osha.gov/dts/osta/bestpractices/firstreceivers_hospital.pdf

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

- 20
- 21 • E54.03.01 – Biological Agent Decontamination;
 - 22 • E54.03.02 – Chemical Agent Decontamination;
 - 23 • E54.03.03 – Radionuclide and Nuclear Decontamination; and
 - 24 • E54.03.04 – Mass Decontamination Operations.

25 The ASTM website is available at www.astm.org.

26
27 **1.5.14 Medical Reserve Corps (MRC)**

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

33
34 In order to promote and ensure the integration of public and private medical capabilities
35 with public health and other first responder systems as described in section 2802(b) of the
36 PHS Act, awardees may consider using HPP CA funds to support the integration of MRC
37 units with local, regional and statewide infrastructure, during any budget period within
38 the three-year project period. Awardees are also encouraged to use multiple sources of
39 funding to establish/maintain the MRC program. HPP CA funds may be used to:

- 40
- 41 • support MRC personnel/coordinators for the primary purpose of integrating the MRC
 - 42 structure with the State ESAR-VHP program;

- 1 • include MRC volunteers in trainings that are integrated with that of other local, State,
2 and regional assets, healthcare systems, or volunteers through the ESAR-VHP
3 program; and/or
- 4 • include MRC volunteers in exercises that integrate the MRC volunteers with other
5 local, State, and regional assets such as healthcare system workers or volunteers that
6 participate in the ESAR-VHP program.

7
8 For more information on what HPP CA funds may be used for, please contact your HPP
9 Project Officer. More information about the MRC program can be found at
10 www.medicalreservercorps.gov or MRCcontact@hhs.gov

11
12 **If MRC related activities are funded during the FY10 or FY11 budget periods, it**
13 **must be reported in each HPP End-of-Year Progress Report.**

14 15 **1.5.15 Critical Infrastructure Protection (CIP)**

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

23
24 The infrastructure protection concepts in the risk management framework highlighted in
25 the NIPP represent a vital component within the “continuum of readiness” and are
26 integrated with the principles and guidance promulgated in the NRF and the NIMS. The
27 NIPP designates HHS as the Sector Specific Agency (SSA) for the Healthcare and Public
28 Health (HPH) Sector. HHS, as SSA, is responsible for facilitating a public/private
29 partnership in support of efforts to identify, prioritize, protect, and ensure resiliency of
30 the nation’s healthcare and public health CI/KR. The partnership is important in
31 that many of the assets critical at the national, regional, State, and local levels are owned
32 and/or operated by private sector organizations. HHS is also responsible for reporting
33 annually on the progress made in the sector.

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

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

44
45 **HHS would like to foster stronger regional, State and local cooperation in CIP*
46 *activities, such as asset identification, asset protection, facility and system resilience, and*

1 *sector continuity of operations.*

2
3 **During any budget period within the three-year project period, awardees may**
4 **propose projects that relate directly to resilience and protection of critical**
5 **healthcare systems and services.** Suggestions should be based on a need identified in
6 State, regional, and/or community-based HVAs, or other assessments. Some examples
7 may include: *upgrading of security systems; movement of switching rooms and*
8 *generators; ensuring adequate back up generators or other power sources for key*
9 *facilities in the region; expanding the functions/services that have back-up power*
10 *(HVAC, elevators, security systems, etc.); or implementing strategies for managing*
11 *hazardous medical waste.*

12
13 HHS recognizes that healthcare system level needs will likely be high for these kinds of
14 activities but *still urges* awardees to consider activities and purchases that support
15 REGIONAL approaches to planning and response due to limited funding and competing
16 demands.

17
18 **1.5.15.1 Relevant Resources**

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

- 20
21 • NIPP – National Infrastructure Protection Plan at www.dhs.gov/nipp
22 • HSPD-7 – Homeland Security Presidential Directive #7 at
23 www.whitehouse.gov/news/releases/2003/12/20031217-5.html
24 • CIP Program for the Healthcare and Public Health Sector at
25 www.hhs.gov/aspr/opeo/cip/index.html
26 • FEMA ICS free online course on the NIPP (IS-860) at
27 www.training.fema.gov/EMIWEB/is/is860.asp

28
29 **If CIP related activities are funded during the FY10 or FY11 budget periods, it**
30 **must be reported in each HPP End-of-Year Progress Report.**

2.0 AWARD INFORMATION

Type of Award: CA

Approximate Award Period Funding: Approximately \$390.5M (Includes direct and indirect costs.)

Approximate Number of Awards: 62

Approximate Average Award: \$6M

Anticipated Award Date: July 1, 2010

Budget Period Length: 12-Months

Project Period Length: Year two 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 financial status 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.
 - (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 systems (including but not limited to those identified on page 6 of this FOA) to participate in the HPP; these facilities should work directly with the appropriate State health department programs. To the extent that such facilities apply for State funding and provide requisite documentation, the State could award funding based on appropriate State law and procedures.

Note: For the purposes of this FOA, the use of the term “State” may include the State, municipality, or associated Territory for which a CA is received.

3.2 Cost Sharing or Matching

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

- For FY10 and 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 FY10 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.

1 To be eligible for an award under this funding opportunity, the awardee must
2 demonstrate, in the budget narrative, they intend to budget not less than the average of
3 their FY08 and FY09 total spending for healthcare preparedness.
4

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

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

17 **3.3.2 Other**

18 PAHPA amended section 319C-1 and 319C-2 of the PHS Act to add certain
19 accountability and compliance requirements that awardees must meet, including the
20 achievement of evidence-based benchmarks, audit requirements, and maximum carryover
21 amounts.
22

23
24 Continuing with the distribution of FY10 funding, awardees that fail substantially to meet
25 for FY10, the State Level Performance Measures described in **APPENDIX G** of this
26 announcement or who fail to submit an effective pandemic influenza plan to CDC as part
27 of their application for PHEP funds, may have funds withheld from their FY11 and
28 subsequent award amounts. Additional information regarding HPP pandemic influenza
29 plan evaluation criteria will be forthcoming. In addition, the maximum percentage
30 amount of the FY10 award an entity may carryover to the succeeding fiscal year is 15%.
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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 FY09 HPP grant award in ‘My Grants List’ at GrantSolutions.gov.

4.1.1 Dun and Bradstreet Data Universal Number System

A Dun and Bradstreet Universal Numbering System (DUNS) number is required for all applications for Federal assistance. Organizations should verify that they have a DUNS number or take the steps necessary to obtain one. Organizations can receive a DUNS number at no cost by calling the dedicated toll-free DUNS Number request line at (866) 705-5711 or at www.whitehouse.gov/omb/grants/duns_num_guide.pdf.

4.2 Content and Form of Application Submission

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

- The FOA – Provides specific information about the availability of funds along with instructions for completing the Continuation application. This document is the FOA. The FOA will be available on the GrantSolutions Web site at 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

- 1 • Program Description
- 2 • Needs Statement
- 3 • Program Outcome Objectives
- 4 • Work-plan and Timetable
- 5 • Evaluation Plan

6
7 The narrative section should be able to stand alone in terms of depth of information. This
8 section should be succinct, self-explanatory and well organized so that internal reviewers
9 can understand the proposed project. Awardees must follow the outline below when
10 writing the program narrative, and it should be written as if the reviewer knows nothing
11 or very little about State healthcare preparedness planning.

12
13 The program narrative of the project must contain the following sections:

- 14
15 1. *Summary:* This section should be an abstract of the program narrative sections of the
16 organization’s capacity to provide the rapid and effective use of resources needed to
17 conduct the project, collect necessary data, and evaluate the project. Awardees
18 should include a description of how they incorporate the input of their partners at the
19 State, Tribal, regional and local level. It is recommended that applicants place an
20 organizational chart in the Appendices of the application.
- 21 2. *Description of Applicant Organization:* In this section, describe the decision-making
22 authority and structure (e.g., department, division, branch or government, and any
23 contractors that work on the project) its resources, experience, existing program units
24 and/or those planned to be established. This description should address personnel,
25 and time and facilities for FY10 and FY11, within this three-year project period.
- 26 3. *Program description:* For each Level 1 Sub-Capability to be maintained and refined
27 and any proposed Level 2 Sub-Capabilities, provide the current status of planning, a
28 needs statement, the outcome objectives, and proposed funding. It should be
29 succinct, self-explanatory and well organized so that reviewers can understand the
30 proposed project.

31
32 A detailed description of each area is provided below.

- 33 a) *Current Status:* In this section, describe the current status of each Level 1
34 Sub-Capability that will be maintained and refined with this funding. If
35 using HPP funds to support any Level 2 Sub-Capabilities, the
36 awardee must provide a statement that all Level 1 Sub-Capabilities are
37 met, and will be maintained and/or refined in FY10.

- 38 (1) All Level 1 Sub-Capabilities must be fully met prior to addressing
39 any funding that will be applied to Level 2 Sub-Capabilities.
- 40 (2) Any request for Level 2 Sub-Capability funding must meet the
41 requirements outlined under the “Project Description” section of
42 this FOA (e.g., the Capability-Based Planning and Gap Analysis
43 section – pages 9).
- 44 (3) This section should describe each Level 2 Sub-Capability in terms
45 of development to date, by explaining how the sub-capability can
46 currently support healthcare system medical surge capacity and

1 capability, how the healthcare system partners have been a part of
2 the process, and their role in further development of each Level 2
3 Sub-Capability.
4

- 5 4. *Needs Statement:* Describe the need for further work to maintain and/or refine each
6 Level 1 Sub-Capability, and proposed Level 2 Sub-Capabilities. Describe the
7 envisioned final product in terms of personnel, training, equipment or systems,
8 organizational, or planning needs that will be addressed with this funding during the
9 FY10 and FY11 budget periods, within this three-year project period. Descriptions
10 should be detailed enough to provide sufficient information to allow the reviewer to
11 understand the depth and breadth of the activities - **budget narratives which are not**
12 **outlined by sub-capability will not be accepted.** It is suggested that the awardee
13 includes the budget justification template that is used by the Office of Grants
14 Management (OGM), which breaks costs out in the same manner as the Notice of
15 Grant Award (NGA), personnel, fringe, travel, etc. The budget justification template
16 can be found in appendix M.
17
- 18 5. *Program Outcome Objectives:* Describe the overall goal of the project **by sub-**
19 **capability**, outline the objectives to be accomplished and the activities that will occur
20 to achieve the sub-capability and ultimately support achievement of the goal. The
21 goal(s), objectives and activities should describe the steps that will be taken to
22 ultimately achieve, in a progressive fashion, development of all funded sub-
23 capabilities during the FY10 and FY11 budget periods, within this three-year project
24 period.
25

26 **Awardees are strongly encouraged to consider the following guidance when*
27 *completing this section. When writing goals and objectives, goals should be*
28 *expressed in terms of the desired long-term impact on the overall preparedness of the*
29 *State, as well as reflect the HPP goals during the FY10 and FY11 budget periods,*
30 *within this three-year project period..*
31

32 When writing the outcome objectives they should be written as a “statement” which
33 defines measurable results the project expects to accomplish (e.g., operational ESAR-
34 VHP system that meets the requirements set forth in the ESAR-VHP section of this
35 FOA). All outcome objectives should be described in terms that are specific,
36 measurable, achievable, realistic, and time-framed (S.M.A.R.T.) for the FY10 and
37 FY11 budget periods, within this three-year project period.
38

39 **Specific:** An objective should specify one major result directly related to the program
40 goal, State who is going to be doing what, to whom, by how much, and in what time-
41 frame. It should specify what will be accomplished and how the accomplishment will
42 be measured.

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

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

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

3 **Time-framed:** An outcome objective should specify a target date or time for its
4 accomplishments. It should State who is going to be doing what, by when, etc.

- 5
6 6. *Work-plan and Timetable:* In this section, outline the objectives and activities that
7 will occur to accomplish the overall project goal (**by sub-capability**) during the FY10
8 and FY11 budget periods, within this three-year project period. The work-plan should
9 be written in terms of who, what, when, where, why and how much. **This section**
10 **should include a budget justification that specifically describes how each item**
11 **will support the achievement of the proposed objectives during the FY10 and**
12 **FY11 budget periods.**

13
14 The budget justification must clearly describe each cost element and explain how
15 each cost contributes to meeting the project’s objectives/goals during the FY10 and
16 FY11 budget periods, within this three-year project period. Consistent with prior
17 years, the HPP strongly encourages awardees to limit the amount of administrative
18 costs (ideally less than or equal to 15%) that collectively include personnel, fringe,
19 travel, supplies and equipment.

20
21 * Suggested budget narrative templates are included as FOA APPENDIX M, and will
22 be emailed to awardees through the HPP listserv.

- 23
24 7. *Evaluation Plan:* In this section please describe the systems and processes in place to
25 track funding, and gather data from hospitals and other partners to track expenditures,
26 monitor progress and aggregate data in order to report performance for all activities
27 during the FY10 and FY11 budget periods, within this three-year project period.

28 29 **4.3 Submission Dates and Times**

30 The deadline for the submission of applications under this program announcement is May
31 21, 2010. Applications must be submitted electronically via GrantSolutions.gov by
32 11:30 PM Eastern Daylight Time.

33
34 **After submitting the non-competing application, GrantSolutions will show a**
35 **confirmation screen providing the applicant with their application number and date**
36 **of submission.**

37 38 **4.4 Intergovernmental Review**

39 Applications under this announcement are not subject to the review requirements of E.O.
40 12372.

41 42 **4.5 Funding Restrictions**

43 Restrictions, which applicants must take into account while writing the budget, are as
44 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/ESF-8 Summit

Awardees must budget for attendance at an ASPR Awardee Conference/ESF-8 Summit, which is anticipated for spring 2011. The conference will be approximately 3 days in length. Additional information will be provided by the HPP Team leader closer to the conference date.

4.6.2 Tax Certifications

In accordance with PL 111-117 Consolidated Appropriations Act 2010; prior to making an award, each current HPP grantee will need to sign and submit a tax certification form. This form should be signed by the States authorized certifying official. If a State fails to submit the tax certificate, ASPR will not grant a continuation award. This form will be forthcoming and will be sent out to each grantee via the HPP listserv.

1 **5.0 APPLICATION REVIEW INFORMATION**

2 **5.1 Criteria**

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

- 5 • Clarity of the needs in terms of personnel, organizational/leadership, equipment and
6 systems, planning and how well applications describe how training and exercises will
7 support developing the sub-capabilities.
- 8 • Clarity of how well the goals, objectives and activities outlined in the application
9 address the needs.
- 10 • Extent to which goals, objectives and activities are written in SMART (specific,
11 measurable, achievable, realistic and time-framed) format.
- 12 • Extent to which the needs of at-risk populations are addressed in the plan.
- 13 • Extent to which the budget justification reflects the costs.

14
15 **5.2 Review and Selection Process**

16 These applications will be reviewed internally within the ASPR using a standardized
17 review format and process. If the application fulfills the review criteria and meets the
18 program requirements, awards will be targeted for a start date of **July 1, 2010**.

19
20 *If recommendations from these reviews result in Conditions of Award (COA), those
21 conditions shall be addressed as instructed in the Notice of Grant Award (NGA).

22
23 **5.3 Anticipated Announcement and Award**

24 *The ASPR *expects to announce CONT awards in June 2010 for a 12 month budget*
25 *period beginning July 1, 2010.*

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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 www.access.gpo.gov/nara/cfr/waisidx_03/45cfrv1_03.html

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

**Awardees that fail to comply with the terms and conditions of this CA, including responsiveness to HPP guidance, measured progress in meeting the performance measures, and adequate stewardship of these Federal funds, may be subject to an administrative enforcement action. Administrative enforcement actions may include temporarily withholding cash payments, or restricting an awardees ability to draw down funds from the Payment Management System until the awardee has taken corrective action.*

6.3 Reporting Requirements

6.3.1 Audit Requirements

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

1 Each entity receiving HPP funds shall, not less often than once every 2 years, audit its
2 expenditures from amounts received under their HPP award. Such audits shall be
3 conducted by an entity independent of the agency administering a program funded under
4 the HPP in accordance with the Comptroller General’s standards for auditing
5 governmental organizations, programs, activities, and functions and using generally
6 accepted auditing standards. Within 30 days following the completion of each audit
7 report, the entity shall submit a copy of that audit report to the following office:

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

12
13 **Grantees that satisfy OMB Circular A-133 audit requirements will also satisfy HPP*
14 *audit requirements.*

16 **6.3.2 Progress Reports and Financial Reports**

17 Applicants funded under this announcement will be required to electronically submit
18 semi-annual progress and Financial Status Reports or FSRs/SF-269. The mid-year
19 progress reports are due 30 days after the first 6 months of the budget period, and year-
20 end reports are due 90 days after the 12 month budget period end date. Reporting
21 formats are established in accordance with provisions of the general regulations that
22 apply under 45 CFR parts 74 and 92. The mid-year FSR will be due 30 days after the
23 first 6 months of the budget period, and final FSRs will be due 90 days after the budget
24 period end date.

- 25
- 26 • In light of the increased emphasis on performance measurement and accountability in
27 the PAHPA, awardees are advised that progress reports (Mid-Year and End-of-Year)
28 are expected to be timely, consistent, and complete.
- 29 • Incomplete or inconsistent reports will be returned to the awardee for corrections.
- 30 • The progress reports will consist of 3 sections: (1) a narrative-based progress report,
31 (2) a report on progress with Performance Measures and (3) Data Elements.
- 32

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

37 **SF-425**

38
39 Recipients must report cash transaction data via the Payment Management System (PMS)
40 using the cash transaction data elements captured on the Federal Financial Report (FFR),
41 Standard Form (SF) 425. Recipients will utilize the “Transactions” section of SF425 in
42 lieu of the SF272. The FFR SF425 cash Transaction Report is due 30 days after the end
43 of each calendar quarter. The FFR SF425 electronic submission and dates for the new
44 quarters will be announced through the Payment Management/SmartLink Payment
45 System’s bulletin board.

1
2 The FFR SF425 was designed to replace the Financial Status Report SF269 and the
3 Federal Cash Transactions Report SF272 with one comprehensive financial reporting
4 form. Until HHS fully migrates to the SF425 FFR, recipients are still required to submit
5 the SF269 Financial Status Report (FSR) semi-annually within 30 days after the first 6
6 month period and within 90 days of the budget period end date. ASPR requires
7 cumulative financial reporting through consecutive funding periods on the SF269 FSR
8 long form.

9
10 Both forms and their instructions may be found at
11 http://www.whitehouse.gov/omb/grants/grants_forms.aspx.

12
13 Please submit the SF425 electronically to the Division of Payment Management and the
14 SF269 to GrantSolutions and asprgrants@hhs.gov

15 16 **6.4 Evidence-based Performance Measures and Program Data** 17 **Elements**

18 **6.4.1 Benchmarks, Performance Measures and Program Data Elements**

19 The ASPR expects that all awardees must continue to achieve, maintain, and report
20 Benchmarks, Performance Measures and Program Data Elements for FY10. The ASPR
21 reserves the right to modify performances measures and data elements on an annual basis
22 as needed and in accordance with directives, goals, and objectives of the ASPR.

23
24 For the purposes of this FOA, the reporting entity is the State. State includes: the 50
25 States; the District of Columbia; the three metropolitan areas of New York City, Los
26 Angeles County and Chicago; the Commonwealths of Puerto Rico and the Northern
27 Mariana Islands; the territories of American Samoa, Guam and the U.S. Virgin Islands;
28 the Federated States of Micronesia; and the Republics of Palau and the Marshall Islands.
29 The State is responsible for the collection of information from participating local
30 healthcare systems directly supported by HPP funds during the budget period.

31
32 **Awardees shall maintain all documentation that substantiates the answers to these*
33 *measures (site visits, surveys, exercises etc.) and make those documents available to*
34 *Federal staff as requested during site visits or through other requests. Documentation*
35 *should contain information on both the method awardees used for collecting particular*
36 *information, as well as the data set prepared from the healthcare system reports.*

37
38 Benchmarks, performance measures and data elements will be reported annually (except
39 for State-level benchmarks collected with the MYR). Calculation of results based on
40 numerator and denominator information submitted by awardees will be conducted by
41 staff in the State and Local Initiatives Team, Evaluation Section at the ASPR.

42 43 **6.4.2 Benchmarks**

44 While the ASPR is interested, in all benchmarks, performance measures, and program
45 data elements, the ASPR has identified benchmarks to be used as a basis for withholding
46 funding for HPP awardees during FY11 and subsequent budget periods. In line with

1 provisions of the PAHPA, awardees that fail to “substantially meet” the benchmarks
2 described in APPENDIX G for FY10 are subject to withholding of funds penalties. The
3 ASPR defines awardees that provide complete and accurate information/responses for all
4 benchmarks as having “substantially met” reporting requirements. In addition, to having
5 “substantially met” benchmarks, awardees are expected to meet the Application
6 Requirements articulated in Sections 1.3, 1.4, and 1.5 of the FY10 FOA. Awardees that
7 demonstrate achievement of these requirements are not subject to withholding of funds
8 for FY11 and subsequent budget periods.
9

10 **6.4.3 Performance Measures**

11 Performance measures serve as indicators for program performance and achievement.
12 They reflect progress in the field and help to inform, guide, and direct programmatic
13 performance. While the ASPR directly funds States, the impact and result are also
14 reflective at the local healthcare system level. As a result of the varying levels of impact,
15 some performance measures focus at the State level, while other performance measures
16 focus at the healthcare system level (for individual participating sub-awardee facilities
17 supported by HPP funds) at any point during the current budget period. The ASPR
18 reserves the right to reclassify performance measures as benchmarks standards subject to
19 withholding provisions on an annual basis as needed and in accordance with directives,
20 goals, and objectives of the ASPR.
21

22 **6.4.4 Data Elements**

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

7.1 Administrative and Budgetary Contacts

For application kits and submission of applications please visit GrantSolutions.gov. Search for your FY09 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. Alexis Lynady
ASPR, Office of Grants Management
O: (202) 245-0976
asprgrants@hhs.gov

7.2 Program Contacts

For HPP assistance, contact:

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

For Data and Evaluation assistance, contact:

Ms. Margaret Sparr
Team Leader, Program Evaluation Section
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Office of Preparedness and Emergency Operations (OPEO)
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For ESAR-VHP assistance, contact:

Ms. Jennifer Hannah
Team Leader
Emergency System for Advance Registration
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1 **APPENDIX A: Key updates to the Medical Surge Capacity**
2 **and Capability Handbook: A Management System for**
3 **Integrating Medical and Health Resources During Large-**
4 **Scale Emergencies¹**

- 5
- 6 • Tier 6 – Federal Support to State, Tribal and Jurisdiction Management – has been
7 rewritten to highlight changes to the Federal emergency response structure. The
8 chapter focuses on the information that medical and public health planners need to
9 know regarding the request, receipt, and integration of Federal public health and
10 medical support under Emergency Support Function #8 of the NRP.
 - 11
 - 12 • The handbook now emphasizes how MSCC concepts can be applied not only to
13 medical surge, but also to maintain normal healthcare services and operations during
14 a crisis (e.g., medical system resiliency).
 - 15
 - 16 • Newly added section 1.4.1 clarifies the role of Incident Command versus the regular
17 administration of an organization during response and recovery operations. Included
18 in this section is a description of the “Agency Executive” role in ICS.
 - 19
 - 20 • In accordance with NIMS, the handbook describes the role of a Multi-agency
21 Coordination Center (MACC), and Multi-agency Coordination Group (MAC Group)
22 in providing emergency operations support to incident command. The application of
23 these concepts at Tiers 2 and 3 is particularly important.
 - 24
 - 25 • Section 1.3.1 draws distinctions between the processes and structures that are used in
26 preparedness planning, and those used during incident response and recovery.
 - 27
 - 28 • An important lesson learned from Hurricane Katrina and included in this update, is
29 the need at all levels of government to plan for the health services support needs of
30 medically fragile populations.
 - 31

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.

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- The structure of the Emergency Operations Plan (EOP) has become increasingly standardized. Section 2.3 of the handbook provides a more detailed description of the requirements of an effective EOP for healthcare organizations.
- The term “healthcare organization” has been substituted for “healthcare facility” to reflect the fact that many medical assets that may be brought to bear in an emergency or disaster are not facility-based.

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

APPENDIX B: FY10 HPP NIMS Implementation for Healthcare Systems

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 early 2010 the results of this working group will be released.

FY10 HPP NIMS implementation will continue to align healthcare systems with their State, territory, Tribal and local partners. During the FY10 funding cycle, HPP awardees will be required to maintain and refine existing implementation activities, and insure that participating healthcare systems are in a position to report fully with regard to implementing the following activities:

1. Adoption

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

2. Preparedness: Planning

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

3. Preparedness: Training

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

4. Communication and Information Management

- a) Promote and ensure that equipment, communication, and data interoperability are incorporated into the healthcare systems acquisition programs.
- b) Apply common and consistent terminology as promoted in NIMS, including the establishment of plain language communications standards.
- c) Utilize systems, tools, and processes that facilitate the collection and

1 distribution of consistent and accurate information during an incident or
2 event.

3
4 **5. Resource Management** - No implementation objective

5
6 **6. Command and Management**

- 7 a) Manage all emergency incidents, exercises, and preplanned
8 (recurring/special) events in accordance with ICS organizational
9 structures, doctrine, and procedures, as defined in NIMS.
10 b) ICS implementation must include the consistent application of Incident
11 Action Planning (IAP) and common communications plans, as
12 appropriate.
13 c) Adopt the principle of Public Information, facilitated by the use of the
14 Joint Information System (JIS) and Joint Information Center (JIC) during
15 an incident or event.
16 d) Ensure that Public Information procedures and processes gather, verify,
17 coordinate, and disseminate information during an incident or event.
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APPENDIX C: FY10 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

1 whole. The National Preparedness Goal uses a capabilities-based planning approach to
2 help answer the following questions:

- 3 1. How prepared are we?
- 4 2. How prepared do we need to be?
- 5 3. How do we prioritize efforts to close the gap?
- 6 4. As a result of HSPD-8 and the National Preparedness Goal, a set of National
7 Planning Scenarios was developed to illustrate the effects and conditions of
8 incidents of national significance for which the Nation should prepare.
9

10 **National Preparedness Goal**

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

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

- 17 1. Implement the National Incident Management System (NIMS) and National
18 Response Framework (NRF).
- 19 2. Expand regional collaboration.
- 20 3. Implement the National Infrastructure Preparedness Plan.
- 21 4. Strengthen information sharing and collaboration capabilities.
- 22 5. Strengthen chemical, biological, radiological, nuclear, and high-yield explosives
23 (CBRNE) weapons detection, response, and decontamination capabilities.
- 24 6. Strengthen interoperable communications capabilities.
- 25 7. Strengthen medical surge and mass prophylaxis capabilities.
- 26 8. Strengthen emergency operations planning and citizen protection capabilities.
27

28 **National Planning Scenarios**

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

- 33 1. Improvised Nuclear Device (IND)
- 34 2. Aerosolized Anthrax
- 35 3. Pandemic Influenza
- 36 4. Plague
- 37 5. Blister Agent
- 38 6. Toxic Industrial Chemical
- 39 7. Nerve Agent
- 40 8. Chlorine Tank Explosion
- 41 9. Major Earthquake
- 42 10. Major Hurricane
- 43 11. Radiological Dispersal Device (RDD)

1 12. Improvised Explosive Device (IED)

2 13. Food Contamination

3 14. Foreign Animal Disease (FAD)

4 15. Cyber

5
6 The National Planning Scenarios serve as the basis for identifying tasks that must be
7 performed to prevent, protect against, respond to, and recover from these incidents, as
8 well as the capabilities required to perform the tasks. The 15 scenarios provide for
9 common planning factors in terms of the potential scope, magnitude, and complexity of
10 major events that will help to determine the target levels of capability required and
11 apportion responsibility among all potential partners. Developing appropriate capabilities
12 to address this range of scenarios will best prepare the Nation for terrorist attacks, major
13 disasters, and other emergencies.

14 15 **Target Capabilities List (TCL)**

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

21 22 **Universal Task List (UTL)**

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

27 28 **Exercise Types:**

29 30 **Discussion-Based Exercises**

31 Discussion-based exercises are normally used as starting points in the building-block
32 approach to the cycle, mix, and range of exercises. Discussion-based exercises include
33 seminars, workshops, tabletop exercises (TTXs), and games. These types of exercises
34 typically highlight existing plans, policies, mutual aid agreements (MAAs), and
35 procedures. Thus, they are exceptional tools for familiarizing agencies and personnel
36 with current or expected jurisdictional capabilities. Discussion-based exercises typically
37 focus on strategic policy-oriented issues; operations-based exercises focus more on
38 tactical response-related issues. Facilitators and/or presenters usually lead the discussion,
39 keeping participants on track while meeting the objectives of the exercise.

40 **Seminars** - are generally used to orient participants to, or provide an overview of,
41 authorities, strategies, plans, policies, procedures, protocols, response resources, or

1 concepts and ideas. Seminars provide a good starting point for jurisdictions that are
2 developing or making major changes to their plans and procedures. They offer the
3 following attributes:

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

10
11 **Workshops** - represent the second tier of exercises in the Homeland Security Exercise
12 and Evaluation Program (HSEEP) building-block approach. Although similar to
13 seminars, workshops differ in two important aspects: participant interaction is increased,
14 and the focus is on achieving or building a product (such as a plan or a policy).

15 Workshops provide an ideal forum for the following:

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

23
24 In conjunction with exercise development, workshops are most useful in achieving
25 specific aspects of exercise design such as the following:

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

29
30 A workshop may be used to produce new standard operating procedures (SOPs),
31 emergency operations plans (EOPs), MAAs, Multi-Year Training and Exercise Plans
32 (output of the TEPW), and improvement plans (IPs). To be effective, workshops must be
33 highly focused on a specific issue, and the desired outcome or goal must be clearly
34 defined.

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

- 36 1. Effective with both small and large groups.
 - 37 2. Facilitated, working breakout sessions.
 - 38 3. Goals oriented toward an identifiable product.
 - 39 4. Information conveyed through different instructional techniques.
 - 40 5. Lack of time constraint from real-time portrayal of events.
 - 41 6. Low-stress environment.
 - 42 7. No-fault forum.
 - 43 8. Plenary discussions led by a workshop leader.
- 44

1 **Tabletop Exercises (TTXs)** - involve senior staff members, elected or appointed
2 officials, or other key personnel in an informal setting discussing simulated situations.
3 This type of exercise is intended to stimulate discussion of various issues regarding a
4 hypothetical situation. It can be used to assess plans, policies, and procedures or to assess
5 types of systems needed to guide the prevention of, response to, and recovery from a
6 defined incident. TTXs are typically aimed at facilitating understanding of concepts,
7 identifying strengths and shortfalls, and/or achieving a change in attitude. Participants
8 are encouraged to discuss issues in depth and develop decisions through slow-paced
9 problem solving rather than the rapid, spontaneous decision-making that occurs under
10 actual or simulated emergency conditions. In contrast to the scale and cost of operations-
11 based exercises and games, TTXs can be cost-effective tools when used in conjunction
12 with more complex exercises. The effectiveness of a TTX is derived from the energetic
13 involvement of participants and their assessment of recommended revisions to current
14 policies, procedures, and plans.

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

- 25 1. Achieving limited or specific objectives.
- 26 2. Assessing interagency coordination.
- 27 3. Conducting a specific case study.
- 28 4. Examining personnel contingencies.
- 29 5. Familiarizing senior officials with a situation.
- 30 6. Participating in information sharing.
- 31 7. Practicing group problem solving.
- 32 8. Testing group message interpretation.

34 **Operations-Based Exercises**

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

42 **Drills** – are a coordinated, supervised activity usually used to test a single specific
43 operation or function in a single agency. Drills are commonly used to provide training on

1 new equipment, develop or test new policies or procedures, or practice and maintain
2 current skills. Typical attributes include the following:

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

7
8 **Functional Exercises (FEs)** - are also known as a Command Post Exercise (CPX), is
9 designed to test and evaluate individual capabilities, multiple functions or activities
10 within a function, or interdependent groups of functions. FEs generally focus on
11 exercising the plans, policies, procedures, and staffs of the direction and control nodes of
12 the Incident Command System (ICS), Unified Command, and Emergency Operations
13 Centers (EOCs). Generally, incidents are projected through an exercise scenario with
14 event updates that drive activity at the management level. Movement of personnel and
15 equipment is simulated.

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

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

26
27 **Full-Scale Exercises (FSEs)** - are multiagency, multijurisdictional exercises that test
28 many facets of emergency response and recovery. They include many first responders
29 operating under the ICS or Unified Command to effectively and efficiently respond to,
30 and recover from, an incident. An FSE focuses on implementing and analyzing the plans,
31 policies, and procedures developed in discussion-based exercises and honed in previous,
32 smaller, operations-based exercises. The events are projected through a scripted exercise
33 scenario with built-in flexibility to allow updates to drive activity. It is conducted in a
34 real-time, stressful environment that closely mirrors a real incident. First responders and
35 resources are mobilized and deployed to the scene where they conduct their actions as if a
36 real incident had occurred (with minor exceptions). An FSE simulates the reality of
37 operations in multiple functional areas by presenting complex and realistic problems that
38 require critical thinking, rapid problem solving, and effective responses by trained
39 personnel in a highly stressful environment. Other entities that are not involved in the
40 exercise, but that would be involved in an actual incident, should be instructed not to
41 respond.

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

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

11 **HSEEP - HPP Connectivity**

12 The Homeland Security Exercise and Evaluation Program (HSEEP) is a capabilities and
13 performance-based exercise program that provides a standardized methodology and
14 terminology for exercise design, development, conduct, evaluation, and improvement
15 planning.

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

21 Continuing for FY10 and FY11, exercise programs funded all or in part by HPP CA
22 funds must meet the intent of the HSEEP practices for exercise program management,
23 design, development, conduct, evaluation and improvement planning. This means if a
24 healthcare system **participates** in an exercise sponsored by another agency, they must
25 ensure the exercise is HSEEP compliant. If the healthcare system **sponsors** the exercise
26 the following four distinct performance requirements must be evidenced:

- 27 1. **Participating healthcare systems are required to conduct annual Training and**
28 **Exercise Plan Workshops (T& EPW), and maintain a Multi-year Training and**
29 **Exercise Plan (MYT&EP). This includes:**
 - 30 a) Training and exercise priorities based on overarching strategy and
31 previous improvement plans.
 - 32 b) Capabilities from the Target Capabilities List (TCL) that the facility will
33 train for and exercise against.
 - 34 c) A multi-year training and exercise schedule which:
 - 35 (1) Reflects the training activities which will take place prior to an
36 exercise, allowing exercises to serve as a true validation of
37 previous training.
 - 38 (2) Reflects all exercises in which the facility participates.
 - 39 (3) Validates planning from previous training and exercises conducted.
 - 40 (4) Employs a “building-block approach” in which training and
41 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: www./hseep/dhs/gov/pages/1001_HSEEP7.aspx

2. **Participating healthcare systems should plan and conduct exercises that are:**

- a) Consistent with the entity’s Multi-year Training and Exercise Plan.
- b) Based on capabilities and their associated critical tasks, which are contained within the Exercise Evaluation Guides (EEGs). For Example, if a facility, based on its risk/vulnerability analysis, determines that it is prone to hurricanes, it may want to validate its evacuation capabilities. In order to validate this capability it would first refer to the “Citizen 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: www/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

1 templates provided in *HSEEP Volume III: Exercise Evaluation and*
2 *Improvement Planning*.

- 3 b) Following each exercise, a draft AAR/IP must be developed based on the
4 information gathered through the use of EEGs.
5 c) Following every exercise, an After-Action Conference (AAC) must be
6 conducted, in which:
7 (1) Key healthcare workers, and the exercise planning team are
8 presented with findings and recommendations from the draft
9 AAR/IP.
10 (2) Corrective actions addressing a draft AAR/IP's recommendation
11 are developed and assigned to responsible parties with due dates
12 for completion.
13 d) A final AAR/IP with recommendations and corrective actions derived
14 from discussion at the AAC must be completed **within 60 days** following
15 the completion of each exercise.
16

17 **4. Tracking and implementing corrective actions identified in the AAR/IP.**

- 18 a) An improvement plan will include broad recommendations from the
19 AAR/IP organized by target capability as defined in the TCL.
20 b) Corrective actions derived from ACC are associated with the
21 recommendations and must be linked to a capability element as defined in
22 the TCL.
23 c) Corrective actions included in the improvement plan must:
24 (1) Be measurable.
25 (2) Designate a projected start and completion date.
26 (3) Be assigned to a facility and a point of contact (POC) within that
27 facility.
28 (4) Identify any supporting entity or agency whose participation or
29 involvement is essential to achieving full implementation and
30 identify an individual point of contact to assist in the
31 implementation process.
32
33 d) Corrective actions are acted upon and tracked to ensure corrective actions
34 from exercises, policy discussions and real-world events are effectively
35 implemented and incorporated in future planning, training and exercise
36 schedules, and individual exercises, as part of a Corrective Action
37 Program.
38 e) .
39 f) An individual should be responsible for managing the overall Corrective
40 Action Program to ensure corrective actions resulting from exercises,
41 policy discussions and real-world events are effectively implemented, and
42 incorporated into the subsequent planning, training and exercise activities.
43
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APPENDIX C2: FY10 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 system 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.

(https://hseep.dhs.gov/pages/1001_HSEEP7.aspx) The HSEEP Policy and Guidance is presented in detail in HSEEP Volumes I-III. Adherence to the policy and guidance presented in the HSEEP Volumes ensures that exercise programs conform to established best practices and helps provide unity and consistency of effort for exercises at all levels of government. An excellent, concise explanation of HSEEP Terminology, Methodology, and Compliance Guidelines is found at https://hseep.dhs.gov/support/HSEEP_101.pdf.

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

7
8 Examples of an entity complying with *HSEEP guidelines* include:

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

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

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

1
2 **HPP Awardee and Sub-Awardee Responsibilities:**
3

4 Awardees and/or sub-awardees should participate in the state Training and Exercise Plan
5 Workshop (T&EPW) process to promote the inclusion of healthcare and public health
6 requirements, objectives and partners at all levels of exercise. HPP awardees and/or sub-
7 awardees should work closely with their State Homeland Security agency, as well as with
8 other local, regional and state partners/stakeholders, in the design, development, conduct,
9 and evaluation of drills and exercises. This collaboration can integrate the exercise
10 requirements and objectives for many different agencies, partners and stakeholders
11 through joint exercises.
12

13 HPP awardees and/or sub-awardees should assure that local, regional and/or statewide
14 exercises incorporate the following HPP overarching and Level 1 Sub-Capabilities:
15

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

22
23 At least one exercise to include each Cities Readiness Initiative (CRI) city/Metropolitan
24 Statistical Area (MSA) and an equal number of exercises in other locations must be
25 conducted. Participating healthcare systems (sub-awardees) in those areas must
26 participate in these exercises.
27

28 Participation in a Homeland Security HSEEP compliant exercise implies that awardees
29 and/or sub-awardees are represented in all of the exercise planning conferences/meetings;
30 to include incorporating their specific exercise objectives in the exercise design; After
31 Action Conference; and completion of an AAR/IP, regardless of agency sponsorship.
32 HPP encourages use of the HSEEP Toolkit
33 (https://hseep.dhs.gov/pages/1001_Toolk.aspx) to prepare these documents, as
34 appropriate. Additional exercise information and support documents can be found in the
35 AHRQ Toolkit (<http://www.ahrq.gov/prep/>). The AHRQ tools provide greater detail
36 specific to healthcare not found in the HSEEP Exercise Evaluation Guide (EEG), and can
37 provide useful information to incorporate into the AAR/IP.
38

39 HPP awardees and sub-awardees participating in exercises must take part in the After
40 Action Conference for their exercise and contribute to the AAR/IP development. If an
41 exercise is not sponsored by emergency management or another state agency, the
42 awardee or sub-awardee should follow the alternate instructions included in the FY10
43 HPP FOA, and HSEEP guidelines detailed earlier. Awardees and/or sub-awardees may
44 use an alternative AAR/IP template as long as the HSEEP format is followed.

1 Improvement Plans must include input from partners and stakeholders and can be
2 captured at the After-Action Conference or in another appropriate format. The final After
3 Action Report with the Improvement Plan in the appendix (AAR/IP) should be preserved
4 and available for audit during site visits by regional/state coordinators and/or ASPR
5 Project Officers. The awardees and sub-awardees must track the completion of their
6 assigned corrective actions.

7
8 ASPR requires awardees to create an executive summary from the AAR/IPs of each
9 CRI/MSA related exercise and an equal number of exercises in other locations, and
10 submit annually starting with the FY08 HPP End-Of-Year Report. For example, if a state
11 has one CRI/MSA, it is required to submit an executive summary for two exercises.
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APPENDIX D: FY10 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 systems. However, TSP is not a requirement of the Hospital Preparedness Program.

Healthcare Systems and Telecommunication Service Providers Instructions

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

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

2. Once they've identified the lines:

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

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

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

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

- 2
- 3 3. Once the healthcare system is ready to move forward, they should request the
- 4 restoration priorities from the TSP Program Office (TSPPO). There are two ways to
- 5 do this:
- 6
- 7 • Option 1 - The “eforms” module that is accessible at the TSP website.
 - 8 (Instructions below) or;
 - 9 • Option 2 - An email w/ spreadsheet sent to tsp@dhs.gov.
- 10
- 11 4. Option 2 is recommended because it is quick and easy. In the body of the email, the
- 12 healthcare system should include the following:
- 13 • Name of facility
 - 14 • Point of Contact name (POC)
 - 15 • POC title
 - 16 • POC address
 - 17 • POC phone number
 - 18 • POC email address
- 19
- 20 5. A spreadsheet should be attached to the email that includes two columns. Column A
- 21 should have the circuit IDs or line numbers that they want the RP for, and Column B
- 22 should have the carrier name that is providing the service.
- 23
- 24 6. The information requested in items (4) and (5) should be emailed to the TSPPO, with
- 25 an email copy to your respective State/territory Hospital Preparedness Program
- 26 Coordinator or designee as record of the request.
- 27
- 28 7. Once the TSPPO receives the email, it will be processed and an email will be sent
- 29 back to the POC. The spreadsheet will be attached with an additional column that
- 30 lists the TSP code that has been assigned to each line.
- 31
- 32 8. The POC should immediately send the TSP codes to their carrier using the procedures
- 33 they discussed with them (item 2 above).
- 34

35 **E-forms Module Instructions**

- 36
- 37 1. The healthcare system will access the NCS web-site at (www.tsp.ncs.gov) to establish
- 38 a TSP account. [Select “**E-forms**”, then “**Register to use e-forms.**”]
- 39
- 40 2. The NCS will email the healthcare system, and provide a login ID and password back
- 41 to them via an email.
- 42
- 43 3. The healthcare system will re-enter the NCS web-site (using the provided login ID
- 44 and password) and will fill out the application form. [Select “**E-forms**”, then “**Access**
- 45 **to e-forms application**”, then “**TSP request for service users (Form 315)**”].
- 46

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

5 For help with this process, call **1-866-NCS-CALL; Option 3.**
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APPENDIX E: FY10 HAvBED Operational Requirements and Definitions

Requirements

1. Report aggregate State level data to the HHS SOC not more than twice daily during emergencies. The frequency of data required from the hospitals is dependent on the incident. The time necessary for data entry must be minimized so that it does not interfere with the other work responsibilities of the hospital staff during a mass casualty incident (MCI). Ideally, all institutions would enter data at the same time on similar days in order to reduce variability due to daily and weekly fluctuations in bed capacity. Possess the following Hospital Identification Information:
 - a) Hospital Name
 - b) Contact Name
 - c) Street Address
 - d) City
 - e) State
 - f) Zip Code
 - g) Area Code
 - h) Local Telephone Number
 - i) County
2. Report on the following categories as defined in the HHS HAvBed system Vacant/ Available Bed Counts:
 - a) Intensive Care Unit (ICU)
 - b) Medical and Surgical (Med/Surge)
 - c) Burn Care
 - d) Peds ICU
 - e) Pediatrics (Peds)
 - f) Psychiatric (Psych)
 - g) Negative Pressure Isolation
 - h) Emergency Department Divert Status
 - i) Decontamination Facility Available
 - j) Ventilators Available

Bed Definitions

3. Vacant/Available Beds: Beds that are vacant and to which patients can be transported immediately. These must include supporting space, equipment, medical material, ancillary and support services, and staff to operate under normal circumstances. These beds are licensed, physically available, and have staff on hand to attend to the patient who occupies the bed.
4. Adult Intensive Care (ICU): Can support critically ill/injured patients, including ventilator support.
5. Medical/Surgical: Also thought of as “Ward” beds.
6. 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.)
7. Pediatric ICU: The same as adult ICU, but for patients 17 years and younger

- 1 8. Pediatrics: Ward medical/surgical beds for patients 17 and younger
- 2 9. Psychiatric: Ward beds on a closed/locked psychiatric unit or ward beds where a
- 3 patient will be attended by a sitter.
- 4 10. Negative Pressure/Isolation: Beds provided with negative airflow, providing
- 5 respiratory isolation. Note: This value may represent available beds included in the
- 6 counts of other types.
- 7 11. Operating Rooms: An operating room that is equipped and staffed and could be made
- 8 available for patient care in a short period.

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

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

15 Further information on the HAVBED system can be found at www.ahrq.gov/prep/havbed/

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1 **APPENDIX F: Emergency System for Advance**
2 **Registration of Volunteer Health Professionals (ESAR-**
3 **VHP) Compliance Requirements (Revised March 2010)**

4
5 The ESAR-VHP compliance requirements identify capabilities and procedures that State²
6 ESAR-VHP programs must have in place to ensure effective management and inter-
7 jurisdictional movement of volunteer health personnel in emergencies.

8 **ESAR-VHP Electronic System Requirements**
9

- 10 1. Each State is required to develop an electronic registration system for recording and
11 managing volunteer information based on the data definitions presented in the
12 *Interim ESAR-VHP Technical and Policy Guidelines, Standards and Definitions*
13 (*Guidelines*).

14
15 These systems must:

- 16 a) Offer Internet-based registration. Information must be controlled and
17 managed by authorized personnel who are responsible for the data.
18
19 b) Ensure that volunteer information is collected, assembled, maintained and
20 utilized in a manner consistent with all Federal, State and local laws
21 governing security and confidentiality.
22
23 c) Identify volunteers via queries of variables as defined by requestor.
24
25 d) Ensure that each State ESAR-VHP System is both backed up on a regular
26 basis and that the back up is not co-located.
27

28
29 Each electronic system must be able to register and collect the credentials and
30 qualifications of health professionals that are then verified with the issuing entity or
31 appropriate authority identified in the *ESAR-VHP Guidelines*.
32

² 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.

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

- 6
7 (1) Physicians (Allopathic and Osteopathic)
8 (2) Registered Nurses,
9 (3) Advanced Practice Registered Nurses (APRNs) including Nurse
10 Practitioners, Certified Nurse Anesthetists, Certified Nurse
11 Midwives, and Clinical Nurse Specialists
12 (4) Pharmacists
13 (5) Psychologists
14 (6) Clinical Social Workers
15 (7) Mental Health Counselors
16 (8) Radiologic Technologists and Technicians
17 (9) Respiratory Therapists
18 (10) Medical and Clinical Laboratory Technologists
19 (11) Medical and Clinical Laboratory Technicians
20 (12) Licensed Practical Nurses and Licensed Vocational Nurses
21 (13) Dentists
22 (14) Marriage and Family Therapists
23 (15) Physician Assistants
24 (16) Veterinarians
25 (17) Cardiovascular Technologists and Technicians
26 (18) Diagnostic Medical Sonographers
27 (19) Emergency Medical Technicians and Paramedics
28 (20) Medical Records and Health Information Technicians
29

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

- 32
33 2. Each electronic system must be able to assign volunteers to all four ESAR-VHP
34 credential levels. Assignment will be based on the credentials and qualifications that
35 the State has collected and verified with the issuing entity or appropriate authority.
36
37 3. Each electronic system must be able to record ALL volunteer health
38 professional/emergency preparedness affiliations of an individual, including local,
39 State, and Federal entities.
40

41 The purpose of this requirement is to avoid the potential confusion that may arise
42 from having a volunteer appear in multiple registration systems (e.g., Medical
43 Reserve Corps (MRC), National Disaster Medical System (NDMS), etc.).
44

- 45 4. Each electronic system must be able to identify volunteers willing to participate in a
46 federally coordinated emergency response.

- 1
- 2
- 3 a) Each electronic system must query volunteers upon initial registration
- 4 and/or re-verification of credentials about their willingness to participate
- 5 in emergency responses coordinated by the Federal government.
- 6 Responses to this question, posed in advance of an emergency, will
- 7 provide the Federal government with an estimate of the potential volunteer
- 8 pool that may be available from the States upon request.
- 9
- 10 b) If a volunteer responds “Yes” to the Federal question, States may be
- 11 required to collect additional information (e.g., training, physical and
- 12 medical status, etc.).
- 13
- 14 5. Each State must be able to update volunteer information and re-verify credentials
- 15 every 6 months.

16 **Note:** ASPR is reviewing this requirement regularly for possible adjustments based

17 on the experience of the States.

18

19 **ESAR-VHP Operational Requirements**

20

- 21 6. Upon receipt of a request for volunteers from any governmental agency or recognized
- 22 emergency response entity, all States must: 1) within 2 hours query the electronic
- 23 system to generate a list of potential volunteer health professionals to contact; 2)
- 24 contact potential volunteers; 3) within 12 hours provide the requester an initial list of
- 25 willing volunteer health professionals that includes the names, qualifications,
- 26 credentials, and credential levels of volunteers; and 4) within 24 hours provide the
- 27 requester with a verified list of available volunteer health professionals.
- 28
- 29 7. All States are required to develop and implement a plan to recruit and retain
- 30 volunteers.
- 31
- 32 ASPR will assist States in meeting this requirement by providing professional
- 33 assistance to develop a National public education campaign, tools for accessing State
- 34 enrollment sites, and customized State recruitment and retention plans. This will be
- 35 carried out in conjunction with existing recruitment and retention practices utilized by
- 36 States.
- 37
- 38 8. Each State must develop a plan for coordinating with all volunteer health
- 39 professional/emergency preparedness entities to ensure an efficient response to an
- 40 emergency, including but not limited to Medical Reserve Corps (MRC) units and the
- 41 National Disaster Medical Systems (NDMS) teams.
- 42
- 43 9. Each State must develop protocols for deploying and tracking volunteers during an
- 44 emergency (Mobilization Protocols):
- 45
- 46 a) Each State is required to develop written protocols that govern the internal

1 activation, operation, and timeframes of the ESAR-VHP system in
2 response to an emergency. Included in these protocols must be plans to
3 track volunteers during an emergency and for maintaining a history of
4 volunteer deployments. ASPR may ask for copies of these protocols as a
5 means of documenting compliance. ASPR will include protocol models in
6 future versions of the *ESAR-VHP Guidelines*.

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

14
15 (1) Intrastate deployment: States must develop protocols that coordinate
16 the use of ESAR-VHP volunteers with those from other volunteer
17 organizations, such as the Medical Reserve Corps (MRC).

18
19 (2) Interstate deployment: States must develop protocols outlining the
20 steps needed to respond to requests for volunteers received from
21 another State. States that have provisions for making volunteers
22 employees or agents of the State must also develop protocols for
23 deployment of volunteers to other States through the State Emergency
24 Management Agency via the Emergency Management Assistance
25 Compact (EMAC).

26
27 Each State must have a process for receiving and maintaining the
28 security of volunteers' personal information sent to them from another
29 State and procedures for destroying the information when it is no
30 longer needed.

31
32 (3) Federal deployment: Each State must develop protocols necessary to
33 respond to requests for volunteers that are received from the Federal
34 government. Further, each State must adhere to the protocol
35 developed by the Federal government that governs the process for
36 receiving requests for volunteers, identifying willing and available
37 volunteers, and providing each volunteer's credentials to the Federal
38 government.

39 40 **ESAR-VHP Evaluation and Reporting Requirements**

41
42 10. Each State must develop a plan for regular testing of its ESAR-VHP system through
43 drills and exercises. These exercises must be consistent with the ASPR Hospital
44 Preparedness Program (HPP), Centers for Disease Control and Prevention (CDC)
45 Public Health Emergency Preparedness (PHEP) Program, and ASPR ESAR-VHP
46 Program requirements for drills and exercises.

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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.

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APPENDIX G: FY10 Hospital Preparedness Program (HPP) Evidence-based Benchmarks Subject to Withholdings

State Benchmarks	
S1.1	The State EOC can report available beds for at least 75% of participating healthcare systems, according to HAvBED definitions, to the HHS SOC within 4 hours or less of a request, during an incident or exercise at least once during the current project period.
S1.2	Please report in number of hours how much time it took to report available beds according to HAvBED definitions for at least 75% of participating healthcare systems, to the HHS SOC.
S2.1	The State/Territory demonstrates the ability to query their ESAR-VHP System during a functional drill, exercise, or actual event to generate a list of potential volunteer health professionals, by discipline and credential level, within 2 hours or less of a request being issued by a requesting body or HHS SOC during the current project period.
S2.2	Please report in hours the amount of time it took to query the ESAR-VHP System to generate a list of potential volunteer health professionals, by discipline and credential level.
S3.1	The State/Territories conduct statewide and regional exercises that incorporate NIMS concepts and principles and includes healthcare systems during the current project period.
S3.2	Please report the total number of statewide and regional exercises conducted that incorporate NIMS concepts and principles during the current project period.
S3.3	<p>Please report the total number of statewide and regional exercises conducted that incorporate NIMS concepts and principles and includes healthcare systems during the current project period.</p> <ul style="list-style-type: none"> – <u>Numerator</u>: The number of statewide and regional exercises conducted by the State/Territories that incorporate NIMS concepts and principles and include healthcare systems during the current project period. – <u>Denominator</u>: 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).

1 **APPENDIX H: HPP State Level Performance Measures/Application Requirements**
 2 **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 report available beds for at least 75% of participating healthcare systems, according to HAvBED definitions, to the HHS SOC within 4 hours or less of a request, during an incident or exercise at least once during the current project period.						●				
S1.2	Please report in number of hours how much time it took to report available beds according to HAvBED definitions for at least 75% of participating healthcare systems, to the HHS SOC.						●				
S2.1	The State/Territory demonstrates the ability to query their ESAR-VHP System during a functional drill, exercise, or actual event to generate a list of potential volunteer health professionals, by discipline and credential level, within 2 hours or less of a request being issued by a requesting body or HHS SOC during the current project period.							●			
S2.2	Please report in hours the amount of time it took to query the ESAR-VHP System to generate a list of potential volunteer health professionals, by discipline and credential level.							●			
S3.1	The State/Territories conduct statewide and regional exercises that incorporate NIMS concepts and principles and includes healthcare systems during the current project period.			●							
S3.2	Please report the total number of statewide and regional exercises conducted that incorporate NIMS concepts and principles during the current project period.	●		●							
S3.3	Please report the total number of statewide and regional exercises conducted that incorporate NIMS concepts and principles and includes healthcare systems during the current project period. - <u>Numerator</u> : The number of statewide and regional exercises conducted by the State/Territories that incorporate NIMS concepts and principles and include healthcare systems during the current project period. - <u>Denominator</u> : 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).										

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APPENDIX I: The FY10 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

- 1 officials. A minimum of three appointed core members, one of whom will be
2 designated a chairperson by the ASPR. Others may be designated as determined by
3 the chairperson. Members of the ARC may not be from the branch or program whose
4 adverse determination is being appealed.
5
- 6 3. **Recipient** - The organization that receives a grant or cooperative agreement award
7 from an awarding agency, and is responsible and accountable for using the funds
8 provided, and for the performance of the grant-supported project or activity. The
9 recipient is the entire legal entity, even if a particular component is designated in the
10 NGA. The term includes “awardee/grantee.”
11
- 12 4. **Corrective action** - Action taken by the awardee that corrects identified
13 deficiencies or produces recommended improvements.
14
- 15 5. **Enforcement** – Actions taken to compel the observance of policies, regulations, and
16 laws governing the administration of an assistance program. Such actions are
17 generally the result of a recipient’s failure to comply with the terms and conditions of
18 an award. These failures may cause an awarding agency to take one or more actions,
19 depending on the severity and duration of the non-compliance. The awarding agency
20 generally will afford the recipient an opportunity to correct the deficiencies before
21 taking enforcement action, unless public health or welfare concerns require
22 immediate action. However, even if an awardee is taking corrective action, the
23 awarding agency may take proactive steps to protect the Federal government’s
24 interests, including placing special conditions on awards, or may take action designed
25 to prevent future non-compliance, such as closer monitoring.
26
- 27 6. **Termination** – The permanent withdrawal by the awarding agency of an awardee’s
28 authority to obligate previously awarded grant funds before that authority would
29 otherwise expire, including the voluntary relinquishment of that authority by the
30 recipient.
31
- 32 7. **Disallowance** – A determination denying payment of an amount claimed under an
33 award, or requiring return of funds or off-set of funds already received.
34
- 35 8. **Void** – A determination that an award is invalid because the award was not
36 authorized by statute or regulation, or because it was fraudulently obtained.
37
- 38 9. **Withholding of funds** – An action taken by an awarding agency to withhold or
39 reduce support within a previously approved or subsequent budget period.
40 Withholding may occur for the following justifiable reasons: (1) an awardee is
41 delinquent in submitting required reports; (2) adequate Federal funds are not available
42 to support the project; (3) an awardee fails to show satisfactory progress in achieving
43 the objectives of the project, e.g., performance measures/benchmarks and/or
44 excessive carryover; (4) an awardee fails to meet the terms of a previous award; (5)
45 An awardee’s management practices fail to provide adequate stewardship of Federal
46 funds; (6) any reason which would indicate that continued funding would not be in

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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 Financial Status Report (SF-269) at the time a carryover request is made, approximately 10 months into the 12 month budget cycle. The threshold amount includes direct and indirect costs.
15. **Outlays or Expenditures** - The charges made to the Federally-sponsored project or program. They may be reported on a cash or accrual basis. For reports prepared on a cash basis, outlays are the sum of cash disbursements for direct charges for goods and services, the amount of indirect expense charged, the value of third party in-kind contributions applied and the amount of cash advances and payments made to sub-awardees.

For reports prepared on an accrual basis, outlays are the sum of cash reimbursements for direct charges for goods and services, the amount of indirect expense incurred, the value of in-kind contributions applied, and the net increase (or decrease) in the amounts owed by the recipient for goods and other property received, for services performed by employees, contractors, sub-awardees and other payees and other amounts becoming owed under programs for which no current services or performance are required.
16. **Audits** – A systematic review or appraisal made to determine whether internal accounting and other control systems provide reasonable assurance of financial operations are properly conducted; financial reports are timely, fair, and accurate; the entity has complied with applicable laws, regulations, and terms and conditions of award; resources are managed and used economically and efficiently; desired results

1 and objectives are being achieved effectively.

2
3 17. **Failure** – Noncompliance with any or all of the provisions of the NGA. which
4 include but not limited to various laws, regulations, assurances, terms, or conditions
5 applicable to the grant or cooperative agreement.

6
7 18. **Matching or Cost Sharing** - The value of state third-party in-kind contributions and
8 the portion of the costs of a federally assisted project or program not borne by the
9 Federal Government. Costs used to satisfy matching or cost-sharing requirements are
10 subject to the same policies governing allowability as other costs under the approved
11 budget.

12 13 **3.0 Background**

14 PAHPA amended section 319C-2 of the PHS Act, and authorizes the Assistant
15 Secretary for Preparedness and Response (ASPR) to award cooperative agreements to
16 eligible entities, to enable such entities to improve surge capacity and enhance
17 community and hospital preparedness for public health emergencies.

18
19 Grantees must meet certain statutory accountability and compliance requirements.

20 Sections 319C-1 and C-2 of the PHS Act require the Department to take certain
21 enforcement actions if grantees fail to meet these requirements. More
22 specifically, this document addresses the following enforcement actions
23 required by the statute: 1) beginning in fiscal year 2009, withholding a
24 statutorily-mandated percentage of the award if an awardee fails substantially
25 to meet established benchmarks and performance measures for the immediately
26 preceding fiscal year or fails to submit a satisfactory pandemic flu plan to the
27 Department; 2) repayment of any funds that exceed the maximum percentage of
28 an award that an entity may carryover to the succeeding fiscal year; and 3)
29 repayment or future withholding or offset as a result of a disallowance decision
30 if an audit shows that funds have not been spent in accordance with section
31 319C-2 of the PHS Act .

32 33 **4.0 Enforcement Actions and Disputes**

34 **4.1 Withholding for failure to meet established benchmarks and** 35 **performance measures or to submit a satisfactory pandemic** 36 **influenza plan.**

37
38 1. Beginning with the distribution of FY 2009 funding, awardees that fail substantially
39 to meet performance measures/benchmarks for the immediately preceding fiscal year
40 and/or who fail to submit a pandemic influenza plan to CDC as part of their
41 application for PHEP funds, may have funds withheld from their FY 2009 and
42 subsequent award amounts. An awardee that fails to correct such noncompliance
43 shall be subject to withholding in the following amounts:
44

- 1 • For the fiscal year immediately following a fiscal year in which the awardee has
2 failed substantially to meet performance measures/benchmarks or who has failed to
3 submit a satisfactory pandemic influenza plan; an amount equal to 10 percent of
4 funding the awardee was eligible to receive.
- 5 • For the fiscal year immediately following two consecutive fiscal years in which an
6 awardee experienced such a failure, an amount equal to 15 percent of funding the
7 awardee was eligible to receive, taking into account the withholding of funds for the
8 immediately preceding fiscal year.
- 9 • For the fiscal year immediately following three consecutive fiscal years in which an
10 awardee experienced such a failure, an amount equal to 20 percent of funding the
11 awardee was eligible to receive, taking into account the withholding of funds for the
12 immediately preceding fiscal years.
- 13 • For the fiscal year immediately following four consecutive fiscal years in which an
14 entity experienced such a failure, an amount equal to 25 percent of funding the
15 awardee was eligible to receive for such a fiscal year, taking into account the
16 withholding of funds for the immediately preceding fiscal year.

17
18 Please note that HHS is required to treat each failure to substantially meet all the
19 benchmarks and each failure to submit a satisfactory pandemic influenza plan as a
20 separate withholding action. For example, an awardee failing substantially to meet
21 benchmarks/performance measures AND who fails to submit a satisfactory pandemic
22 influenza plan could have 10% withheld for each failure for a total of 20% for the first
23 year this happens. If this situation remained unchanged, HHS would then be required to
24 assess 15% for each failure for a total of 30% for the second year this happens.
25 Alternatively, if one of the two failures is corrected in the second year but one remained,
26 HHS is required to withhold 15% of the second year funding.

27 28 **2. Technical assistance and notification of failures**

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

37
38 The awardee shall submit the required progress report on or before the specified due date
39 according to the terms and conditions of the NGA. The Project Officer shall, within 15
40 days of receipt of the required progress report, assess performance, provide technical
41 assistance to the awardee as required, and issue a written letter acknowledging
42 completion of assessment and that the assessment has been forwarded to the GMO.

43
44 Upon determination that the awardee has failed to comply with the terms and conditions
45 of a grant or cooperative agreement, the Project Officer (PO) shall issue a written
46 recommendation and provide a complete documentation package to the Grants

1 Management Officer (GMO) based on the review and monitoring of the awardee.

2
3 **Within 15 days** of receipt of the recommendation from the PO, the GMO shall issue an
4 initial failure notification to the awardee in writing. This document will provide
5 compliance requirements as submitted by the PO and will include the total amount of
6 Federal funds which will be withheld or reduced in the subsequent fiscal year due to
7 noncompliance, absent corrective action by the awardee that is satisfactory to the GMO.
8 The document will specify that the GMO will take such other remedies as may be legally
9 available and appropriate in the circumstances, such as withholding of Federal funds.

10
11 The awardee must provide a proposed Corrective Action Plan (CAP) in writing to the
12 GMO, within 15 days of receipt of the initial failure notification. The GMO will forward
13 a copy to the PO. The awardee may request technical assistance at this time.

14
15 Within 15 days of receipt of the proposed CAP, the PO will assess the remedies and
16 provide a recommendation to the GMO. If the GMO finds the corrective action measures
17 satisfactory, the GMO shall, **within 15 days** of receipt of the PO's assessment, provide
18 notification to the awardee of the awarding agency's intent to rescind the initial failure
19 notification.

20
21 If in the GMO's judgment the awardee has still failed to comply with the terms and
22 conditions of a grant or cooperative agreement, the GMO shall issue a final failure
23 notification and provide information about the appeal process to include applicable
24 timelines in writing. The GMO will concurrently issue his/her decision to the awardee
25 and the Agency Review Committee (ARC).

26 27 **3. Dispute process**

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

38
39 If the awardee chooses to appeal the GMO decision, the awardee must do so directly to
40 the ARC **within ten days** of receipt of the GMO's final failure notification. The Notice
41 of Appeal shall include: 1) a detailed description of the reason for appeal including
42 supporting documentation and 2) a description of how the enforcement action impacts the
43 affected organization. The awardee should be aware that they bear the burden of proof to
44 the extent of the type of modification or reversal of the GMO's decision they seek and the
45 necessity for modification or reversal.

46

1 **Within ten days** of receipt of the awardee’s notice of appeal, the GMO will 1) brief the
2 ARC on the issues of the case, 2) submit any relevant documentation supporting the
3 decision, and 3) provide a written statement responding to the notice of appeal.
4

5 **Within ten days** of receipt of the brief and documentation submitted by the GMO, the
6 ARC will acknowledge, in writing, the notice of appeal to the awardee and the GMO.
7 The ARC will review the relevant information, **within seven days of providing written**
8 **notification to awardee and GMO**, and use one or a combination of the following
9 methods for dispute resolution:
10

- 11 a) Documentation Review – an independent evaluation of documents to
12 verify compliance with laws, regulations, or policies;
- 13
- 14 b) Conference – allow parties an opportunity to make an oral presentation to
15 clarify issues, question both parties to obtain a clear understanding of the
16 facts, and provide recommendations for resolution. Telephone
17 conferences are acceptable.
- 18

19 Based on the outcome of the review or conference, the ARC will decide on the resolution
20 of an issue **within seven days**. The ARC may decide that the Department should waive
21 or reduce the withholding as described above for a single entity or for all entities in a
22 fiscal year, if the ARC reviews and determines that mitigating conditions exist that justify
23 the waiver or reduction. The ARC will notify the GMO, PO, and the awardee, in writing,
24 of their final decision that the Department should waive or withhold federal funds.
25

26 If the ARC’s final decision is to for the Department to waive the federal funds to be
27 withheld or withhold Federal funds for the subsequent fiscal year, the GMO shall issue,
28 in writing, a final decision to the awardee **within ten days** from the receipt of the ARC’s
29 final decision.
30

31 Funds that are withheld for failure to substantially meet benchmarks/performance
32 measures and/or to submit a satisfactory pandemic influenza plan will be reallocated so
33 that the Secretary may make awards under section 319C-2 to entities described in
34 subsection (b)(1) of that section (i.e., Healthcare Facility Partnership grants).
35

36 4. Responsibilities

- 37 a) **PO/Public Health Advisor shall:**
 - 38 (1) During the corrective action phase, provide technical assistance to
 - 39 the awardee to meet the requirement.
 - 40 (2) If determined the awardee will not meet the requirement, the PO
 - 41 shall issue a written recommendation to the GMO based on the
 - 42 review and monitoring of awardee progress.
 - 43 (3) Provide a timely documentation package to the GMO regarding a
 - 44 decision to withhold or reduce cooperative agreement funds.
 - 45

- 46 b) **GMO shall:**

- 1 (1) Rescind initial failure notification or issue a final failure
- 2 notification and provide the awarding agency's process for appeal
- 3 to include applicable timelines, in writing, to the awardee and
- 4 provide a copy to ARC.
- 5 (2) Brief ARC on issues pertaining to disputes.
- 6 (3) Prepare and submit a complete documentation package to the ARC
- 7 regarding a decision to withhold or reduce cooperative agreement
- 8 funds.
- 9

10 c) **ARC shall:**

- 11 (1) Establish regular committee members and consult with subject
- 12 matter experts in the Department as necessary.
- 13 (2) Receive initial Notice of Appeal.
- 14 (3) Send acknowledgements to the awardee and GMO.
- 15 (4) Review disputes by documentation or conference.
- 16 (5) Provide recommendations and facilitate disputes to preclude
- 17 further action.
- 18 (6) Provide the ARC decisions on appeals.
- 19

20 d) **Awardee or Complainant shall:**

- 21 (1) Remedy non-compliance issues during the corrective action phase.
- 22 If the GMO determines that corrective actions have not been
- 23 adequate, the awardee may submit a written request for review.
- 24 (2) If awardee disputes the GMO's final decision, submit dispute to
- 25 ARC after Failure Notification is received from the agency
- 26 awarding office. The dispute must contain the following:
- 27 (a) a detailed description of the reason for dispute including
- 28 supporting documentation and
- 29 (b) a description of how the enforcement action impacts the affected
- 30 organization.
- 31

32 **4.2 Repayment of any funds that exceed the maximum percentage**

33 **of an award that an entity may carryover to the succeeding**

34 **fiscal year.**

- 35
- 36 1. For each fiscal year, the ASPR, in consultation with the States and political
 - 37 subdivisions, will determine the maximum percentage amount of an award that an
 - 38 awardee may carryover to the succeeding fiscal year. This percentage amount will be
 - 39 listed in the funding opportunity announcement (FOA). For fiscal year 2008 awards,
 - 40 this maximum percentage amount that an awardee may carryover is 15%. For each
 - 41 fiscal year, if the percentage amount of an award unobligated by an awardee exceeds
 - 42 the maximum percentage permitted (i.e., 15% for FY 2008 awards), the awardee shall
 - 43 repay the portion of the unobligated amount that exceeds the maximum amount
 - 44 permitted to be carried over to the succeeding fiscal year.
 - 45

46 2. **Notification of failure**

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

7
8 The awardee must provide a proposed Corrective Action Plan (CAP) in writing to the
9 GMO, within 15 days of receipt of the initial failure notification. The GMO will provide
10 a copy to the PO. The awardee may request technical assistance at this time.

11
12 Within 15 days of receipt of the proposed CAP, the PO will assess the remedies and
13 provide a recommendation to the GMO. The GMO shall, **within 15 days** of receipt of
14 the PO's assessment, provide notification to the awardee of the awarding agency's intent
15 to rescind the initial failure notification. If the awardee has still failed to comply with the
16 terms and conditions of a grant or cooperative agreement, the GMO shall issue a final
17 failure notification in writing and provide information about the appeal process and
18 application for waiver of repayment to include applicable timelines. The GMO will
19 concurrently issue his/her decision to the awardee and the Agency Review Committee
20 (ARC).

21 22 **3. Dispute process**

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

33
34 **Within ten days** of receipt of the awardee's notice of appeal, the GMO will 1) brief the
35 ARC on the issues of the case, 2) submit any relevant documentation supporting the
36 decision, and 3) provide a written statement responding to the notice of appeal.

37
38 **Within ten days** of receipt of the brief and documentation submitted by the GMO, the
39 ARC will acknowledge, in writing, the notice of appeal to the awardee and the GMO.

40
41 The ARC will review the relevant information, **within seven days**, and use one or a
42 combination of the following methods for dispute resolution:

- 43
44 a) Documentation Review – an independent evaluation of documents to
45 verify compliance with laws, regulations, or policies;
46

- 1 b) Conference – allow parties an opportunity to make an oral presentation to
2 clarify issues, question both parties to obtain a clear understanding of the
3 facts, and provide recommendations for resolution. Telephone
4 conferences are acceptable.
5

6 The ARC may decide that the Department should waive or reduce the amount to be
7 repaid for a single entity or for all entities in a fiscal year, if the ARC reviews and
8 determines that mitigating conditions exist that justify the waiver or reduction. The ARC
9 will notify the GMO, PO, and the awardee, in writing, of their final decision that the
10 Department should waive or require repayment of the portion of the unobligated amount
11 of HPP funds that exceeds the maximum amount permitted to be carried over to the
12 succeeding fiscal year.
13

14 If the ARC’s final decision is to waive or to require repayment of the portion of the
15 unobligated amount of HPP funds that exceeds the maximum amount permitted to be
16 carried over to the succeeding fiscal year, the GMO shall issue a final decision in writing
17 to the awardee **within ten days** from the receipt of the ARC’s final decision.
18

19 Funds that are repaid to the ASPR will be reallocated so that the Secretary may make
20 awards under section 319C-2 to entities described in subsection (b) (1) of that section
21 (i.e., Healthcare Facility Partnership grants).
22

23 **4. Responsibilities**

24 a) **PO/Public Health Advisor shall:**

- 25 (1) If determined the awardee has exceeded the maximum carryover
26 percentage, the PO shall issue a written recommendation to the
27 GMO based on the review and monitoring of awardee progress.
28 (2) Provide a timely documentation package to the GMO regarding a
29 decision to repay unobligated HPP funds that exceed the maximum
30 carryover percentage.
31

32 b) **GMO shall:**

- 33 (1) Rescind initial failure notification or issue a final failure
34 notification and provide the awarding agency’s process for appeal
35 to include applicable timelines, in writing, to the awardee and
36 provide a copy to ARC.
37 (2) Brief ARC on issues pertaining to disputes.
38 (3) Prepare and submit a complete documentation package to the ARC
39 regarding a decision to repay.
40

41 c) **ARC shall:**

- 42 (1) Establish regular committee members and consult with subject
43 matter experts in the Department, as necessary.
44 (2) Receive initial Notice of Appeals.
45 (3) Send acknowledgements to the awardee and GMO.
46 (4) Review disputes by documentation or conference.

- 1 (5) Provide recommendations and facilitate disputes to preclude
- 2 further action.
- 3 (6) Provide the ARC decisions on appeals.
- 4

5 d) **Awardee or Complainant shall:**

- 6 (1) Remedy non-compliance issues during the corrective action phase.
- 7 If the GMO determines that corrective actions have not been
- 8 adequate, the awardee may submit a written request for review.
- 9 (2) If awardee disputes the GMO's final decisions, submit dispute to
- 10 ARC after Failure Notification is received from the agency
- 11 awarding office as described in the NGA. The dispute must
- 12 contain the following:
- 13 (a) a detailed description of the reason for dispute including
- 14 supporting documentation;
- 15 (b) a description of how the enforcement action impacts the affected
- 16 organization; and
- 17 (c) request for a waiver of repayment that includes an explanation why
- 18 such requirement (for maximum percentage of carryover amount)
- 19 should not apply to the awardee and the steps taken by the awardee
- 20 to ensure that all HPP funds will be expended appropriately
- 21

22 **4.3 Repayment or future withholding or offset as a result of a**

23 **disallowance decision if an audit shows that funds have not been**

24 **spent in accordance with section 319C-2 of the PHS Act.**

- 25 1. Awardees shall, not less often than once every 2 years, audit their expenditures from
- 26 HPP funds received. Such audits shall be conducted by an entity independent of the
- 27 agency administering the HPP program in accordance with the Comptroller General's
- 28 standards for auditing governmental organizations, programs, activities, and functions
- 29 and generally accepted auditing standards. Within 30 days following completion of
- 30 each audit report, awardees should submit a copy of that audit report to the ASPR.
- 31

32 Awardees shall repay to the United States amounts found not to have been expended in

33 accordance with section 319C-2 of the PHS Act.

34

35 If such repayment is not made, the ASPR may offset such amounts against the amount of

36 any allotment to which the awardee is or may become entitled under section 319C-2 or

37 may otherwise recover such amount. The ASPR may withhold payment of funds to any

38 awardee which is not using its allotment under section 319C-2 in accordance with such

39 section. The ASPR may withhold such funds until it finds that the reason for the

40 withholding has been removed and there is reasonable assurance that it will not recur.

41

42 **2. Disallowance notification**

43 Upon determination as a result of audit findings that the awardee has not expended funds

44 in accordance with section 319C-2, the GMO shall issue a disallowance notification to

45 the awardee for the portion of funds not expended in accordance with section 319C-2 and

46 require repayment of those funds to the United States.

1
2 **3. Dispute process**

3 HHS has established a DAB for the purpose of providing awardees a fair and flexible
4 process to appeal certain written final decisions involving grant and cooperative
5 agreement programs administered by agencies of HHS. This document notifies HPP
6 awardees that an opportunity exists to appeal a **disallowance** enforcement action to the
7 DAB. If the awardee chooses to appeal a final disallowance decision by the GMO, the
8 awardee must do so directly to the DAB **within thirty days** of receipt of the GMO's final
9 disallowance notification. The Notice of Appeal shall include: 1) a copy of the final
10 decision, 2) a statement of the amount in dispute in the appeal, and 3) a brief statement of
11 why the decision is wrong. More details about the DAB's procedures may be found at 45
12 C.F.R. part 16.
13

14 **5.0 References**

15 **Code of Federal Regulations (CFR)**

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

18
19 * 45 CFR Part 74 and Appendix E, Uniform Administrative Requirements for
20 Awards and Sub-awards to Institutions of Higher Education, Hospitals, Other
21 Nonprofit organizations and commercial organizations
22

23 * 45 CFR Part 92, Uniform Administrative Requirements for Grants and
24 Cooperative Agreements to State, Local, and Tribal Governments
25

26 **OMB Circulars**

27 * A-87, Cost Principles for State, Local and Indian Tribal Governments

28 * A-102, Grants and Cooperative Agreements with State and Local
29 Governments
30

31 * A-110, Uniform Administrative Requirements for Grants and Other
32 Agreements with Institutions of Higher Education, Hospitals, and Other
33 Non-Profit Organizations.

34 * A-133, Audits of States, Local Governments, and Non-Profit
35 Organizations Requirements
36

37 **HHS Grants Policy Statement, January 1, 2007**
38
39
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Appendix J: At Risk Individuals

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

Before, during, and after an incident, members of at-risk populations may have additional needs in one or more of the following functional areas: communication, medical care, maintaining independence, supervision, and transportation. In addition to those individuals specifically recognized as at-risk in the Pandemic and All-Hazards Preparedness Act (i.e., children, senior citizens, and pregnant women), individuals who may need additional response assistance include those who have disabilities; live in institutionalized settings; are from diverse cultures; have limited English proficiency or are non-English speaking; are transportation disadvantaged; have chronic medical disorders; and have pharmacological dependency.

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

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

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

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

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

1 consumable medical supplies (diapers, formula, bandages, ostomy supplies, etc.), durable
2 medical equipment (wheelchairs, walkers, scooters, etc.), service animals, and/or
3 attendants or caregivers. Supplying needed support to these individuals will enable them
4 to maintain their pre-disaster level of independence.
5

6 **Supervision** – Before, during, and after an emergency individuals may lose the support
7 of caregivers, family, or friends or may be unable to cope in a new environment
8 (particularly if they have dementia, Alzheimer’s or psychiatric conditions such as
9 schizophrenia or intense anxiety). If separated from their caregivers, young children may
10 be unable to identify themselves; and when in danger, they may lack the cognitive ability
11 to assess the situation and react appropriately.
12

13 **Transportation** – Individuals who cannot drive or who do not have a vehicle may
14 require transportation support for successful evacuation. This support may include
15 accessible vehicles (e.g., lift-equipped or vehicles suitable for transporting individuals
16 who use oxygen) or information about how and where to access mass transportation
17 during an evacuation.
18

19 This approach to defining at-risk individuals establishes a flexible framework that
20 addresses a broad set of common function-based needs irrespective of specific diagnoses,
21 statuses, or labels (e.g., those with HIV, children, the elderly). At-risk individuals, along
22 with their needs and concerns, must be addressed in all Federal, Territorial, Tribal, State,
23 and local emergency plans.
24

25 The following examples may assist with the understanding and identification of who may
26 be considered at-risk.
27

28 **Example #1**

29 An individual with HIV/AIDS who does not speak English and who contracts
30 influenza could easily find herself in a precarious situation. In addition to treatment
31 for influenza, her functional needs would be *medical care* (for the HIV/AIDS) and
32 *communication* (her lack of English may keep her from hearing about where and how
33 to access services). Without addressing those functional needs, she cannot get
34 healthcare services.
35

36 **Example #2**

37 During an influenza pandemic, the health status of an individual who receives home
38 dialysis treatment and who relies on a local Para-transit system to attend medical
39 appointments and food shopping could quickly become critical if 40% of the
40 workforce is ill and transportation is suspended. In addition to treatment for
41 influenza, his functional needs would be *medical care* (for dialysis) and
42 *transportation*. Without addressing those functional needs, he cannot get healthcare
43 services.
44

Hospital Preparedness Program At-Risk/Pediatric Resources:

- 1
- 2 • EMSC National Resource Center -
- 3 www.childrensnational.org/EMSC/PubRes/PDPreparedness.aspx
- 4
- 5 • Pediatric Disaster Resource and Training Center - www.chladisastercenter.org
- 6
- 7 • National Commission on Children and Disasters Interim Report, October 14, 2009 -
- 8 www.childrenanddisasters.acf.hhs.gov/20091014_508IR_partII.pdf
- 9
- 10 • Pediatric Terrorism and Disaster Preparedness Resource (PTDPR) -
- 11 www.ahrq.gov/RESEARCH/PEDPREP/resource.htm
- 12 • National Advisory Committee on Children and Terrorism (NACCT) -
- 13 www.bt.cdc.gov/children/
- 14 • Pediatric Terrorism and Disaster Preparedness: A Resource for Pediatricians (AHRQ) -
- 15 www.ahrq.gov/research/pedprep/pedresource.pdf
- 16 • Children in Disasters: Hospitals Guidelines for Pediatrics Preparedness, 3rd ed. 2008
- 17 (NYC DOHMH) - [www.nyc.gov/html/doh/downloads/pdf/bhpp/hepp-peds-](http://www.nyc.gov/html/doh/downloads/pdf/bhpp/hepp-peds-childrenindisasters-010709.pdf)
- 18 [childrenindisasters-010709.pdf](http://www.nyc.gov/html/doh/downloads/pdf/bhpp/hepp-peds-childrenindisasters-010709.pdf)
- 19 • Pediatric Disaster Hospital Tabletop Exercise Toolkit -
- 20 <http://www.nyc.gov/html/doh/html/bhpp/bhpp-focus-ped.shtml#1>
- 21 • Pediatric Terrorism Awareness Level Training, University of Kentucky Terrorism and
- 22 Response Program - www.kiprc.uky.edu/trap/peds.html

23 **EXAMPLE PRACTICES:**

24 **Children's Hospital Boston**

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

34 **Illinois Emergency Medical Services for Children (EMSC)**

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

5 **Miami Children’s Hospital**

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

12 **National Association of School Psychologists**

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

20 **New York City Department of Health and Mental Hygiene**

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

26 **FAMILY AND CAREGIVER RESOURCES:**

27 **American Academy of Pediatrics**

- 28 • **Family Readiness Kit: Preparing to Handle Disasters, 2nd Edition.** This kit is for
29 parents to use at home to help prepare for most kinds of disasters. It includes information
30 on understanding disasters; steps to take to prepare for a disaster involving your family;
31 family disaster supplies list; disaster fact sheets addressing hurricanes, earthquakes,
32 floods, tornadoes, tsunamis, winter storms, and terrorism, and is also available in
33 Spanish. (Accessed September 2008)
- 34 • **Children and Disasters.** This section of the American Academy of Pediatrics’ website
35 includes information about disaster preparedness for children, families, teachers and
36 others and offers a wide variety of resources including planning kits and reference
37 materials. (Accessed September 2008)

1 **American Red Cross**

- 2 • **Masters of Disasters**. This online resource is divided into educational areas for teachers
3 and children and includes a family readiness kit, games and other informational resources
4 to assist children in learning how to prepare for disasters. (Accessed September 2008)
- 5 • **Children and Disasters**. This section of the American Red Cross' website offers
6 resources for families and caregivers relating to disaster preparedness and children
7 including the collaborative American Red Cross and Federal Emergency Management
8 Agency (FEMA) document, Preparing for Disasters. (Accessed September 2008)
- 9 • **Pediatric Disaster Preparedness Coloring Books**. Be Ready 1-2-3 helps children ages
10 5 to 8 learn about home fires, earthquakes, and winter storms through activities and
11 demonstrations led by "experts" Cool Cat (Home Fires), Ready Rabbit (Winter Storms),
12 and Disaster Dog (Earthquakes). A second coloring book is also available for children
13 ages 3-10. (1993)

14 **Florida Institute for Family Involvement**

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

21 **National Association of Child Care Resource and Referral Agencies**

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

26 **NYU Child Study Center**

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

32 **Texas Department of State Health Services**

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

APPENDIX K: FY10 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.

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

3
4 **Emergency System for Advance Registration of Volunteer Health Professionals**
5 **(ESAR-VHP):** ESAR-VHP is a national network of state-based systems designed to
6 assist medical professionals in volunteering for disasters by providing verifiable, up-to-
7 date information regarding the health volunteer’s identity and licensing, credentialing,
8 privileging and certification to hospitals and other medical facilities that request their
9 services.

10
11 **Full-Scale Exercises (FSE):** A full-scale exercise is a multi-agency, multi-jurisdictional,
12 multi-discipline exercise involving functional (e.g., joint field office, emergency
13 operation centers, etc.) and "boots on the ground" response (e.g., firefighters
14 decontaminating mock victims).

15
16 **Functional Exercise (FE):** A functional exercise is a single or multi-agency activity
17 designed to evaluate capabilities and multiple functions using a simulated response. An
18 FE is typically used to: evaluate the management of Emergency Operations Centers,
19 command posts, and headquarters; and assess the adequacy of response plans and
20 resources.

21
22 **Hospital Available Beds for Emergencies and Disasters (HAvBED) System:**
23 HAvBED is a system of hospital bed definitions that provide uniform terminology for
24 organizations tracking the availability of beds in the aftermath of a public health
25 emergency or bioterrorist event. Definitions were vetted by members from Federal and
26 State governments, hospitals around the Nation, and the private sector for the following:
27 Licensed Beds, Physically Available Beds, Staffed Beds, Unstaffed Beds, Occupied Bed,
28 and Vacant/Available Beds. Beds also can be categorized according to the type of patient
29 they serve: Adult Intensive Care (ICU), Medical/Surgical, Burn or Burn ICU, Pediatric
30 ICU, Pediatrics, Psychiatric, Negative Pressure/Isolation, and Operating Rooms. For
31 purposes of estimating institutional surge capability in dealing with patient disposition
32 during a large mass casualty incident, the following bed availability estimates also may
33 be reported: 24-hour Beds Available and 72-hour Beds Available.

34
35 **Hospital Preparedness Program (HPP) Participating Hospitals:** HPP participating
36 hospitals are hospitals that receive funding, benefits, and/or services through the
37 State/Recipient’s Cooperative Agreement with HPP during the specified
38 funding/reporting period.

39
40 **Improvement Plan (IP):** An IP lists the corrective actions that will be taken, the
41 responsible party or agency, and the expected completion date. The IP is included at the
42 end of the AAR.

43
44 **Incident Commander (IC).** The IC is the individual responsible for all incident
45 activities, including the development of strategies and tactics and the ordering and release
46 of resources. The IC has overall authority and responsibility for conducting incident

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

3
4 **Incident Command System (ICS).** The ICS is a standardized on scene emergency
5 management construct specifically designed to provide for the adoption of an integrated
6 organizational structure that reflects the complexity and demands of single or multiple
7 incidents, without being hindered by jurisdictional boundaries. ICS is the combination of
8 facilities, equipment, personnel, procedures, and communications operating with a
9 common organizational structure, designed to aid in the management of resources during
10 incidents. ICS is used for all kinds of emergencies and is applicable to small as well as
11 large and complex incidents.

12
13 **Integration:** Integration is ensuring unity of effort among all levels of government and
14 all elements of a community.

15
16 **Mass Immunization:** An immunization is the introduction of antigens into the body in
17 order to stimulate the development of antibodies against a particular disease. Mass
18 immunization is the prophylaxis of large numbers of individuals (certain populations)
19 against a specific disease agent, usually within a prescribed period of time.

20
21 **Mass Prophylaxis:** Particular action(s) that lead to the prevention of disease or of the
22 processes that can lead to disease. Mass prophylaxis refers to the distribution of material
23 to large numbers of individuals (certain populations) to prevent them from contracting a
24 particular disease. A mass vaccination or prophylaxis plan or clinic can be implemented
25 for a variety of public health emergencies. Local health departments provide vaccination
26 or prophylaxis services for the general public in their jurisdiction, whereas hospitals
27 provide these services for their staff and families.

28
29 **National Incident Management System (NIMS):** The NIMS standard was designed to
30 enhance the ability of the United States to manage domestic incidents by establishing a
31 single, comprehensive system for incident management. It is a system mandated by
32 HSPD-5 that provides a consistent, nationwide approach for Federal, State, local, and
33 Tribal governments, the private sector, and non-governmental organizations to work
34 effectively and efficiently together to prepare for, respond to, and recover from domestic
35 incidents, regardless of cause, size, or complexity.

36
37 **National Preparedness Goal:** The National Preparedness Goal was set to achieve and
38 sustain capabilities that enable the Nation to successfully prevent terrorist attacks on the
39 homeland and rapidly and effectively respond to and recover from any terrorist attack,
40 major disaster, or other emergency that does occur in order to minimize the impact on
41 lives, property, and the economy.

42
43 **Negative Pressure/Isolation:** Beds provided with negative airflow, providing respiratory
44 isolation.

45
46 **Operations-Based Exercises:** Operations-based exercises are a category of exercises

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

7
8 **Personal Protective Equipment (PPE):** PPE is specialized clothing or equipment worn
9 by employees for protection against health and safety hazards. PPE is designed to protect
10 many parts of the body (e.g., eyes, head, face, hands, feet, and ears).

11
12 **Pharmaceutical Cache:** Pharmaceutical Caches are established to provide emergency
13 medical support in the event of a natural disaster, emergency, or terrorist attack. The
14 cache is a stockpile of medications, treatment kits, intravenous solutions, and other
15 medical supplies.

16
17 **Prophylaxis:** Prophylaxis refers to any medical or public health procedure whose
18 purpose is to prevent, rather than treat or cure, disease. Vaccines and antibiotics are
19 prophylactic: they are used before illness develop, either being administered to large
20 numbers of people in order to prevent infection, or in some cases (such as the smallpox
21 vaccine) to people who have been exposed to a disease but have not yet become ill.

22
23 **Public Information Officer (PIO):** The PIO is a member of the Command Staff
24 responsible for interfacing with the public, media, or with other agencies with incident
25 related information requirements. The responsibility of the Public Information Officer is
26 to ensure the rapid dissemination of accurate instructions and information to the public
27 and to the State using available public information systems.

28
29 **Redundant Communication:** Redundant communications is the use of multiple
30 communications capabilities to sustain business operations and eliminate single points of
31 failure that could disrupt primary services. Redundancy solutions include having multiple
32 sites where a function is performed, multiple communications offices serving sites, and
33 multiple routes between each site and the serving central offices.

34
35 **Secretary's Operation Center (SOC):** is the focal point for synthesis of critical public
36 health and medical information on behalf of the United States Government. During
37 emergency situations or exigent circumstances, the Secretary's Operations Center
38 coordinates incident management system responses for the Department of the Health and
39 Human Services (HHS).

40
41 **Tabletop Exercises (TTX):** TTX are intended to stimulate discussion of various issues
42 regarding a hypothetical situation. They can be used to assess plans, policies, and
43 procedures or to assess types of systems needed to guide the prevention of, response to,
44 or recovery from a defined incident. During a TTX, senior staff, elected or appointed
45 officials, or other key personnel meet in an informal setting to discuss simulated
46 situations. TTXs are typically aimed at facilitating understanding of concepts, identifying

1 strengths and shortfalls, and/or achieving a change in attitude. Participants are
2 encouraged to discuss issues in depth and develop decisions through slow-paced
3 problem-solving rather than the rapid, spontaneous decision-making that occurs under
4 actual or simulated emergency conditions.
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APPENDIX L: FY10 Hospital Preparedness Program (HPP)/AHRQ Awardee Resources

Training

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

Hospital Exercise Evaluation

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

Scarce Resource Management

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

Medical Surge Strategy Tools

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

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At-Risk/Pediatrics Resources

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

Pandemic Influenza

- Community-Based Mass Prophylaxis: A Planning Guide for Public Health Preparedness - www.ahrq.gov/research/cbmprophyl/cbmpro.htm
- Home Health Care During an Influenza Pandemic: Issues and Resources - 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)	\$ -	\$ -	\$ -

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APPENDIX N: FY10 Hospital Preparedness Program Funding by State, Selected Cities, and Territories

State/City/US Territory	Total Funding FY 10
Alabama	\$5,959,171
Alaska	\$1,295,371
Arizona	\$7,819,583
Arkansas	\$3,836,580
California	\$31,967,442
City of Chicago	\$3,874,144
Colorado	\$6,142,385
Connecticut	\$4,660,301
Delaware	\$1,513,099
District of Columbia	\$1,682,835
Florida	\$21,973,177
Georgia	\$11,615,246
Hawaii	\$2,025,920
Idaho	\$2,240,733
Illinois	\$12,357,745
Indiana	\$7,994,316
Iowa	\$4,039,814
Kansas	\$3,781,030
Kentucky	\$5,492,721
LA County	\$12,308,636
Louisiana	\$5,589,694
Maine	\$2,068,743
Maryland	\$7,166,017
Massachusetts	\$8,141,119
Michigan	\$12,483,796
Minnesota	\$6,633,486
Mississippi	\$3,954,888
Missouri	\$7,435,455
Montana	\$1,621,303
Nebraska	\$2,599,056
Nevada	\$3,462,259
New Hampshire	\$2,060,815
New Jersey	\$10,856,284
New Mexico	\$2,820,161
New York	\$13,666,210
New York City	\$10,250,742
North Carolina	\$11,012,906
North Dakota	\$1,254,791
Ohio	\$14,124,698
Oklahoma	\$4,748,620
Oregon	\$4,892,898
Pennsylvania	\$15,267,347

FY10 Hospital Preparedness Program Funding Opportunity Announcement

State/City/US Territory	Total Funding FY 10
Puerto Rico	\$5,162,374
Rhode Island	\$1,767,281
South Carolina	\$5,629,437
South Dakota	\$1,428,159
Tennessee	\$7,668,219
Texas	\$28,404,362
Utah	\$3,526,992
Vermont	\$1,240,595
Virginia	\$9,572,306
Washington	\$8,091,982
West Virginia	\$2,658,572
Wisconsin	\$7,095,720
Wyoming	\$1,111,323
Guam (US)	\$444,189
Virgin Islands (US)	\$379,165
Federated States of Micronesia	\$378,369
Northern Marianas Islands (US)	\$340,367
American Samoa (US)	\$318,662
Marshall Islands	\$316,983
Palau	\$273,406
Grand Total	\$390,500,000

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APPENDIX O: FY10 ASPR HPP - CDC PHEP Cooperative Agreement Crosscutting Initiatives Project

The CDC PHEP (BP10) CA asks awardees to use the CDC PHEP PAHPA elements below to help determine priorities.

HPP awardees shall coordinate all relevant crosscutting activities (**highlighted in blue**) with those executing through the CDC PHEP to facilitate collaboration and maximize economies of scale.

CDC PHEP BP10 CA (Appendix 1)

1. National Preparedness and Response, Leadership, Organization, and Planning
 - a. *Distribution of qualified countermeasures and qualified pandemic or epidemic products*
 - HPP awardees should coordinate distribution of HPP funded countermeasures and/or pandemic products for healthcare systems and related activities as appropriate with those executing through the CDC PHEP. (**HPP Guidance: 1.5.11 Pharmaceutical Caches/1.5.12 PPE – Page 27**)
 - b. Distribution of the Strategic National Stockpile
 - c. Logistical support for medical and public health aspects of federal responses to public health emergencies
 - d. *Addressing the needs of at-risk individuals*
 - HPP awardees should coordinate HPP funded at-risk activities with those executing through the CDC PHEP. (**HPP Guidance: 1.4.2 At-Risk – Page 12/APPENDIX J – Page 87**)
2. Public Health Security Preparedness
 - a. Evidence-based benchmarks and objective standards
 - b. State pandemic influenza plan
 - c. Matching requirements
 - d. *Near-real-time electronic nationwide public health situational awareness capability through an interoperable network of systems*
 - HPP awardees should coordinate HPP funded HAvBED activities with any situational awareness activities executing through the CDC PHEP. (**HPP Guidance: 1.5.4 HAvBED – Page 19 /APPENDIX E – Page 66**)
 - e. Tracking distribution of influenza vaccine in an influenza pandemic
 - f. Curriculum and training for laboratory workers
 - g. Assessment and evaluation of laboratory capacity
3. All-Hazards Medical Surge Capacity
 - a. *Analysis of community health care facilities*

- HPP awardees should coordinate any HPP funded healthcare system analysis of medical surge with similar activities executing through the CDC PHEP. (**HPP Guidance: 1.3.1 Capabilities-Based Planning/1.3.2 Gap Analysis – Page 9**)
- b. ***Adequate supply of volunteer health professionals***
 - HPP awardees should appropriately coordinate ESAR-VHP activities with those executing through the CDC PHEP. (**HPP Guidance: 1.5.5 ESAR-VHP – Page 20/APPENDIX F – Page 68**)
 - National verification of licenses and credentials via a single interoperable network
 - Waiver of licensing requirements in an emergency
- c. ***Curriculum and training for core health and medical response workers***
 - HPP awardees should coordinate HPP funded healthcare worker training with those executing through the CDC PHEP. (**HPP Guidance: 1.4.3 Education and Preparedness Training – Page 12**)

CDC PHEP CA: Component 2 (BP 10) Application for Funding

Component 2 includes program requirements, budget requirements, administrative requirements, and PAHPA requirements.

A. Program Requirements

Awardees should describe plans to address programmatic activities including the requirements noted below during the upcoming closeout year. The awardees should refer to the hyperlinks provided to ensure they are addressing all requirements, through a combination of responses in the BP9 mid-year progress report and the BP10 Application for Funding submission. (**CDC PHEP: Page 7-11**)

1. Comply with Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) guidelines.

PHEP awardees are required to describe how they work with their state Hospital Preparedness Program to continue adopting and implementing the *Interim ESAR-VHP Technical and Policy Guidelines, Standards, and Definitions (ESAR-VHP Guidelines – Appendix 8)*. FY10 applications for HPP funding should clearly describe how ESAR-VHP activities and funding are coordinated with those executing through the CDC PHEP. (**HPP Guidance: 1.5.5 ESAR-VHP – Page 20/APPENDIX F – Page 68**)

3. Engage the State Office for Aging or equivalent office in addressing the emergency preparedness, response, and recovery needs of the elderly.

Describe the activities the awardee will undertake in BP10 to further work with this resource on behalf of the elderly in awardee communities. FY10 applications for HPP funding should clearly describe how at-risk activities, including those for the elderly, are coordinated with those executing through the CDC PHEP. (**HPP Guidance: 1.4.2 At-Risk – Page 12/APPENDIX J – Page 87**)

1 **5. Collaborate with Centers for Public Health Preparedness (CPHP).**
2

3 Awardees should describe plans during BP10 to work with any of the 27 CPHPs
4 to develop, deliver, and evaluate competency-based training and education
5 programs based on identified needs of state and local public health agencies for
6 building workforce preparedness and response capabilities in conjunction with
7 the CPHP program. Remember to include any CPHP contracts in budget requests
8 (Appendix 12). FY10 applications for HPP funding should clearly describe how
9 healthcare worker education and training or related programs are coordinated
10 with those executing through the CDC PHEP. (HPP Guidance: 1.4.3 Education
11 and Preparedness Training – Page 12)
12

13 **8. Continue the Development of Mass Prophylaxis and Countermeasure**
14 **Distribution and Dispensing Operations.**
15

16 Countermeasure distribution and dispensing is defined in the Homeland Security
17 Presidential Directive 21 (HSPD-21), issued October 18, 2007, as a critical
18 component of public health and medical preparedness. While much has been
19 done to address this critical component of preparedness, existing plans and
20 procedures must be tested to demonstrate state and local operational capability.
21 In accordance with the requirements of HSPD-21, HHS must work with current
22 cooperative agreement programs to demonstrate specific capabilities in tactical
23 exercises and establish procedures to gather performance data from state and
24 local participants on a regular basis to assess readiness. Consequently, CDC has
25 included this mass prophylaxis section and the specified exercise requirements
26 below in the BP10 continuation guidance. FY10 applications for HPP funding
27 should clearly describe how distribution plans/procedures regarding HPP funded
28 countermeasures and/or pandemic products for healthcare systems and related
29 activities are coordinated with those executing through the CDC PHEP. FY10
30 applications should also describe HPP funded efforts to meet HPP exercise
31 requirement through coordination with CDC PHEP funded exercises. 1. (HPP
32 Guidance: 1.5.11 Pharmaceutical Caches/1.5.12 PPE – Page 27), 2. (HPP
33 Guidance: 1.4.4 Exercises, Evaluation and Corrective Actions – Page
34 13/APPENDIX C – Page 50)
35

36 a. Statewide

- 37 • Based on the state’s public health preparedness planning infrastructure,
38 describe the actions that will be taken during BP10 to ensure that within
39 each planning/local jurisdiction medical countermeasures can be rapidly
40 dispensed to the affected population.
41
42 • Describe actions that will be taken in BP10 to ensure that critical medical
43 supplies and equipment are appropriately secured, managed, distributed,
44 and restocked in a timeframe appropriate to the incident. Include a brief
45 discussion of plans to exercise statewide medical supplies management,
46 distribution plans, and personnel, and submit the resulting exercise after

1 action report(s) and improvement plan(s) to CDC's Division of Strategic
2 National Stockpile (DSNS) Program Preparedness Branch (PPB) mailbox
3 (sns_ppb@cdc.gov) by November 9, 2010. Note that all scheduled
4 exercises and documents also should be posted to LLIS or the National
5 Exercise Schedule (NEXS) (if access is available).
6

7 b. Cities Readiness Initiative (CRI)

- 8 • Describe the actions that will be taken by the planning/local
9 jurisdiction(s) within a CRI metropolitan statistical area (MSA) during
10 BP10 to achieve the point of dispensing (POD) standards provided by
11 DSNS.
12
- 13 • Describe plans to ensure that each planning/local jurisdiction within a
14 CRI MSA and the four directly funded cities conducts at least three
15 different drills from the range of eight possible drills and submits the
16 appropriate documentation no later than November 9, 2010.
17
- 18 • Describe plans to conduct at least one full-scale or functional exercise
19 that tests key components in mass prophylaxis/dispensing plans in
20 each CRI MSA (including the four directly funded cities) that includes
21 all pertinent jurisdictional leadership and emergency support function
22 leads, planning and operational staff, and all applicable personnel.
23 Submit the resulting applicable exercise data collection worksheet(s)
24 and after action report(s), to the DSNS PPB mailbox
25 (sns_ppb@cdc.gov) by November 9, 2010. All scheduled exercises
26 and documents should be posted to LLIS or NEXS (if access is
27 available).
28
- 29 • In an annual scheduling process between the DSNS program
30 consultants and the state and local coordinators, DSNS is responsible
31 for reviewing 25% of the CRI 10 MSA planning/local jurisdictions,
32 and the state is responsible for reviewing 75% of the CRI MSA
33 planning/local jurisdictions by August 9, 2010, using the DSNS Local
34 Technical Assistance Review tool in BP10 to further work with this
35 resource on behalf of the elderly in awardee communities.
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APPENDIX P: FY10 HPP Expert Panel: CA Guidance Recommendations

The HPP facilitated a meeting of experts in public health, hospital and healthcare delivery, and emergency preparedness and management on February 26, 2010 in Washington, DC to discuss challenges and recommendations regarding current HPP sub-capabilities and requirements, with a special emphasis on planning, conducting, and evaluating exercises and building partnerships and coalitions. The following are primary recommendation from the panel, and key areas in the FY10 HPP CA Guidance that provide direction.

Recommendations: Partnership and Coalition Building

HPP Guidance: 1.5.8 Partnership/Coalition Development – Page 23/APPENDIX A – Page 46

HPP guidance should encourage healthcare systems to function within partnerships, as regional coordination is essential to community resilience. HPP should focus on medical surge at the community level and the regional capability of healthcare systems, not individual hospitals. Entities that are important to include in community partnerships and coalitions include: hospitals, Public Health, Fire, Emergency Medical Services (EMS), Law Enforcement, Medical Reserve Corps (MRC) units, Behavioral Health (BH), mortuary services, and academic institutions. There is great variability among states on how to form and operationalize partnerships, and various working models of partnerships and coalitions that successfully leverage community emergency response assets. HPP funding should also encourage bringing in non-hospital partners.

In order for hospitals to invest into coalitions, they must understand the benefit of their participation in these activities. Awardees that have strong and successful partnership models could help to provide information to other Awardees on incentives that have motivated their partners to join a coalition. Benefits of an operational partnership include increased community resilience and learning from the experience of collaborative responses to real events.

Recommendations: Planning, Conducting, and Evaluating Exercises

HPP Guidance: 1.4.4 Exercises, Evaluations and Corrective Actions – Page 13/APPENDIX C – Page 50/APPENDIX O – Page 102

HPP state coordinators should clearly explain the benefits of performing required exercises. Hospitals can meet some of the Joint Commission requirements by performing HPP required exercises, but all should focus on larger multi-disciplinary exercises using HSEEP principles.

HPP and CDC PHEP awards could be used to collaborate on exercise requirements. Integrate HPP exercise requirements with CDC PHEP and Strategic National Stockpile

1 (SNS) exercises to satisfy requirements from both programs. Additionally, states could
2 adopt train-the-trainer models for the National Incident Management System (NIMS),
3 and HSEEP.
4

5 **HPP can encourage Awardees to demonstrate the value of the program through**
6 **exercises and routine events.** Exercises should be designed to test sub-capabilities that
7 the HPP funds have supported. Some Awardees can showcase their response to real-life
8 events as a measure of HPP's impact on their state's community emergency response
9 efforts. After action reports (AARs) could then be used as a tool to measure the
10 effectiveness of the program and dissemination of AARs can help to promote public
11 awareness of HPP and partners' activities. Additionally, HPP should encourage
12 Awardees to utilize DHS's Lessons Learned and Information Sharing (LLIS) website.
13 HPP Awardees should be reminded that the DHS LLIS site will remain a viable and
14 useful tool for information-sharing. **HPP Guidance: LLIS Information and URL –**
15 **Page 14**
16

17 **Recommendation: Federal Collaboration**

18

19 **HPP guidance should encourage state-level personnel who are involved with**
20 **preparedness planning grants and cooperative agreements to collaborate.** HPP could
21 work to strengthen the collective language in all preparedness related guidance's across
22 Agencies/Departments related to collaboration between individuals working on
23 preparedness issues. Personnel involved in the Center for Disease Control and
24 Prevention (CDC) Public Health Emergency Preparedness (PHEP) Program, the
25 Department of Homeland Security (DHS), and the HPP Cooperative Agreements should
26 collaborate from the beginning, including joint application writing sessions. **HPP**
27 **Guidance: 1.2.4 Integrating Preparedness Activities Across Federal Agencies – Page**
28 **9**
29