Centers for Disease Control and Prevention (CDC)
Procurement and Grants Office
Instructions for Preparing an Interim Progress Report
Catalog of Federal Domestic Assistance (CFDA) Number:
93.074 – National Bioterrorism Hospital Preparedness Program
and Public Health Emergency Preparedness Program
Funding Opportunity Announcement (FOA) Number: CDC-RFA-TP12-120102CONT13

Hospital Preparedness Program (HPP) and Public Health Emergency Preparedness (PHEP) Cooperative Agreements

Assistant Secretary for Preparedness and Response/National Healthcare Preparedness Programs
Centers for Disease Control and Prevention/Office of Public Health Preparedness and Response

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Eligibility and Available Funding

This award will be a continuation of funds intended only for awardees previously awarded under CDC-RFA-TP12-1201: Hospital Preparedness Program (HPP) and Public Health Emergency Preparedness (PHEP) Cooperative Agreements. A total of $928,796,000 is currently available for Budget Period 2, which begins July 1, 2013, and ends June 30, 2014. The funding amounts available are shown in Appendices 1, 2, and 3. These numbers are for planning purposes only and will be revised based on the final fiscal year 2013 budget.

The U.S. Department of Health and Human Services' (HHS) Office of the Assistant Secretary for Preparedness and Response (ASPR) and the Centers for Disease Control and Prevention (CDC) require awardees to submit their interim progress reports through www.Grants.gov. Awardees that encounter any difficulties submitting their interim progress reports through www.Grants.gov should contact CDC's Technical Information Management Section at (770) 488-2700 prior to the submission deadline. For further information regarding the application process, contact Glynnis Taylor at (770) 488-2752. For HPP-specific information, contact R. Scott Dugas at (202) 245-0732; for PHEP information, contact Sharon Sharpe at (404) 639-0817.

Reports must be submitted by **5 p.m. Wednesday, May 1, 2013**. Late or incomplete reports could result in a delay in the award, a reduction in funds, or other action. ASPR and CDC will accept requests for a deadline extension on rare occasions and after adequate justification has been provided.

Budget Period 2 Introduction

This guidance document is designed to assist awardees with developing a comprehensive Budget Period 2 funding application and to act as a reference guide for fiscal, programmatic, and administrative requirements of the Hospital Preparedness Program (HPP) and the Public Health Emergency Preparedness (PHEP) cooperative agreements.

Awardees should refer to the CDC-RFA-TP12-1201 funding opportunity announcement (http://www.cdc.gov/phpr/documents/cdc-rfa-tp12-1201_4_17_12_FINAL.pdf) for the HPP and PHEP cooperative agreements for overarching guidance on the description, background, program implementation, and recipient activities. The purpose of the 2012-2017 HPP-PHEP cooperative agreement programs is to provide technical assistance and resources that support state, local, territorial, and tribal public health departments and healthcare systems/organizations in demonstrating measurable and sustainable progress toward achieving public health and healthcare preparedness capabilities that promote prepared and resilient communities.

Budget Period 2 should serve as a continuation of activities designed to develop, sustain, and demonstrate progress toward achieving the public health and healthcare preparedness capabilities. This capabilities-based model assists state and local planners in identifying gaps in preparedness, determining specific jurisdictional priorities, and developing plans for building and sustaining specific public health and healthcare capabilities. More information on the capabilities can be found at

http://www.phe.gov/Preparedness/planning/hpp/reports/Documents/capabilities.pdf and http://www.cdc.gov/phpr/capabilities/DSLR_capabilities_July.pdf .

Awardees should continue to improve collaborative efforts to ensure that public health and healthcare system planning and response are coordinated and integrated. Awardees can use HPP and PHEP cooperative agreement funding for activities and infrastructure that support this collaboration.

In addition to greater HPP and PHEP alignment, Budget Period 2 will focus on collaboration with the U.S. Department of Homeland Security's (DHS) Federal Emergency Management Agency (FEMA) and other federal emergency preparedness programs. This collaboration will better support public health, healthcare preparedness, homeland security, and emergency management coordination. Budget Period 2 funding applications should describe engagement among the following stakeholders in the public and private sectors, as applicable: emergency management, public health, healthcare, law enforcement, transportation, and other entities that distribute grant funds and/or provide technical assistance and national strategies in support of preparedness activities.

Presidential Policy Directive (PPD) 8: National Preparedness, issued in March 2011, strengthens the country's security and resilience by systematically preparing for the threats that pose the greatest risk to the nation's security. PPD 8 directed the development of a National Preparedness Goal (NPG), which defines the core capabilities necessary to strategically prepare for the specific types of incidents that pose the greatest risk to the nation's security. The core capabilities establish a common framework in which agencies can work together to improve national preparedness.

The core capabilities are designed to ensure that preparedness, response, and recovery operations are comprehensive, synchronized, and mutually supportive. Of the 31 NPG core capabilities, one focuses specifically on public health and medical components; however, many of the other core capabilities contain public health and medical components necessary for successful implementation of the NPG. ASPR's *Healthcare Preparedness Capabilities: National Guidance for Healthcare System Preparedness* and CDC's *Public Health Preparedness Capabilities: National Standards for State and Local Planning* inform state and local activities that operationally support these public health and medical components of the core capabilities.

For instance, two public health and healthcare capabilities support the public information and warning core capability to deliver coordinated, prompt, reliable, and actionable information to the whole community. Public health agencies are responsible for disseminating critical health and safety information to alert the media, public, and other stakeholders to potential health risks and reduce the risk of exposure to ongoing and potential hazards, while hospitals and healthcare coalitions are responsible for assessing an incident's impact on healthcare delivery to determine immediate healthcare organization resource needs to assist with developing processes for notification and information exchange between relevant response partners, stakeholders, and healthcare organization.

HPP and PHEP projects must be conducted in a coordinated manner with FEMA and other preparedness agencies, and HPP-PHEP funding applications should describe operational and complementary engagement among emergency management, public health, health care, law enforcement, transportation, and other preparedness programs as applicable. For example, in the NPG's prevention mission area, conducting biosurveillance is one of the critical tasks of the Screening, Search, and Detection core capability. This critical task is led collaboratively by DHS, HHS, and the U.S. Department of Justice (DOJ). Funding and planned activities should be coordinated among these lead federal departments to capitalize on common interests and avoid redundancy.

HPP-specific changes for Budget Period 2 better align HPP priorities with those of the PHEP program and other federal partners, resulting in fewer HPP stand-alone requirements and reducing the awardee reporting burden. For example, HPP training and exercise plans are more closely coordinated with PHEP plans, and the HPP-PHEP risk assessment requirements are aligned with FEMA's Threat and Hazard Identification and Risk Assessment (THIRA) process. Routine progress reports are now due exclusively during the application, mid-year, or end-of-year reporting cycles, and, to simplify reporting, the HPP application budget remains focused on the function level. In Budget Period 2, HPP and PHEP work plans now must address capability goals, objectives, and planned activities.

PHEP-specific changes for Budget Period 2 include modifications to medical countermeasure planning and reporting processes. CDC will no longer use the medical countermeasure distribution and dispensing (MCMDD) composite measure as a collective indicator of preparedness and operational capability within local/planning jurisdictions, CRI areas, states, directly funded cities, territories, and freely associated states. CDC will continue to conduct annual technical assistance reviews (TARs) of all 62 PHEP awardees but will implement in Budget Period 2 a progress report format in lieu of the standard TAR. This will allow CDC to maintain accountability in Budget Period 2 for medical countermeasure planning while redesigning the TAR tool for Budget Period 3. This change also provides more time for awardees to focus on the recommendations and operational gaps identified in prior TAR assessments.

Lastly, ASPR and CDC recognize the unique infrastructure and geographic challenges faced by the U.S. territories and freely associated states that receive limited HPP and PHEP cooperative agreement funding. These jurisdictions include the territories of American Samoa, Commonwealth of the Northern Mariana Islands, Guam, and U.S. Virgin Islands and the freely associated states including Federated States of Micronesia, Republic of the Marshall Islands, and Republic of Palau. Consequently, ASPR and CDC have responded by modifying the HPP and PHEP requirements that these awardees can realistically achieve in Budget Period 2. More details can be found in Appendix 9.

Program Requirements

For HPP-PHEP Budget Period 2, awardees must address and comply with joint program requirements, as well as specific HPP and PHEP requirements. See Appendix 9 for modified requirements for American Samoa, Commonwealth of the Northern Mariana Islands, Guam, and U.S. Virgin Islands and the freely associated states including Federated States of Micronesia, Republic of the Marshall Islands, and Republic of Palau.

Joint HPP-PHEP Requirements

1. Cross-Discipline Coordination

   - Foster greater HPP and PHEP program alignment and collaboration with other federal preparedness programs. Awardees must continue to coordinate public health and healthcare preparedness program activities. Awardees can use HPP and PHEP funding to support coordination activities and must track accomplishments.

     HHS strongly encourages awardees to work collaboratively with other federal health and preparedness programs in their jurisdictions to maximize resources and prevent duplicative

efforts. Specifically, the DHS Homeland Security Grant Program grants provide preparedness funding to build the 31 NPG core capabilities, many of which have public health and healthcare system activities. In addition, although no longer funded by DHS as a stand-alone grant program, many activities and objectives associated with the Metropolitan Medical Response System (MMRS) grant program may be considered allowable costs for HPP and PHEP programs as well as the DHS Homeland Security Grant Program and will be considered on a case-by-case basis.

Public health department and the healthcare sector awardees must actively participate with their emergency management and public safety partners in FEMA's annual State Preparedness Report (SPR), which is a self-assessment of preparedness capabilities in comparison with target capabilities established in the state THIRA. The Post-Katrina Emergency Management Reform Act of 2006 (PKEMRA), at 6 U.S.C. § 752, requires an SPR from any state or territory receiving federal preparedness assistance administered by DHS. Those jurisdictions submit an annual SPR to FEMA. Awardees should contact their jurisdiction's state administrative agency to identify the appropriate SPR point of contact. This will ensure that the state report reflects the full range of preparedness activities occurring in each jurisdiction.

Additionally, as the daily delivery of public health and healthcare (e.g. Accountable Care Organizations, Health Information Exchanges, etc.) impacts both public health and healthcare preparedness and response, awardees are to consider linkages with programs and activities that would improve the ability to execute the public health or healthcare preparedness capabilities.

- Conduct jurisdictional risk assessments. Awardees are required to conduct jurisdictional risk assessments (JRA) to identify potential hazards, vulnerabilities, and risks within the community, including interjurisdictional (e.g., cross-border) risks as appropriate, that relate to the public health, medical, and mental/behavioral systems and the functional needs of at-risk individuals. Findings from the jurisdictional risk assessments should inform capability-based planning, prioritize preparedness investments, and serve as a basis for coordinating with emergency management.

  HPP and PHEP awardees must coordinate activities with their emergency management and homeland security counterparts. ASPR and CDC recognize that independently administered public health and healthcare system JRAs and their planning priorities may differ from emergency management and homeland security risk assessment findings. However, risk assessments must be coordinated with relevant emergency management and homeland security programs to account for specific factors that affect the community. Active coordination supports "whole community" planning, informs the comprehensive jurisdictional THIRA process, and contributes to overall preparedness and response planning efforts, including Homeland Security Grant Program and Emergency Management Performance Grant funding opportunity announcement requirements. More specific THIRA information is available at http://www.fema.gov/plan.

- Establish senior advisory committees. Awardees must establish and maintain advisory committees of senior officials from governmental and nongovernmental organizations involved in homeland security, healthcare, public health, and behavioral health to help integrate preparedness efforts across jurisdictions and to maximize funding streams. This will enable HPP and PHEP programs to better coordinate with relevant public health, healthcare, and preparedness programs.

The senior advisory committee must include regional officials directly responsible for administering DHS preparedness grants and ASPR and CDC preparedness cooperative agreements. These include:

- State administrative agency (SAA),
- Jurisdictional HPP director, principal investigator, or coordinator,
- Jurisdictional PHEP director or principal investigator,
- Jurisdictional emergency management agency representative,
- Jurisdictional emergency medical services representative,
- Jurisdictional medical examiner, and
- Jurisdictional hospital representative.

In addition, awardees are strongly encouraged to include healthcare coalition representatives as applicable, as well as representatives from additional disciplines (e.g., legal, Medicare, Medicaid, private insurance), local jurisdictions and associations, regional working groups, and other whole community partners.

- Obtain public comment and input on public health emergency preparedness and response plans and their implementation using existing advisory committees or a similar mechanism to ensure continuous input from other state, local, and tribal stakeholders and the general public including those with an understanding of at-risk individuals and their needs.

- Comply with SAFECOM requirements. Awardees and subawardees that use federal preparedness grant funds to support emergency communications activities must comply with the fiscal year 2013 SAFECOM Guidance for Emergency Communications Grants. The guidance provides recommendations to awardees seeking federal grant funding for interoperable emergency communications projects; grants management best practices for administering emergency communications grants; and information on standards that ensure greater interoperability. The guidance is intended to ensure that federally funded investments are compatible and support national goals and objectives for improving nationwide interoperability. SAFECOM guidance is available at http://www.safecomprogram.gov.

2. Administrative Preparedness

- Continue to develop and implement administrative preparedness strategies. Awardees should work with their local public health jurisdictions to strengthen administrative preparedness planning. Such planning should address, among other things, emergency use authorizations and public health and law enforcement collaboration. See Appendix 10 for resources to guide these efforts.

- Monitor subawardee activities. As required by 45 CFR Part 92.40, awardees must monitor activities supported by grants and subgrants to ensure compliance with applicable federal requirements and that the performance goals are being met. See Appendix 10 for resources to guide these efforts.

3. Capabilities Development

Awardees must address and comply with the following Budget Period 2 requirements.

- Achieve progress on capability development. In Budget Period 2, HPP and PHEP cooperative agreement funds will be used to build and sustain capability development at the state and local levels through associated planning, personnel, equipment, training, exercises, and healthcare coalition development. Funded activities, including sustainment activities to preserve current capabilities, should demonstrate measurable and sustainable progress toward achieving public health and healthcare preparedness capabilities that promote prepared and resilient communities.

- Develop short-term capability goals and objectives. Awardees must develop short-term goals, supporting objectives, and planned activities for the capabilities they are addressing in Budget Period 2. For both programs, these short-term goals, objectives, and planned activities should support the long-term goals to achieve each program's capabilities over the five-year project period. Capability short-term goals, supporting objectives, and planned activities must have measurable outputs linked to program activities and outcomes.

  HPP awardees must continue to address capability required resource elements in the capabilities plan component of the Budget Period 2 work plan, outlining the status of completion or progression from the Budget Period 1 capabilities plan. Also, HPP budget allocations will continue to be focused at the function level. In addition to these requirements, and before funding additional activities based on the prioritization process, specific capability components must be fully addressed as described below.

- Comply with application and reporting requirements. Awardees must complete and submit all required funding application components, including project narratives, work plans, and budgets, with an emphasis on short-term (Budget Period 2) and long-term (project period) plans to address the *Healthcare Preparedness Capabilities: National Guidance for Healthcare System Preparedness* and the *Public Health Preparedness Capabilities: National Standards for State and Local Planning*. In addition, awardees must report during the mid-year and end-of-year reporting cycles on the status of planned activities described in the work plans submitted as part of the funding applications.

- Continue to develop healthcare coalitions. Awardees are expected to continue to develop or refine healthcare coalitions as outlined in ASPR's *Healthcare Preparedness Capabilities: National Guidance for Healthcare System Preparedness*, Capability 1: Healthcare System Preparedness, Function 1: Develop, refine, and sustain healthcare coalitions; and in Capability 10: Medical Surge, Function 1: The healthcare coalition assists with the coordination of the healthcare response during incidents that require medical surge. PHEP awardees should strongly encourage and promote local health department participation in healthcare coalitions to the maximum extent possible.

Healthcare coalitions are expected to develop throughout the five-year project period following a staged approach. The development of a coalition is based on the assessment of functionality associated with Capability 1: Healthcare System Preparedness. Awardees and their project officers will collaborate on the timeline for the development of the coalition. A coalition development rating system will be released in concert with the HPP performance measures.

- Coordinate HPP-PHEP Training and Exercise Programs. Training and exercise activities must support jurisdictional priorities. These priorities are generally informed by risk assessments and operational gaps identified during self-assessments, exercises, and actual response/recovery operations. Preparedness exercises must be conducted according to the Homeland Security Exercise and Evaluation Program (HSEEP).

  For Budget Period 2, awardees must submit an updated multiyear training and exercise plan (MYTEP). PHEP awardees must conduct at least one PHEP annual exercise during Budget Period 2; HPP awardees must submit a Budget Period 2 gap-based training schedule and also perform and evaluate required exercises within the five-year project period. Additionally, all awardees must conduct one joint, full-scale exercise (FSE) during the five-year project period and must submit exercise documentation according to the established evaluation and progress reporting requirements contained in Appendix 7.

  In addition, there must be evidence in the Budget Period 2 work plans, budget justifications, and technical assistance plans that all training is purposefully designed to close operational gaps and sustain jurisdictionally required preparedness competencies. For HPP awardees this includes National Incident Management System (NIMS) documentation requirements outlined in Appendix 7. Awardees must report on preparedness training conducted during Budget Period 2 in their annual progress reports, describing the impact that training had on the jurisdictions.

  Other federally funded preparedness programs have similar exercise and training requirements which could provide collaborative opportunities. Exercise and training activities should be coordinated across the jurisdiction(s) to the maximum extent possible with the purpose of including the whole jurisdictional community. Exercises conducted by other preparedness grant programs with similar exercise requirements may be used to fulfill the annual HPP-PHEP exercise requirements if HHS preparedness capabilities are tested and evaluated. Awardees are encouraged to invite participation from representatives/planners involved with other federally mandated or private exercise activities. At a minimum, ASPR and CDC encourage HPP and PHEP awardees to share their MYTEP schedules with those departments, agencies, and organizations included in their plans.

- Meet Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) compliance requirements. The ESAR-VHP compliance requirements identify capabilities and procedures that state ESAR-VHP programs must have in place to ensure effective management and interjurisdictional movement of volunteer health personnel in emergencies. Awardees must coordinate with volunteer health professional

entities and are encouraged to collaborate with the Medical Reserve Corps (MRC) to facilitate the integration of MRC units with the local, state, and regional infrastructure to help ensure an efficient response to a public health emergency. More information about the MRC program can be found at www.medicalreservecorps.gov or MRCcontact@hhs.gov.

- Engage in technical assistance planning. Awardees must actively work with ASPR and CDC project officers to update existing awardee technical assistance plans quarterly or more frequently if needed to include Budget Period 2 activities. The consolidated HPP-PHEP technical assistance plans will include awardee-identified and project officer-identified technical assistance needs and a joint strategy for addressing those needs. The updated technical assistance plans following the quarter ending December 31, 2013, satisfy mid-year technical assistance reporting requirements.

- Plan and conduct joint site visits. Awardees should be actively involved in the planning and execution of routine site visits conducted by ASPR and CDC project officers to assess the activities, progress, and challenges of awardees. Awardees shall maintain all program documentation that substantiates achievement of capabilities, performance measures, and other programmatic requirements, including all-hazards public health emergency preparedness and response plans, and make those documents available to ASPR and CDC staff, as requested, during site visits or through other requests. Awardees should plan to host site visits every 12 to 18 months.

- Participate in mandatory meetings and training. The following Budget Period 2 meetings are considered mandatory, and annual travel budgets should include travel funds for the following HPP and PHEP staff:
  - Program director or coordinator to participate in the annual Public Health Preparedness Summit sponsored by NACCHO
  - Two designated staff members to participate in the Directors of Public Health Preparedness annual meeting sponsored by ASTHO

  In addition, awardees must participate in other mandatory training sessions that may be conducted via webinar or other remote meeting venues. Examples include:
  - HPP performance measurement refinement processes (e.g. webinars, surveys, etc.)
  - HPP 2013 performance measurement introductory training
  - HPP/HPP-PHEP training on new information technology system for electronic reporting of performance measurement data

4. Meet National Incident Management System (NIMS) compliance requirements. Awardees must meet NIMS requirements and adhere to national guidance and policies set forth in publications such as the National Response Framework, Presidential Policy Directive 8: National Preparedness, the National Preparedness Goal, and the National Preparedness System. In addition, awardee jurisdictions must conduct operations in accordance with the Incident Command System and applicable Hospital Incident Command Systems. HPP awardees must update NIMS information submitted during Budget Period 1 with applicable changes. See Appendix 7 for more detailed information.

5. Engage the state office on aging or equivalent office in addressing the public health emergency preparedness, response, and recovery needs of older adults. Awardees must provide evidence that this state office or equivalent is engaged in the jurisdictional planning process.

6. Develop preparedness and response strategies and capabilities that address the public health, mental/behavioral health, and medical needs of at-risk individuals in the event of a public health emergency. Awardees must have structures or processes in place, including the use of functional needs assessments, to ensure the needs of at-risk individuals are included in response strategies and the needs are identified and addressed in operational plans. In addition, awardees are encouraged to coordinate emergency preparedness planning with state and local agencies that provide services for disabled populations, including pregnant women and women of childbearing age, and those with functional disabilities. At risk-individuals include children, senior citizens, and pregnant women. In addition, individuals in need of additional response assistance may 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.

7. Utilize Emergency Management Assistance Compact (EMAC) or other mutual aid agreements for medical and public health mutual to support coordinated activities and to share resources, facilities, services, and other potential support required when responding to public health emergencies.

8. Submit influenza pandemic preparedness plans as required by Sections 319C-1 and 319C-2 of the Public Health Service Act and amended by the Pandemic and All-Hazards Preparedness Act (PAHPA). ASPR and CDC have determined that awardees can satisfy the 2013 annual requirement through the required submission of other program data such as the 2013 capability self-assessment and Budget Period 2 application that provide ample evidence on the status of state and local influenza pandemic response readiness as well as the barriers and challenges to preparedness and operational readiness. ASPR and CDC will review these data to develop summary reports on operational readiness for influenza pandemic response and use these reports to enhance pandemic and all-hazards preparedness through individual awardee technical assistance plans.

9. Provide performance measure data. Awardee performance reporting provides critical information needed to evaluate how well HPP and PHEP funding has improved the nation's ability to prepare for and respond to public health emergencies. ASPR and CDC used the performance measure data collected at Budget Period 1 mid-year to determine the need for further refinements to the measures based on real-world experience and data.

   ASPR and CDC expect to release Budget Period 2 performance measure guidance, including new reporting requirements, by June 2013. Expected modifications to the performance measures changes may include, but are not limited to, fewer performance measures and required data elements as well as changes to select existing measures. The new guidance will supersede performance measure

requirements outlined in the HPP and PHEP Budget Period 1 Performance Measures Specifications and Implementation Guidance documents and Appendices 6 and 9 of the CDC-RFA-TP12-1201 funding opportunity announcement.

Performance measures considered provisional in Budget Period 1 and retained for Budget Period 2 will no longer be considered provisional and will be subject to public dissemination by ASPR and CDC. Any new measures introduced in Budget Period 2 may be considered provisional with the public release of these data restricted to the extent allowable by law. All other measures may be subject to public dissemination.

To reduce reliance on performance measurement and overall reporting burden, ASPR and CDC intend to explore other methods of evaluating awardee capability and performance. Examples may include site visits by evaluation staff, analysis of after-action reports and similar documents, measurement based on local, regional, or statewide responses, and other forms of evaluation. Awardees are encouraged to consider future requests by ASPR or CDC to conduct these activities in their jurisdictions.

PHEP-specific Provisions

To reduce reporting burden on the majority of island jurisdictions, the following PHEP awardees will not be required to report PHEP performance measures data in Budget Period 2: American Samoa, Commonwealth of the Northern Mariana Islands, Guam, Federated States of Micronesia, Republic of the Marshall Islands, Republic of Palau, and U.S. Virgin Islands. However, these awardees will be required to submit data on newly developed performance goals specifically designed to assess fundamental aspects of preparedness in these jurisdictions (see Appendix 9). In addition, these awardees will be required to submit data for the two HPP-PHEP performance measures (currently 6.1 and 15.1) related to the information sharing and volunteer management capabilities.

In addition, the PHEP program, in collaboration with CDC's Epidemiology and Laboratory Capacity program as well as CDC's Office of Surveillance, Epidemiology and Laboratory Services (OSELS), intends to pilot performance measures related to electronic laboratory reporting (ELR). Further guidance and reporting requirements will be released in Budget Period 2.

Performance Measure Reporting Requirements

For planning purposes, including contract negotiation with subawardees, HPP and PHEP awardees should adhere to reporting requirements as stated in these programs' respective performance measures guidance documents. ASPR's Fiscal Year 2012 Hospital Preparedness Program (HPP) Performance Measure Manual Guidance for Using the New HPP Performance Measures can be found at http://www.phe.gov/Preparedness/planning/evaluation/Documents/fy2012-hpp-082212.pdf. CDC's PHEP Budget Period 1 Performance Measure Specifications and Implementation Guidance is available at http://www.cdc.gov/phpr/documents/PHEP+BP1+PM+Specifications+and+Implementation+Guidance_v1_1.pdf.. The updated HPP and PHEP performance measure guidance documents to be released by ASPR and CDC by June 2013 will include detailed reporting requirements for Budget Period 2. ASPR and CDC recommend that awardees reflect performance measure requirements, including contingencies for possible changes to these requirements, in contracts, memoranda of understanding, and other binding documents with subawardees.

HPP and PHEP awardees are required to report Budget Period 2 performance measure and related evaluation and assessment data to ASPR and CDC. Budget Period 2 performance measures include

those that are specific to HPP, specific to PHEP, and a subset of performance measures jointly developed by ASPR and CDC used to satisfy the requirements of both programs. Supporting data related to the HPP and HPP-PHEP performance measures may be solicited from HPP and PHEP awardees during both the mid-year (January 31, 2014) and the end-of-year (September 30, 2014) reporting cycles for Budget Period 2. ASPR and CDC may reach out to awardees and other partners to gain insight and feedback on existing measures as well as suggestions for improvement.

10. Meet evidence-based benchmarks. ASPR and CDC have specified a subset of measures and select program requirements as benchmarks as mandated by Sections 319C-1 and 319C-2 of the PHS Act as amended by PAHPA. Awardees must document, or demonstrate, that they have met or substantially met a benchmark by providing complete and accurate information describing how the benchmark was met. ASPR and CDC expect awardees to achieve, maintain, and report on benchmarks throughout the five-year project period. Data for select HPP and PHEP benchmarks are required to be submitted no later than January 31, 2014, as part of the mid-year progress report, or as otherwise indicated by ASPR or CDC (. e.g., Laboratory Response Network proficiency testing, etc.). Note that a key benchmark for both programs, "demonstrated adherence to application and reporting deadlines," requires timely submission of applicable information throughout Budget Period 2 – not just at mid-year.

    HPP and PHEP benchmarks can be found in Appendices 4 and 5.

    Awardees should review funding opportunity announcement CDC-RFA-TP12-1201 for information on PAHPA accountability provisions and enforcement actions and disputes, as well as withholding and repayment guidance.

HPP Requirements

1. Comply with HAvBED (National Hospital Available Beds for Emergencies and Disasters**)** standards. While this requirement is no longer an HPP benchmark, awardees still are required to maintain and refine an operational bed tracking, accountability/ availability system compatible with the HAvBED data standards and definitions. Systems must be maintained, refined, and adhere to all requirements and definitions included in the CDC-RFA-TP12-1201funding opportunity announcement, with the ongoing ability to submit required data to the HHS Secretary's Operations Center (HHS SOC) using either the HAvBED Web portal or the HAvBED EDXL Communication Schema (found at https://havbedws.hhs.gov). Information and technical assistance will be provided to awardees on both options. The HAvBED Web portal is available at https://havbed.hhs.gov.

2. Identify existing healthcare coalitions. Awardees must update the following basic information about the healthcare coalitions that exist within their states in their annual progress reports.

    - For each coalition, identify the:
        - Coalition name;
        - Coalition members by type (see Appendix 6), name, and national provider identification (NPI) number;

- Coalition stage of development;
- Coalition point of contact (POC) name;
- POC telephone number;
- POC street address;
- POC e-mail address; and
- Coalition Web site address (if one exists)

o An updated coalition map that delineates the geographic boundaries of all the coalitions within the state.

In partnership with each HPP awardee, all identified coalitions may be asked to complete a questionnaire to describe their characteristics and functions. ASPR will use this data to update information on existing coalitions. Results will be shared with the awardees.

PHEP Requirements

1. Seek local health department and tribal concurrence *(applicable to decentralized state health departments and those with federally recognized tribes).* Awardees must consult with local public health departments, American Indian/Alaska Native tribes, or other subdivisions within the jurisdiction to reach consensus, approval, or concurrence on the overall strategies, approaches, and priorities described in their work plans. Awardees who are unable to gain 100% concurrence, must address the reasons for lack of concurrence.

2. Coordinate with cross-cutting public health preparedness partners. PHEP program components as a whole should complement and be coordinated with other public health, healthcare, and emergency management programs as applicable. For example, some public health laboratory, surveillance and epidemiological investigation, and information sharing capability functions may mutually support activities described within CDC's Epidemiology and Laboratory Capacity (ELC) for Infectious Diseases cooperative agreement. PHEP awardees also should work with immunization programs and partners on syndromic surveillance and other activities to assure preparedness for vaccine-preventable diseases, influenza pandemics, and other events requiring a response. In addition, preparedness planning across jurisdictions (e.g., cross-border) and multiple disciplines, to include U.S. border health preparedness and response activities for the states sharing an international boundary with Canada and Mexico, will better prepare awardees to assess, notify, and respond to natural, accidental, or deliberate public health events.

3. Assure compliance with the following requirements. Unless otherwise noted, no specific narrative response or attachment is necessary as CDC's Procurement and Grants Office (PGO) considers that acceptance of the Budget Period 2 funding awards constitutes assurance of compliance with these requirements.
   - Maintain a current all-hazards public health emergency preparedness and response plan and submit to CDC when requested and make available for review during site visits.
   - Submit required program progress reports and financial data, including progress in achieving evidence-based benchmarks and objective standards; performance measures data including data from local health departments as applicable; the outcomes of annual preparedness exercises including strengths, weaknesses and associated corrective actions;

accomplishments highlighting the impact and value of the PHEP program in their jurisdictions; and descriptions of incidents requiring activation of the emergency operations center and Incident Command System. Reports must describe:
    - preparedness activities that were conducted with PHEP funds;
    - purposes for which PHEP funds were spent and the recipients of the funds;
    - the extent to which stated goals and objectives as outlined in awardee work plans have been met; and
    - the extent to which funds were expended consistent with the awardee funding applications.
- In coordination with the Hospital Preparedness Program, inform and educate hospitals and healthcare coalitions within the jurisdiction on their role in public health emergency preparedness and response. (Capability 10: Medical Surge, Function 1: Assess the nature and scope of the incident.)
- Submit an independent audit report of PHEP expenditures every two years to the Federal Audit Clearinghouse within 30 days of receipt of the report.
- Have in place fiscal and programmatic systems to document accountability and improvement.
- Provide CDC with situational awareness data generated through interoperable networks of electronic data systems. (Capability 6: Information Sharing.)

Please note the following two annual requirements apply only to those awardees funded for these activities.

4. Comply with Cities Readiness Initiative (CRI) guidelines. To align with the PHEP cooperative agreement's capabilities-based approach, CRI requirements support Capability 8: Medical Countermeasure Dispensing and Capability 9: Medical Materiel Management and Distribution. As described in those capabilities, CRI supports medical countermeasure distribution and dispensing (MCMDD) for all-hazards events. In Budget Period 2, CDC will no longer use the MCMDD composite measure as an indicator of MCMDD preparedness and operational capability within local/planning jurisdictions, CRI areas, states, directly funded localities, territories, and freely associated states. Instead, Budget Period 2 CRI requirements include a minimum TAR local progress report score of 69 (average of all CRI jurisdictional local TAR scores in a single state). Each local planning jurisdiction within the 72 CRI metropolitan statistical areas, including the four directly funded localities, must conduct three different drills during Budget Period 2. The results of the drill data submissions and compliance with dispensing and distribution standards will be reviewed during site visits to evaluate local MCMDD preparedness.

5. Continue Level 1 chemical laboratory surge capacity activities. The 10 awardees must address objectives related to chemical emergency response surge capacity as outlined in Capability 12: Public Health Laboratory Testing, including staffing and equipping the lab, maintaining critical instrumentation in a state of readiness, training and proficiency testing for staff, and participating in local, state, and national exercises. In addition, awardees must describe how they plan to increase their laboratory capabilities and capacities consistent with the Laboratory Response Network for chemical terrorism program objectives, including the

addition of new high-throughput sample preparation and analysis techniques and analytical capability for new threat agents.

Preparing and Submitting Budget Period 2 Interim Progress Reports/Funding Applications

Funding applications are due 60 calendar days after the Budget Period 2 continuation guidance is posted on www.grants.gov. Awardees must download the SF-424 application package associated with this continuation guidance from www.grants.gov.

Accessing Required Application Package

- Go to: www.Grants.gov
- Select: "Apply for Grants"
- Select: "Step 1: Download a Grant Application"
- Insert the Funding Announcement Number only, formatted as:
  - CDC-RFA-TP12-1201-2CONT13
- Download application package and complete all sections.

Checklist of Required Application Contents

The mandatory application package associated with this funding opportunity includes:

- Application for Federal Domestic Assistance-Short Organizational Form (SF424)
- SF-424A Budget Information for Non-Construction Programs
- Budget Justification
- Indirect Cost Rate Agreement
- Project Narrative Attachment Form
- Other Attachments Forms (1 each unless otherwise noted)
  - Attachment A: Additional SF-424A
  - Attachment B: Budget Justification
  - Attachment C: Budget Detail
  - Attachment D: Budget Association to Work Plan
  - Attachment E: Additional Indirect Cost Rate Agreement
  - Attachment F: Additional Project Narrative
  - Attachment G: Work Plan (Capabilities Plan - one each for HPP and PHEP)
  - Attachment H: Local Concurrence Letters (applicable PHEP awardees) or documentation of negotiation process
  - Attachment I: Tribal Concurrence Letters (applicable PHEP awardees only) or negotiation documentation of process
  - Attachment J: Standard Operating Procedures for Subawardee Monitoring (optional if SOPs fully addressed in project narrative)
  - Attachment K: Subawardee Contracts Plan (optional)
  - Attachment L: Budget Change Report (optional carry-over request)

Application for Federal Domestic Assistance-Short Organizational Form
Complete all sections.

- In addition to inserting the legal name of your organization in Block #5a, insert the HPP-PHEP Award Number provided in the CDC Notice of Award. Failure to provide the award number could cause delay in processing the application.
- Please insert awardee's business official information in Block #8.

Note: SF-424A Budget Information for Non-Construction Programs, Budget Justification and Indirect Cost Rate Agreement should be attached to the application through the "Mandatory Documents" section of the "Grant Application" page. Select "Other Attachments Form" and attach as a PDF file.

HPP and PHEP Submission Requirements

The HPP-PHEP funding application requires submission of a joint application containing the following information via www.grants.gov:

- Project narrative (one each must be submitted for HPP and PHEP, but it can be the same narrative)
- Work plan (one each for HPP and PHEP)
- Itemized budget (one each for HPP and PHEP)

Project Narrative

The project narrative should summarize the overall preparedness strategy for the remainder of the five-year project period highlighting significant successes and challenges encountered in Budget Period 1.

The project narrative must be uploaded in a PDF file format when submitting via www.grants.gov. The narrative must be submitted in the following format:

- Maximum number of pages: 15. If the narrative exceeds the page limit, only the first 15 pages will be reviewed.
- Narrative must be prepared in English.
- Font size: 12 point unreduced, Times New Roman
- Single spaced.
- Page margin size: 1 inch.
- Number all narrative pages; not to exceed the maximum number of pages.
- Application attachments must be in PDF format.

Awardees are strongly encouraged to use the Budget Period 2 project narrative template to ensure all required aspects of the project narrative are submitted. The project narrative consists of the following major components.

1. Five-year Forecast Update.
   The five-year forecast should be based on the operational needs of the jurisdiction, preparedness program gaps, overarching guidance of the public health and healthcare preparedness capabilities, and other operational considerations as appropriate. It should summarize the overall preparedness strategy for the remainder of the project period and represent a phased plan for completing the preparedness program work associated with the capabilities. The forecast should contain the following elements:

- Jurisdictional Prioritization. Based on the jurisdiction's operational needs, awardees should prioritize the capabilities they need to work on during Budget Periods 2-5. This prioritization should focus on closing the most important program gaps first, represent a phased approach to achieving the capabilities during the five-year project period, and include plans for working with local and tribal health departments or healthcare coalitions as appropriate. Specifically, the capability prioritization must include detailed plans for capabilities being addressed in Budget Period 2, a rationale for choosing those capabilities, and an indication when work on the remaining capabilities will be conducted. For example, if the fatality management capability will not be addressed until Budget Period 4, that should be reflected in the phased plan.
- Budget Period 1 Challenges. Describe any challenges or barriers encountered in Budget Period 1 that hindered progress on the capabilities and any anticipated challenges or barriers that may affect the ability to complete or make progress on the capabilities in Budget Period 2.
- Budget Period 1 Successes. Identify and describe any completed capability activities from HPP and PHEP investments in Budget Period 1 that resulted in measureable changes or improved outcomes. If these were submitted as part of the Budget Period 1 mid-year progress report, awardees can refer to that report to avoid repeating the same information in this application.

2. Administrative Preparedness Strategies

Administrative preparedness plans should be incorporated into all-hazards preparedness plans. As applicable, awardees should describe any updates, changes, and enhancements to administrative preparedness plans submitted in Budget Period 1 including responses to the following questions:

- Did you implement all or part of the administrative preparedness plan that was submitted as part of the Budget Period 1 requirement?
- If yes, describe any lessons learned.
- If no, did you review the plan to see if it was still viable? Describe the review process and any changes that were included as part of your revised plan.
- Do you have emergency legal authorities, including, but not limited to:
  - Receiving, allocating, and spending emergency funds
  - Waivers or similar legal processes to minimize the potential conflicts between emergency use authorizations (EUA) and state-based pharmaceutical, prescribing, labeling, and other drug-related laws
  - Formal memoranda of understanding or agreement (MOU/MOA) for conducting joint law enforcement and epidemiological investigations
  - Protection of volunteers against tort liability and workers' compensation claims

3. Subawardee Monitoring

Awardees must describe or, if available, submit copies of their standard operating procedures (SOPs) for subawardee monitoring. As required by 45 CFR Part 92.40, awardees must monitor activities supported by grants and subgrants to ensure compliance with applicable federal requirements and that the performance goals are being met. The SOP should include:

- Type of monitoring such as:
  - Site visits
  - Reporting (program and financial)
  - Voucher submission and review
- Procedures for documenting and verifying program activities, such as:
  - Progress on capabilities
  - Participation in training and exercises
  - Focus on emergency use authorizations (EUA) to ensure local jurisdictions understand how EUAs may affect local response planning

    - Ensuring adequate policies and procedures are in place for conducting joint law enforcement and epidemiological investigations
- Procedures for documenting and verifying expenses, such as:
    - A-133 audit compliance and resolutions of any findings
    - Matching funds
    - Allowable costs

See Appendix 10 for more information and tools to assist with subawardee monitoring.

4. Advisory Committee Activities
Awardees must describe plans for maintaining a senior advisory committee or an equivalent entity in Budget Period 2 to provide input on preparedness strategies, plans to address operational gaps, and potential preparedness investments. Comprised of senior officials (from governmental and nongovernment organizations), the advisory committee should enhance the integration of disciplines involved in homeland security, healthcare, public health, behavioral health, emergency management and emergency medical services; include representatives of at-risk individual groups; improve coordination of preparedness efforts across the jurisdiction; and leverage funding streams. Awardees should also describe whether their advisory committees include citizen representation to obtain public input and comment on emergency preparedness planning.

5. Local Health Department Concurrence (PHEP awardees only)
Awardees must describe, as applicable, the process used to consult with local public health departments to reach consensus, approval, or concurrence on overall strategies, approaches, and priorities outlined in their work plans. The narrative should explain whether concurrence was obtained, issues that were encountered, and plans to address any concerns. In addition, awardees must provide documented evidence that at least a majority, if not all, of local health departments within their jurisdictions approves or concurs with the strategies, approaches, and priorities described in the awardee work plans. State applicants will be required to provide signed letters of concurrence on official agency letterhead from local health departments or representative entities upon request. Awardees who are unable to gain 100% concurrence, despite good-faith efforts to do so, should submit a PDF document with their applications describing the reasons for lack of concurrence and the steps taken to address them.

6. Tribal Concurrence (PHEP awardees only)
As applicable, awardees must describe the process used to consult with American Indian/Alaska Native tribes to reach consensus, approval, or concurrence on overall strategies, approaches, and priorities outlined in their work plans. The narrative should explain whether concurrence was obtained, issues that were encountered, and plans to address any concerns. In addition, awardees must provide documented evidence that a majority, if not all, of American Indian/Alaska Native tribes within their jurisdictions approves or concurs with the approaches and priorities described in the awardee funding applications. State applicants will be required to provide signed letters of concurrence on official agency letterhead from tribal health departments or representative entities upon request. Awardees who are unable to gain 100% concurrence, despite good-faith efforts to do so, should submit a PDF document with their applications describing the reasons for lack of concurrence and the steps taken to address them.

7. Engagement with State Office on Aging
Awardees must describe the process or approach used to engage the state office on aging or equivalent office in addressing the public health emergency preparedness, response, and recovery

needs of older adults. This description also should include the specific capabilities the awardee plans on addressing with this entity.

8. National Incident Management System (NIMS) Compliance
   Awardees must indicate whether they have met NIMS requirements as outlined in Appendix 7.

9. At-risk Individuals
   Awardees must describe in general terms the structures or processes in place to ensure the needs of at-risk individuals are included in response strategies and are identified and addressed in operational work plans. In addition, awardees should describe any plans to coordinate emergency preparedness planning with state and local agencies that provide services for disabled populations, including pregnant women and women of childbearing age, and those with functional disabilities.

10. Emergency Management Assistance Compact (EMAC)
    Awardees must describe EMAC agreement or other mutual aid agreement processes in place for use during emergency response and recovery operations or in other surge situations where additional assistance is required.

11. Coordination with Cross-cutting Public Health Preparedness Partners (PHEP awardees only)
    Awardees should describe how their PHEP program components are coordinated with other public health, healthcare, and emergency management programs as applicable. For example, awardees should outline any PHEP activities that mutually support activities within CDC's Epidemiology and Laboratory Capacity (ELC) for Infectious Diseases cooperative agreement. The project narrative also should include how PHEP awardees work with immunization programs and related partners on syndromic surveillance and other activities to assure preparedness for vaccine-preventable diseases, influenza pandemics, and other events requiring a response.

Work Plan: Capabilities Plan; Subawardee Contracts Plan

Work plan

The work plan describes awardees' short-term goals, objectives, and planned activities for Budget Period 2 and consists of two components:

- Capabilities plan (required)
- Subawardee contracts plan (optional)

Capabilities Plan

The capabilities plan must describe the goals, objectives, and planned activities associated with each capability the awardees are making investments in or otherwise working on during Budget Period 2.

HPP awardees must continue to address all eight healthcare preparedness capabilities for successful completion over the project period. In Budget Period 2, awardees must describe goals, objectives, and planned activities that support their capability-based five-year strategy. To adequately address these capabilities, HPP awardees must address the funded functions and required resource elements within the narrative of their short-term goal, objectives, or planned activity submissions for Budget Period 2. The

goals, objectives, and planned activities should be related to the capabilities and their associated function and resource element guidelines.

PHEP awardees are expected to achieve the 15 preparedness capabilities by the end of the five-year project period and are granted the flexibility to choose the specific capabilities they work on in a single budget period. For those capabilities awardees plan to work on during Budget Period 2, awardees must describe the goals, objectives, and planned activities to support the planned activity type (build, sustain, or scale back). Applications cannot be submitted if one or more capabilities are missing a short-term goal, an objective, planned activities for an objective, or a rationale why there are no planned activities for a capability.

HPP and PHEP awardees must provide updates to their capabilities plans in the form of outcome and output descriptions in the Budget Period 2 mid-year progress report (January 31, 2014) and in the Budget Period 2 annual progress report (September 30, 2014). These updates must thoroughly describe what HPP and PHEP programs achieved in Budget Period 2. Awardees are encouraged to keep these reporting requirements in mind as they design their capability short-term goals, objectives, and planned activities for the Budget Period 2 application submission.

A complete Budget Period 2 capabilities plan includes the following elements:

1. A chosen planned activity type for each capability, using one of the following options:
   - Build
   - Sustain
   - Scale back
   - No planned activities this budget period

   If "sustain" is selected, the awardee must identify in the short-term goal to what level or target sustainment is desired during this budget period.

   If there are no planned activities, the awardee must:
   - Identify any challenges or barriers that may have led to having no planned activities this budget period from the drop-down menu in the application module.
   - Indicate and describe, if applicable, any self-identified technical assistance needs for the capability.

2. Short-term goal. Awardees' short-term goal descriptions must directly link to the capability's functions, tasks, or resource elements and answer the question: "Based on the jurisdictional needs, what aspects of the capability does the awardee need to address in Budget Period 2 and to what degree?" Both parts of the short-term goal are important and the description must identify the specific, quantifiable changes or desired outcomes awardees need to achieve for each capability or to what degree the capability needs to be sustained. The goal can span multiple functions, tasks, or resource elements for each capability.

   Each capability's short term goal must identify the desired outcomes or changes for that capability. If met, each short-term goal reported in the application submission will be linked to achieved "outcomes" that are reported as part of mid-year and annual progress reports.

3. If awardees have planned activities for a capability they must select one of the following types of funding for that capability:
   - HPP

- PHEP
- HPP and PHEP
- Other funding source (state, local, DHS, other)

For HPP awardees, any capability with objectives that have associated functions that are supported by HPP funding must have at least one budget line item associated to that function in the budget.

For PHEP awardees, any capability with objectives that are supported by PHEP funding must have at least one budget line item associated to that capability in the budget.

4. Objectives. Awardees must provide at least one objective that directly supports the short-term goal for a specific capability. Similar to the short-term goal, the objective descriptions must also be specific, measurable, and directly support or contribute to the achievement of the short-term goal.

5. Planned Activities. Awardees must provide at least one planned activity for each objective that describes the necessary deliverables, products, or outputs required to meet the objective. If met, each planned activity reported in the application submission will be linked to achieved "outputs" that are reported as part of the mid-year and annual progress reports. Planned activities must indicate which aspects of the functions and resource elements will be built or sustained during Budget Period 2 and should contain the following elements:

   - Defined deliverables, products, or outputs the planned activities are expected to produce; and
   - Milestones that are specific, measureable, realistic, and refer to what is being built or sustained.

6. Function Associations. Awardees must associate objectives to functions for a specific capability through a functions drop-down menu.

7. Technical Assistance. Awardees should describe, if applicable, any self-identified technical assistance needs for the objective.

Subawardee Contracts Plan

Awardees who propose contracts in their budget with local or tribal health departments/entities, healthcare coalitions, or healthcare organizations may submit an optional subawardee contracts plan describing the contractual arrangements. The plan is most beneficial for identical contracts that apply to multiple subawardees as in the case of many state relationships with local health departments and healthcare coalitions. Each subawardee still requires a separate budget line item, but the justification can simply refer to the subawardee contracts plan instead of rewriting or copying and pasting the justification numerous times. The plan should describe the full scope of work expected from the subawardees and the specific capabilities to be addressed.

For each separate contract entered into the subawardee contracts plan, the following information must be submitted:

- A unique contract name for the subawardee contract;
- An indication of the type of subawardee or jurisdiction the plan is written for;
- An indication of which capabilities or other work plan associations this contract will be supporting; and

- A narrative that describes the scope of work, planned activities, and desired outcomes of the contract per capability. It is important to include this narrative for every capability included in the subawardee contracts plan.

Contracts not intended for multiple subawardees should be listed separately in the budget and should not be included in the subawardee contracts plan. For example, contracts to single entities, such as academic institutions or information management vendors should not be submitted as part of a subawardee contracts plan. For these individual contracts, all of the required contract information should be included in the budget justification.

Budget

SF-424A Budget Justification

A. Download the form from www.grants.gov.
B. Complete all applicable sections.
C. Estimated unobligated funds
    1. Provide an estimate of anticipated unobligated funds at the end of the current budget period.
    2. If use of estimated unobligated funds is requested in addition to funding for the next year, complete all columns in Section A of 424A and submit an interim Federal Financial Report (FFR), Standard Form-425, available at http://grants.nih.gov/grants/forms.htm#closeout.
D. The estimated unobligated balance should be realistic to be consistent with the annual Federal Financial Report (FFR) to be submitted following the end of the budget period.
E. Based on the current rate of obligation, if it appears there will be un-obligated funds at the end of the current budget period, provide detailed actions that will be taken to obligate this amount.
F. If it appears there will be insufficient funds, (1) provide detailed justification of the shortfall; and (2) list the actions taken to bring the obligations in line with the authorized funding level.
G. The proposed budget should be based on the federal funding level stated in the HPP-PHEP Budget Period 2 guidance.
H. In a separate narrative, provide a detailed, line-item budget justification of the funding amount requested to support the activities to be carried out with those funds. Attach in the "Mandatory Documents" box under "Budget Narrative Attachment Form." Document needs to be in the PDF format.
I. The budget justification must be prepared in the general form, format, and to the level of detail as described in the CDC Budget Guidance. The sample budget guidance is provided at: http://www.cdc.gov/od/pgo/funding/grants/foamain.shtm.
J. For all contracts not included in the subawardee contracts plan, both newly requested and existing, must contain the following information requirements. If these contract elements are not available at application the contract budget line item could be restricted.
    i. Name(s) of contractor(s)
    ii. Scope of work
    iii. Method of selection (competitive or sole source); *procurement by noncompetitive proposals may be used only when the award of a contract is infeasible under small purchase procedures, sealed bids or competitive proposals and is justified under criteria in 45 Code of Federal Regulations Part 92.36.*
    iv. Period of performance

v. Method of accountability
vi. Itemized budget with narrative justification

K. For nonfederal Matching requirement, provide a line-item list of non-federal contributions including source, amount, and/or value of third- party contributions proposed to meet a matching requirement. (For further information, see "Cost Sharing or Matching" section on page 26.)

L. For Maintenance of Funding requirements, provide documentation ensuring that expenditures for public health security are maintained at a level not less than the average of such expenditures for the previous two years. (For further information, see "Maintenance of Funding (MOF)[1] section on page 26.)

Indirect Cost Rate Agreement

(This is not applicable to awardees subject to OMB Guidance A-21 – Educational Institutions. The rates stay the same as the first-year award.)

- If indirect costs are requested, include a copy of the current negotiated federal indirect cost rate agreement or a cost allocation plan approval letter for those awardees under such a plan.
- Clearly describe the method used to calculate indirect costs. Make sure the method is consistent with the Indirect Cost Rate Agreement.
- To be entitled to use indirect cost rates, a rate agreement must be in effect at the start of the budget period.
- If an Indirect Cost Rate Agreement is not in effect, indirect costs may be charged as direct if (1) this practice is consist with the awardee's/applicant's approved accounting practices; and (2) if the costs are adequately supported and justified. Please see the CDC Budget Guidance (http://www.cdc.gov/od/pgo/funding/grants/foamain.shtm) for additional information.
- If applicable, attach in the "Mandatory Documents" box under "Other Attachments Form." Name document "Indirect Cost Rate."
- If awardees requests indirect costs in the budget, a copy of the current indirect cost rate agreement is required. If the indirect cost rate is a provisional rate, the agreement should have an effective date no more than 12 months prior to the application due date. The indirect cost rate agreement should be uploaded as a PDF file attachment when submitting via Grants.gov.

Awardees should consider the following in development of their budgets (SF-424A) and budget justification narratives.

- The itemized budget for conducting the project and the corresponding justification is allowable under ASPR and CDC programs, is reasonable and consistent with public health and healthcare preparedness program capabilities, and is consistent with stated objectives and planned program activities.
- Direct Assistance: PHEP awardees may request direct assistance (DA) for personnel (e.g., public health advisors, Career Epidemiology Field Officers, Career Informatics Field Officers, or other technical consultants), provided the work is within scope of the cooperative agreements and is financially justified. PHEP awardees planning to request DA for personnel in lieu of financial assistance should complete and submit the DA request form no later than March 15, 2013. DA may also be requested for any Statistical Analysis Software (SAS) licenses desired for future budget periods. DA requests for SAS licenses should be submitted no later than November 15, 2013.

Additional budget preparation guidance is available at:
http://www.cdc.gov/od/pgo/funding/grants/foamain.shtm; and
http://www.cdc.gov/od/pgo/funding/budgetguide.htm

Funding Restrictions

Restrictions, which apply to both awardees and their subrecipients, must be taken into account while writing the budget. Restrictions are as follows:

- Recipients may not use funds for fund raising activities or lobbying.
- Recipients may not use funds for research.
- Recipients may not use funds for construction or major renovations.
- Recipients may not use funds for clinical care.
- Recipients may not use funds to purchase vehicles to be used as means of transportation for carrying people or goods, e.g., passenger cars or trucks, electrical or gas-driven motorized carts.
- PHEP-only recipients may (with prior approval) use funds to purchase industrial or warehouse-use trucks to be used to move materials, such as forklifts, lift trucks, turret trucks, etc. Vehicles must be of a type not licensed to travel on public roads.
- Recipients may not use funds for reimbursement of pre-award costs.
- Recipients may supplement but not supplant existing state or federal funds for activities described in the budget.
- The direct and primary recipient in a cooperative agreement program must perform a substantial role in carrying out project objectives and not merely serve as a conduit for an award to another party or provider who is ineligible.
- Payment or reimbursement of backfilling costs for staff is not allowed.
- None of the funds awarded to these programs may be used to pay the salary of an individual at a rate in excess of Executive Level II or $179,700 per year

Joint Application Review Criteria

Applications will be initially reviewed for completeness by the CDC Procurement and Grants Office staff. In addition, applications will be jointly reviewed for responsiveness to program requirements and technical acceptability by project officers from ASPR and CDC's Division of State and Local Readiness (DSLR) and subject matter experts (SMEs). Eligible applications must meet all requirements defined in this continuation guidance and associated funding opportunity announcement. Specifically, eligible applications will be evaluated against the following criteria:

- Evidence that HPP and PHEP program activities are well coordinated with each other, emergency management agencies (EMA), and other community or state partners. Activities reflect sustained or strengthened coordination between public health, healthcare, EMA, and other partners.
- A jurisdictional risk assessment (JRA) has been completed or there are plans to complete the JRA in Budget Period 2.
- Senior advisory processes are in place and described. If there are no changes from prior year structures or activities, awardees must simply verify the advisory board and associated processes are still active.
- Sufficient administrative preparedness plans are in place to meet the needs of the jurisdiction during surge requirements or there is evidence of Budget Period 2 planned activities to close gaps in administrative preparedness plans. Administrative preparedness plans include the ability to effectively receive, obligate, and account for HPP and PHEP funds including the ability to move funding to the local level in a timely manner.
- There is evidence in the application narratives and budget justifications that training is designed to close operational gaps or meet recurring training requirements.
- There is evidence the State Office of Aging and groups representing at-risk populations are part of HPP and PHEP program engagement, and the planning considerations surrounding these groups are part of operational plans.

- All elements required in the project narrative are present, comply with the guidance, and collectively describe how the jurisdiction plans to build and sustain capabilities in Budget Period 2.
- Project narrative and work plan review:
  - Awardees' work plan narrative descriptions, the project narrative, technical assistance descriptions, budget justifications, and five-year forecasts have reasonable relationships, correlation, and continuity with each other and describe how the jurisdiction is building, sustaining, or scaling back the public health and healthcare preparedness capabilities. Since this is continuation guidance, the narrative descriptions should also be consistent with narratives provided in Budget Period 1 or describe why there is significant variance between budget periods.
  - Awardees have adequate planned activities to monitor and demonstrate HPP and PHEP defined performance measures and PAHPA benchmarks.
  - Awardee work plans and budgets are clearly and adequately linked through budget associations to the capabilities or function and resource element level.
  - Budget line items contain sufficiently detailed justifications and cost calculations, specifically for contract line items.
  - Short-term goals are at the capability level and describe the overall target or desired outcomes for that capability in Budget Period 2.
  - Objectives directly link to and support the short-term goal for each capability and are measurable and achievable descriptions of how a capability will be built, sustained, or scaled back.
  - Planned activity descriptions define desired products or outputs and have measurable milestones. They must also relate to the short-term goal and directly support the objectives.

HPP-specific Application Review Criteria

- Awardees comply with HAvBED standards.

PHEP-specific Application Review Criteria

- There are processes in place to engage local health departments and federally recognized American Indian/Alaska Native Tribes and have resulted in documented evidence showing local or tribal concurrence, as applicable, with the PHEP strategy and work plan approach to Budget Period 2. Acceptable evidence includes a copy of written consensus on official letterhead of a majority of local or tribal health officials whose jurisdictions encompass a majority of the state's population or a written recommendation of the SACCHO or Tribal Health Board or equivalent.
- Medical countermeasure planned activities are sufficient to meet the PAHPA benchmarks for Budget Period 2.
- Sufficient descriptions exist that outline Level 1 chemical laboratory operations and processes, as applicable.

Budget Period 2 applications that do not substantially meet these review criteria must be resubmitted within 30 days after receipt of the Notice of Award (NOA) from CDC's Procurement and Grants Office. At the awardee's request, HPP and PHEP program staff will provide technical assistance to help the awardee with deficiencies noted during the application review.

Use of Budget Period 2 Funds for Response

HPP
Section 319C-2 of the PHS Act authorizes the HHS Secretary to award grants in the form of cooperative agreements to enable eligible entities to improve surge capacity and enhance community and hospital preparedness for public health emergencies. As awardees expend funds to meet the applicable goals outlined in section 2802(b) of the PHS Act, in general, HPP funds are to be used only for activities which prepare for public health emergencies and improve surge capacity – consistent with approved spend plans. Awardees, nevertheless, may be able to expend HPP funds for response activities, subject to approval by ASPR, provided the activities meet statutory and administrative requirements. Following are examples of response activities that may be considered for approval.

Situation 1: HPP Staff Conducting Activities Consistent with Approved Project Goals
Awardees may use HPP funds to support positions performing preparedness-related activities consistent with the awardee's project goals and may utilize those positions within any phase of the disaster cycle, provided that the staff members in those positions continue to do work within statutory limitations, the notice of award, and the approved spending plan. For example, an employee's salary may be permissible for response activities if that employee is carrying out the same responsibilities he or she would carry out as part of his or her preparedness responsibilities.

Situation 2: Using an Emergency as a Training Exercise
Under certain conditions, HPP funds may, on a limited, case-by-case basis, be reallocated to support response activities to the extent they are used for the purposes provided for in Section 319C-2 of the PHS Act (the program's authorizing statute), applicable cost principles, the funding opportunity announcement, and the awardee's application (including the jurisdiction's all-hazards plan). Awardees should contact their assigned HPP project officers and grants management specialists for guidance on the process to make such a change. ASPR encourages awardees to develop criteria such as costs versus benefits for determining when to request a scope-of-work change to use a real incident as a required exercise.

The request to use an actual response as a required exercise and to pay salaries with HPP funds will be considered for approval under these conditions:

- A state or local declaration of an emergency, disaster, or public health emergency is in effect.
- No other funds are available for the cost.
- The awardee agrees to submit within 60 days (of the conclusion of the disaster or public health emergency) an after-action report, a corrective action plan, and other documentation that support the actual dollar amount spent.

PHEP
Use of PHEP funds during response operations has not changed since Budget Period 1. PHEP cooperative agreement funding is intended primarily to support preparedness activities that help ensure state and local public health departments are prepared to prevent, detect, respond to, mitigate, and recover from a variety of public health threats. The PHEP cooperative agreement provides technical assistance and resources that strengthen public health preparedness and enhance the capabilities of state and local governments to respond to these threats. PHEP funds may, on a limited, case-by-case basis, be reallocated to support response activities to the extent they are used for the purposes provided for in Section 319C-1 of the PHS Act (the program's authorizing statute), applicable cost principles, the funding opportunity announcement,

and the awardee's application (including the jurisdiction's all-hazards plan). Awardees must receive approval from CDC to use PHEP funds during response for new activities not previously approved as part of their annual funding applications or subsequent budget change requests.

Funding Formula

The distribution of HPP and PHEP funds is calculated using a formula established by the HHS Secretary that includes a base amount for each awardee plus population-based funding. More information on how the funding formula is calculated is available in the CDC-RFA-TP12-1201 funding opportunity announcement.

Cost Sharing or Matching

Cost sharing or matching requirements remain in effect for Budget Period 2, with states required to make available nonfederal contributions in the amount of 10% ($1 for each $10 of federal funds provided in the cooperative agreement) of the award. 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 Budget Period 2 application for funds, follow procedures for generally accepted accounting practices, and meet audit requirements.

Exceptions to Matching Funds Requirement

- The match requirement does not apply to the political subdivisions of New York City, Los Angeles County, or Chicago.
- Pursuant to department grants policy implementing 48 U.S.C. 1469a(d), any required matching (including in-kind contributions) of less than $200,000 is waived with respect to cooperative agreements to the governments of American Samoa, Guam, the Virgin Islands, or the Northern Mariana Islands (other than those consolidated under other provisions of 48 U.S.C. 1469). For instance, if 10% (the match requirement) of the award is less than $200,000, then the entire match requirement is waived. If 10% of the award is greater than $200,000, then the first $200,000 is waived, and the entity must meet the match requirements for the balance.

Maintenance of Funding (MOF)[1]

Maintenance of funding requirements remain in effect for Budget Period 2. Awardees must maintain expenditures for healthcare preparedness and public health security at a level that is not less than the average level of such expenditures maintained by the awardee for the preceding two-year period. For more information, refer to the CDC-RFA-TP12-1201 funding opportunity announcement.

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[1]This funding opportunity announcement uses one term that applies to both maintenance of funding (MOF) and maintaining state funding (MSF). Section 319C-1 requires PHEP awardees to maintain expenditures for public health security. Section 319C-2 requires HPP awardees to maintain expenditures for healthcare preparedness. This provision addresses both requirements.

Maximum Amount of Carry-over Funds

Awardees may request to carry over unobligated funds. The carry-over request must present a justifiable reason for not executing a spend plan on schedule (e.g., a jurisdictional hiring freeze). The awardee must immediately communicate with ASPR and CDC any events occurring during the performance period that have a significant impact upon timely execution of the spend plan. The Pandemic and All-Hazards Act (PAHPA) of 2006 requires the HHS Secretary to determine the maximum amount of unobligated funds that can be carried over into each succeeding budget period. Awardees must repay any funds that exceed the maximum percentage of an award that may be carried over to the succeeding fiscal year. The carry-over maximum percentage varies for the HPP and PHEP programs; however, ASPR and CDC review all awardee requests on a case-by-case basis to determine appropriateness.

- HPP awardees may carry over a maximum of 15 percent of Budget Period 1 funds into Budget Period 2. Awardees must submit a waiver request to carry over funds that exceed the 15 percent limit.
- PHEP awardees may request to carry over up to 100 percent of Budget Period 1 funds into Budget Period 2.

ASPR and CDC reserve the right to restrict carry-over amounts for awardees that maintain high balances of unobligated funds.

HPP and PHEP awardees may request carry-over funds as part of their Budget Period 2 applications based on the interim Federal Financial Reports (FFR) submitted with their Budget Period 2 applications. (See the Budget section above - use of estimated unobligated funds.) These budget change requests are submitted as an attachment to the application and must include a ***separate***, revised work plan and budget identifying the following elements:

- Description of a bona fide need for permission to use an unobligated balance,
- List of proposed activities,
- Itemized budget, and
- Narrative justification of those activities.

The grants management officer retains the right to determine how much of the estimated unobligated balance may be processed as carry-over funds. If funds are authorized for carry-over, the awarding office may add the funds to the full amount otherwise approved for the noncompeting continuation award for Budget Period 2, the budget period into which the funds are carried, and allow them to be used for the purpose(s) for which they were originally authorized or other purposes within the scope of the application as originally approved (the approved budget is modified and/or increased accordingly). ASPR and CDC will provide additional guidance on submitting carry-over requests.

Reporting Requirements

- Pandemic influenza plans: Section 319C-1 of the PHS Act, as amended by PAHPA, currently requires that HPP and PHEP awardees annually submit influenza pandemic plans. ASPR and CDC have determined that awardees can satisfy the 2013 annual requirement through the

required submission of other program data such as the 2013 self-assessment and Budget Period 2 application that provide ample evidence on the status of state and local influenza pandemic response readiness as well as the barriers and challenges to preparedness and operational readiness. No further awardee action will be required in Budget Period 2.

- Awardees must document and submit annually data on their current preparedness status and self-identified gaps based on the public health and healthcare preparedness capabilities as they relate to overall jurisdictional needs. Further guidance and templates will be provided separately.
- Federal Funding Accountability And Transparency Act of 2006 (FFATA): Public Law 109-282, the Federal Funding Accountability and Transparency Act of 2006 as amended (FFATA), requires full disclosure of all entities and organizations receiving federal funds including grants, contracts, loans and other assistance and payments through a single publicly accessible Web site, www.USASpending.gov. The Web site includes information on each federal financial assistance award and contract over $25,000, including such information as:

    1. The name of the entity receiving the award;
    2. The amount of the award;
    3. Information on the award including transaction type, funding agency, etc.;
    4. The location of the entity receiving the award;
    5. A unique identifier of the entity receiving the award; and
    6. Names and compensation of highly compensated officers (as applicable).

    Compliance with this law is primarily the responsibility of the federal agency. However, two elements of the law require information to be collected and reported by recipients: 1) information on executive compensation when not already reported through the Central Contractor Registry; and 2) similar information on all sub-awards/subcontracts/consortiums over $25,000.

    For the full text of the requirements under the Federal Funding Accountability and Transparency Act of 2006, please review the following Web site: http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=109_cong_bills&docid=f:s2590enr.txt.pdf
- Updated Federal Financial Report cash transaction reports (FFR SF-425) must be filed in the Payment Management System (PMS) within 30 days of the end of each quarter (i.e., no later than October 30, 2013; January 30, 2014; and May 30, 2014). The FFR 425 form and instructions are available at:
    - http://www.whitehouse.gov/sites/default/files/omb/grants/standard_forms/ff_report.pdf
    - http://www.nea.gov/manageaward/FFR-Instructions.pdf

- Each funded awardee must provide an annual Interim Progress Report submitted via www.grants.gov. The interim progress report will serve as the noncompeting continuation application.
- Additionally, funded awardees must provide an original plus two hard copies of the following reports for Budget Period 2:

- A mid-year progress report due 30 days after the first six months of the budget period. This report should include work plan updates; status updates on applicable PAHPA benchmarks, applicable performance measure data, and technical assistance plans; and estimated HPP and PHEP financial reports.
- An annual progress report due 90 days after the end of the budget period. This report should include updates on work plan activities including local contracts and progress on implementation of technical assistance plans; PAHPA benchmark data; performance measure data and supporting information; training updates; preparedness accomplishments, success stories, and program impact statements; healthcare coalition assessments (HPP only); and updated healthcare coalition information (HPP only); NIMS compliance activities, and ESAR-VHP requirements (HPP only).
- Separate HPP and PHEP Federal Financial Reports (FFR) SF-425) no later than 90 days after the end of the budget period.
- A combined HPP and PHEP Federal Financial Report (FFR) SF-425 submitted via the electronic FFR system in eRA Commons no later than 90 days after the end of the budget period.

Audit Requirements

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

In addition, HPP and PHEP awardees shall, not less often than once every two years, audit their expenditures from amounts received under these awards. Such audits shall be conducted by an entity independent of the agency administering a program funded, in accordance with the Comptroller General's standards for auditing governmental organizations, programs, activities, and functions and using generally accepted auditing standards. Awardees may choose to include HPP and PHEP as major programs in their required A-133 audit process to fulfill the PAHPA-required biennial audit. However, if awardees choose not to include HPP and PHEP expenditures as part of their required A-133 audit process, a separate audit must be performed to fulfill the PAHPA-required biennial audit.

The A-133 audit is submitted to the Federal Audit Clearinghouse, Bureau of the Census, Web site: http://harvester.census.gov/fac/collect/ddeindex.html. For other audits conducted for HPP, copies must be submitted to asprgrants@hhs.gov.

Audits that indicate funds have not been spent in accordance with section 319C-1 or 319C-2 of the PHS Act may result in a disallowance decision requiring repayment or future withholding or offset of awards.

Appendix 1: HPP Budget Period 2 (Fiscal Year 2013) Funding*

Awardee	FY 2013 Total Funding Available
Alabama	$5,378,598
Alaska	$1,224,921
American Samoa	$317,806
Arizona	$7,024,227
Arkansas	$3,476,230
California	$28,502,812
Chicago	$3,251,353
Colorado	$5,633,218
Connecticut	$4,148,022
Delaware	$1,416,506
District of Columbia	$1,114,169
Florida	$19,690,188
Georgia	$10,388,028
Guam	$434,606
Hawaii	$1,888,437
Idaho	$2,100,005
Illinois	$10,844,663
Indiana	$7,117,910
Iowa	$3,609,364
Kansas	$3,412,131
Kentucky	$4,929,121
Los Angeles	$10,521,689
Louisiana	$5,127,138
Maine	$1,855,836
Marshall Islands	$317,221
Maryland	$6,392,970
Massachusetts	$7,183,057
Michigan	$10,588,069
Micronesia	$359,370
Minnesota	$5,913,629
Mississippi	$3,528,671
Missouri	$6,612,799
Montana	$1,509,880
Nebraska	$2,364,116
Nevada	$3,256,408
New Hampshire	$1,843,699
New Jersey	$9,473,742
New Mexico	$2,601,770
New York	$11,934,686
New York City	$8,844,224
North Carolina	$10,232,711
North Dakota	$1,186,503

Awardee	FY 2013 Total Funding Available
Northern Mariana Islands	$299,316
Ohio	$12,275,120
Oklahoma	$4,328,942
Oregon	$4,410,314
Palau	$271,311
Pennsylvania	$13,465,110
Puerto Rico	$4,302,852
Rhode Island	$1,574,338
South Carolina	$5,221,033
South Dakota	$1,331,020
Tennessee	$6,977,365
Texas	$26,165,661
Utah	$3,321,052
Vermont	$1,138,684
Virgin Islands (US)	$362,020
Virginia	$8,666,514
Washington	$7,363,627
West Virginia	$2,391,321
Wisconsin	$6,304,613
Wyoming	$1,075,284
Total FY 2013 HPP Funding*	**$348,796,000**

* Funding amounts are planning numbers subject to change based on the final FY 2013 budget.

Appendix 2: Public Health Emergency Preparedness (PHEP) Budget Period 2 (Fiscal Year 2013) Funding*

Awardee	FY 2013 Total Base plus Population Funding	FY 2013 Cities Readiness Initiative Funding	FY 2013 Level 1 Chemical Laboratory Funding	FY 2013 Total Funding Available
Alabama	$8,253,305	$297,200	$0	$8,550,505
Alaska	$3,780,600	$169,600	$0	$3,950,200
American Samoa	$373,014	$0	$0	$373,014
Arizona	$10,025,328	$1,104,674	$0	$11,130,002
Arkansas	$6,204,823	$197,771	$0	$6,402,594
California	$33,153,601	$5,159,220	$993,604	$39,306,425
Chicago	$7,965,109	$1,577,831	$0	$9,542,940
Colorado	$8,527,481	$670,116	$0	$9,197,597
Connecticut	$6,928,213	$546,650	$0	$7,474,863
Delaware	$3,986,900	$311,470	$0	$4,298,370
Florida	$23,664,113	$2,761,704	$763,718	$27,189,535
Georgia	$13,647,490	$1,388,154	$0	$15,035,644
Guam	$498,785	$0	$0	$498,785
Hawaii	$4,495,077	$251,136	$0	$4,746,213
Idaho	$4,722,896	$162,442	$0	$4,885,338
Illinois	$14,139,197	$1,907,058	$0	$16,046,255
Indiana	$10,126,207	$736,647	$0	$10,862,854
Iowa	$6,348,183	$202,044	$0	$6,550,227
Kansas	$6,135,800	$387,136	$0	$6,522,936
Kentucky	$7,769,305	$383,765	$0	$8,153,070
Los Angeles County	$15,800,288	$3,151,142	$0	$18,951,430
Louisiana	$7,982,531	$519,089	$0	$8,501,620
Maine	$4,459,973	$169,600	$0	$4,629,573
Marshall Islands	$372,384	$0	$0	$372,384
Maryland	$9,345,586	$1,347,741	$0	$10,693,327
Massachusetts	$10,196,358	$1,233,622	$903,414	$12,333,394
Michigan	$13,862,895	$1,131,906	$887,768	$15,882,569
Micronesia	$417,771	$0	$0	$417,771
Minnesota	$8,829,430	$846,633	$915,450	$10,591,513
Mississippi	$6,261,292	$232,320	$0	$6,493,612
Missouri	$9,582,300	$870,731	$0	$10,453,031
Montana	$4,087,445	$169,600	$0	$4,257,045
Nebraska	$5,007,292	$195,544	$0	$5,202,836
Nevada	$5,968,117	$514,089	$0	$6,482,206
New Hampshire	$4,446,904	$279,824	$0	$4,726,728
New Jersey	$12,662,981	$2,221,450	$0	$14,884,431
New Mexico	$5,263,199	$233,713	$918,754	$6,415,666
New York	$15,312,942	$1,633,375	$1,524,067	$18,470,384
New York City	$13,992,498	$3,742,763	$0	$17,735,261

Awardee	FY 2013 Total Base plus Population Funding	FY 2013 Cities Readiness Initiative Funding	FY 2013 Level 1 Chemical Laboratory Funding	FY 2013 Total Funding Available
North Carolina	$13,480,244	$409,821	$0	$13,890,065
North Dakota	$3,770,198	$169,600	$0	$3,939,798
Northern Mariana Islands	$353,104	$0	$0	$353,104
Ohio	$15,679,523	$1,459,374	$0	$17,138,897
Oklahoma	$7,123,029	$330,117	$0	$7,453,146
Oregon	$7,210,651	$471,490	$0	$7,682,141
Palau	$322,948	$0	$0	$322,948
Pennsylvania	$16,960,911	$1,692,135	$0	$18,653,046
Puerto Rico	$7,094,934	$0	$0	$7,094,934
Rhode Island	$4,156,854	$277,313	$0	$4,434,167
South Carolina	$8,083,638	$261,796	$838,072	$9,183,506
South Dakota	$3,894,848	$169,600	$0	$4,064,448
Tennessee	$9,974,867	$689,504	$0	$10,664,371
Texas	$30,636,943	$3,809,972	$0	$34,446,915
Utah	$6,037,726	$296,185	$0	$6,333,911
Vermont	$3,770,198	$169,600	$0	$3,939,798
Virgin Islands (US)	$420,624	$0	$0	$420,624
Virginia	$11,793,753	$1,456,814	$792,661	$14,043,228
Washington	$10,390,797	$1,021,249	$0	$11,412,046
Washington, D.C.	$5,661,341	$609,113	$0	$6,270,454
West Virginia	$5,036,586	$183,695	$0	$5,220,281
Wisconsin	$9,250,444	$486,802	$1,148,980	$10,886,226
Wyoming	$3,770,198	$169,600	$0	$3,939,798
TOTAL FY 2013 PHEP Funding*	**$519,471,972**	**$50,841,540**	**$9,686,488**	**$580,000,000**

* Funding amounts are planning numbers subject to change based on the final FY 2013 budget.

Appendix 3: Cities Readiness Initiative (CRI)
Budget Period 2 (Fiscal Year 2013) Funding*

Awardee	CRI City	2010 Census Population	FY 2013 Awardee Total
Alabama	Birmingham	1,128,047	$297,200
Alaska	Anchorage	380,821	$169,600
Arizona	Phoenix	4,192,887	$1,104,674
Arkansas	Little Rock	699,757	$197,771
Arkansas	Memphis	50,902	
California	Los Angeles	3,010,232	$5,159,220
California	Riverside	4,224,851	
California	Sacramento	2,149,127	
California	San Diego	3,095,313	
California	San Francisco	4,335,391	
California	San Jose	1,836,911	
California	Fresno	930,450	
Chicago	Chicago	2,695,598	$1,577,831
Colorado	Denver	2,543,482	$670,116
Connecticut	Hartford	1,212,381	$546,650
Connecticut	New Haven	862,477	
Delaware	Philadelphia	538,479	$311,470
Delaware	Dover	162,310	
Florida	Miami	5,564,635	$2,761,704
Florida	Orlando	2,134,411	
Florida	Tampa	2,783,243	
Georgia	Atlanta	5,268,860	$1,388,154
Hawaii	Honolulu	953,207	$251,136
Idaho	Boise	616,561	$162,442
Illinois	Chicago	5,891,011	$1,907,058
Illinois	St Louis	703,664	
Illinois	Peoria	379,186	
Indiana	Chicago	708,070	$736,647
Indiana	Indianapolis	1,756,241	
Indiana	Cincinnati	79,262	
Indiana	Louisville	252,436	
Iowa	Des Moines	569,633	$202,044
Iowa	Omaha	123,145	

Awardee	CRI City	2010 Census Population	FY 2013 Awardee Total
Kansas	Wichita	623,061	$387,136
Kansas	Kansas City	846,346	
Kentucky	Louisville	1,031,130	$383,765
Kentucky	Cincinnati	425,483	
Los Angeles County	Los Angeles	9,818,605	$3,151,142
Louisiana	Baton Rouge	802,484	$519,089
Louisiana	New Orleans	1,167,764	
Maine	Portland	514,098	$169,600
Maryland	Baltimore	2,710,489	$1,347,741
Maryland	Washington D.C	2,303,870	
Maryland	Philadelphia	101,108	
Massachusetts	Boston	4,134,036	$1,233,622
Massachusetts	Providence	548,285	
Michigan	Detroit	4,296,250	$1,131,906
Minnesota	Fargo	58,999	$846,633
Minnesota	Minneapolis	3,154,469	
Mississippi	Jackson	539,057	$232,320
Mississippi	Memphis	238,060	
Missouri	St. Louis	2,115,946	$870,731
Missouri	Kansas City	1,188,988	
Montana	Billings	158,050	$169,600
Nebraska	Omaha	742,205	$195,544
Nevada	Las Vegas	1,951,269	$514,089
New Hampshire	Boston	418,366	$279,824
New Hampshire	Manchester	400,721	
New Jersey	New York City	6,471,215	$2,221,450
New Jersey	Philadelphia	1,316,762	
New Jersey	Trenton	366,513	
New Mexico	Albuquerque	887,077	$233,713
New York	Albany	870,716	$1,633,375
New York	Buffalo	1,135,509	
New York	New York City	4,193,392	
New York City	New York City	8,175,133	$3,742,763
North Carolina	Charlotte	1,531,965	$409,821
North Carolina	Virginia Beach	23,547	
North Dakota	Fargo	149,778	$169,600
Ohio	Cincinnati	1,625,406	$1,459,374

Awardee	CRI City	2010 Census Population	FY 2013 Awardee Total
Ohio	Cleveland	2,077,240	
Ohio	Columbus	1,836,536	
Oklahoma	Oklahoma City	1,252,987	$330,117
Oregon	Portland	1,789,580	$471,490
Pennsylvania	Philadelphia	4,008,994	$1,692,135
Pennsylvania	Pittsburgh	2,356,285	
Pennsylvania	New York City	57,369	
Rhode Island	Providence	1,052,567	$277,313
South Carolina	Columbia	767,598	$261,796
South Carolina	Charlotte	226,073	
South Dakota	Sioux Falls	228,261	$169,600
Tennessee	Nashville	1,589,934	$689,504
Tennessee	Memphis	1,027,138	
Texas	Dallas	6,371,773	$3,809,972
Texas	Houston	5,946,800	
Texas	San Antonio	2,142,508	
Utah	Salt Lake City	1,124,197	$296,185
Vermont	Burlington	211,261	$169,600
Virginia	Richmond	1,258,251	$1,456,814
Virginia	Virginia Beach	1,648,136	
Virginia	Washington D.C	2,623,079	
Washington	Seattle	3,439,809	$1,021,249
Washington	Portland	436,429	
Washington D.C	Washington D.C	601,723	$609,113
West Virginia	Charleston	304,284	$183,695
West Virginia	Washington D.C	53,498	
Wisconsin	Chicago	166,426	$486,802
Wisconsin	Milwaukee	1,555,908	
Wisconsin	Minneapolis	125,364	
Wyoming	Cheyenne	91,738	$169,600
Total FY 2013 Cities Readiness Initiative Funding*		**175,240,879**	**$50,841,540**

* Funding amounts are planning numbers subject to change based on the final FY 2013 budget.

Appendix 4: HPP Budget Period 2 Benchmarks
Hospital Preparedness Program BP2 (Fiscal Year 2013)
Evidence-Based Benchmarks Subject to Withholding

	PAHPA Benchmark
PAHPA1	Awardees will submit timely and complete data for the mid-year progress report, the end-of-year annual progress report, and the final Federal Financial Report (FFR).
PAHPA2	Awardees will assure that all healthcare coalitions within their jurisdictions are within Stage 1 of development.
PAHPA3	Awardees shall develop and submit in accordance with Budget Period 2 guidance requirements exercise plans that must include a proposed exercise schedule and a discussion of the plans for healthcare entity exercise development, conduct, evaluation, and improvement planning. This exercise plan must demonstrate participation by healthcare coalitions and the participating hospitals to include the participating organizations and anticipated capabilities to be tested.
PAHPA4	Awardees will submit in accordance with Budget Period 2 guidance requirements a comprehensive inventory that lists each of its participating hospitals by name and by national provider identifier (NPI) (formerly known as HIPAA ID); identifies each of the 11 National Incident Management System (NIMS) implementation activities that have been achieved; and identifies each activity still in progress. This must also include the plans to address the gaps for the identified hospitals that are not 100% compliant with NIMS requirements.

Appendix 5: PHEP Budget Period 2 Benchmarks
Public Health Emergency Preparedness BP2 (Fiscal Year 2013)
Evidence-Based Benchmarks Subject to Withholding

CDC has identified the following fiscal year 2013 benchmarks for Budget Period 2 to be used as a basis for withholding of fiscal year 2014 funding for PHEP awardees. As mandated by PAHPA, awardees that fail to "substantially meet" the benchmarks are subject to withholding of funds penalties to be applied the following fiscal year. Awardees that demonstrate achievement of these requirements are not subject to withholding of funds.

1. Demonstrated adherence to all PHEP application and reporting deadlines. Failure to submit required PHEP program data and reports by the stated deadlines will constitute a benchmark failure. A failure to timely report key program data hinders CDC's ability to analyze data and submit accountability reports as required and jeopardizes CDC's ability to accurately reflect PHEP program achievements and barriers to success. This benchmark applies to all 62 awardees. Required data and reports include:
   - PHEP Budget Period 2 funding application due 60 calendar days following initial publication of the continuation guidance and interim progress reports/noncompeting continuation funding applications for subsequent PHEP budget periods are due no less than 90 days before the end of the budget period;
   - PHEP Budget Period 2 mid-year progress reports, due 30 days after the first six months of the budget period, including work plan updates; status updates on applicable PAHPA benchmarks, applicable performance measure data, and technical assistance plans; and estimated HPP and PHEP financial reports status.
   - Annual PHEP Budget Period 2 progress report, due 90 days after the end of the budget period, to include updates on work plan activities including local contracts and progress on implementation of technical assistance plans; PAHPA benchmark data; performance measure data and supporting information; training updates; preparedness accomplishments, success stories, and program impact statements; healthcare coalition assessments (HPP only); and updated healthcare coalition information (HPP only); NIMS compliance activities, and ESAR-VHP requirements (HPP only).
   - PHEP Budget Period 2 financial report, no later than 90 days after the end of the budget period.

2. Demonstrated capability to receive, stage, store, distribute, and dispense material during a public health emergency. As part of their response to public health emergencies, public health departments must be able to provide countermeasures to 100% of their identified population within 48 hours after the federal decision to do so. To achieve this standard, public health departments must maintain the capability to plan and execute the receipt, staging, storage, distribution, and dispensing of material during a public health emergency.

   In Budget Period 2, CDC will evaluate medical countermeasure distribution and dispensing (MCMDD readiness using a modified version of the standard technical assistance review (TAR) process. A progress report format will allow CDC to maintain accountability in Budget Period 2 for medical countermeasure planning while redesigning the TAR tool for Budget Period 3. This change also provides more time for awardees to focus on the recommendations and operational gaps identified in prior TAR assessments.

To demonstrate the current capacity and degree of advancement in emergency response capabilities during Budget Period 2, public health departments must comply with the following requirements and submit all required supporting documentation by May 1, 2014.

- The 50 states must meet a minimum overall TAR progress report benchmark of **89** for Budget Period 2.

- All CRI jurisdictions within a state must meet a minimum average TAR progress report benchmark of **69** for Budget Period 2
  - When there are multiple planning/local jurisdictions within a Cities Readiness Initiative (CRI) metropolitan statistical area (MSA), CDC is responsible for performing TAR progress report reviews for a minimum of 25% of the CRI jurisdictions, and the state is responsible for performing TAR progress report reviews for 75% of the CRI jurisdictions.

- The four directly funded localities must meet a minimum overall TAR progress report benchmark of **89** for Budget Period 2. Directly funded locality scores will be derived from a local TAR progress report review conducted during Budget Period 2. CDC is responsible for performing TAR progress report reviews for the directly funded localities.

- American Samoa, Commonwealth of the Northern Mariana Islands, Federated States of Micronesia, Guam, Puerto Rico, Republic of the Marshall Islands, Republic of Palau, and the U.S. Virgin Islands must meet a minimum overall TAR progress report benchmark of **60** for Budget Period 2. An island TAR progress report review must be conducted during Budget Period 2. CDC is responsible for conducting all island TAR progress report reviews.

3. Demonstrated ability to pass laboratory proficiency testing and/or exercises for biological and chemical agents.
   - **Awardees must ensure that Laboratory Response Network biological (LRN-B) laboratories pass proficiency testing.** CDC proficiency tests are composed of a number of unknown samples that are tested to evaluate the abilities of LRN reference and/or national biological laboratories to receive, test, and report on one or more suspected biological agents. To demonstrate this capability, the LRN-B laboratory must successfully pass CDC proficiency tests for all LRN agents/assays for which they have requested access to LRN-B reagents from CDC during each budget period. Preliminary funding withholding tables will be calculated with data received by April 30, 2014, to determine the awardees "at risk" of failing to reach the PAPHA benchmark.
     1. Successfully passed is defined as:
        a. The agent is detected or not detected in all samples as expected
        b. The lab follows the appropriate algorithm for testing samples and interpreting results
        c. The lab submits data to CDC within the prescribed deadline
     2. Using the definition as described above, CDC will use the following elements to calculate if the laboratory passed:
        a. Number of LRN-B proficiency tests successfully passed by the LRN-B laboratory during first attempt (numerator)
        b. Number of LRN-B proficiency tests participated in by the LRN-B laboratory (denominator)
     3. The minimum performance for each year of the PHEP project period is:
        a. Budget Period 1: Laboratory cannot miss more than two PT challenges
        b. Budget Periods 2-5: Laboratory cannot miss more than one PT challenge

In Budget Period 2, the LRN-B proficiency testing (PT) benchmark is applicable to each of the 50 state public health laboratories () plus the LRN-B laboratories in Los Angeles County, New York City, and Washington, D.C. Although a lab that fails a challenge may retest (i.e., undergo remediation) for purposes of being able to continue to test for that agent, retests will not apply to the numerator for this benchmark.

- **Awardees must ensure that at least one LRN chemical (LRN-C) laboratory in their jurisdictions passes the LRN-C Specimen packaging, and shipping (SPaS) exercise.** This annual exercise evaluates the ability of a laboratory to collect relevant samples for clinical chemical analysis and ship those samples in compliance with International Air Transport Association regulations. This benchmark applies to the 50 states; the directly funded localities of Los Angeles County, New York City, and Washington, D.C.; and Puerto Rico. These awardees must ensure at least one LRN-C laboratory passes CDC's SPaS exercise. If a laboratory fails the exercise on its first attempt but passes on the second attempt, then the awardee will meet the benchmark. If a PHEP awardee has multiple laboratories, at least one laboratory must participate and pass.

- **Awardees must ensure that LRN-C laboratories pass proficiency testing in core and additional analysis methods**. This benchmark applies to the 10 awardees with Level 1 laboratories (California, Florida, Massachusetts, Michigan, Minnesota, New Mexico, New York, South Carolina, Virginia, and Wisconsin). Although this PAHPA benchmark does not apply to awardees with Level 2 laboratories during Budget Period 2, awardees with Level 2 laboratories must report on LRN-C proficiency testing performance measures as specified in PHEP performance measure guidance. Proficiency testing data must be received by April, 30, 2014, to determine awardees potentially at risk for failure to meet the PAHPA benchmark.

LRN methods can help determine how widespread an incident is, identify who does/does not need long-term medical treatment, assist with nonemergency medical guidance, and help law enforcement officials determine the origin of the agent. Proficiency testing is the most effective method for evaluating laboratory performance, and participation is required, where possible, by the Clinical Laboratory Improvements Amendment of 1988. The LRN-C conducts proficiency testing for all Level 1 and Level 2 chemical laboratories to support meeting the regulatory requirements for the reporting of patient results as part of an emergency response program. Each high complexity test is proficiency tested three times per year (budget period) and each laboratory is evaluated on the ability to report accurate and timely results through secure electronic reporting mechanisms.

CDC has identified nine core methods and four additional methods for detecting and measuring these agents and conducts testing to determine a laboratory's proficiency in these methods. The core methods are 1) arsenic in urine by DRC ICP-MS; 2) cadmium/lead/mercury in blood by ICP-MS; 3) cyanide in blood by headspace GC-MS; 4) volatile organic chemicals (VOCs) in blood by SPME GC-MS; 5) nerve agent metabolites in urine by LC-MS/MS; 6) toxic elements (barium, beryllium, cadmium, lead, uranium, and thallium) in urine by ICP-MS; 7) tetramine in urine by GC-MS; 8) metabolic toxins in urine by LC/MS/MS; and 9) plant toxins in urine by LC-MS/MS. Additional methods are 1) sulfur mustard metabolite in urine by LC-MS/MS; 2) Lewisite metabolite in urine by LC-ICP-MS; 3) nitrogen mustard metabolites in urine by LC-MS/MS; and 4) tetranitromethane biomarker in urine by LC-MS/MS.

Influenza Pandemic Plans

Section 319C-1 of the PHS Act, as amended by PAHPA, currently requires that PHEP awardees annually submit influenza pandemic plans. CDC has determined that awardees can satisfy the 2013 annual requirement through the required submission of other program data such as the 2013 capability self-assessment and Budget Period 2 application and performance measure data that provide ample evidence on the status of state and local influenza pandemic response readiness as well as the barriers and challenges to preparedness and operational readiness. Section 319C-1 also requires withholding of funding from PHEP awardees that fail to submit acceptable pandemic influenza operations plans each fiscal year.

Table 1: Criteria to Determine Potential Withholding of PHEP Fiscal Year 2014 Funds

	Benchmark Measure	Yes	No	Possible % Withholding
1	Did the awardee (all awardees) meet all application and reporting deadlines?			10%
2	Did the awardee (all awardees) demonstrate capability to receive, stage, store, distribute, and dispense material during a public health emergency?			
3	Did the applicable awardee demonstrate proficiency in public health laboratory testing and/or exercises for biological and chemical agents?			
4	Did the awardee (all awardees) meet the 2013 Pandemic Influenza Plan (Public Health Component Meets Standards) requirement?			10.0%
Total Potential Withholding Percentage				20.0%

Scoring Criteria

The first three benchmarks are weighted the same, so failure to substantially meet any one of the three benchmarks will count as one failure and result in withholding of 10% of the fiscal year 2014 PHEP base award. Failure to submit the 2013 influenza pandemic plan as required may result in withholding of 10% of the fiscal year 2013 PHEP base award.

More information on withholding and repayment is available in the CDC-RFA-TP12-1201 funding opportunity announcement posted at http://www.cdc.gov/phpr/documents/cdc-rfa-tp12-1201_4_17_12_FINAL.pdf.

Appendix 6: Guidance for Classifying Members of Healthcare Coalitions

Coalition Member Types

Member Type for Dropdown Listing	Description	Criteria for this Coalition Member Classification		Examples of *Eligible* Coalition Members
		Do NOT Include:	**ONLY Include:**	
For purposes of creating national data consistency, awardees with a coalition member that corresponds to an example listed in Column 5 should classify their member using the member type in Column 1				
Inpatient Hospitals	24/7 nonfederal, inpatient acute care hospitals	• *Freestanding psychiatric hospitals* • *Hospitals operated by the federal government* • *Hospitals that qualify as Level 1-3 trauma centers* • *Subacute care facilities* • *Freestanding emergency departments*	• *Hospitals that operate 24/7*	• *General hospitals* • *Children's hospitals* • *Rehabilitation hospitals* • *Long-term care hospitals* • *Community access hospitals (CAHs)*
Trauma Centers	24/7, nonfederal, trauma centers	• *Hospitals operated by the federal government*	• *Trauma centers classified as Levels 1-3*	
Long-term Care	24/7, nonfederal, sub-acute and long term care inpatient providers	• *Freestanding psychiatric hospitals* • *Psychiatric residential treatment facilities (PRTFs* • *Halfway houses* • *Any type of 24/7 inpatient provider agency operated by the federal government* • *Hospitals that operate 24/7, even if they include swing beds*	• *Long-term care facilities that are licensed by the state* • *Inpatient facilities that operate 24/7*	• *Nursing homes(NHs)* • *Skilled nursing facilities(SNFs)* • *Subacute care facilities* • *Rehabilitation facilities* • *Long-term care facilities (LTCFs)* • *Intermediate care facilities for persons with mental retardation (ICFs/MR)* • *PACE facilities* • *Hospice* • *Religious nonmedical healthcare institutions* • *Alternative living facilities (ALFs)or alternative residential facilities (ARFs)* • *Group homes*
Community Health Centers	Nonfederal, community health centers	• *Any type of CHC or FQHC operated by the federal government* • *Inpatient facilities that operate 24/7* • *Community mental or behavioral health centers or substance abuse clinics*	• *Community health centers* • *Federally qualified health centers (FQHCs)*	

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		Do NOT Include:	**ONLY Include:**		
For purposes of creating national data consistency, awardees with a coalition member that corresponds to an example listed in Column 5 should classify their member using the member type in Column 1					
Other Outpatient or In-Home Providers	Other nonfederal outpatient or in-home healthcare providers	• *Any community health center or FQHC* • *Any type of outpatient or in-house provider agency operated by the federalgovernment* • *Inpatient facilities that operate 24/7* • *Community mental or behavioral health centers or substance abuse clinics* • *Any private practice physician office groups or hospital-based clinics*	• *Outpatient or in-home healthcare providers that are NOT community health centers or FQHCs*	• *Ambulatory surgical centers* • *Home health agencies* • *Comprehensive outpatient rehabilitation facilities (CORF)* • *Organ procurement organizations* • *Rural health clinics* • *End-stage dialysis facilities*	
Individual Physicians - Primary Care	Individual (hospital-based or private practice) allopathic, osteopathic, and podiatric physicians - primary care	• *Physicians that are specialists as per examples under* "**Individual Physicians - Specialists"** • *Nurse practitioners, or physician assistants who provide primary care* • *Psychiatrists*	• *Allopathic, osteopathic, or podiatric physicians* • *Physicians that are in private practice or are part of a hospital-based group* • *Primary care physicians* • *Licensed practitioners*	• F*amily practice* • *Geriatrics,* • *Gerontology* • *General pediatrics* • *General practice* • *General internal medicine*	
Individual Physicians - Specialists	Individual (hospital-based or private practice) allopathic, osteopathic, and podiatric physicians - specialists	• *Physicians that are specialists as per examples under* "**Individual Physicians - Primary care"** • *Nurse practitioners, or Physician Assistants who provide anesthesia or other specialty medicine* • *Other specialists who are NOT physicians* • *Psychiatrists*	• *Allopathic, osteopathic, or podiatric physicians* • *Physicians that are in private practice or are part of a hospital-based group* • *Licensed practitioners*	• *General surgery* • *Allergy/immunology* • *Otolaryngology* • *Anesthesiology* • *Cardiology* • *Dermatology* • *Intervention pain management* • *Neurology* • *Oncology* • *Obstetrics/gynecology*	• *Orthopedics* • *Pathology* • *Plastic and reconstructive surgery* • *Physical medicine and rehabilitation* • *Proctology* • *Pulmonary, diagnostic radiology* • *Urology* • *Nuclear medicine*

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		Do NOT Include:	**ONLY Include:**		
For purposes of creating national data consistency, awardees with a coalition member that corresponds to an example listed in Column 5 should classify their member using the member type in Column 1					
				• *Ophthalmology,* • *Oral surgery*	• *Infectious diseases* • *Emergency medicine* • *Gastroenterology*
Other Non-Physician Specialists	Other individual healthcare providers ***who are not physicians***	• *Any physician that is a licensed practitioner of allopathic, osteopathic, or podiatric medicine* • *Clinical psychologists or psychiatric social workers* • *Specialty outpatient institutions or in home providers, as per the examples listed above*	• *Specialists that are in private practice or are part of a hospital-based group* • *Licensed, certified, or registered, as required by state law*	• *Dietitians* • *Chiropractors* • *Certified nurse-midwives* • *Optometrists* • *Specialty nurses* • *Physician assistants* • *Physical therapists* • *Occupational therapists* • *Respiratory therapists*	• *Hand therapists* • *Dentists* • *Oral surgeons* • *Speech therapists* • *Recreation therapists* • *Music therapists* • *Art therapists* • *Massage therapists*
Behavioral Health	Nonfederal behavioral health (inpatient or outpatient)	• *Any type of inpatient, outpatient or individual specialist provider group operated by the federal government* • *Psychiatric services provided as part of a general acute care hospital program* • *General healthcare services that do not include behavioral health* • *Self-help groups that do not operate under a plan of care developed in accordance with licensure requirements*	• *Mental health, behavioral health, or substance abuse providers licensed, certified, or registered, as required by law* • *Institutional, inpatient, or outpatient-based behavioral health services that are provided under a plan of care developed in accordance with licensure requirements*	• *Freestanding psychiatric hospitals* • *Psychiatric residential treatment centers(PRTFs)* • *Community mental health centers and clinics* • *Substance abuse clinics* • *Halfway houses* • *Group homes for the mentally ill* • *Family therapists* • *Psychotherapists* • *Psychiatrists* • *Clinical psychologists* • *Psychiatric social workers* • *Psychiatrists* • *Clinical psychologists*	
Healthcare Support Suppliers	Nonfederal providers or suppliers of healthcare support services	• *Any type of provider or supplier agency operated by the federal government* • *Suppliers of healthcare support that are employed by*	• *Suppliers that are licensed, certified, or registered, as required by state law*	• *Blood banks* • *Pharmacies* • *Poison control centers* • *Laboratories* • *Mammography centers*	

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		Do NOT Include:	**ONLY Include:**	
For purposes of creating national data consistency, awardees with a coalition member that corresponds to an example listed in Column 5 should classify their member using the member type in Column 1				
		or operate under the license of another overarching healthcare providers, such as hospitals, nursing homes, community health centers		• *X-ray providers* • *Durable medical equipment (DME) supply centers*
Federal Hospitals	24-hour federal hospitals	• *Tribal clinics* • *Inpatient long term care facilities even though operated by the federal government* • *Outpatient health centers, clinics ,or other outpatient healthcare services even though operated by the federal government*	• *Any hospital or trauma center that is owned and /or operated by the federal government* • *Inpatient hospital providers that operate 24/7*	• *Veterans Administration (VA) hospitals* • *Department of Defense (DOD) hospitals* • *Indian Health Service (IHS) hospitals*
Other Federal Healthcare Providers	Other federal healthcare (not hospital-based) providers	• *Tribal clinics* • *Any hospital or trauma center that is owned and /or operated by the federal government*	• *Other inpatient healthcare facilities operated by the federal government* • *Outpatient health centers, clinics ,or other outpatient healthcare services operated by the federal government*	• *VA nursing homes* • *DOD nursing homes* • *VA clinics* • *IHS clinics*
Other Federal Entities	Other federal representatives that are NOT healthcare entities	• *Any federal agency-providing behavioral or general healthcare program or services*	• *Employees, representatives or grantors from U.S. government agencies and who are members of healthcare coalitions*	• FEMA representatives • CDC representatives • U.S. Navy
Emergency Medical Services (EMS)	Emergency medical services (EMS)			
Public Health	Public health			
Public Safety	Public safety			• *Police* • *Fire*

Appendix 6: Guidance for Classifying Members of Healthcare Coalitions

Coalition Member Types

Member Type for Dropdown Listing	Description	Criteria for this Coalition Member Classification		Examples of *Eligible* Coalition Members
		Do NOT Include:	**ONLY Include:**	
For purposes of creating national data consistency, awardees with a coalition member that corresponds to an example listed in Column 5 should classify their member using the member type in Column 1				
				• Law *enforcement* • *National Guard*
Emergency Management	Emergency management			
Medical Reserve Corps	Medical Reserve Corps			
Academia	Academia			• *Universities* • *Colleges* • *Schools* • *Research facilities*
Airport / Transportation	Airport/ transportation			
Communication Groups	Communications			• *Ham radio operators* • *Internet providers*
Grassroot/ Volunteer/ nonprofit Advocacy or Service Organizations	Grassroots, volunteer organizations, and other nonprofit advocacy or service organizations	• *Volunteer agencies or organizations that are not MRC*		• *American Red Cross* • *Disability organizations* • *Children's advocacy groups* • *Child care providers* • *Public libraries*
Trade Organizations	Healthcare provider or healthcare consumer trade organizations			*National, state, and local healthcare provider associations* *AARP*
Other State and Local Entities	Other state and local government services (that have not otherwise been listed)			
Private Business	Private business			e.g., Walmart

Appendix 7: Training and Exercise Evaluation Requirements

Training and Exercise Overview

Training and exercise activities must support jurisdictional priorities. These priorities are generally informed by risk assessments and operational gaps identified during self-assessments, exercises and actual response/recovery operations. HPP and PHEP training and exercise requirements vary in Budget Period 2, but awardees are encouraged to plan and execute these requirements with inclusion from both the HPP and the PHEP programs, emergency management agencies, and community partners at the state and local levels.

HPP Training Requirements

1. National Incident Management System (NIMS) Documentation
   HPP awardees will assess and report annually which participating hospitals currently have adopted all NIMS implementation activities and which are still in the process of implementing the 11 activities. For any participating hospital still working to implement NIMS activities, funds must be prioritized and made available during HPP Budget Period 2 to ensure the full implementation and maintenance of all activities during the five-year project period.
   The Budget Period 2 application must include a hospital status update that identifies each of the 11 NIMS implementation activities that have been achieved, including each activity still in progress.
2. Training Schedule
   HPP awardees must specifically identify gap-based training on a schedule detailed in the HPP-provided template, which can be found in the PERFORMS Resource Library. The completed schedule is due September 30, 2013.

Joint HPP-PHEP Training Requirements

1. Multiyear Training and Exercise Plan (MYTEP)

   Each year, awardees must conduct, or participate, in a training and exercise planning workshop (TEPW) and submit a MYTEP. Awardees must submit the MYTEP no later than September 30, 2013, as an uploaded attachment in PERFORMS. A template for the MYTEP can be found PERFORMS Resource Library.

2. Exercise Schedule and Narrative

   In addition to the MYTEP, awardees must specifically identify required exercises and include a narrative that describes Homeland Security Exercise and Evaluation Program compliance, community participation, the five-year exercise strategy, and joint exercises. The exercise schedule and narrative must be completed as outlined in the templates located in the PERFORMS Resource Library. The exercise schedule and narrative must be submitted by September 30, 2013, as an uploaded attachment in PERFORMS.

3. Joint Training Report
   As part of the Budget Period 2 annual progress report due September 30, 2014, awardees must report on preparedness training conducted during Budget Period 2 and describe the impact the training had on the jurisdiction. The template for this report can be found in the PERFORMS Resource Library.

Budget Period 2 Exercise Requirements

Awardees must conduct preparedness exercises in accordance with the Homeland Security Exercise and Evaluation Program (HSEEP). Further information on these guidelines and exercise policy can be found at https://hseep.dhs.gov/pages/1001_HSEEP7.aspx

HPP-specific Requirements

Within the five-year project period, awardees must perform and evaluate required exercises. ASPR and CDC will monitor documentation through mid-year and annual progress reports and during technical assistance visits. Awardees must meet these requirements during the remainder of the five-year period:

- Each identified healthcare coalition must participate in at least one required exercise. This may be at the substate regional level or the statewide level.
- All HPP participating hospitals (and if possible other healthcare organizations) must participate in a required exercise. This should be in conjunction with their respective healthcare coalitions' participation.
- There must be participation in a joint full-scale exercise (FSE). This requirement is for the healthcare coalition(s) within the associated Cities Readiness Initiative metropolitan statistical area.

Note: A real incident may be substituted for a required exercise; however the after-action report (AAR) must document healthcare coalition involvement as outlined in the exercise reporting section below.

To qualify as an acceptable exercise, each HPP exercise must meet the following criteria:

- Exercises must be a substate regional or statewide functional or full-scale exercise.
- HPP exercises must test the capabilities of the participants from a single healthcare coalition or multiple healthcare coalitions and demonstrate the following:
  - Resource and information management as outlined in Capability 3: Emergency Operations Coordination and Capability 6: Information Sharing.
  - Components of Capability 10: Medical Surge to include at a minimum implementation of prehospital coordination and surge capacity and capability operations as outlined in Capability 10: Medical Surge, Functions 2 and 3.
    - **Note:** This demonstration does not require every component of Capability 10: Medical Surge, Functions 2 and 3 to be tested. However, the associated performance measure (e.g. PM 10.1), must be tested.
    - **Note:** If the primary risk for the healthcare coalition requires full-scale evacuation and shelter-in-place operations to occur, the components of Capability 10: Medical Surge, Function 5: Medical Evacuation/Shelter-in-Place operations may be considered as the medical surge demonstration.
  - Each exercise must demonstrate, in some capacity, the continuation of essential healthcare services as outlined in Capability 1: Healthcare System Preparedness, Function 3. This describes planning for essential healthcare delivery services and the ability of the healthcare system to implement essential continuity services (e.g., business operations, power, water, information management, heating, ventilation, and air conditioning (HVAC) redundancies).
  - Demonstrations for Capability 2: Healthcare System Recovery, Capability 5: Fatality Management, Capability 14: Responder Safety and Health, and Capability 15: Volunteer Management may be achieved through allowable drills or functional or full-scale exercises. However, awardees must demonstrate that the capability has been tested within their jurisdictions.

- Over the five-year project period, ASPR encourages coalitions to test each of the healthcare preparedness capabilities but recognizes certain capabilities such as Capability 2: Healthcare System Recovery, Capability 5: Fatality Management, Capability 14: Responder Safety and Health, and Capability 15: Volunteer Management may be demonstrated at a statewide only or at a singular (one substate region) level.
  - A rotational strategy is highly recommended for awardees with a large number of healthcare coalitions and must be forecasted in the five-year exercise schedule, with the realization that the forecast may change.
  - Awardees are expected to work with relevant state and local officials to provide information for the National Exercise Schedule (NEXS), so that exercises can be coordinated across levels of government and healthcare entities. Additionally, at-risk populations and/or those who represent them must be engaged in preparedness planning and exercise activities.

HPP Allowable Costs

Activities for funding consideration under this requirement include:

- Costs associated with planning, developing, executing, and evaluating exercises.
  - During Budget Period 1 and beyond HPP allows grant funding for functional or full-scale exercise development and execution using the HSEEP methodology. Grants can be used to fund workshops, drills, tabletop exercises, and other HSEEP planning meetings (e.g., concepts and objectives, initial planning conferences, mid-planning conferences, etc.), only to the extent these funded elements, in line with the HSEEP building block approach for exercise development and execution, dovetail with a functional or full-scale exercise during the five-year project period.
  - Allowable drills as described above to meet specific performance measure requirements for Capability 2: Healthcare System Recovery, Capability 5: Fatality Management, Capability 14: Responder Safety and Health, and Capability 15: Volunteer Management may also be funded for activities that test these capabilities for an entire healthcare sector (e.g. long-term care facilities, community health centers, and Medical Reserve Corps, etc.). Awardees should discuss these drilling strategies with their field project officers.
  - Individual facility exercises are not allowable.
- Costs associated with enhancement and upgrade of emergency operations plans based on exercise evaluation and improvement plans (including those from the previous budget period).
- Costs associated with release time for healthcare workers to attend exercises.

Note: Salaries for backfilling are not allowable costs under this funding announcement.

PHEP-specific Exercise Requirements

The Public Health Service Act, Section 319C-1, requires each PHEP-funded awardee to conduct at least one annual exercise to test preparedness and response capabilities including submission of an after-action report (AAR) and improvement plan (IP). The HSEEP building block approach could be an acceptable model leading up to a jurisdiction's full-scale exercise. This annual exercise could include tabletop, functional or full-scale exercises that test public health preparedness and response capabilities. The AAR/IPs for each exercise are due as part of the PHEP Budget Period 2 annual progress report due on September 30, 2014.

Awardee response and recovery operations supporting real incidents could meet the criteria for this annual exercise requirement if the response was sufficient in scope and the AAR/IPs adequately detail which public health preparedness capabilities were tested and evaluated.

Medical countermeasure-related (MCM) drills, by themselves, are very narrowly focused and are no longer sufficient to meet this annual exercise requirement, which should be focused more broadly to address multiple operational gaps and developmental areas for the jurisdiction. Annual PHEP exercises must be jointly planned and executed with as many healthcare sector, emergency management agency, and community partners as are available.

Joint Exercise Requirement: Conduct one joint full-scale exercise during the five year project period
Within the five-year project period, awardees and Cities Readiness Initiative (CRI) planning jurisdictions must participate in one joint full-scale exercise that includes MCM distribution and dispensing elements outlined in the Performs Resource Library. This requirement applies to the healthcare coalition(s) and all public health departments encompassed by the associated CRI metropolitan statistical areas (MSA).

Several PHEP awardees performed the requirements for a joint full scale-exercise in which preparedness capabilities were tested and validated by an acceptable AAR/IP during an actual response and recovery operation, or during a validated full-scale exercise, during Budget Period 11 (August 10, 2011, through August 9, 2012). These awardees are required to conduct another joint full-scale exercise no later than Budget Period 5 in accordance with the HSEEP cycle. In addition, several HPP and PHEP awardees performed the requirements for a joint full scale-exercise in which preparedness capabilities were tested and validated by an acceptable AAR/IP during an actual response and recovery operation, or during a validated full-scale exercise, during Budget Period 1 (July 1, 2012, through June 30, 2013). These awardees have met the full-scale exercise requirement for the project period.

Awardees must submit the joint full-scale exercise AAR/IP documentation in accordance with established evaluation and progress reporting requirements.

During the five-year project period, distribution full-scale exercises are required for the 50 states and four directly funded localities. Dispensing full-scale exercises are required for the 72 CRI MSAs and each local planning jurisdiction within the 72 CRI areas and four directly funded localities. This requirement applies to the healthcare coalition(s) and all public health departments encompassed by the associated CRI MSAs. HPP and PHEP programs encourage awardees to include the distribution and dispensing requirements as part of broader full-scale exercises. Distribution and dispensing full-scale exercises are optional for the eight U.S. territories and freely associated states.

Exercise Requirement Reporting

All HPP and PHEP AAR/IPs are due by September 30, 2014, and must be submitted based on the exercise reporting template located in the Performs Resource library. AAR/IPs must be posted on the CDC/DSLR secure channel on www.llis.gov.

Appendix 8: Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) Compliance Requirements

The ESAR-VHP compliance requirements identify capabilities and procedures that state[2] ESAR-VHP programs must have in place to ensure effective management and interjurisdictional movement of volunteer health personnel in emergencies. Each state must meet all of the compliance requirements.

ESAR-VHP Electronic System Requirements

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

   These systems must:

   a. Offer Internet-based registration. Information must be controlled and managed by authorized personnel who are responsible for the data.

   b. Ensure that volunteer information is collected, assembled, maintained and utilized in a manner consistent with all federal, state, and local laws governing security and confidentiality.

   c. Identify volunteers via queries of variables as defined by the requester.

   d. Ensure that each state ESAR-VHP system is both backed up on a regular basis and that the backup is not co-located.

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

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

      1) Physicians (allopathic and osteopathic)

[2] For purpose of this document, state refers to the 50 states, the District of Columbia, the three metropolitan areas of Chicago, New York City, Los Angeles County, the Commonwealths of Puerto Rico and the Northern Mariana Islands, the territories of American Samoa, Guam and the United States Virgin Islands, the Federated States of Micronesia, and the Republics of Palau and the Marshall Islands.

2) Registered nurses
3) Advanced practice registered nurses (APRNs) including nurse practitioners, certified nurse anesthetists, certified nurse-midwives, and clinical nurse specialists
4) Pharmacists
5) Psychologists
6) Clinical social workers
7) Mental health counselors
8) Radiologic technologists and technicians
9) Respiratory therapists
10) Medical and clinical laboratory technologists
11) Medical and clinical laboratory technicians
12) Licensed practical nurses and licensed vocational nurses
13) Dentists
14) Marriage and family therapists
15) Physician assistants
16) Veterinarians
17) Cardiovascular technologists and technicians
18) Diagnostic medical sonographers
19) Emergency medical technicians and paramedics
20) Medical records and health information technicians

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

c. To increase ESAR-VHP functionality immediately after a disaster or public health emergency, states are encouraged to develop expedited ESAR-VHP registration and credential verification processes to facilitate the health response.

3. Each electronic system must be able to assign volunteers to one of four ESAR-VHP credential levels. Assignment will be based on the credentials and qualifications that the state has collected and verified with the issuing entity or appropriate authority.

4. Each electronic system must be able to record all volunteer health professional/emergency preparedness affiliations of an individual, including local, state, and federal entities. The purpose of this requirement is to avoid the potential confusion that may arise from having a volunteer appear in multiple registration systems, e.g., Medical Reserve Corps (MRC), National Disaster Medical System (NDMS), etc.

5. Each electronic system must be able to identify volunteers willing to participate in a federally coordinated emergency response.

a. Each electronic system must query volunteers upon initial registration and/or re-verification of credentials about their willingness to participate in emergency responses coordinated by the federal government. Responses to this question, posed in advance of an emergency, will provide the federal government with an estimate of the potential volunteer pool that may be available from the states upon request.

b. If a volunteer responds “Yes” to the federal question, states may be required to collect additional information (e.g., training, physical and medical status, etc.).

6. Each state must be able to update volunteer information and reverify credentials annually. (**Note:** ASPR will review this requirement regularly for possible adjustments based on industry standards and the experience of the states.)

ESAR-VHP Operational Requirements

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

8. Each state must develop a plan to recruit and retain volunteers.

9. Each state must develop a plan for coordinating with all volunteer health professional/emergency preparedness entities to ensure an efficient response to an emergency, including but not limited to MRC units, NDMS teams, and the Federal Emergency Management Agency (FEMA) Citizen Corps.

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

    a. Each state is required to develop written protocols that govern the internal activation, operation, and timeframes of the ESAR-VHP system in response to an emergency. Included in these protocols must be plans to track volunteers during an emergency and for maintaining a history of volunteer deployments. ASPR may ask for copies of these protocols as a means of documenting compliance.

    b. Each state ESAR-VHP program is required to establish a working relationship with external partners, such as the local and/or state emergency management agency and develop protocols outlining the required actions for deploying volunteers during an emergency. These protocols should ensure continuous (24/7) operability of the ESAR-VHP system. There are three areas of focus:

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

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

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

        3) Federal deployment: Each state must develop protocols necessary to respond to requests for volunteers that are received from the federal government. Further, each

state must adhere to the protocol developed by the federal government that governs the process for receiving requests for volunteers, identifying available volunteers, and providing each volunteer's credentials to the federal government.

ESAR-VHP Evaluation and Reporting Requirements

11. Each state must test its ESAR-VHP system through drills and exercises. These exercises must be consistent with the ASPR Hospital Preparedness Program (HPP), Centers for Disease Control and Prevention's (CDC) Public Health Emergency Preparedness (PHEP) program, and ASPR ESAR-VHP program requirements for drills and exercises.

12. 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.

Appendix 9: HPP-PHEP Budget Period 2 Requirements for Territories and Freely Associated States

ASPR and CDC recognize the unique infrastructure and geographic challenges faced by the U.S. territories and freely associated states that receive limited HPP and PHEP cooperative agreement funding. These jurisdictions include the territories of American Samoa, Commonwealth of the Northern Mariana Islands, Guam, and U.S. Virgin Islands and the freely associated states including Federated States of Micronesia, Republic of the Marshall Islands, and Republic of Palau.

ASPR and CDC have responded by modifying the HPP and PHEP requirements that these awardees can realistically achieve in Budget Period 2. These requirements will incrementally increase over the remaining project period. This appendix serves as a guide to help these seven territorial and freely associated state awardees achieve a level of preparedness that will assure appropriate public health and healthcare response and mitigation strategies. The modified requirements do not apply to the territory of Puerto Rico.

Background and Rationale
Public health preparedness efforts and challenges in the territories and freely associated states differ from the U.S. mainland. The geographical isolation and distinctive infrastructures present unique challenges that result in equally unique strategies for achieving preparedness. HPP and PHEP funds have been used to promote public health preparedness understanding and awareness within the health departments, ministries, and communities in these areas but have been and currently are being used primarily for building and maintaining basic public health capacities.

Awardees are expected to use their cooperative agreement funding to build and sustain the public health and healthcare preparedness capabilities, ensuring that federal preparedness funds are directed to priority areas within their jurisdictions as identified through their strategic planning efforts.

HPP and PHEP Requirements for Territories and Freely Associated States
Following are 22 Budget Period 2 requirements, including performance goals, for the seven territories and freely associated states of American Samoa, Commonwealth of the Northern Mariana Islands, Guam, Federated States of Micronesia, Republic of the Marshall Islands, Republic of Palau, and U.S. Virgin Islands.

11. Complete and submit all required Budget Period 2 application components and reports.*

Project Narrative: The narrative should summarize the overall preparedness strategy for the project period, as well as describe specific plans for capabilities to be addressed during Budget Period 2. The project narrative may briefly address cross-cutting activities and plans for addressing any challenges or barriers that may impede progress. Examples include:

- Leadership capacity and organizational stability
- Technical capacity in information technology infrastructure and use
- Budget and accounting system as it relates to administrative preparedness
- Staff retention for maintaining project continuity
- Collaboration between partners, hospitals, department of health programs, local grants management staff
- Delays in awarding subcontracts, which impinge on ability to carry out public health and healthcare preparedness projects in a timely manner
- Manual collection of public health surveillance records

Awardees should review the Budget Period 1 project narrative and revise if necessary. If no revisions are needed, the Budget Period 1 project narrative should be renamed and submitted as the Budget Period 2 project narrative.

Capabilities Work Plan and Budget: The Budget Period 2 capabilities work plan and budget should address the *Public Health Preparedness Capabilities: National Standards for State and Local Planning* and the *Healthcare Preparedness Capabilities: National Guidance for Healthcare System Preparedness* and take into consideration the results from the jurisdictional risk assessment conducted in Budget Period 1. In the capabilities work plan, awardees must describe plans and related objectives to build, sustain, or scale back each of the 15 capabilities in Budget Period 2.

Budget Period 2 Submission Requirements:

- Interim progress reports/funding applications are due 60 calendar days following initial publication of the Budget Period 2 continuation guidance on www.grants.gov.
- Mid-year progress reports are due 30 days after the first six months of the budget period and must include work plan updates; status updates on applicable PAHPA benchmarks, applicable performance measure data, and technical assistance plans; and estimated HPP and PHEP financial reports.
- Annual progress reports are due 90 days after the end of the budget period and will include updates on work plan activities, progress on implementation of technical assistance plans; preparedness accomplishments; success stories; and final financial reports.

12. Foster greater PHEP and HPP program alignment.
Upon request, awardees must show documented progress in coordinating public health and healthcare preparedness program activities to include leveraging of funding to support those activities and tracking alignment accomplishments.

13. Conduct multiyear training and exercise planning.
Awardees must update their Budget Period 1 multiyear training and exercise plans to include planned training sessions for public health and healthcare preparedness capabilities. Plans should include goals and objectives for each exercise and training activity. Updated plans must be submitted as part of the funding applications.

During the project period, awardees should conduct one joint, full-scale exercise. Joint exercises should meet multiple program requirements, including HPP, PHEP, and medical countermeasure planning requirements. HSEEP-compliant after-action reports and improvement plans based on results of exercises or real events should be submitted within 90 days of the exercise/event at ad hoc attachments in PERFORMS.

14. Engage with HPP and PHEP project officers.

Awardees must actively collaborate with their project officers to maintain individualized technical assistance plans. The technical assistance plans will include awardee-identified and project officer-identified needs and a joint strategy for addressing those needs.

Awardees should be actively involved with HPP and PHEP project officers in planning and executing routine site visits to assess the activities, progress, and challenges of awardees and provide/coordinate technical assistance. Awardees should plan on hosting site visits from HPP and PHEP project officers once every 12 to 18 months.

15. Submit pandemic influenza plans annually as required by Section 319C-1 and 319C-2 of the PHS Act and amended by PAHPA.* †

    ASPR and CDC have determined that awardees can satisfy the 2013 annual requirement through the required submission of other program data that provide ample evidence on the status of state and local influenza pandemic response readiness as well as the barriers and challenges to preparedness and operational readiness.

16. Assure compliance with the following requirements. Unless otherwise noted, no specific narrative response or attachment is necessary as CDC's Procurement and Grants Office (PGO) considers that acceptance of the Budget Period 2 funding awards constitutes assurance of compliance with these requirements.
    - Maintain a current all-hazards public health emergency preparedness and response plan and submit to CDC when requested and make available for review during site visits.
    - Submit required progress reports and program and financial data.
    - Submit an independent audit report every two years to the Federal Audit Clearinghouse within 30 days of receipt of the report.
    - Have in place fiscal and programmatic systems to document accountability and improvement.
    - Provide CDC, as feasible, with situational awareness data.

17. Mandatory attendance at meetings.
    At least one representative from each jurisdiction is required to attend the annual Public Health Preparedness Summit once every two years. Information on dates and location for the 2014 summit will be provided to awardees when they are finalized.

Budget Period 2 Performance Goals

The performance goals below are a set of achievable measures to gauge preparedness progress across each of the 15 public health preparedness and eight healthcare preparedness capabilities. The HPP and PHEP project officers will conduct an evidence-based analysis of these performance goals during site visits and provide technical assistance as needed.

Overall

18. **Performance Goal:** Awardees conduct at least semi-annual (preferably quarterly) reconciliation of the program's financial records with the Payment Management System draw-down records to ensure accurate accounting and timely expenditures of funds.*
    Demonstration: Provide notes from meeting with local jurisdictional fiscal staff to include any discrepancies noted.

Capability 1: Community /Healthcare System Preparedness

19. **Performance Goal:** Public health emergency operations plans address preparedness and response strategies that address the public health and medical needs of at-risk individuals and the elderly in the event of a public health emergency. †
    Demonstration: Provide excerpt from the public health emergency operations plans that address at-risk and elderly individuals.

20. **Performance Goal:** A committee comprised of senior advisors from partner governmental and nongovernmental organizations and representatives from the general public is developed to provide input on the public health preparedness and response activities. † In addition, a healthcare coalition should be established to collaborate on roles and responsibilities for healthcare preparedness and

response. Jurisdictions may elect to combine these two functions into one joint committee to address the needs for both the public health senior advisory committee (PHEP) and healthcare coalition (HPP).

Demonstration: Documented minutes of regular advisory committee/coalition meetings, to include participants, decisions made, and actions implemented, should be available upon request.

Capability 2: Community/Healthcare System Recovery

No performance goals for Budget Period 2.

Capability 3: Emergency Operations Coordination

21. **Performance Goal:** An Emergency Management Assistance Compact (EMAC) or other mutual aid agreements for medical and public health mutual aid is in force. This requirement applies only to Guam and U.S. Virgin Islands (PL 104-321). †

    Demonstration: Provide copy of EMAC and/or current mutual aid agreements.

22. **Performance Goal:** A role-based activation list with the names and phone numbers of responders is maintained with current data and exercised at least semi-annually.

    Demonstration: Provide copy of two unannounced call down drills or real incidents which documents the ability to contact responders to activate the emergency operations center.

Capability 4: Emergency Public Information and Warning

23. **Performance Goal:** Emergency operations plans include the process to alert the public to a potential health hazard.

    Demonstration: Evidence of the development and dissemination of a health alert to the general public in response to a real incident or as a drill.

Capability 5: Fatality Management

No performance goals for Budget Period 2.

Capability 6: Information Sharing

No performance goals for Budget Period 2.

Capability 7: Mass Care

24. **Performance Goal:** An electronic database for determining hospital bed availability throughout the jurisdiction is in place.

    Demonstration: Provide information on hospital bed availability to HPP staff when requested.

Capability 8: Medical Countermeasure Dispensing

25. **Performance Goal:** Achieve a score of 60 or higher on the Budget Period 2 island technical assistance review (ITAR) progress report. **

    Demonstration: The ITAR score received in Budget Period 1 will extend into Budget Period 2. Awardees may improve their scores by providing updates to elements of the ITAR with documentation to demonstrate the jurisdiction's competencies in medical countermeasure distribution and dispensing.

Capability 9: Medical Materiel Management and Distribution

26. **Performance Goal:** Conduct three (3) operational drills from the PHEP cooperative agreement online Data, Collection and Reporting Suite.

Demonstration: Utilize the online reporting template found at http://ophprsurveys.cdc.gov./mrlWeb/mrlWeb.dll?1.Project=DCARSMenu_BP1&1.user1=drills to conduct and report the observed data on any three *different* drills during Budget Period 2.

Capability 10: Medical Surge
No performance goals for Budget Period 2.

Capability 11: Non-Pharmaceutical Interventions
No performance goals for Budget Period 2.

Capability 12: Public Health Laboratory Testing

27. **Performance Goal:** Laboratory staff members are trained and certified to package and ship laboratory specimens.
    Demonstration: Provide copies of International Air Transport Association (IATA) certification for at least three laboratory staff members.

28. **Performance Goal:** Standard operating procedures are in place for packaging and shipping specimens.
    Demonstration: Provide documentation of standard procedures for packaging and shipping specimens.

Capability 13: Public Health Surveillance and Epidemiological Investigation

29. **Performance Goal:** Collect syndromic surveillance data from healthcare facilities, schools, and large businesses.
    Demonstration: Written standard operating procedures for collecting and analyzing syndromic surveillance data.

30. **Performance Goal:** Develop a team of specialists who analyze health indicator and syndromic surveillance data weekly.
    Demonstration: Provide documentation of weekly analysis conducted by surveillance team.

Capability 14: Responder Safety and Health

31. **Performance Goal:** Meet National Incident Management System (NIMS) compliance requirement. † Information on NIMS is located at http://www.fema.gov/emergency/nims/.
    Demonstration: Document certification of training completion by public health response staff. If trainees are not U.S. citizens, other documentation of training completion is acceptable.

Capability 15: Volunteer Management

32. **Performance Goal:** Meet Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) guidelines. †
    Demonstration: Describe the system utilized to coordinate hospital and public health volunteers to meet the intent of the ESAR-VHP requirement.

* Failure to meet this requirement may be grounds for withholding funds in future years.
†Pandemic and All-Hazards Preparedness Act (PAHPA) requirement

HPP-PHEP Budget Period 2
Summary of Requirements for Territories and Freely Associated States

Requirement		PHEP	HPP
1	Submit Budget Period 2 application and required reports *	Yes	Yes
2	Foster HPP and PHEP alignment	Yes	Yes
3	Develop multiyear training and exercise plan	Yes	Yes
4	Engage with project officers	Yes	Yes
5	Submit influenza pandemic plans*†	Yes	No
6	Comply with PGO assurances†	Yes	Yes
7	Attend annual Public Health Preparedness Summit	Yes	Yes
8	Reconcile financial records†	Yes	Yes
9	Include plans for at-risk and elderly populations†	Yes	Yes
10	Develop senior advisory committee/healthcare coalition†	Yes	Yes
11	Develop mutual aid agreements or EMAC *(Guam & USVI only)* †	Yes	No
12	Conduct call down drills	Yes	Yes
13	Disseminate public information	Yes	No
14	Collect and report on hospital bed availability*	No	Yes
15	Achieve a score of 60 or higher on the ITAR*	Yes	No
16	Conduct three (3) medical countermeasure dispensing drills	Yes	No
17	Maintain IATA certification for laboratory staff	Yes	No
18	Develop procedures for specimen shipping*	Yes	No
19	Collect syndromic surveillance data	Yes	No
20	Analyze syndromic surveillance data	Yes	No
21	Meet NIMS compliance†	Yes	Yes
22	Address volunteer management†	Yes	Yes

* Failure to meet this requirement may be grounds for withholding funds in future years.
†Pandemic and All-Hazards Preparedness Act (PAHPA) requirement

Appendix 10: Awardee Resources

Administrative Preparedness

- Emergency Use Authorization (EUA) toolkit - Outlines key concepts of how federal and state emergency declarations initiate various response authorities and liability protections. http://www.astho.org/EUAToolkit/?terms=legal+toolkit
- Food and Drug Administration main EUA site - http://www.fda.gov/EmergencyPreparedness/Counterterrorism/ucm182568.htm
- Emergency Authority and Immunity (EAI) toolkit - Outlines key concepts of how federal and state emergency declarations initiate various response authorities and liability protections. http://www.astho.org/EAIToolkit/?terms=legal+toolkit
- Memoranda of Understanding (MOU) with the Federal Bureau of Investigation - To promote collaboration between the disciplines of public health and law enforcement, CDC and the U.S. Federal Bureau of Investigation (FBI) developed a Joint Criminal and Epidemiological Investigations Workshop for public health and law enforcement personnel. Awardees can obtain details for scheduling this free workshop by contacting their nearest FBI field office WMD coordinator or by contacting their HPP or PHEP project officers. Additional resources to advance jurisdictional planning include:
  - Criminal and Epidemiological Investigation Handbook (2011 - This handbook facilitates the use of resources and to maximize communication and interaction among law enforcement and public health officials in an effort to minimize potential barriers to communication and information sharing during a bioterrorism incident. http://www.fbi.gov/about-us/investigate/terrorism/wmd/criminal-and-epidemiological-investigation-handbook
  - Radiological/Nuclear Law Enforcement and Public Health Investigation Handbook – This handbook provides an introduction to radiological/nuclear law enforcement and public health investigations so personnel have a better understanding of each other's information requirements and investigative procedures. http://emergency.cdc.gov/radiation/pdf/Radiological%20Nuclear%20handbook%2009%2001%2011.pdf
  - Joint Public Health – Law Enforcement Investigations: Model Memorandum of Understanding (MOU) - Also referenced within *Public Health Preparedness Capabilities: National Standards for State and Local Planning*, this document provides factors and provisions for consideration for adoption by state, tribal, local, and other jurisdictions when developing methods for coordinating joint public health and law enforcement investigations of bioterrorism, suspected bioterrorism, or other public health concerns possibly resulting from deliberate, criminal actions. http://www.nasemso.org/Projects/DomesticPreparedness/documents/JIMOUFinal.pdf

Capabilities

- *Healthcare Preparedness Capabilities: National Guidance for Healthcare System Preparedness* - http://www.phe.gov/Preparedness/planning/hpp/reports/Documents/capabilities.pdf.
- *Public Health Preparedness Capabilities: National Standards for State and Local Planning* - http://www.cdc.gov/phpr/capabilities/DSLR_capabilities_July.pdf

ESF#8

- Emergency Support Function #8 (ESF #8) – Public Health and Medical Services Annex http://www.fema.gov/emergency/nrf/

Executive Directives

- Presidential Policy Directive 8: National Preparedness - http://www.dhs.gov/xabout/laws/gc_1215444247124.shtm
- Strategic National Risk Assessment in Support of PPD 8: A Comprehensive Risk-Based Approach toward a Secure and Resilient Nation - http://www.dhs.gov/xlibrary/assets/rma-strategic-national-risk-assessment-ppd8.pdf
- National Health Security Strategy - http://www.phe.gov/preparedness/planning/authority/nhss/Pages/default.aspx

Exercise and Evaluations

- Homeland Security Exercise and Evaluation Program Guidance - https://hseep.dhs.gov/pages/1001_HSEEP7.aspx

HAvBED

- HAvBED EDXL Communication Schema - https://havbedws.hhs.gov
- HAvBED Web Portal - https://havbed.hhs.gov

HHS Office of the Assistant Secretary for Preparedness and Response

- http://www.phe.gov/preparedness/pages/default.aspx

HHS Centers for Disease Control and Prevention

- Office of Public Health Preparedness and Response - http://www.cdc.gov/phpr/
- Funding, Guidance, and Technical Assistance - http://www.cdc.gov/phpr/coopagreement.htm
- Division of Strategic National Stockpile – http://www.cdc.gov/phpr/stockpile/stockpile.htm

HHS National Healthcare Preparedness Programs Healthcare Systems Evaluation Branch

- Public Health and Healthcare Systems Evaluation Branch Web page - http://www.phe.gov/Preparedness/planning/evaluation/Pages/default.aspx
- Fiscal year 2012/Budget Period 1Hospital Preparedness Program (HPP) Performance Measure Manual Guidance for Using the New HPP Performance Measures - http://www.phe.gov/Preparedness/planning/evaluation/Documents/fy2012-hpp-082212.pdf
- Hospitals Rising to the Challenge: The First Five Years of the U.S. Hospital Preparedness Program and Priorities Going Forward - http://www.upmc-biosecurity.org/website/resources/publications/2009/pdf/2009-04-16-hppreport.pdf
- Healthcare Facilities Partnership Program and Emergency Care Partnership Program Evaluation Report - http://www.upmc-biosecurity.org/website/resources/publications/2010/pdf/2010-01-29-hfpp_eval_rpt.pdf
- The Next Challenge in Healthcare Preparedness: Catastrophic Health Events - http://www.upmc-biosecurity.org/website/resources/publications/2010/pdf/2010-01-29-prepreport.pdf
- Guidance for Establishing Crisis Standards of Care for Use in Disaster Situations: A Letter Report - http://www.iom.edu/Reports/2009/DisasterCareStandards.aspx
- Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response - http://www8.nationalacademies.org/cp/projectview.aspx?key=49130
- Allocation of Scarce Resources During Mass Casualty Events (MCEs) - http://www.ahrq.gov/clinic/tp/scarcerestp.htm

- Home Health Care During an Influenza Pandemic: Issues and Resources - http://www.flu.gov/professional/hospital/homehealth.html.

Pandemic and All-Hazards Preparedness Act (PAHPA)

- PAHPA Overview - http://www.phe.gov/preparedness/legal/pahpa/pages/default.aspx
- PAHPA Full Text - http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=109_cong_public_laws&docid=f:publ417.109.pdf

Preparedness Reports

- CDC State Preparedness Reports - http://www.cdc.gov/phpr/pubs-links/pubslinks.htm
- From Hospitals to Healthcare Coalitions: Transforming Health Preparedness & Response in Our Communities - http://www.phe.gov/Preparedness/planning/hpp/Documents/hpp-healthcare-coalitions.pdf

Research Activities

- Distinguishing Public Health Research and Public Health Non-Research - http://www.cdc.gov/od/science/integrity/docs/cdc-policy-distinguishing-public-health-research-nonresearch.pdf

Subawardee Monitoring

These tools from the Association of Government Auditors (AGA) have been reviewed by the HHS Office of the Inspector General as relevant tools for administering and monitoring grant programs.

- AGA's Risk Assessment Monitoring Tool - http://www.agacgfm.org/AGA/Documents/Performance%20%26%20Programs/riskassessmentmonitoringtool.pdf
- AGA's Financial and Administrative Monitoring Tool - http://www.agacgfm.org/AGA/Documents/Performance%20%26%20Programs/financialadministrativemonitoringtool.pdf
- AGA's Fraud Prevention Toolkit - http://www2.agacgfm.org/tools/FraudPrevention/.