Hospital Preparedness Program (HPP) and Public Health Emergency Preparedness (PHEP) Cooperative Agreements Budget Period 3 Continuation Guidance Supplemental Information

Table of Contents

Eligibility and Available Funding
Budget Period 3 Introduction
HPP-PHEP Program Requirements
Evaluating Performance
Preparing and Submitting Budget Period 3 Interim Progress Reports/Funding Applications
    Assessing Required Application Package
    Grants.gov Checklist of Required Application Contents
Application for Federal Domestic Assistance – Short Organization Form
HPP and PHEP Submission Requirements
    Project Narrative
    Work Plan: Capabilities Plan; Subawardee Contracts Plan
    Budget
Use of Budget Period 3 Funds for Response
Funding Formula
Cost Sharing or Matching
Maintenance of Funding
Unobligated Funds
Application Review Criteria
Reporting Requirements
Audit Requirements

Appendix 1:	Hospital Preparedness Program Budget Period 3 Funding
Appendix 2:	Public Health Emergency Preparedness Budget Period 3 Funding
Appendix 3:	Cities Readiness Initiative Budget Period 3 Funding
Appendix 4:	Hospital Preparedness Program Budget Period 3 Benchmarks
Appendix 5:	Public Health Emergency Preparedness Budget Period 3 Benchmarks
Appendix 6:	Creating a Model Linkage for Capability-based Emergency Preparedness
Appendix 7:	Hospital Preparedness Program Budget Period 3 Training and Exercise Requirements
Appendix 8:	Public Health Emergency Preparedness Budget Period 3 Training and Exercise Requirements
Appendix 9:	Public Health Emergency Preparedness Budget Period 3 Requirements for Territories and Freely Associated States
Appendix 10:	Checklist of Requirements for Laboratory Response Network-B Standard Level Reference Laboratories
Appendix 11:	HPP-PHEP Awardee Resources

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 $840,250,000 is currently available for Budget Period 3, which begins July 1, 2014, and ends June 30, 2015. The HPP and PHEP funding amounts available are shown in Appendices 1, 2, and 3.

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/funding applications 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 with CDC's Procurement and Grants Office (PGO) at (770) 488-2752. For HPP-specific information, contact R. Scott Dugas at (202) 245-0732; for PHEP-specific information, contact Sharon Sharpe at (404) 639-0817.

Reports must be submitted by **11:59 p.m. EDT, Friday, May 9, 2014**. 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 3 Introduction

This guidance document is designed to assist awardees with developing a comprehensive Budget Period 3 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. Awardees should note that the Pandemic and All-Hazards Preparedness Reauthorization Act of 2013 modified some requirements described in the funding opportunity announcement. This continuation guidance describes the updated provisions of the Act and the new awardee requirements. In any instance where the two documents are inconsistent, this guidance supersedes the funding opportunity announcement.

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 3 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, which can help guide preparedness investments. 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 collaborative efforts to ensure that public health and healthcare system planning and response are coordinated and integrated. To the extent consistent with this guidance, applicable funding opportunity announcements, and notices of awards, awardees can use HPP and PHEP cooperative agreement funding for activities and infrastructure that support this collaboration. ASPR and CDC encourage awardees to carefully consider their jurisdictional priorities when developing work plans and budgets for the next year.

CDC strongly recommends that PHEP awardees prioritize their work and resulting investments regarding the 15 public health preparedness capabilities based upon: 1) their jurisdictional risk assessments, 2) their self-assessment of current capabilities and gaps, and 3) CDC's recommended tiered strategy for capabilities:

Tier 1 Public Health Preparedness Capabilities:

- Public Health Laboratory Testing
- Public Health Surveillance and Epidemiological Investigation
- Community Preparedness
- Medical Countermeasure Dispensing
- Medical Materiel Management and Distribution
- Responder Safety and Health
- Emergency Operations Coordination
- Emergency Public Information and Warning
- Information Sharing

Tier 2 Public Health Preparedness Capabilities:

- Non-Pharmaceutical Intervention
- Medical Surge*
- Volunteer Management*
- Community Recovery
- Fatality Management*
- Mass Care

*PHEP funding should support the development of these Tier 2 capabilities in coordination with HPP activities.

CDC's tiered strategy is designed to emphasize the Tier 1 capabilities as they provide the foundation for public health preparedness. PHEP awardees are strongly encouraged to build the priority resource elements in the Tier 1 capabilities prior to making significant or comprehensive investments in Tier 2 public health preparedness capabilities.

Based on current funding levels, ASPR recommends HPP awardees use their capability self-assessment data and prioritize work based on:

1. Closely linking coalition development and respective coalition activities to systems of daily healthcare delivery
2. Targeting coalitions to areas of highest risk—whether as a result of high threat areas or jurisdictions with higher vulnerability (i.e. at-risk populations)
3. The ability to successfully implement their highest priority healthcare preparedness capabilities, based on their jurisdictional risk assessments and capability tiering.
4. Describing what activities require delay or even elimination in Budget Period 3 as a result of current resources.

ASPR expects HPP awardees to prioritize efforts based on availability of funding and their planning model, consistent with the planning process of the U.S. Department of Homeland Security (DHS) preparedness cycle, which is outlined in Chapter 4 of the Federal Emergency Management Agency's (FEMA) *Developing and Maintaining Emergency Operations Plans, Comprehensive Preparedness Guide (CPG) 101, Version 2.0.*

ASPR suggests the following tiering strategy for the healthcare preparedness capabilities, enabling awardees to successfully advance HPP program measures, indicators, and Healthcare Coalition Developmental Assessment (HCCDA) factors and meet exercise requirements:

Tier 1: Healthcare Preparedness Capabilities:
Capability 1: Healthcare System Preparedness
Capability 2: Healthcare System Recovery, Function 2 (continuity of operations)
Capability 3: Emergency Operations Coordination
Capability 6: Information Sharing
Capability 10: Medical Surge

Tier 2: Healthcare Preparedness Capabilities:
Capability 2: Healthcare System Recovery, Function 1
Capability 5: Fatality Management
Capability 14: Responder Safety and Health
Capability 15: Volunteer Management

Given current funding levels, ASPR has modified HPP requirements to reduce awardee burden. Examples include:

- Reducing reporting requirements by eliminating 22% of questions for the Budget Period 2 annual progress report.
- Retiring the healthcare coalition stages of development and streamlining healthcare coalition reporting into the Healthcare Coalition Developmental Assessment (HCCDA) factors.
- Eliminating the exercise and training section of the Budget Period 2 annual progress report and implementing an awardee-suggested process of timely submission of Homeland Security Exercise and Evaluation Program after-action reports/improvement plans and training plans during Budget Period 3.
- Eliminating the National Provider Identifier (NPI) reporting requirement.
- Populating forms in the reporting database.
- Making improvements to the reporting software to better facilitate the submission of information (i.e. increasing character limits and improving wording).

In addition to greater HPP and PHEP alignment, awardees should continue to focus in Budget Period 3 on integrating activities as appropriate with DHS/FEMA and other federal emergency preparedness programs such as local Metropolitan Medical Response Systems and local Medical Reserve Corps units. This collaboration is intended to better support public health preparedness, healthcare preparedness, homeland security, and emergency management coordination. Budget Period 3 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. 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 the public health and medical components of the 31 core capabilities.

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, healthcare, 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. More information on the synchronization of the core capabilities with the HHS preparedness capabilities can be found in Appendix 6.

In 2013, two events reinforced the critical importance of national health security and the key role state and local preparedness plays in helping to assure our nation's health security is protected. The reauthorization of the Pandemic and All-Hazards Preparedness Act (PAHPA) updated legal authorities that have advanced public health and healthcare capabilities and reauthorized funding for public health and medical preparedness programs. The release of the National Health Security Preparedness Index provided a snapshot of today's national preparedness landscape and highlighted the significant progress made in national health security.

Pandemic and All-Hazards Preparedness Reauthorization Act

On March 13, 2013, the President signed into law the Pandemic and All-Hazards Preparedness Reauthorization Act (PAHPRA) of 2013, a critical step in making our nation more resilient to public health emergencies and disasters. The reauthorization recognizes the importance of supporting state and local public health and healthcare preparedness.

Congress passed the first PAHPA in 2006, in the wake of Hurricane Katrina, and the 2013 law builds upon work undertaken by the U.S. Department of Health and Human Services (HHS) and the 62 state, local, and territorial public health departments that receive HPP and PHEP funding to advance national health security. PAHPRA reauthorizes HPP and PHEP appropriations through fiscal year 2018 and revises authorities for activities to improve public health and bioterrorism emergency planning, preparedness, and response.

Preparedness Goals

PAHPRA continues to emphasize the development of a coordinated National Health Security Strategy and implementation plan for public health emergency preparedness and response. HPP and PHEP awardees are directed to use their cooperative agreement funding to achieve the following preparedness goals described in section 2802 of the Public Health Service Act (42 U.S.C. § 300hh-1), which align with the public health and healthcare preparedness capabilities.

(1) Integration (HPP and PHEP)
Integrating public health and public and private medical capabilities with other first responder systems, including through--
(A) the periodic evaluation of federal, state, local, and tribal preparedness and response capabilities through drills and exercises, including drills and exercises to ensure medical surge capacity for events without notice; and
(B) integrating public and private sector public health and medical donations and volunteers.

(2) Medical (HPP only)
Increasing the preparedness, response capabilities, and surge capacity of hospitals, other health care facilities (including mental health and ambulatory care facilities and which may include dental health facilities), and trauma care, critical care, and emergency medical service systems, with respect to public health emergencies (including related availability, accessibility, and coordination), which shall include developing plans for the following:
(A) Strengthening public health emergency medical and trauma management and treatment capabilities.
(B) Fatality management.
(C) Coordinated medical triage and evacuation to appropriate medical institutions based on patient medical need, taking into account regionalized systems of care.
(D) Rapid distribution and administration of medical countermeasures.[1]
(E) Effective utilization of any available public and private mobile medical assets (which may include such dental health assets) and integration of other federal assets.
(F) Protecting health care workers and health care first responders from workplace exposures during a public health emergency.
(G) Optimizing a coordinated and flexible approach to the medical surge capacity of hospitals, other health care facilities, critical care, trauma care (which may include trauma centers), and emergency medical systems.

(3) Public health (PHEP only)
Developing and sustaining federal, state, local, and tribal essential public health security capabilities,

[1] HPP funding to meet this goal should be designated for first responders and healthcare workers.

including the following:

(A) Disease situational awareness domestically and abroad, including detection, identification, and investigation.

(B) Disease containment including capabilities for isolation, quarantine, social distancing, and decontamination.

(C) Risk communication and public preparedness.

(D) Rapid distribution and administration of medical countermeasures.

(4) At-risk individuals (HPP and PHEP)

(A) Taking into account the public health and medical needs of at-risk individuals, including the unique needs and considerations of individuals with disabilities, in the event of a public health emergency, where the term "at-risk individuals" means children, pregnant women, senior citizens and other individuals who have special needs in the event of a public health emergency, as determined by the Secretary.

(5) Coordination (HPP and PHEP)

Minimizing duplication of, and ensuring coordination between, federal, state, local, and tribal planning, preparedness, and response activities (including the State Emergency Management Assistance Compact). Such planning shall be consistent with the National Response Plan, or any successor plan, and the National Incident Management System and the National Preparedness Goal.

(6) Continuity of operations (HPP and PHEP)

Maintaining vital public health and medical services to allow for optimal federal, state, local, and tribal operations in the event of a public health emergency.

Key PAHPRA Elements

PAHPRA modified existing provisions and mandated new activities. Following is a summary of the changes that HPP and PHEP awardees must take into consideration as they develop their Budget Period 3 work plans and budgets. These changes are in addition to the existing legislative requirements that have been in place since PAHPA was enacted in 2006.

Specifically, awardees, as applicable, must include in their all-hazards public health emergency preparedness and response plans descriptions of:

- activities to be conducted to meet preparedness goals with respect to chemical, biological, radiological, or nuclear threats, whether naturally occurring, unintentional, or deliberate;
- how they will partner with relevant public and private stakeholders in public health emergency preparedness and response;
- how jurisdictions will coordinate emergency public health preparedness and response plans with state educational agencies (as defined in section 9101(41) of the Elementary and Secondary Education Act of 1965 (20 U.S.C. § 7801(41)) and state child care lead agencies (designated under section 658D of the Child Care and Development Block Grant Act of 1990 (42 U.S.C. § 9858b));
- activities that specifically enhance cross-border public health emergency preparedness and response capabilities at the United States-Canada border or the United States-Mexico border, including activities for disease detection, identification, investigation, and reporting related to infectious disease outbreaks or chemical, biological, or radiological-nuclear events, whether naturally occurring, accidental, or intentional; and
- activities to analyze real-time clinical specimens for pathogens of public health or bioterrorism

significance, including any utilization of poison control centers (PHEP only).

In addition, PHEP awardees must assure that their annual exercises and drills, and their reports of strengths, weaknesses, and corrective actions identified through such exercises and drills, specifically address the needs of at-risk individuals.

Two key provisions reaffirmed by PAHPRA require that PHEP awardees continue to:

- obtain public comment and input on their all-hazards public health emergency preparedness and response plans and to describe the process used to obtain comment from the public and from other state, local, and tribal stakeholders; and
- as relevant, provide a description of the process used to consult with local public health departments to reach consensus, approval, or concurrence on the relative distribution of funding amounts.

A key provision reaffirmed by PAHPRA requires that HPP awardees continue to:

- strengthen the HPP emphasis on at-risk populations, dental facilities, collaboration with public health and emergency management, and facilitating dissemination of best practices.

The focus on cross-border preparedness in PAHPRA acknowledges the importance of coordination and collaboration of entities that operate on the United States-Mexico border or the United States-Canada border on disease detection, identification, investigation, and preparedness and response activities related to emerging diseases and infectious disease outbreaks whether naturally occurring or due to bioterrorism. This focus on cross-border activity reinforces the U.S. public health and health system preparedness whole-of-community approach which is essential for local-to-global threat risk management and response to actual events regardless of source or origin.

Temporary Reassignment of State and Local Personnel during a Public Health Emergency

Section 201 of PAHPRA amended section 319 of the Public Health Service (PHS) Act to give the HHS Secretary discretion, after declaring a public health emergency, to, upon request from a governor or a tribal organization, authorize the temporary reassignment of state, tribal, and local personnel funded under PHS programs during the period of the public health emergency and any extension. This new temporary reassignment authority provides an important flexibility to state and local health departments and tribal organizations during an event requiring all the resources at their disposal. The provision is applicable to personnel whose positions are funded, in full or in part, through programs authorized under the PHS Act and allows such personnel to immediately respond to the public health emergency in the affected jurisdiction. During the temporary reassignment, the salaries of the affected personnel can be charged to the HHS program to which they are normally charged, as appropriate. States and tribal organizations that temporarily reassign personnel must submit after-action reports outlining the effects of the temporary reassignments on their programs and also must participate in an independent evaluation of the temporary reassignment provision to be conducted by the U.S. Comptroller General.

HHS issued proposed guidance on this new authority in September 2013, followed by a public comment period that closed in mid-December. Currently, HHS is reviewing the comments received and is expected to release final guidance later this year. ASPR and CDC encourage HPP and PHEP awardees to develop, in advance, written plans to initiate the intent of the draft guidelines in the event of a declared federal public health emergency and include the implementation of this provision in any response exercises conducted throughout the year. Such plans are in addition to other plans required in the jurisdiction's all-hazards

public health preparedness and emergency response plans. These HPP and PHEP Budget Period 3 awards are not, however, conditioned upon any awardee's agreement to develop such plans or otherwise seek permission to use this reassignment authority.

Availability of HPP and PHEP Funds

PAHPRA modified provisions regarding the use of unobligated HPP and PHEP funds, stating that funds that remain unobligated at the end of the current fiscal year will remain available to awardees for the next fiscal year for the purposes for which such funds were provided. The new PAHPRA provision eliminates many of the previous guidelines affecting the use of unobligated funds, including 1) limits on the maximum amount of unobligated funds awardees can carry forward into the next fiscal year; and 2) limits on the purposes for which carry-over funds may be used. Carry-over funds now may be used for new activities in the second year, so long as they are used for the purposes for which they were originally authorized and are within the scope of the original funding opportunity announcement and notices of award. More information on the carry-over process is available in the Unobligated Funds Section.

National Health Security Preparedness Index

On December 4, 2013, the National Health Security Preparedness Index (NHSPI) was officially released, offering a snapshot of national preparedness to demonstrate progress and identify areas where greater improvement is needed. The 2013 NHSPI includes 128 public health and healthcare system measures, five of which are PHEP performance measures. HPP measures were in revision when the 2013 NHSPI was developed and were not included, but future versions of the NHSPI are likely to include selected HPP measures as well as metrics from other preparedness sectors.

The 2013 NHSPI results show that substantial health security preparedness capability exists across the nation and that great progress has been made. The 2013 overall index results of 7.2 (out of a total target of 10) were calculated by averaging the state results in five major domains. The 2013 NHSPI results, which will be updated annually, revealed great strengths as well as challenges in national preparedness. Areas in greatest need of further development, according to the 2013 results, include community planning and engagement and surge management. Areas of relative strength include health surveillance, incident and information management, and countermeasure management.

The NHSPI is intended to help guide efforts to improve state and local public health systems and achieve a higher level of health security preparedness. HPP and PHEP awardees should review findings of the 2013 NHSPI and use the results to help them assess their jurisdictional strengths and weaknesses. The results should be analyzed, along with other data sources such as the HHS Capabilities Planning Guide, jurisdictional risk assessments, incident after-action reports and improvement plans, site visit observations, and other jurisdictional priorities and strategies, to help determine their strategic priorities, identify program gaps, and, ultimate, prioritize preparedness investments.

More information on the NHSPI can be found at http://www.nhspi.org/.

International Health Regulations

In addition to key national legislation, strategies and executive directives, the United States is party to the

International Health Regulations (IHR) (2005)[2]. This legally binding international agreement among member states of the World Health Organization (WHO) obligates countries, including the United States, to develop, maintain, and report on core public health preparedness and response capacities to detect, assess, report, notify, and respond to public health threats that may have cross-border implications. The IHR (2005) also provides a global framework for the international coordination and management of events that may constitute potential public health emergencies of international concern (PHEIC). Countries have been implementing the IHR (2005) since June 15, 2007[3], and the capacity-building efforts under PHEP and HPP continue to be critical to U.S. compliance with these international obligations. The U.S. IHR Program, located within the ASPR Office of Policy and Planning's Division of International Health Security, has worked with the HPP and PHEP programs to align the IHR core capacity obligations with public health and healthcare preparedness capabilities and reporting mechanisms. This alignment will allow the United States to obtain critical data from state, local, and territorial public health preparedness capabilities to report the United States' efforts under the IHR mandate. More information on these new cross-border preparedness requirements can be found in the Program Requirements and Application Submission sections.

HPP-specific Changes

Following are HPP-specific changes for Budget Period 3.

- ASPR has shifted from evaluating eight performance measures to evaluating two program measures and 14 indicators
- ASPR will transition from healthcare coalition stages of development to new Healthcare Coalition Developmental Assessment (HCCDA) factors.
    - Submission of HCCDA factor data will be included as an additional HPP benchmark subject to funding penalties.
- Awardees should submit HPP after-action reports (using available templates) directly to ASPR within 90 days of completing an exercise.
- Awardees will be required to submit training plan updates as part of the annual progress report.
- ASPR will strengthen the HPP emphasis on verification and validation of deliverables (i.e. comprehensive, updated all-hazards plans) with the implementation of a program assessment reporting tool for staff and awardees to identify strengths and potential gaps, better review and evaluate progress, and engage in technical assistance.

PHEP-specific Changes

The Budget Period 3 continuation guidance includes updated information on two PHEP program improvements designed to assure continued progress at the state and local levels regarding public health laboratory testing and medical countermeasure planning.

Effective July 1, 2014, CDC will implement a new method of evaluating state and local medical countermeasure operational readiness. For nearly a decade, CDC used the technical assistance review

[2] International Health Regulations: WHO background: http://www.who.int/ihr/about/en/; U.S. Government http://www.phe.gov/preparedness/international/ihr/pages/default.aspx

[3] U.S. Government specific IHR information: http://www.phe.gov/preparedness/international/ihr/pages/default.aspx and http://www.cdc.gov/globalhealth/ihrMaterial/IHRFaq.htm

(TAR) process to assess medical countermeasure preparedness at the state and local levels. The TAR effectively outlined the planning steps needed to support distribution and dispensing of medical countermeasures but did not accurately reflect the ability of state, local, and territorial jurisdictions to implement and execute their medical countermeasure operational plans. The new assessment process is designed to better measure a jurisdiction's ability to plan and successfully execute any large-scale response requiring distribution and dispensing of medical countermeasures and to provide a snapshot of the nation's medical countermeasure programs as a whole. This new assessment builds upon the medical countermeasure planning progress PHEP awardees have made over the years and is intended to identify medical countermeasure response operational capabilities as well as gaps that may require more targeted technical assistance. More information on the new medical countermeasure readiness review process can be found in the PHEP-specific program requirements section.

CDC has revised its Laboratory Response Network (LRN) policy to refine membership requirements for biological reference level laboratories. The LRN-B reconfiguration will establish three levels of reference laboratories to be known as Limited, Standard, and Advanced, based on their testing capabilities. Specific requirements for maintaining laboratory capability and capacity have been developed for Standard level laboratories that will serve as the foundation of the network. The majority of these laboratories currently receive PHEP funding.
The intent of the new minimum requirements is to assure that all 50 states as well as Urban Areas Security Initiative (UASI) jurisdictions are capable of providing a standard battery of tests for high priority biological threats and emerging infectious diseases. To comply with the new LRN-B policy, PHEP awardees will be required to work with their state laboratory programs to ensure that state public health laboratories that receive PHEP funding meet LRN-B Standard reference level requirements and ensure that LRN-B Standard reference level capability is available in or near UASI jurisdictions. Awardees will have until June 30, 2015, to meet the new requirements or to have plans in place to address testing gaps.

HPP-PHEP Program Requirements

For HPP-PHEP Budget Period 3, awardees must address and comply with joint program requirements, as well as specific HPP and PHEP requirements. See Appendix 9 for modified PHEP requirements for American Samoa, Commonwealth of the Northern Mariana Islands, Guam, U.S. Virgin Islands, the freely associated states including Federated States of Micronesia, Republic of the Marshall Islands, and Republic of Palau. The joint and HPP requirements will apply to all awardees, including the territories and freely associated states. HPP project officers will work with awardees to ensure that requirements can be met.

Joint Requirements
HPP and PHEP awardees must address and comply with the following Budget Period 3 joint requirements.

Cross-Discipline Coordination

1. 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.

   In addition to greater HPP and PHEP alignment, awardees should continue to focus in Budget Period 3 on integrating activities as appropriate with the U.S. Department of Homeland Security's

(DHS) Federal Emergency Management Agency (FEMA) and other federal emergency preparedness programs, including local Metropolitan Medical Response Systems (MMRS), local Medical Reserve Corps (MRC), and local Cities Readiness Initiative (CRI) programs. HHS strongly encourages awardees to work collaboratively with these other federal health and preparedness programs in their jurisdictions to maximize resources and prevent duplicative efforts. Many activities and objectives associated with the MMRS grant program may be considered allowable costs for HPP and PHEP programs. Awardees should also consider coordinating with emergency management to leverage use of DHS grants, which may apply to MMRS activities. In addition, HPP awardees should consider incorporating MMRS jurisdictions in their preparedness and response efforts.

Public health department and healthcare sector awardees must continue to actively participate with their emergency management and public safety partners to contribute content for the FEMA-required annual State Preparedness Report (SPR). The SPR is a self-assessment of preparedness capabilities that compares awardee preparedness with target capabilities established in the state's Threat and Hazard Identification and Risk Assessment (THIRA). Any state or territory that receives federal preparedness assistance from DHS is required by law to submit an annual SPR to FEMA. Awardees should contact their jurisdiction's state administrative agency to identify the appropriate SPR point of contact.

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

   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.

   In 2011, the CDC Risk-based Funding (RBF) pilot project provided $10 million for select PHEP awardee jurisdictions to promote accelerated development of strategies that mitigate the public health risks associated with higher population areas. The primary goal of this project is to identify resources, processes, and findings around risk assessment that can be used by all awardees to inform risk reduction strategies and to advance planning. CDC plans to make RBF findings and promising practices available to all HPP and PHEP awardees, who are encouraged to use these pilot site tools, user guides, and other resources as they develop their jurisdictional risk assessments.

3. Support integration with the daily healthcare delivery system. As the national healthcare delivery system undergoes changes outlined in the Affordable Care Act (ACA) and other initiatives, awardees should consider how to incorporate those changes into disaster preparedness. 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 should consider linkages with programs and activities that would improve their ability to execute the public health or healthcare preparedness capabilities.

4. Establish and maintain senior advisory committees. Awardees must establish and maintain advisory committees or similar mechanisms 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 HPP and PHEP 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, including those representing at-risk populations.

5. 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.

6. Comply with SAFECOM requirements. Awardees and subawardees that use federal preparedness grant funds to support emergency communications activities must comply with current 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.

Administrative Preparedness

7. 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.

Capabilities Development

8. Achieve progress on capability development. In Budget Period 3, 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.

9. Develop short-term capability goals and objectives. Awardees must develop short-term goals, supporting objectives, and planned activities that lead to proposed outputs for the capabilities they are addressing in Budget Period 3. For both programs, these short-term goals, objectives, planned activities, and proposed outputs should support the long-term goals of building and sustaining each program's capabilities. Planned activities should lead to measurable outputs linked to program activities and outcomes.

   HPP awardees are expected to build and sustain the eight healthcare preparedness capabilities during the five-year project period. For those capabilities funded in Budget Period 3, awardees should identify work plan objectives and planned activities that result in outcomes and outputs aligned with HPP program measures and HCCDA factors. Any capability functions with objectives that are supported by HPP funding must have at least one budget line item associated with that function in the budget.

   PHEP awardees are expected to build and sustain the 15 public health 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.

10. Comply with application and reporting requirements. Awardees must complete and submit all required HPP and PHEP program components by the published deadlines. The required components include:
    - Funding application project narratives
    - Funding application work plans and follow-up responses to work plan conditions of award
    - Funding application budgets and follow-up responses to budget restrictions and other items that need more information
    - Annual progress reports and performance/program measure data
    - Quarterly financial reports and Federal Financial Reports
    - Quarterly reviews of technical assistance plans
    - Local and tribal concurrence documentation (PHEP only)

Previously, several HPP and PHEP awardees have failed to submit these required program components according to published deadlines. Compliance with this key programmatic requirement will be a high priority in Budget Period 3.

11. Continue to develop healthcare coalitions. HPP 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 and follow current HPP program measures, related indicators, and HCCDA factors as they build operational healthcare coalitions that surge and implement immediate bed availability (IBA) components.

    Healthcare coalitions are expected to develop throughout the five-year project period. The development of a healthcare coalition is based on the assessment of functionality. Healthcare coalition development will be evaluated based on the HCCDA factors (http://www.phe.gov/Preparedness/planning/evaluation/Documents/hpp-bp2-measuresguide-2013.pdf). Healthcare coalitions should facilitate the execution the program measures of medical surge and continuity of healthcare operations. See Appendix 4 for HPP benchmarks.

    PHEP awardees should strongly encourage their local health departments to participate in healthcare coalitions to the maximum extent possible.

12. 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). Awardees must update their multiyear training and exercise plans (MYTEP) to reflect planned activities for Budget Period 3. 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 exercise reporting requirements contained in Appendix 7 and Appendix 8.

    During Budget Period 3, PHEP awardees must address the needs of at-risk individuals in their exercises or drills and report on the strengths and weaknesses identified through such exercises or drills and corrective actions taken to address material weaknesses in the following year's funding application. HPP awardees should consider the needs of at-risk individuals as they plan healthcare coalition-based exercises.

    In addition, there must be evidence in the Budget Period 3 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 3 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 joint 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 exercise plans.

13. Complete and submit after-action report/improvement plan (AAR/IP). Awardees are encouraged to submit AARs/IPs for all responses to real incidents and for exercises conducted during Budget Period 3. At a minimum, awardees must submit AARs/IPs for the responses and exercises used to demonstrate compliance with HPP and PHEP program requirements. The AARs/IPs must include observations, strengths, challenges, and corrective action plans for responses or exercises and should relate to the public health and healthcare preparedness capabilities as applicable. Awardees should submit AARs/IPs as soon as possible following the event or exercise, but all Budget Period 3 AARs/IPs must be submitted no later than September 30, 2015, with the Budget Period 3 annual progress report.

14. 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.

15. Engage in technical assistance planning. Both awardees and project officers will identify technical assistance strategies that can help build and sustain capabilities and close significant gaps. Technical assistance can help awardees better leverage its resources to effectively reach program milestones. Awardees must actively work with their HPP and PHEP project officers to properly identify, manage, and update technical assistance plans at least quarterly during Budget Period 3.

16. Plan and conduct joint site visits. Awardees should actively participate in the planning and execution of routine site visits conducted by HPP and PHEP project officers. Site visits will be scheduled to occur at least once every 12 months to 18 months. The objectives of the site visits are to 1) assess current planned activities, 2) discuss an awardee's ability to operationalize capabilities and demonstrate progress, 3) identify barriers that impede progress, and 4) coordinate technical assistance strategies. Awardees must maintain all program documentation that substantiates progress in building and sustaining capabilities, measuring performance, and demonstrating compliance with joint and HPP- and PHEP-specific programmatic requirements. Documentation must include updated all-hazards public health emergency preparedness and response plans as outlined by PAHPRA. Awardees must make these documents available to project officers for

review during site visits and throughout the year as requested. In addition, awardees are encouraged to invite HPP and PHEP project officers and senior staff to observe scheduled exercises and to attend regional meetings supported by HPP and PHEP funding.

In addition, PHEP site visits may often include medical countermeasure (MCM) assessments, verification of Receipt, Stage, and Store (RSS) sites, and other medical countermeasure-related work.

17. Participate in mandatory meetings and training. The following meetings are considered mandatory, and awardees should budget travel funds accordingly:
    - Annual Preparedness Summit sponsored by NACCHO
    - Directors of Public Health Preparedness annual meeting sponsored by ASTHO
    - Healthcare Coalition Conference

    Awardees also must participate in other mandatory training sessions that may be conducted via webinar or other remote meeting venues.

18. Meet National Incident Management System (NIMS) compliance requirements. Awardees must meet NIMS requirements and adhere to national guidance and policies set forth in national strategies 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 allocate Budget Period 3 resources to ensure continued implementation of the 11 NIMS activities for each healthcare coalition's participating hospitals and report on those activities in the Budget Period 3 annual progress report. See Appendix 7.

19. Engage the state offices on aging or equivalent office. HPP and PHEP awardees should engage the state office on aging or equivalent office (e.g. other agencies that serve older Americans) 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.

20. Develop preparedness and response strategies that address the access and functional needs of at-risk individuals. At-risk individuals have needs in one or more of the following access or functional areas: communication, maintaining health, independence, services/support/self-determination, and transportation (CMIST Framework). At-risk groups may include children, senior citizens, and pregnant women as well as people 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, or have pharmacological dependency. Awardees must have preparedness, response, and recovery strategies and capabilities that address the public health, medical, and mental/behavioral health needs of at-risk individuals in the event of a public health emergency. Awardees also must have structures or processes in place, including the use of access and 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 at-risk populations. Specifically, awardees should engage with the Health Resources and Services Administration's Emergency Medical Services for Children (EMSC) program managers to leverage expertise and federal funding to integrate pediatric disaster plans with emergency medical services. Engagement should also include state offices on disabilities or the equivalent, specifically agencies that serve people with disabilities, such as Councils on Developmental Disabilities and Statewide Independent Living Councils. Department of Homeland Security Homeland Security Grant funds may be used to ensure emergency preparedness programs include the integration of disabled individuals who have access and functional needs. See Appendix 11 for additional resources regarding at-risk populations.

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

22. Submit pandemic influenza preparedness plans. Awardees must submit descriptions of the activities they will carry out with respect to pandemic influenza as required by Sections 319C-1 and 319C-2 of the Public Health Service Act and as amended. ASPR and CDC have determined that awardees can satisfy the annual requirement through the submission of required program data such as the capability self-assessment and program/performance measures that provide information on the status of state and local pandemic response readiness, barriers and challenges to preparedness and operational readiness, and efforts to address the needs of at-risk individuals. In addition, PHEP awardees may be required to complete a pandemic influenza readiness assessment designed to identify operational gaps and inform CDC's technical assistance and guidance for pandemic preparedness planning.

23. Conduct activities to enhance border health. Awardees in jurisdictions located on the United States-Mexico border or the United States-Canada border must conduct activities that enhance border health, particularly regarding disease detection, identification, investigation, and preparedness and response activities related to emerging diseases and infectious disease outbreaks whether naturally occurring or due to bioterrorism. This focus on cross-border preparedness reinforces the U.S. public health and health system preparedness whole-of-community approach which is essential for local-to-global threat risk management and response to actual events regardless of source or origin.

24. Provide performance and program measure data and supporting documentation for indicators. Federal law requires HPP and PHEP awardees to report on the progress federal funding has had on advancing national preparedness. To meet this requirement, ASPR evaluates HPP awardees using program measures, indicators, and the HCCDA Tool. CDC evaluates PHEP awardees using performance measures and other evaluation tools. In addition to their individual evaluations, ASPR and CDC evaluate HPP and PHEP awardees according to the joint performance measures. See the Evaluating Performance section for more information.

25. Provide ASPR and CDC with situational awareness data during emergency response operations and other times as requested.

HPP-Specific Requirements

1. Comply with HAvBED (National Hospital Available Beds for Emergencies and Disasters) standards. While this requirement is no longer an HPP benchmark, awardees 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. Ensure healthcare coalition hospitals address NIMS implementation activities. HPP awardees must include information in their Budget Period 3 work plans that describes how they will ensure that the hospitals in their healthcare coalitions are conducting the 11 NIMS implementation activities for hospitals.

3. Include community health, long-term care, dialysis, and poison control centers, among others, in healthcare coalition development, exercise, and training activities if applicable.

4. Identify existing healthcare coalitions. Awardees must update maps that delineate the geographic boundaries of all the healthcare coalitions within awardee jurisdictions. Updated maps should be submitted with awardees' annual progress reports. In addition, in partnership with each HPP awardee, all identified coalitions may be asked to complete a questionnaire that describes their characteristics and functions. HPP will use this data, to be submitted with the Budget Period 3 annual progress report, to update information on existing coalitions. Results will be shared with awardees.

5. Comply with training and exercise requirements as described in Appendix 7.

6. Submit required program progress reports and financial data, including progress in achieving evidence-based benchmarks and objective standards as applicable.

PHEP-specific Requirements

1. Obtain local and tribal concurrence. As applicable, awardees must seek and obtain 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 their jurisdictions to reach consensus, approval, or concurrence on the overall strategies, approaches, and priorities described in their work plans and on the relative distribution of funding as outlined in the budgets associated with the work plans. Awardees do not need to obtain concurrence on the specific funding amounts but rather the process and formula used to determine local health department or tribal award amounts. Awardees must describe the process used to obtain concurrence, including any nonconcurrence issues encountered and plans to resolve issues identified through this process.

2. Coordinate with cross-cutting public health preparedness partners. PHEP programs should complement and be coordinated with other public health, healthcare, and emergency management programs as applicable. For example, some public health emergency preparedness activities such as laboratory, surveillance, epidemiological investigation, and information sharing capability functions may directly complement the core public health activities 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 national jurisdictions for states that share borders with Mexico and Canada 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 3 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 if requested and make available for review during site visits. Awardees must describe in their project narratives activities to be conducted to meet preparedness goals with respect to chemical, biological, radiological, or nuclear threats, whether naturally occurring, unintentional, or deliberate. Awardees also should include provisions for utilizing other state and local personnel from their jurisdictions who are reassigned to preparedness and response activities during a public health emergency.
   - 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 programs 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.
   - Conduct an annual exercise or drill to test preparedness and response capabilities, including addressing the needs of at-risk individuals.
   - In coordination with HPP colleagues, inform and educate hospitals and healthcare coalitions within the jurisdiction on their role in public health emergency preparedness and response.
   - 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, including monitoring of subrecipient activities.
   - Provide CDC with situational awareness data during emergency response operations and other times as requested.

4. Comply with medical countermeasure planning/Cities Readiness Initiative (CRI) guidelines. To align with the PHEP cooperative agreement's capabilities-based approach, medical countermeasure planning and CRI requirements support multiple public health preparedness capabilities with a specific focus on Capability 8: Medical Countermeasure Dispensing and Capability 9: Medical Materiel Management and Distribution. These capabilities outline standards that support distribution and dispensing functions that should be part of a jurisdiction's all-hazards planning. PHEP awardees are responsible for ensuring medical countermeasure distribution and dispensing (MCMDD) capabilities are built and sustained in their jurisdictions and can be operationalized to support any large-scale public health event requiring a medical countermeasure response. PHEP resources can be used to build and sustain any public health preparedness capability that supports medical countermeasure planning and response.

   CDC provides dedicated funding to support medical countermeasure planning in 72 CRI jurisdictions. The President's Office of Management and Budget (OMB) has revised the U.S. metropolitan statistical areas (MSAs), based on Census Bureau data. These changes affect the planning jurisdictions now included in the 72 CRI cities. They include name changes for 25 MSAs, additions of 27 counties in 17 of the 72 CRI MSAs, and deletions of 14 counties in 10 of the 72 CRI MSAs. State awardees must account for these changes in their CRI planning for Budget Period 3. The 72 CRI MSAs, their population, and CRI funding amounts for Budget Period 3 can be found in Appendix 3.

   In Budget Period 3, CDC will implement a new method of evaluating state and local medical countermeasure operational readiness. This new objective assessment is intended to identify medical countermeasure response operational capabilities as well as gaps that may require more targeted technical assistance. CDC designed the new medical countermeasure assessment tool with input from national partner associations and representatives of state and local medical countermeasure program staff.

   CDC will use the new assessment tool in Budget Period 3 to review all 62 PHEP awardee jurisdictions on their ability to implement their medical countermeasure plans. State awardees will be required to review, in conjunction with CDC, one local planning jurisdiction within each of their CRI metropolitan statistical areas (MSAs) using the new assessment tool. For those states that have overlapping CRI MSA jurisdictions with adjoining states, the state with the majority of the MSA population will be responsible for conducting the operational readiness review in that CRI MSA.

   CDC may choose to review additional CRI local jurisdictions based on risk, operational gaps, or other criteria. In addition, awardees may request that CDC conduct other local medical countermeasure operational readiness reviews. The data collected using the new medical countermeasure operational readiness review tool will be considered provisional with the public release of these data restricted to the extent allowable by law.

   State awardees must continue to collect local jurisdictional data for those local CRI jurisdictions where the medical countermeasure readiness review will not be conducted, and state awardees must verify that these local CRI jurisdictions remain ready to conduct a large scale medical countermeasure dispensing mission. In addition, each local planning jurisdiction within the 72 CRI metropolitan statistical areas, including the four directly funded localities, must continue to conduct three different drills during Budget Period 3. The results of the drill data submissions and

compliance with dispensing and distribution standards will be reviewed during site visits to further evaluate local medical countermeasure distribution and dispensing preparedness.

All PHEP awardees also will be required to have current Receipt, Stage, and Store (RSS) site survey information on file with CDC for all potential RSS sites in their jurisdictions. RSS site information should be updated to reflect any changes affecting operational capabilities. Awardees must survey their RSS sites at least once every three years and provide updated RSS site information to CDC.

CDC will release later in May 2014 more detailed guidance on the new medical countermeasure operation readiness assessment process and the data collection tool that will be used as part of this new evaluation.

5. Continue Level 1 chemical laboratory surge capacity activities. The 10 awardees who receive Level 1 chemical laboratory funding 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.

6. Comply with new biological laboratory requirements. CDC has revised its Laboratory Response Network (LRN) policy to refine membership requirements for biological reference level laboratories. Reconfiguration of the LRN-B will establish three levels of reference laboratories to be known as Limited, Standard, and Advanced, based on their testing capabilities. Specific requirements for maintaining laboratory capability and capacity have been developed for Standard level laboratories that will serve as the foundation of the network. To comply with the new LRN-B policy, PHEP awardees must prioritize preparedness investments to ensure that state public health laboratories that receive PHEP funding meet LRN-B Standard reference level requirements and ensure that LRN-B Standard reference level capability is available in or near Urban Areas Security Initiative (UASI) jurisdictions. Awardees will have until June 30, 2015, to meet the new requirements or to have plans in place to address testing gaps.

7. Review information technology investments in secure alerting systems. While Health Alert Networks are no longer a mandatory PHEP requirement, CDC encourages PHEP awardees to review their current secure alerting systems to ensure they are maximizing their IT communication investments. CDC recommends that PHEP awardees consider other multipurpose mechanisms for secure communication messaging such as emergency operations center software products that provide other functionality as well.

Evaluating Performance

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 use performance and program measure data to assess performance within a budget period and over time. These data also are used to drive program improvement and help identify critical areas of need, including technical assistance needs, and to demonstrate accountability to Congress and the public regarding the use of appropriated funds.

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. To reduce reporting burden, ASPR and CDC will continue 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.

Performance Measure Reporting Requirements

For planning purposes, including contract negotiation with subawardees, HPP and PHEP awardees can reference reporting requirements as stated in each program's respective Budget Period 2 performance/program measures guidance. The updated HPP and PHEP program/performance measure guidance documents to be released by ASPR and CDC by June 2014 will include detailed reporting requirements for Budget Period 3. 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 3 program/performance measures and related evaluation and assessment data to ASPR and CDC. Budget Period 3 measures include those that are specific to HPP, specific to PHEP, and a subset of performance measures jointly developed by HPP and PHEP used to satisfy the requirements of both programs.

HPP-specific Provisions

In Budget Period 2, ASPR modified its HPP evaluation model, moving from eight performance measures to two program measures: medical surge and continuity of healthcare operations. Each of the program measures include seven indicators, which were also refined in Budget Period 2. The refined indicators incorporate critical components of ASPR's *National Healthcare Preparedness Capabilities: National Guidance for Healthcare System Preparedness* and align with the National Health Security Strategy. The indicators represent more concise and informed measures that integrate key tenets and reduce awardee burden. ASPR expects that these HPP program measures and indicators will stay consistent throughout the remainder of the project period.

Awardees are required to collect performance measure indicators and report their data to ASPR as part of the Budget Period 3 annual progress reports. The unit of measurement for the majority of HPP-specific indicators is at the healthcare coalition level. Awardees must collect and aggregate the healthcare coalition indicators and report these along with awardee-level data. To meet HPP requirements, awardees must submit a response to ASPR for each program measure indicator.

In addition to the refined program measures and indicators, ASPR introduced the HCCDA in Budget Period 2. The HCCDA factors determine a healthcare coalition's ability to perform essential functions. The HCCDA factors foster communication between healthcare coalitions and awardees and gauge the level of healthcare coalition development over time and across the disaster spectrum.

In summary, during Budget Period 3 ASPR will evaluate HPP awardees based on these sources of information:

- Medical surge program measure: Seven indicators (three that are measured at the awardee level, and four that are measured at the healthcare coalition level) that address essential aspects of medical surge and related preparedness and response efforts.
- Continuity of healthcare operations program measure: Seven indicators (all measured at the healthcare coalition level) that address the maintenance of vital public health and medical services for optimization of federal, state, local, and tribal healthcare operations in the event of a public health emergency.
- HCCDA: Twenty factors (all measured at the healthcare coalition level) that determine a healthcare coalition's ability to perform certain functions, encourage and foster communications between the awardee and the healthcare coalitions in its jurisdiction, and gauge the level of healthcare coalition development over time and across the disaster spectrum.
- Provisional program measures: ASPR may study one or two additional provisional program measures to help guide future work.

More information is available in the HPP Program Measure Manual: Implementation Guidance for the HPP Program Measures at www.phe.gov/Preparedness/planning/evaluation/Documents/hpp-bp2-measuresguide-2013.pdf).

PHEP-specific Provisions

CDC expects to release Budget Period 3 performance measure guidance, including new reporting requirements, by June 2014. Expected modifications 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 PHEP Budget Period 1 and Budget Period 2 Performance Measures Specifications and Implementation Guidance documents and Appendix 9 of the CDC-RFA-TP12-1201 funding opportunity announcement. The new guidance will state explicit requirements for reporting data on all performance measures and evaluation tools. Awardees must comply with reporting requirements for all performance measures and evaluation tools as stated in the guidance. Except where noted in the performance measure implementation guidance, a small subset of measures will require data drawn from real incidents, exercises, or drills. For these measures, awardees will not be permitted to indicate they have no data to report; instead, they must conduct an exercise or, if permissible, a drill, to collect appropriate data if they are not able to do so from a real incident or if they do not experience a real incident. Finally, awardees that experience significant public health emergencies or disasters are strongly encouraged to collect relevant performance measure or evaluation tool data from such incidents.

New performance measures introduced in Budget Period 3, as well as data collected through the new medical countermeasure operational readiness assessment, 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 reporting burden on the majority of island jurisdictions, the following PHEP awardees will not be required to report PHEP performance measure data in Budget Period 3: 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. All PHEP awardees will be required to submit data using the community preparedness evaluation tool as well as the community recovery and mass care evaluation tools if responses involve use of these latter two capabilities.

Select PHEP performance measures and evaluation tools (e.g., PHEP 5.1, 6.1, 7.1, 11.1, 14.1, 15.1, and the community preparedness, community recovery and mass care evaluation tools) may require state awardees to collect data from subawardees on key activities and performance. This is dependent upon the governance structure and how public health preparedness and response activity is organized in each state. It is the responsibility of awardees to monitor subawardee activities, progress, and performance in these areas, including having processes and procedures to collect data from subawardees as applicable. Awardees are encouraged to work closely with subawardees to communicate expectations regarding key activities and deliverables, including collection and reporting of performance measure data, to train subawardees as appropriate and feasible, and to collect data from subawardees in a timely manner.

PHEP Program Metrics

To better understand the tangible products and outputs of PHEP investments and to enhance program accountability, CDC is developing a small number of PHEP program metrics intended to capture key preparedness and response activities to which PHEP funds contribute. These are not intended to measure performance but rather provide information on the degree to which PHEP funding contributes to key capabilities and capacities. Examples may include, but not be limited to, the number of full and partial emergency operations center activations, the number of epidemiological investigations conducted or supported by PHEP-funded staff, the number of exercises coordinated or led by awardees, the number of trainings conducted using PHEP funds; percentage of PHEP-funded epidemiology staff, and the types of public health systems built and supported using PHEP resources. These examples are subject to change. CDC anticipates releasing final program metrics for Budget Period 3 activities by June 2014.

Evidence-based Benchmarks

HPP and PHEP 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. 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. Note that a key benchmark for both programs, "demonstrated adherence to application and reporting deadlines," requires timely submission of applicable information throughout Budget Period 3. 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 accountability provisions, enforcement actions and disputes, as well as withholding and repayment guidance.

Preparing and Submitting Budget Period 3 Funding Applications

Funding applications are due no later than **11:59 p.m. EDT on May 9, 2014**, to 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-TP12-1201-3CONT14
- Download application package and complete all sections.

Grants.gov Checklist of Required Application Contents

The mandatory application package associated with this funding opportunity includes:

- Application for Federal Domestic Assistance - Short Organizational Form (SF-424)
- 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: Subawardee Contracts Plan (optional)
  - Attachment K: Budget Change Report (optional for carry-over request)
  - Attachment L: Health Department Organizational Chart (one each for HPP and PHEP)

Application for Federal Domestic Assistance - Short Organizational Form

Awardees must complete all sections.

- In addition to inserting the legal name of the awardee's 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, via www.grants.gov, of a joint application containing the following information:

- Budget Period 2 progress report (data will be submitted as part of the project narrative)
- 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

For Budget Period 3, awardees will complete their project narratives in the application module, instead of submitting the narratives as a separate attachment as in previous budget periods. ASPR and CDC have streamlined the project narrative and will only collect the specific data needed at the time of application to comply with program, grant administration, and legislative requirements. HPP and PHEP project officers will request to review additional information during site visits or monthly calls.

Following are the major sections included in the project narrative.

Strategic Forecast

Awardees must briefly describe the top jurisdictional strategic priorities for the remainder of the project period. These priorities should be based on jurisdictional risk assessments, exercise or response observations, or other sources of information used to determine a program's operational gaps. This strategic forecast is different than the five-year forecast required in previous budget periods and should be a very brief description of the overall priorities for the remaining three years of the project period. A bulleted list of priorities with a very brief description is sufficient. The forecast must include a brief discussion of challenges or barriers awardees expect to encounter in Budget Period 3.

Budget Period 2 Progress Report

This section requires a brief program update on Budget Period 2 planned activities. For those capabilities on which an awardee worked during Budget Period 2, a brief description is required for planned activities that produced measurable changes and/or tangible outputs. The intent is to briefly show the impact HPP and PHEP program investments in Budget Period 2 had on awardee preparedness programs. Awardees must also describe significant challenges or barriers experienced in Budget Period 2. In addition, awardees must also include requests for technical assistance needed in Budget Period 3.

Administrative Preparedness Strategies
Awardees must update the current status of plans to improve various components of administrative preparedness.

Jurisdictional Risk Assessment
Awardees must provide the date the jurisdictional risk assessment was completed or is projected to be completed.

Full-scale Exercise
Awardees must provide the date the full-scale exercise was conducted or is projected to be conducted.

Response Plans for Chemical, Biological, Radiological, or Nuclear Threats
Awardees must describe activities to be conducted to meet preparedness goals with respect to chemical, biological, radiological, or nuclear threats, whether naturally occurring, unintentional, or deliberate.

Advisory Committee Activities
Awardees must describe plans for maintaining a senior advisory committee or an equivalent entity in Budget Period 3 to provide input on preparedness strategies, 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.

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.

National Incident Management System (NIMS) Compliance (HPP awardees only)
Awardees must allocate funds to ensure the 11 NIMS implementation activities continue for hospitals engaged in healthcare coalition development and report on status of those activities within the healthcare coalition section of the Budget Period 3 annual progress report.

At-risk Individuals
Awardees must describe the structures or processes in place to ensure the functional 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 individuals with access and/or functional needs including children, pregnant women, senior citizens, and people with disabilities.

For more information on the HHS definition of at-risk individuals, please see: http://www.phe.gov/Preparedness/planning/abc/Pages/at-risk.aspx.

Emergency Management Assistance Compact (EMAC)
Awardees must describe how they activate EMAC agreement or other mutual aid agreement processes used during emergency response and recovery operations or in other surge situations where additional assistance is required.

Coordination of Emergency Public Health Preparedness and Response Plans with Educational Agencies and State Child Care Lead Agencies
Awardees must describe the process they use to ensure emergency preparedness and response coordination with designated educational agencies and lead child care agencies in their jurisdictions.

Conduct Activities to Enhance Border Health
Awardees must describe activities they plan to conduct specific to the border area, for those jurisdictions located on the United States-Mexico border or the United States-Canada border, including disease detection, identification, investigation, and preparedness and response activities related to emerging diseases and infectious disease outbreaks whether naturally occurring or due to bioterrorism.

Local and Tribal Concurrence (PHEP awardees only)
As applicable, awardees must seek and obtain 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 their jurisdictions to reach consensus, approval, or concurrence on the overall strategies, approaches, and priorities described in their work plans and on the relative distribution of funding as outlined in the budgets associated with the work plans. Awardees do not need to obtain concurrence on the specific funding amounts but rather the process and formula used to determine local health department or tribal award amounts. Awardees must describe the process used to obtain concurrence, including any nonconcurrence issues encountered and plans to resolve issues identified.

State applicants will be required to provide signed letters of concurrence on official agency letterhead from local and 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. CDC will work with awardees who were unable to gain concurrence to help develop strategies to resolve nonconcurrence issues.

Coordination with Cross-cutting Public Health Preparedness Partners (PHEP awardees only)
Awardees must describe how their PHEP program components are coordinated with other public health, healthcare, and emergency management programs as applicable. For example, awardees should describe public health emergency preparedness activities that directly complement the core public health activities within CDC's Epidemiology and Laboratory Capacity (ELC) for Infectious Diseases cooperative agreement. The project narrative also should describe 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.

Analysis of Real-time Clinical Specimens (PHEP awardees only)
Awardees must describe plans to analyze real-time clinical specimens for pathogens of public health or bioterrorism significance, including any utilization of poison control centers.

Work Plan

Capabilities Plan

Awardees are required to describe goals, objectives, planned activities, and proposed outputs in their Budget Period 3 work plans. Proposed outputs were not required in Budget Period 2, but many awardees chose to include them in addition to the planned activities for each of their objectives. Proposed outputs are required elements in Budget Period 3, and HPP and PHEP awardees must include a minimum of one proposed output for each objective in their capabilities plans.

ASPR and CDC will populate all or some of the Budget Period 3 application short-term goals, objectives, planned activities, and proposed outputs in the Budget Period 3 annual progress report module. This information is intended to serve as a starting point to help awardees complete their annual progress reports. Awardees should keep this in mind when completing their work plans.

Similar to Budget Period 2, HPP awardees are expected to describe in their applications specific activities to build or sustain any funded capability from the eight healthcare preparedness capabilities. Funded projects and corresponding objectives and planned activities should assist awardees in developing outcomes and outputs that align with HPP program measures and HCCDA factors.

In Budget Period 3, PHEP awardees are expected to continue efforts to build and sustain the 15 public health preparedness capabilities. CDC provides PHEP awardees with the flexibility to choose the specific capabilities they work on in a single budget period. The overarching PHEP program goal is to achieve the 15 public health preparedness capabilities by the end of the current five-year project period; however PHEP awardees should approach this goal based on their jurisdictional priorities and resources. CDC encourages awardees to build and maintain each capability to the scale that best meets their jurisdictional needs, so they are fully capable of responding to public health emergencies regardless of size or scenario.

A complete Budget Period 3 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 for Budget Period 3

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 for Budget Period 3.
   - Indicate and describe, if applicable, any self-identified technical assistance needs for the capability.

2. Short-term goals. Awardees' short-term goal descriptions should be designed to answer the question: For a specific capability, what are the operational gaps, programs, or systems that need to be created or improved with program funding during this budget period? The description must identify the specific, measurable changes 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 within each capability. Awardees can enter multiple goals per capability, but, as in Budget Period 2, there will only be one text field to enter these goals, so awardees are asked to number or otherwise designate the multiple goals.

3. If awardees have planned activities for a capability they must select one of the following types of funding for that capability:
   - HPP
   - PHEP
   - Other funding source (state, local, DHS, other)

Capability functions that have objectives and are supported by HPP or PHEP funding must be associated with the budget.

4. Objectives. Awardees must provide at least one objective for each short-term goal. The objective descriptions must also be specific, measurable, and directly support or contribute to the achievement of the short-term goal. The objectives should also describe a desired outcome which could be reported as part of the Budget Period 3 annual progress report. Since there could be multiple goals for each capability, awardees are asked to associate the objectives to a specific goal.

5. Planned activities. Awardees must provide at least one planned activity for each objective that describes the necessary tasks, deliverables, or products required to meet the objective. The planned activities should describe specific actions that support the objectives and should be written in a way that can be reflected in the Budget Period 3 annual progress report. Planned activities are captured for specific objectives, and there is no need to further associate them.

6. Proposed outputs. In addition to the planned activities, awardees must provide at least one proposed output for each objective. The proposed outputs should directly relate to the expected results of completing the planned activities or objectives. These proposed outputs will also be populated in the Budget Period 3 annual progress report to facilitate the end-of-year reporting cycle. Proposed outputs are captured for specific objectives, and there is no need to further associate them.

7. Function associations. Awardees must associate objectives to functions for a specific capability.

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

9. Biological laboratory requirements (PHEP awardees only). Awardees must describe their plans to meet updated LRN-B program requirements for Standard reference level laboratories as outlined in Appendix 10. Minimum requirements for Standard Reference Level LRN-B laboratories describe the tools and resources necessary for LRN-B membership including staffing and equipment requirements, maintaining proficiency, maintaining communications with sentinel laboratories, and providing support for the detection of emerging infectious diseases. In addition, awardees must describe how they will ensure that LRN-B Standard reference level capability is available in or near Urban Areas Security Initiative (UASI) jurisdictions as outlined in the 2014 DHS Homeland Security Grant Program. Awardees must meet Standard Reference Level LRN-B program requirements by June 30, 2015.

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. If use of estimated unobligated funds is requested in addition to funding for Budget Period 3, complete all columns in Section A of 424A and submit an interim Federal Financial Report (FFR), SF-425, available at http://grants.nih.gov/grants/forms.htm#closeout.
    a. The amount of estimated unobligated funds *requested* as carry-over should be entered into Section A of 424A - Federal (c) and Non-Federal (d).
    b. The carry-over funds requested may not exceed 75% of the estimated unobligated funds reported on the interim FFR to be submitted with the application.
D. 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.
E. The proposed budget should be based on the federal funding level stated in the HPP-PHEP Budget Period 3 guidance.
F. 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." The document must be in the PDF format.

G. 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.
H. 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.
    a. Name(s) of contractor(s)
    b. Scope of work
    c. Method of selection (competitive or sole source); *procurement by noncompetitive proposals may be used only when the award of a contract is not feasible under small purchase procedures, sealed bids, or competitive proposals and is justified under criteria in 45 Code of Federal Regulations Part 92.36.*
    d. Period of performance
    e. Method of accountability
    f. Itemized budget with narrative justification
I. For nonfederal matching requirement, provide a line-item list of nonfederal contributions including source, amount, and/or value of third-party contributions proposed to meet a matching requirement. For more information, see the Cost Sharing or Matching section.
J. 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 more information, see the Maintenance of Funding (MOF) section.

Note: HHS is expected to issue final guidance in 2014 on the temporary reassignment of state and local employees during a public health emergency. At that time, ASPR and CDC will provide awardees with more information on potential considerations for effectively using these additional resources in their budget plans.

Indirect Cost Rate Agreement

- 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 request 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 HPP and PHEP programs, is reasonable and consistent with public health and healthcare preparedness program capabilities, and is consistent with stated objectives and planned program activities.
- While the HPP and PHEP programs are aligned and complementary, activities and their respective costs are not interchangeable. All costs must meet the criteria specified in the appropriate cost principles as necessary and reasonable for proper and efficient performance and administration of the respective HPP or PHEP components.
- Direct Assistance: PHEP awardees may request direct assistance (DA) for personnel (e.g. public health advisors, Career Epidemiology Field Officers, 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 February 20, 2015. 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 14, 2014.

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 subawardees, 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

Use of Budget Period 3 Funds for Response

HPP Funds

Section 319C-2 of the Public Health Service Act (PHS) 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, including, as appropriate, capacity and preparedness to address the needs of children and other at-risk individuals. 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 HPP spend plans. Awardees, nevertheless, may be able to expend HPP funds for response activities, subject to approval by HPP, 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. HPP 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 an after-action report, a corrective action plan, and other documentation that support the actual dollar amount spent within the time frame that is indicated on the relevant forms.

PHEP Funds

Use of PHEP funds during response operations has not changed since Budget Period 2. 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 under section 319C-1(h) of the PHS Act, as amended. States receive the greater of a minimum amount prescribed by the formula or a base amount, as determined by the Secretary, supplemented by a population-based formula, and possible additional funding based on findings about significant unmet needs or high degree of risk. Eligible political subdivisions receive an amount determined by the Secretary and possible additional funding based on findings about significant unmet needs or high degree of risk.

Cost Sharing or Matching

Cost sharing or matching requirements remain in effect for Budget Period 3, 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 3 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)[4]

Maintenance of funding requirements remain in effect for Budget Period 3. 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.

Unobligated Funds

Awardees may request to carry forward unobligated funds from the current budget period to the next budget period. HPP and PHEP awardees may submit requests to carry-over unobligated Budget Period 2 funds as part of their Budget Period 3 applications based on interim Federal Financial Reports (FFR) submitted with their Budget Period 3 applications. (See the Budget section - estimated unobligated funds.)

[4]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.

Carry-over funds may be used to supplement the Budget Period 3 budget, including personnel costs for less than full-time employees who will be needed to complete Budget Period 3 activities. These budget change requests are submitted as an attachment to the Budget Period 3 application and must include a *separate*, revised work plan and budget identifying the following elements:

- List of proposed activities,
- Itemized budget, and
- Narrative justification of those activities.

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 3, 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 funding opportunity announcement as originally approved. ASPR and CDC will provide additional guidance on submitting carry-over requests.

Application Review Criteria

Joint Review Criteria

CDC's Procurement and Grants Office staff will review applications initially for completeness. In addition, ASPR and CDC project officers and subject matter experts will jointly review applications for responsiveness to program requirements and technical acceptability. 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 3.
- 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 3 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 3.
- Project narrative and work plan review:
  - Awardees' work plan narrative descriptions, the project narrative, technical assistance descriptions, and budget justifications, 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 Periods 1 and 2 or describe why there is significant variance between budget periods.
- Awardees have adequate planned activities to monitor and demonstrate HPP and PHEP program/performance measures and PAHPRA benchmarks.
- Awardee work plans and budgets are clearly and adequately linked through budget associations to the capabilities (PHEP) or function and resource element level (HPP).
- 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 3.
- Objectives directly link to and support the short-term goals for each capability and are measurable and achievable descriptions of how a capability will be built, sustained, or scaled back.
- Planned activity descriptions define specific tasks and actions that will lead directly to achieving the objective and producing tangible outputs.
- Proposed outputs relate to the planned activities and describe desired products. They must also directly relate to the associated short-term goals and the objective they support.
- The Budget Period 2 progress update portion of the project narrative reflects activities that clearly built or sustained jurisdictional capabilities and correlate to the goals, objectives, and planned activities in the Budget Period 2 applications.

HPP-specific Review Criteria

- Awardees comply with HAvBED standards.
- Awardees meet the guidelines for the 11 NIMS implementation activities for hospitals within coalitions.

PHEP-specific 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 3. 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 PAHPRA benchmarks for Budget Period 3.
- Sufficient descriptions exist that outline Level 1 chemical laboratory operations and processes, as applicable.
- Inclusion of activities relating to chemical, biological, radiological or nuclear threats.
- A description of the activities the awardee will carry out with respect to an influenza pandemic.
- Satisfactory compliance with all project narrative requirements.

Budget Period 3 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.

Reporting Requirements

HPP and PHEP awardees must submit required reports and other data by the published deadlines. Awardees may submit requests for extensions of reporting deadlines to ASPR and CDC. Such requests must be made in writing at least five business days prior to the deadline and submitted to preparedness@cdc.gov. Following is a summary of the Budget Period 3 reporting requirements.

- Descriptions of pandemic influenza plans: Sections 319C-1 and 319C-2 of the PHS Act, as amended, currently requires that HPP and PHEP awardees annually submit descriptions of their pandemic influenza preparedness and response activities. ASPR and CDC have determined that awardees can satisfy the annual requirement through the submission of required program data such as the capability self-assessments and program/performance measure data that provide information on the status of state and local pandemic influenza response readiness, barriers and challenges to preparedness and operational readiness, and efforts to address the needs of at-risk individuals. In addition, PHEP awardees may be required to complete a pandemic influenza readiness assessment designed to identify operational gaps and to inform CDC's technical assistance and guidance for pandemic preparedness planning.

  - 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.

  - A Budget Period 3 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; applicable PAHPRA benchmark data; program/performance measure data and supporting information; training updates; preparedness accomplishments, success stories, and program impact statements; PHEP outputs; healthcare coalition assessments (HPP only); and updated healthcare coalition information (HPP only); NIMS compliance activities for hospitals within healthcare coalitions; and ESAR-VHP requirements (HPP only).

  - A combined HPP and PHEP Budget Period 3 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.

  - Separate HPP and PHEP Budget Period 3 Federal Financial Reports (SF-425) submitted no later than 90 days after the end of the budget period.

  - 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.fsrs.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 subawards/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 July 30, 2014; October 30, 2014; January 30, 2015; and April 30, 2015). 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 for the following 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.

Note: If the Office of Management and Budget enacts a new circular, the dollar amount requiring federal audit may change. HHS will inform awardees of this change if it takes place.

Appendix 1
HPP Budget Period 3
(Fiscal Year 2014) Funding

Awardee	FY 2014 Total Funding Available
Alabama	$3,237,341
Alaska	$913,025
American Samoa	$278,408
Arizona	$4,007,263
Arkansas	$2,004,404
California	$23,324,282
Chicago	$2,695,627
Colorado	$3,223,094
Connecticut	$2,478,410
Delaware	$1,068,469
Florida	$11,648,741
Georgia	$5,970,165
Guam	$352,993
Hawaii	$1,217,945
Idaho	$1,218,950
Illinois	$8,743,125
Indiana	$4,115,905
Iowa	$2,083,867
Kansas	$2,078,328
Kentucky	$2,873,535
Los Angeles County	$9,155,699

Awardee	FY 2014 Total Funding Available
Louisiana	$3,150,334
Maine	$1,076,998
Marshall Islands	$266,504
Maryland	$4,943,757
Massachusetts	$4,228,980
Michigan	$6,065,597
Micronesia	$275,664
Minnesota	$3,526,348
Mississippi	$2,168,560
Missouri	$3,780,117
Montana	$917,530
Nebraska	$1,372,877
Nevada	$1,928,013
New Hampshire	$1,113,252
New Jersey	$5,820,991
New Mexico	$1,517,542
New York	$9,825,062
New York City	$7,841,384
North Carolina	$6,183,490
North Dakota	$875,113
Northern Mariana Islands	$269,970
Ohio	$7,442,831
Oklahoma	$2,605,636
Oregon	$2,534,407

Awardee	FY 2014 Total Funding Available
Palau	$255,069
Pennsylvania	$8,118,396
Puerto Rico	$2,503,028
Rhode Island	$951,741
South Carolina	$3,107,080
South Dakota	$859,947
Tennessee	$4,048,785
Texas	$15,859,228
Utah	$1,918,379
Vermont	$900,000
Virgin Islands (US)	$339,824
Virginia	$6,188,517
Washington	$4,211,758
Washington, D.C.	$951,425
West Virginia	$1,383,580
Wisconsin	$3,641,719
Wyoming	$840,991
Total FY 2014 HPP Funding	**$228,500,000**

Appendix 2
Public Health Emergency Preparedness (PHEP)
Budget Period 3 (Fiscal Year 2014) Funding

Awardee	FY 2014 Total Base plus Population Funding	FY 2014 Cities Readiness Initiative Funding	FY 2014 Level 1 Chemical Laboratory Funding	FY 2014 Total Funding Available
Alabama	$8,634,331	$308,437	$0	$8,942,768
Alaska	$4,015,042	$169,600	$0	$4,184,642
American Samoa	$364,263	$0	$0	$364,263
Arizona	$10,661,884	$1,151,129	$0	$11,813,013
Arkansas	$6,449,966	$205,490	$0	$6,655,456
California	$35,934,308	$5,368,044	$1,051,433	$42,353,785
Chicago	$8,169,931	$1,649,890	$0	$9,819,821
Colorado	$9,069,322	$698,368	$0	$9,767,690
Connecticut	$7,200,743	$566,590	$0	$7,767,333
Delaware	$4,072,538	$317,152	$0	$4,389,690
Florida	$25,596,549	$2,881,694	$808,167	$29,286,410
Georgia	$14,596,827	$1,451,728	$0	$16,048,555
Guam	$487,027	$0	$0	$487,027
Hawaii	$4,625,777	$261,170	$0	$4,886,947
Idaho	$4,866,120	$169,413	$0	$5,035,533
Illinois	$14,889,301	$1,970,437	$0	$16,859,738
Indiana	$10,646,252	$803,203	$0	$11,449,455
Iowa	$6,596,407	$189,818	$0	$6,786,225
Kansas	$6,374,612	$396,703	$0	$6,771,315
Kentucky	$8,122,306	$378,859	$0	$8,501,165

Awardee	FY 2014 Total Base plus Population Funding	FY 2014 Cities Readiness Initiative Funding	FY 2014 Level 1 Chemical Laboratory Funding	FY 2014 Total Funding Available
Los Angeles County	$16,542,104	$3,299,780	$0	$19,841,884
Louisiana	$8,382,418	$544,187	$0	$8,926,605
Maine	$4,553,746	$169,600	$0	$4,723,346
Marshall Islands	$380,091	$0	$0	$380,091
Maryland	$9,882,637	$1,401,845	$0	$11,284,482
Massachusetts	$10,772,003	$1,283,202	$955,994	$13,011,199
Michigan	$14,558,083	$1,176,946	$939,437	$16,674,466
Micronesia	$424,542	$0	$0	$424,542
Minnesota	$9,291,756	$900,486	$968,730	$11,160,972
Mississippi	$6,492,797	$238,490	$0	$6,731,287
Missouri	$10,045,969	$901,107	$0	$10,947,076
Montana	$4,175,974	$169,600	$0	$4,345,574
Nebraska	$5,169,921	$203,364	$0	$5,373,285
Nevada	$6,221,350	$534,464	$0	$6,755,814
New Hampshire	$4,545,695	$284,206	$0	$4,829,901
New Jersey	$13,371,261	$2,299,693	$0	$15,670,954
New Mexico	$5,436,801	$242,159	$972,226	$6,651,186
New York	$16,305,838	$1,878,237	$1,602,584	$19,786,659
New York City	$14,617,483	$3,917,158	$0	$18,534,641
North Carolina	$14,401,182	$526,263	$0	$14,927,445
North Dakota	$4,015,042	$169,600	$0	$4,184,642
Northern Mariana Islands	$360,109	$0	$0	$360,109
Ohio	$16,511,827	$1,532,567	$0	$18,044,394

Awardee	FY 2014 Total Base plus Population Funding	FY 2014 Cities Readiness Initiative Funding	FY 2014 Level 1 Chemical Laboratory Funding	FY 2014 Total Funding Available
Oklahoma	$7,462,739	$343,668	$0	$7,806,407
Oregon	$7,561,006	$490,662	$0	$8,051,668
Palau	$324,598	$0	$0	$324,598
Pennsylvania	$17,928,670	$1,756,695	$0	$19,685,365
Puerto Rico	$7,270,658	$0	$0	$7,270,658
Rhode Island	$4,228,381	$287,761	$0	$4,516,142
South Carolina	$8,524,264	$301,649	$886,849	$9,712,762
South Dakota	$4,015,042	$169,600	$0	$4,184,642
Tennessee	$10,549,334	$739,659	$0	$11,288,993
Texas	$33,479,359	$3,975,513	$0	$37,454,872
Utah	$6,338,909	$298,127	$0	$6,637,036
Vermont	$4,015,042	$169,600	$0	$4,184,642
Virgin Islands (US)	$423,124	$0	$0	$423,124
Virginia	$12,574,657	$1,517,289	$838,795	$14,930,741
Washington	$11,064,407	$1,064,071	$0	$12,128,478
Washington, D.C.	$5,708,464	$638,667	$0	$6,347,131
West Virginia	$5,171,477	$184,240	$0	$5,355,717
Wisconsin	$9,695,142	$504,770	$1,321,085	$11,520,997
Wyoming	$4,015,042	$169,600	$0	$4,184,642
TOTAL FY 2014 PHEP Funding	**$548,182,450**	**$53,222,250**	**$10,345,300**	**$611,750,000**

Appendix 3
Cities Readiness Initiative (CRI)
Budget Period 3 (Fiscal Year 2014) Funding

Awardee	CRI City	2012 Census Population	FY 2014 Awardee Total
Alabama	Birmingham	1,128,093	308,437
Alaska	Anchorage	380,789	169,600
Arizona	Phoenix	4,210,193	1,151,129
Arkansas	Little Rock	700,952	205,490
Arkansas	Memphis	50,618	
California	Los Angeles	3,021,840	5,368,044
California	Riverside	4,234,011	
California	Sacramento	2,153,736	
California	San Diego	3,100,500	
California	San Francisco	4,348,880	
California	San Jose	1,843,860	
California	Fresno	930,517	
Chicago	Chicago	2,702,471	1,649,890
Colorado	Denver	2,554,243	698,368
Connecticut	Hartford	1,211,280	566,590
Connecticut	New Haven	860,995	
Delaware	Philadelphia	539,665	317,152
Delaware	Dover	162,785	
Florida	Miami	5,598,297	2,881,694
Florida	Orlando	2,147,534	
Florida	Tampa	2,793,814	
Georgia	Atlanta	5,309,620	1,451,728
Hawaii	Honolulu	955,215	261,170

Awardee	CRI City	2012 Census Population	FY 2014 Awardee Total
Idaho	Boise	619,618	169,413
Illinois	Chicago	5,884,735	1,970,437
Illinois	St Louis	701,733	
Illinois	Peoria	378,886	
Indiana	Chicago	707,184	803,203
Indiana	Indianapolis	1,891,035	
Indiana	Cincinnati	63,446	
Indiana	Louisville	276,009	
Iowa	Des Moines	571,592	189,818
Iowa	Omaha	122,659	
Kansas	Wichita	629,157	396,703
Kansas	Kansas City	821,765	
Kentucky	Louisville	959,751	378,859
Kentucky	Cincinnati	425,906	
Los Angeles	Los Angeles	9,840,024	3,299,780
Louisiana	Baton Rouge	802,389	544,187
Louisiana	New Orleans	1,187,945	
Maine	Portland	515,398	169,600
Maryland	Baltimore	2,715,650	1,401,845
Maryland	Washington D.C	2,310,416	
Maryland	Philadelphia	101,109	
Massachusetts	Boston	4,144,506	1,283,202
Massachusetts	Providence	548,739	
Michigan	Detroit	4,304,617	1,176,946
Minnesota	Fargo	58,937	900,486
Minnesota	Minneapolis	3,234,543	

Awardee	CRI City	2012 Census Population	FY 2014 Awardee Total
Mississippi	Jackson	568,972	
Mississippi	Memphis	246,576	238,490
Missouri	St. Louis	2,108,267	
Missouri	Kansas City	1,187,485	901,107
Montana	Billings	159,017	169,600
Nebraska	Omaha	743,795	203,364
Nevada	Las Vegas	1,954,773	534,464
New Hampshire	Boston	419,167	
New Hampshire	Manchester	401,101	284,206
New Jersey	New York City	6,473,734	
New Jersey	Philadelphia	1,316,971	
New Jersey	Trenton	366,442	2,299,693
New Mexico	Albuquerque	885,683	242,159
New York	Albany	870,890	
New York	Buffalo	1,135,411	
New York	New York City	4,863,254	1,878,237
New York City	New York City	8,199,221	3,917,158
North Carolina	Charlotte	1,889,032	
North Carolina	Virginia Beach	35,746	526,263
North Dakota	Fargo	150,240	169,600
Ohio	Cincinnati	1,624,734	
Ohio	Cleveland	2,074,824	
Ohio	Columbus	1,905,725	1,532,567
Oklahoma	Oklahoma City	1,256,947	343,668
Oregon	Portland	1,794,570	490,662

Awardee	CRI City	2012 Census Population	FY 2014 Awardee Total
Pennsylvania	Philadelphia	4,009,604	
Pennsylvania	Pittsburgh	2,357,981	
Pennsylvania	New York City	57,437	1,756,695
Rhode Island	Providence	1,052,471	287,761
South Carolina	Columbia	767,299	
South Carolina	Charlotte	335,968	301,649
South Dakota	Sioux Falls	229,333	169,600
Tennessee	Nashville	1,676,419	
Tennessee	Memphis	1,028,845	739,659
Texas	Dallas	6,455,146	
Texas	Houston	5,935,934	
Texas	San Antonio	2,149,153	3,975,513
Utah	Salt Lake City	1,090,384	298,127
Vermont	Burlington	211,581	169,600
Virginia	Richmond	1,210,200	
Virginia	Virginia Beach	1,650,894	
Virginia	Washington D.C	2,688,310	1,517,289
Washington	Seattle	3,453,748	
Washington	Portland	438,037	1,064,071
Washington D.C	Washington D.C	605,759	638,667
West Virginia	Charleston	226,621	
West Virginia	Washington D.C	53,545	184,240
Wisconsin	Chicago	166,373	
Wisconsin	Milwaukee	1,554,593	
Wisconsin	Minneapolis	125,205	504,770

Awardee	CRI City	2012 Census Population	FY 2014 Awardee Total
Wyoming	Cheyenne	91,719	169,600
Total FY2014 Cities Readiness Initiative Funding		**177,012,793**	**$53,222,250**

Revised OMB MSA Listing

The President's Office of Management and Budget (OMB) has revised the U.S. metropolitan statistical areas (MSAs), based on Census Bureau data. These changes affect the planning jurisdictions now included in the 72 CRI cities. They include name changes for 25 MSAs, additions of 27 counties in 17 of the 72 CRI MSAs, and deletions of 14 counties in 10 of the 72 CRI MSAs.

New 2013 OMB MSA Name	Previous 2010 OMB MSA Name
Atlanta-Sandy Springs-Roswell, GA	Atlanta-Sandy Springs-Marietta, GA
Baltimore-Columbia-Towson, MD	Baltimore-Towson, MD
Boise City, ID	Boise City-Nampa, ID
Boston-Cambridge-Newton, MA-NH	Boston-Cambridge-Quincy, MA-NH
Buffalo-Cheektowaga-Niagara Falls, NY	Buffalo-Niagara Falls, NY
Charlotte-Concord-Gastonia, NC-SC	Charlotte-Gastonia-Rock Hill NC-SC
Chicago-Naperville-Elgin, IL-IN-WI	Chicago-Joliet-Naperville, IL-IN-WI
Cincinnati, OH-KY-IN	Cincinnati-Middletown, OH-KY-IN
Cleveland-Elyria, OH	Cleveland-Elyria-Mentor, OH
Denver-Aurora-Lakewood, CO	Denver-Aurora-Broomfield, CO
Detroit-Warren-Dearborn, MI	Detroit-Warren-Livonia, MI
Houston-The Woodlands-Sugar Land, TX	Houston-Sugar Land-Baytown, TX
Indianapolis-Carmel-Anderson, IN	Indianapolis-Carmel, IN
Las Vegas-Henderson-Paradise, NV	Las Vegas-Paradise, NV
Los Angeles-Long Beach-Anaheim, CA	Los Angeles-Long Beach-Santa Ana, LA
Miami-Fort Lauderdale- West Palm Beach, FL	Miami-Fort Lauderdale-Pompano Beach, FL
New Orleans-Metairie, LA	New Orleans-Metairie-Kenner, LA
New York-Newark-Jersey City, NY-NJ-PA	New York-Northern New Jersey-Long Island, NY-NJ-PA
Phoenix-Mesa-Scottsdale, AZ	Phoenix-Mesa-Glendale, AZ
Portland-South Portland, ME	Portland-South Portland-Biddeford, ME
Providence-Warwick, RI-MA	Providence-New Bedford-Fall River, RI-MA
Sacramento-Roseville-Arden-Arcade, CA	Sacramento-Arden-Arcade-Roseville, CA
San Diego-Carlsbad, CA	San Diego-Carlsbad-San Marcos, CA
San Francisco-Oakland-Hayward, CA	San Francisco-Oakland-Fremont, CA
Urban Honolulu, HI	Honolulu, HI

27 County Additions

Atlanta-Sandy Springs-Roswell, GA
Morgan County, GA

Billings, MT
Golden Valley County, MT

Charlotte-Concord-Gastonia, NC-SC
Iredell County, NC
Lincoln County, NC
Rowan County, NC
Chester County, SC
Lancaster County, SC

Cincinnati, OH-KY-IN
Union County, IN

Columbus, OH
Hocking County, OH
Perry County, OH

Dallas-Fort Worth-Arlington, TX
Hood County, TX
Somervell County, TX

Indianapolis-Carmel-Anderson, IN
Madison County, IN

Jackson, MS
Yazoo County, MS

Louisville/Jefferson County, KY-IN
Scott County, IN

Memphis-TN-MS-AR
Benton County, MS

Minneapolis-St. Paul-Bloomington, MN-WI
Le Sueur County, MN
Mille Lacs County, MN
Sibley County, MN

Nashville-Davidson-Murfreesboro-Franklin, TN
Maury County, TN

New Orleans-Metairie, LA
St James Parish, LA

New York-Newark-Jersey City, NY-NJ-PA
Dutchess County, NY
Orange County, NY

Virginia Beach-Norfolk-Newport News, VA-NC
Gates County, NC

Washington-Arlington-Alexandria, DC-VA-MD-WV
Culpeper County, VA
Rappahannock County, VA

Wichita, KS
Kingman County, KS

14 County Deletions

Charleston, WV
Lincoln County, WV
Putnam County, WV

Charlotte-Concord-Gastonia, NC-SC
Anson County, NC

Cincinnati, OH-KY-IN
Franklin County, IN

Dallas-Fort Worth-Arlington, TX
Delta County, TX

Houston- The Woodlands-Sugar Land, TX
San Jancinto County, TX

Kansas City, MO-KS
Franklin County, KS

Louisville/Jefferson County, KY-IN
Meade County, KY
Nelson County, KY

Richmond, VA
Cumberland County, VA
King and Queen County, VA
Louisa County, VA

Salt Lake City, UT
Summit County, UT

St. Louis, MO-IL
Washington County, MO

Appendix 4
Hospital Preparedness Program
Budget Period 3 (Fiscal Year 2014)
Evidence-Based Benchmarks Subject to Withholding

PAHPRA Benchmark	
PAHPRA1	Awardees submit timely and complete data for the end-of-year annual progress report, and the final Federal Financial Report (FFR).
PAHPRA2	Awardees submit Healthcare Coalition Development Assessment (HCCDA) factor data with their annual progress reports.
PAHPRA3	Awardees develop and submit in accordance with Budget Period 3 guidance requirements exercise plans that must include a proposed exercise schedule and a discussion of the plans for healthcare organization exercise development, conduct, evaluation, and improvement planning. Exercise plans must demonstrate participation by healthcare coalitions and their participating hospitals to include the participating organizations and anticipated capabilities to be tested.
PAHPRA4	Awardees submit in accordance with Budget Period 3 continuation guidance requirements work plan activities that ensure their coalitions' hospitals are addressing the 11 NIMS implementation activities for hospitals and report on the status of those activities for each hospital with their annual progress reports.

Appendix 5
Public Health Emergency Preparedness
Budget Period 3 (Fiscal Year 2014)
Evidence-Based Benchmarks Subject to Withholding

CDC has identified the following fiscal year 2014 benchmarks for Budget Period 3 to be used as a basis for withholding of fiscal year 2015 funding for PHEP awardees. 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 all required PHEP program data and reports due during Budget Period 3 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 jeopardizes CDC's ability to accurately determine PHEP program achievements and barriers to success. This benchmark applies to all 62 awardees. Required data and reports include:
   - PHEP Budget Period 2 annual progress reports, due 90 days after the end of Budget Period 2 (September 30, 2014). Annual progress reports must include updates on work plan activities including local contracts and progress on implementation of technical assistance plans; PAHPRA benchmark data; performance measure data and supporting information; responses to program data questions and other supplemental questions; training updates; preparedness accomplishments, success stories, and program impact statements.
   - PHEP Budget Period 2 Federal Financial Reports, due 90 days after the end of Budget Period 2 (September 30, 2014).
   - Preparedness capabilities self-assessments due in May 2015 documenting awardees' current preparedness status and self-identified gaps based on the public health preparedness capabilities as they relate to overall jurisdictional needs.
   - PHEP Budget Period 4 funding applications due approximately 60 calendar days following initial publication of the continuation guidance.

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.

   During Budget Period 3, PHEP awardees must ensure that each local planning jurisdiction within their CRI metropolitan statistical areas, including the four directly funded localities, conduct three different drills. Drills are critical components of a jurisdiction's training, exercise, and evaluation program. As one of the building blocks in the Homeland Security Exercise and Evaluation Program (HSEEP), drills serve as integral tools that allow for controlled and systematic advancement of operational-based competencies. The results of the drill data submissions and compliance with dispensing and distribution standards will be reviewed during site visits to further evaluate local medical countermeasure distribution and dispensing preparedness.

In addition, all PHEP awardees must maintain and provide to CDC current Receipt, Stage, and Store (RSS) information for all potential RSS facilities in their jurisdictions using the RSS checklist or new RSS site survey form. Site surveys must be conducted at least once every three years to ensure they reflect current operational capabilities.

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 May 1, 2015, to determine the awardees "at risk" of failing to reach this benchmark.
     1. Successfully passed is defined as:
        a. The agent is detected or not detected, as appropriate, in all samples.
        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. CDC will use the following elements to determine if the awardee met this benchmark:
        a. Number of LRN-B proficiency tests successfully passed by the LRN-B laboratory during first attempt
        b. Number of LRN-B proficiency tests participated in by the LRN-B laboratory
     3. The minimum performance for each year of the PHEP project period is:
        a. Budget Period 1: Laboratory cannot fail more than two PT challenges
        b. Budget Periods 2-5: Laboratory cannot fail more than one PT challenge

     In Budget Period 3, 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.

     CDC's LRN Program requires LRN labs to participate in all available PT challenges specific to each lab's testing capability; if a lab has testing capability for a specific agent and a PT challenge for that agent is being offered, the lab *must participate* in that PT challenge. Laboratories that are offline long-term, undergoing renovation, or have other special circumstances are not expected to have their PT challenges completed by partner or back-up labs (e.g., municipal labs or labs in neighboring states). Instead, those labs are expected to report to the LRN Program what they would do in real situations had the PT challenge been associated with a true emergency event. In such a circumstance, this will not adversely affect an awardee in terms of determining whether this benchmark has been met.

- **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. To pass, a laboratory must receive a score of at least 80% for the exercise.

- **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 benchmark does not apply to awardees with Level 2 laboratories during Budget Period 3, 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, 2015, to determine awardees potentially at risk for failure to meet this 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.

  To meet this benchmark, the laboratory must pass/qualify on 90% of the methods tested.

Pandemic Influenza Preparedness Plans

Section 319C-1 of the PHS Act, as amended, currently requires that PHEP awardees annually submit pandemic influenza preparedness plans. CDC has determined that awardees can satisfy the 2014 annual requirement through the required submission of other program data such as capability self-assessment , 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 2015 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 2014 pandemic influenza plan requirement?			10%
Total Potential Withholding Percentage				20%

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 2015 PHEP base award. Failure to submit the 2014 pandemic influenza preparedness plan as required may result in withholding of 10% of the fiscal year 2015 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
Creating a Model Linkage for Capability-based Emergency Preparedness

Presidential Policy Directive (PPD)-8, National Preparedness, was enacted in March 2011 to strengthen the security and resilience of the United States through a systematic preparation for the threats that pose the greatest risk to the nation's security. PPD-8 directed the development of a National Preparedness Goal (NPG) in coordination with other executive departments and agencies.

The NPG defines the core capabilities necessary to prepare for the specific types of incidents that pose the greatest risk to the nation's security and to emphasize actions designed to achieve an integrated, coordinated, complementary, and layered approach to preparedness, response, and recovery.[5] The core capabilities that cascade from the NPG were developed with the input of multiple federal agencies and state and local partners, and their purpose is to establish an overarching, common framework for interagency execution in a unified manner.

The core capabilities are strategic in nature to ensure that prevention, protection, mitigation, response, and recovery operations are comprehensive, synchronized, and mutually supportive.[6] Of the 31 NPG core capabilities, one focuses specifically on public health and medical components; however many of the other core capabilities also contain public health and medical components necessary for successful implementation of the NPG.

Similarly, the Department of Health and Human Services' preparedness programs have developed state and local preparedness capabilities that operationalize the public health and medical components of the core capabilities. 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 operational guidance for state and local public health and healthcare systems, assist in the execution of the core capabilities, and bridge federal capabilities with state and local actions.

The NPG provides the desired strategic outcomes and facilitates the development of goals, systems, and frameworks, including federal interagency operational plans (IOPs). The NPG contains five frameworks: Prevention, Protection, Mitigation, Response, and Recovery. The Federal IOPs[7] provide actionable steps to demonstrate integration between federal agencies and provide a framework that can be used to achieve the NPG as well as the integration of all five mission areas.

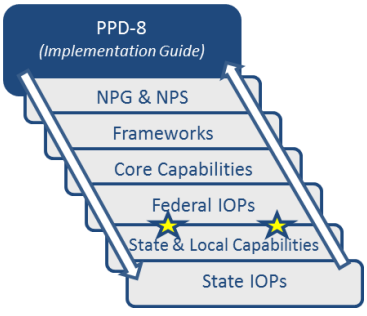

Figure 1 – Complementary Role of ASPR/CDC Healthcare and Public Health Preparedness Capabilities

[5] http://www.fema.gov/ppd8

[6] http://ne-cipa.org/html/pdf/peo_nationalprotectionframeworkdraft_20120501[1].pdf

[7] http://www.fas.org/sgp/crs/homesec/R42073.pdf

In addition to the other IOP components, the Recovery IOP identifies the use of "integration factors" or actionable steps/critical tasks as the elements that address interdependencies, interactions, and information related to shared risks and coordination points among the five recovery core capabilities.

Linking Capability-based Emergency Preparedness

A review of the following documents provides examples of the intersections between the public health and medical sectors and the core capabilities.

- PPD-8, March 2011
- National Protection Framework, draft version July 2012
- National Prevention Framework, draft version July 2012
- National Response Framework, draft version July 2012
- National Mitigation Framework, draft version July 2012
- Federal Interagency Operational Plan (FIOP)-Recovery, draft version July 2012
- National Recovery Framework, September 2011
- *Public Health Preparedness Capabilities: National Standards for State and Local Planning*, March 2011
- *Healthcare System Capabilities: National Guidance for Healthcare System Preparedness*, January 2012

These intersections are described in the following table. Since the National Disaster Recovery Framework is organized into recovery support functions (RSFs) that are divided into tactical, actionable steps that should occur either before or after a disaster at the federal, state, or local level versus goal outcomes that should be achieved when all agencies and communities have worked together, the complementary fit is identified at the appropriate disaster action step level.

NPG Framework	NPG Capability	NPG Capability Definition Language	NPG Capability Critical Task, FIOP Integration Factor or Associated RSF Disaster Action Steps	Public Health (PHEP) or Healthcare Preparedness (HPP) Complementary Capability Content
Prevention	Screening, Search, and Detection	Identify, discover, or locate threats and/or hazards through active and passive surveillance and search procedures. This may include the use of systematic examinations and assessments, sensor technologies, or physical investigation and intelligence.	Conduct biosurveillance. This critical task involves the passive and active detection to discover, identify, and locate biological threats that may have a nexus to terrorism. This detection is conducted through technical ambient surveillance (such as Biowatch), as well as medical and public health surveillance and epidemiologic investigations.	**PHEP Public Health Surveillance and Epidemiological Investigation:** Conduct ongoing systematic collection, analysis, interpretation, and management of public health-related data to verify a threat or incident of public health concern, and to characterize and manage it effectively through all phases of the incident. Maintain surveillance systems that can identify health problems, threats, and environmental hazards and receive and respond to (or investigate) reports 24/7.
Prevention	Forensics and Attribution	Conduct forensic analysis and attribute terrorist acts (including the means and methods of terrorism) to their source, to include forensic analysis as well as attribution for an attack and for the preparation for an attack in an effort to prevent initial or follow-on acts and/or swiftly develop counter-options.	Analyze intelligence and forensics results to refine/confirm investigative leads.	**PHEP Public Health Surveillance and Epidemiological Investigation:** Conduct investigations of disease, injury or exposure in response to natural or man-made threats or incidents and ensure coordination of investigation with jurisdictional partner agencies. Partners include law enforcement, environmental health practitioners, public health nurses, maternal and child health, and other regulatory agencies if illegal activity is suspected.

NPG Framework	NPG Capability	NPG Capability Definition Language	NPG Capability Critical Task, FIOP Integration Factor or Associated RSF Disaster Action Steps	Public Health (PHEP) or Healthcare Preparedness (HPP) Complementary Capability Content
Protection	Intelligence and Information Sharing	Intelligence sharing is providing timely, accurate, and actionable information resulting from intelligence processes concerning threats to the United States, its people, property, or interests; the development, proliferation, or use of WMDs; or any other matter bearing on U.S. national or homeland security by local, state, tribal, territorial, Federal, and other stakeholders. Information sharing is the capability to exchange intelligence, information, data, or knowledge among local, state, tribal, territorial, Federal, or private sector entities as appropriate.	Participation in the routine exchange of security information—including threat assessments, alerts, attack indications and warnings, and advisories—among partners.	**PHEP Information Sharing**: Prior to and during an incident, collaborate with and participate in jurisdictional health information exchange (e.g., fusion centers, health alert system, or equivalent).

NPG Framework	NPG Capability	NPG Capability Definition Language	NPG Capability Critical Task, FIOP Integration Factor or Associated RSF Disaster Action Steps	Public Health (PHEP) or Healthcare Preparedness (HPP) Complementary Capability Content
Protection	Interdiction and Disruption	Delaying, diverting, intercepting, halting, apprehending, or securing threats and/or hazards. These threats and hazards include people, materials, or activities that pose a threat to the Nation, including domestic and transnational criminal and terrorist activities and the malicious movement and acquisition/transfer of chemical, biological, radiological, nuclear, and explosive (CBRNE) materials and related technologies.	Implement public health measures to mitigate the spread of disease threats abroad and prevent disease threats from crossing national borders.	**PHEP Public Health Surveillance/Epidemiology:** Conduct public health surveillance and detection; Conduct public health epidemiological investigations; Recommend, monitor, and analyze mitigation actions; Improve public health surveillance and epidemiological investigation systems **PHEP Non Pharmaceutical Interventions:** Coordinate with health partners, government agencies, community sectors (e.g., education, social services, faith-based, and business), and jurisdictional authorities (e.g., law enforcement, jurisdictional officials, and transportation) to make operational, and if necessary, enforce, the recommended non-pharmaceutical intervention(s).

NPG Framework	NPG Capability	NPG Capability Definition Language	NPG Capability Critical Task, FIOP Integration Factor or Associated RSF Disaster Action Steps	Public Health (PHEP) or Healthcare Preparedness (HPP) Complementary Capability Content
Mitigation	Community Resilience	Lead the integrated effort to recognize, understand, communicate, plan, and address risks so that the community can develop a set of actions to accomplish mitigation and improve resilience.	Know the community's systems—who makes up the community and how to build constructive partnerships.	**PHEP Community Preparedness**: Identify and engage with public and private community partners who can: • Assist with the mitigation of identified health risks • Be integrated into the jurisdiction's all-hazards emergency plans with defined community roles and responsibilities related to the provision of public health, medical, and mental/behavioral health as directed under the Emergency Support Function (ESF) #8 definition at the state or local level. **HPP Healthcare System Preparedness**: Develop, refine, or sustain Healthcare Coalitions consisting of a collaborative network of healthcare organizations and their respective public and private sector response partners within a defined region. Healthcare Coalitions serve as a multi-agency coordinating group that assists Emergency Management and ESF #8 with preparedness, response, recovery, and mitigation activities related to healthcare organization disaster operations.

NPG Framework	NPG Capability	NPG Capability Definition Language	NPG Capability Critical Task, FIOP Integration Factor or Associated RSF Disaster Action Steps	Public Health (PHEP) or Healthcare Preparedness (HPP) Complementary Capability Content
Mitigation	Public Information and Warning	Deliver coordinated, prompt, reliable, and actionable information to the whole community through the use of clear, consistent, accessible, and culturally and linguistically appropriate methods to effectively relay information regarding any threat or hazard and, as appropriate, the actions being taken and the assistance being made available.	Use social media, Web sites (e.g., Ready.gov), and smartphone applications, as well as more traditional mechanisms, such as community meetings or ethnic media.	**PHEP Emergency Public Information and Warning:** Utilizing crisis and emergency risk communication principles, disseminate 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; Disseminate information to the public using pre-established message maps in languages and formats that take into account jurisdiction demographics, at-risk populations, economic disadvantages, limited language proficiency, and cultural or geographical isolation. **HPP Emergency Operations Coordination:** Assess and notify stakeholders of healthcare delivery status. Assess the incident's impact on healthcare delivery in order to determine immediate healthcare organization resource needs. Assist with developing processes for notification and information exchange between relevant response partners, stakeholders, and healthcare organization. Community notification of healthcare delivery status: The State and Healthcare Coalitions, in coordination with healthcare organizations, emergency management, ESF-8, relevant response partners, and stakeholders will develop refine, and sustain a plan for communication that provides a unified message about the status of healthcare delivery through a Joint Information System for dissemination to the community.

NPG Framework	NPG Capability	NPG Capability Definition Language	NPG Capability Critical Task, FIOP Integration Factor or Associated RSF Disaster Action Steps	Public Health (PHEP) or Healthcare Preparedness (HPP) Complementary Capability Content
Mitigation	Threats and Hazard Identification	Identify the threats and hazards that occur in the geographic area; determine the frequency and magnitude; and incorporate this into analysis and planning processes so as to clearly understand the needs of a community or entity.	Identify data requirements across stakeholders.	**PHEP Information Sharing:** Identify stakeholders within the jurisdiction across public health, medical, law enforcement, and other disciplines that should be included in information exchange, and identify inter-jurisdictional public health stakeholders that should be included in information exchange; Prior to and as necessary during an incident, identify public health events and incidents that, when observed, will necessitate information exchange.

NPG Framework	NPG Capability	NPG Capability Definition Language	NPG Capability Critical Task, FIOP Integration Factor or Associated RSF Disaster Action Steps	Public Health (PHEP) or Healthcare Preparedness (HPP) Complementary Capability Content
Mitigation	Risk and Disaster Resilience Assessment	Assess risk and disaster resilience so that decision makers, responders, and community members can take informed action to reduce their entity's risk and increase their resilience.	Incorporate vulnerability data sets, such as population, demographic, infrastructure inventory and condition assessment information; climatological, geological, and environmental factors; critical infrastructure, lifelines, and key resources; building stock; and economic data to calculate the risk from the threats and hazards identified.	**PHEP Community Preparedness:** Identify the potential hazards, vulnerabilities, and risks in the community that relate to the jurisdiction's public health, medical, and mental/behavioral health systems, the relationship of those risks to human impact, interruption of public health, medical, and mental/behavioral health services. Written plans should include a jurisdictional risk assessment, utilizing an all-hazards approach with the input and assistance of the following elements: – Public health and non–public health subject matter experts (e.g., emergency management, state radiation control programs/ radiological subject matter experts – Existing inputs from emergency management risk assessment data, health department programs, community engagements, and other applicable sources, that identify and prioritize jurisdictional hazards and health vulnerabilities – Potential hazards, vulnerabilities, and risks in the community related to the public health, medical, and mental/ behavioral health systems – The relationship of these risks to human impact, interruption of public health, medical, and mental/behavioral health services – The impact of those risks on public health, medical, and mental/behavioral health infrastructure. **HPP Healthcare System Preparedness:** Coordinate healthcare planning to prepare the healthcare system for a disaster: Coordinate with emergency management to develop local and state emergency operations plans that address the concerns and unique needs of healthcare organizations. This includes the assessment phases of planning to determine needs and priorities of healthcare organizations. Healthcare System situational assessments: A coordinated healthcare situational assessment is adapted from the local hazard vulnerability assessments and risk assessments. The assessment also includes estimates of casualties and fatalities based on the identified risks.

NPG Framework	NPG Capability	NPG Capability Definition Language	NPG Capability Critical Task, FIOP Integration Factor or Associated RSF Disaster Action Steps	Public Health (PHEP) or Healthcare Preparedness (HPP) Complementary Capability Content
Mitigation	Risk and Disaster Resilience Assessment	Assess risk and disaster resilience so that decision makers, responders, and community members can take informed action to reduce their entity's risk and increase their resilience.	Incorporate data from lessons learned and statistical information to target consideration of populations (such as for individuals with disabilities or access and functional needs, LEP populations, and racially and ethnically diverse communities).	**PHEP Community Recovery:** Implement corrective actions to mitigate damages from future incidents that are within the scope or control of public health to affect short and long-term recovery. **HPP Healthcare System Preparedness**: Improve healthcare response capabilities through coordinated exercise and evaluation. Coordinate an exercise, evaluation, and corrective action program to continuously improve healthcare preparedness, response, and recovery. Exercises should be coordinated vertically and horizontally with healthcare and emergency response partners.
Response	Situational Assessment	Provide all decision makers with decision-relevant information regarding the nature and extent of the hazard, any cascading effects, and the status of the response.	Deliver information sufficient to inform decision making regarding immediate lifesaving and life-sustaining activities, and engage governmental, private, and civic sector resources within and outside of the affected area to meet basic human needs and stabilize the incident. Deliver enhanced information to reinforce activities, and engage governmental, private, and civic sector resources within and outside of the affected area to meet basic human needs, stabilize the incident, and transition to recovery.	**PHEP Information Sharing**: Prior to and during an incident, collaborate with and participate in jurisdictional health information exchange (e.g., fusion centers, health alert system, or equivalent). **HPP Information Sharing:** Provide healthcare situational awareness that contributes to the incident common operating picture: Provide situational awareness regarding the status of healthcare delivery into the ongoing flow of information to assist with the creation of an incident common operating picture. This includes providing information to the full spectrum of healthcare partners. This encompasses the real time sharing of actionable information between healthcare organizations and incident management to assist decision makers with resource allocation and provide healthcare organizations with incident specific information.

NPG Framework	NPG Capability	NPG Capability Definition Language	NPG Capability Critical Task, FIOP Integration Factor or Associated RSF Disaster Action Steps	Public Health (PHEP) or Healthcare Preparedness (HPP) Complementary Capability Content
Response	Fatality Management Services	Provide fatality management services, including body recovery and victim identification, working with state and local authorities to provide temporary mortuary solutions, sharing information with Mass Care Services for the purpose of reunifying family members and caregivers with missing persons/remains, and providing counseling to the bereaved.	Establish and maintain operations to recover a significant number of fatalities over a geographically dispersed area.	**PHEP Fatality Management:** Coordinate with the lead jurisdictional authority (e.g., coroner, medical examiner, sheriff, or other agent) to identify the roles and responsibilities of jurisdictional public health entities in fatality mgmt. activities; Facilitate access to resources in accordance with public health jurisdictional standards and practices and as requested by lead jurisdictional authority; Assist, if requested, the lead jurisdictional authority and jurisdictional and regional partners to gather and disseminate antemortem data; Coordinate with the lead jurisdictional authority and jurisdictional and regional partners to support the provision of non-intrusive, culturally sensitive mental/behavioral health support services to family members of the deceased, incident survivors, and responders, if requested. **HPP Fatality Management:** Coordinate surges of deaths and human remains at healthcare organizations with community fatality mgmt. operations. Coordinate with agencies responsible for fatality mgmt. (e.g., medical examiner, coroner's office, emergency mgmt.) to assist with the temporary storage of human remains during periods of death surges at healthcare organizations when morgue space is exceeded or unavailable. Coordinate surges of concerned citizens with community agencies responsible for family assistance. Provide assistance to the community regarding ante-mortem data to provide assistance to HCOs for the processes to direct family and community members seeking information about missing family members to the right locations that are

NPG Framework	NPG Capability	NPG Capability Definition Language	NPG Capability Critical Task, FIOP Integration Factor or Associated RSF Disaster Action Steps	Public Health (PHEP) or Healthcare Preparedness (HPP) Complementary Capability Content
				available in the community. Mental/behavior support at the healthcare organization level. Coordinate with the lead jurisdictional authority and jurisdictional and regional mental/behavioral health partners to assist healthcare organizations with the processes to solicit support for the provision of non-intrusive, culturally sensitive mental/behavioral health support services to family members of the deceased, incident survivors, and responders, if requested.
Response	Mass Care Services	Provide life-sustaining services to the affected population with a focus on hydration, feeding, and sheltering to those with the most need, as well as support for reunifying families.	Move and deliver resources and capabilities to meet the needs of disaster survivors, including individuals with access and functional needs. Establish, staff, and equip emergency shelters and other temporary housing options (including accessible housing) for the affected population. Move from congregate care to non-congregate care alternatives, and provide relocation assistance or interim housing solutions for families unable to return to their pre-disaster homes.	**PHEP Mass Care:** At the time of an incident, coordinate with response partners to complete a facility-specific environmental health and safety assessment of the selected or potential congregate locations; Coordinate with partner agencies to provide access to health services, medication and consumable medical supplies (e.g., hearing aid batteries and incontinence supplies), and durable medical equipment for the impacted population. **HPP Healthcare System Preparedness:** Coordinate with planning for at-risk individuals and those with special medical needs. Coordination with public health and ESF#6 mass care planning to determine the transfer and transport options and protocols for individuals with special medical needs to and from shelters/healthcare facilities.

NPG Framework	NPG Capability	NPG Capability Definition Language	NPG Capability Critical Task, FIOP Integration Factor or Associated RSF Disaster Action Steps	Public Health (PHEP) or Healthcare Preparedness (HPP) Complementary Capability Content
Response	Public Health and Medical Services	Provide lifesaving medical treatment via emergency medical services and related operations, and avoid additional disease and injury by providing targeted public health and medical support and products to all people in need within the affected area.	Deliver medical countermeasures to exposed populations. Complete triage and the initial stabilization of casualties and begin definitive care for those likely to survive their injuries. Return medical surge resources to pre-incident levels, complete health assessments, and identify recovery processes.	**PHEP Medical Materiel Management and Distribution Capability** **PHEP Medical Surge:** Support jurisdictional medical surge operations; Support demobilization of medical surge operations. **HPP Medical Surge:** Coordinate integrated healthcare surge operations with pre-hospital Emergency Medical Services (EMS) operations. Assist healthcare organizations with surge capacity and capability. This consists of the rapid expansion of the capacity and capability of the healthcare system to provide the appropriate and timely clinical level of care in response to an incident. **HPP Emergency Operations Coordination:** Demobilize and evaluate healthcare operations. This includes the processes that assist healthcare organizations with the return of resources that are no longer required to support the incident.
Recovery	Planning	Conduct a systematic process engaging the whole community as appropriate in the development of executable strategic, operational, and/or community-based approaches to meet defined objectives.	**FIOP Integration Factor** **(Protection):** Assess risks and threats/hazard identification to support and inform recovery operations. **FIOP Integration Factor** **(Mitigation):** Employ lessons learned during the recovery process to inform	**PHEP Community Recovery:** Assess the impact of an incident on the public health system in collaboration with the jurisdictional government and community and faith-based partners, in order to determine and prioritize the public health, medical, or mental/behavioral health system recovery needs. **PHEP Community Recovery:** Implement corrective actions to mitigate damages from future incidents.

NPG Framework	NPG Capability	NPG Capability Definition Language	NPG Capability Critical Task, FIOP Integration Factor or Associated RSF Disaster Action Steps	Public Health (PHEP) or Healthcare Preparedness (HPP) Complementary Capability Content
			future mitigation actions. **RSF Community Planning/Capacity Building** **Pre-Disaster**: Coordinates educational and cross-training opportunities for key participants in community recovery planning and capacity support including, but not limited to: emergency managers; city managers; planning, economic development and other local officials; and nonprofit and private sector partners for recovery. **Post Disaster:** Captures after-action recommendations and lessons learned.	**HPP Healthcare System Preparedness:** Develop, refine, or sustain Healthcare Coalitions. Provide a regional healthcare multi-agency coordination function to share incident specific healthcare situational awareness to assist with resource coordination during response and recovery activities. **HPP Healthcare System Recovery:** Develop recovery processes for the healthcare delivery system: Identify healthcare organization recovery needs and develop priority recovery processes to support a return to normalcy of operations or a new standard of normalcy for the provision of healthcare delivery to the community. Promote healthcare organization participation in state and/or local pre- and post-disaster recovery planning activities as described in the National Disaster Recovery Framework (NRDF) in order to leverage recovery resources, programs, projects, and activities. **HPP Healthcare System Recovery:** Assist healthcare organizations to implement COOP: Maintain continuity of the healthcare delivery by coordinating recovery across functional healthcare organizations and encouraging business continuity planning. Develop coordinated healthcare strategies to assist healthcare organizations transition from COOP operations to normalcy or the new norm for healthcare operations.

NPG Framework	NPG Capability	NPG Capability Definition Language	NPG Capability Critical Task, FIOP Integration Factor or Associated RSF Disaster Action Steps	Public Health (PHEP) or Healthcare Preparedness (HPP) Complementary Capability Content
Recovery	Health and Social Services	Restore and improve health and social services networks to promote the resilience, health, independence and well- being of the whole community.	**FIOP Integration Factor (Response):** Support medical surveillance and monitoring efforts and evaluate the need for longer term epidemiological follow-up and medical monitoring. Conduct health and safety hazard assessments and disseminate guidance and resources, to include information about hazardous materials, to support environ-mental health and safety actions. **Health and Social Services RSF Pre-disaster**: Develops strategies to address recovery issues for health, behavioral health and social services – particularly the needs of response and recovery workers, children, seniors, people living with disabilities, people with functional needs, people from diverse cultural origins, people with limited English proficiency and underserved populations. **Post-disaster**: Establishes communication and information-sharing forum(s) for Health and Social Services RSF stakeholders with the State and/or community. Identifies and coordinates with other local, State, Tribal and Federal partners the assessment of food, animal, water and air conditions to ensure their safety.	**PHEP Community Recovery**: Facilitate interaction among community and faith-based organizations (e.g., businesses and non-governmental organizations) to build a network of support services which will minimize any negative public health effects of the incident. **HPP Healthcare System Recovery:** Assess the impact of an incident on the healthcare systems ability to deliver essential services to the community and prioritize healthcare recovery needs. Assist healthcare organizations to implement COOP. Identify the healthcare essential services that must be continued to maintain healthcare delivery following a disaster. **PHEP Information Sharing:** Identify stakeholders to be incorporated into information flow **PHEP Public Health Surveillance and Epidemiological Investigation:** Conduct ongoing systematic collection, analysis, interpretation, and management of public health-related data to verify a threat or incident of public health concern, and to characterize and manage it effectively through all phases of the incident; Recommend, monitor, and analyze mitigation actions. **HPP Information Sharing**: Provide healthcare situational awareness that contributes to the incident common operating picture. Provide situation awareness regarding the status of healthcare delivery into the ongoing flow of information to assist with the creation of an incident common operating picture. Utilize coordinated information sharing protocols to receive and transmit timely, relevant, and actionable incident specific healthcare information to incident management during response and recovery.

NPG Framework	NPG Capability	NPG Capability Definition Language	NPG Capability Critical Task, FIOP Integration Factor or Associated RSF Disaster Action Steps	Public Health (PHEP) or Healthcare Preparedness (HPP) Complementary Capability Content
Recovery	Infrastructure Systems	Stabilize critical infrastructure functions, minimize health and safety threats, and efficiently restore and revitalize systems and services to support a viable, resilient community.	**FIOP Integration Factor (Response)** Re-establish critical infrastructure within the affected areas to support recovery activities. **Infrastructure RSF Post Disaster:** Participates in the coordination of damage and community needs assessments as appropriate to ensure infrastructure considerations integrate into the post-disaster public and private sector community planning process. Deploys RSF resources, as required by the specific disaster situation and consistent with the specific authorities and programs of the participating departments and agencies, to the field to assist the affected community in developing an Infrastructure Systems Recovery action plan that: • Avoids the redundant, counter-productive or unauthorized use of limited capital resources necessary for infrastructure or recovery. • Helps resolve conflicts, including those across jurisdictional lines, resulting from the competition for key resources essential to infrastructure systems recovery. • Sets a firm schedule and sequenced time structure for future infrastructure recovery projects.	**HPP Healthcare System Preparedness:** Identify and prioritize essential healthcare assets and services within a healthcare delivery area or region. Develop processes for healthcare organizations to quickly restore essential medical services in the aftermath of an incident. Develop strategies for resource allocation that assist with the continued delivery of essential services. **HPP Healthcare System Recovery:** Assist healthcare organizations to implement Continuity of Operations (COOP). Alert healthcare organizations within communities threatened by disaster and if requested and feasible, assist them with the activation of COOP such that healthcare delivery to the community is minimally impacted.

Hospital Preparedness Program (HPP)
Budget Period 3 Training and Exercise 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 and recovery operations. Hospital Preparedness Program (HPP) and Public Health Emergency Preparedness (PHEP) training and exercise requirements vary in Budget Period 3, but awardees are encouraged to plan and execute these requirements with inclusion from both HPP and PHEP programs, emergency management agencies, healthcare coalitions, and community partners at the state and local levels.

HPP Budget Period 3 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 3 to ensure the full implementation and maintenance of all activities during the five-year project period.
   The Budget Period 3 application must include funded or in-kind work plan elements to ensure hospitals maintain the 11NIMS implementation activities.

2. Training Schedule: HPP awardees must provide their training schedules using the template in the PERFORMS Resource Library. All proposed training projects (funded) for Budget Period 3 must be listed on the schedule. This schedule provides the proposed training for Budget Period 3. The completed schedule is due September 30, 2014.

Budget Period 3 Exercise Requirements

HPP-specific Qualifying Exercise Requirements: Within the five-year project period, awardees must provide evidence of successful completion of healthcare coalition-required exercises. To document the exercise, the awardee must submit the healthcare coalition's after-action report/improvement plan (AAR/IP) to ASPR. Additionally, exercises may be documented through annual progress reports and during technical assistance visits. Awardees must meet requirements for exercise planning, implementation, evaluation, and reporting during the remainder of the five-year period.

1. Exercise Planning: HPP awardees must complete a proposed schedule of qualifying exercises for Budget Period 3 and provide an exercise narrative describing Homeland Security Exercise and Evaluation Program (HSEEP) compliance, community participation, and the remaining five-year project period strategy for healthcare coalition and hospital participation in joint exercise planning and rotational execution. The awardee must submit the following documents by September 30, 2014:
   a) Exercise Schedule: HPP awardees must provide a schedule of proposed Budget Period 3 exercises on the template in the PERFORMS Resource Library. Please refer to the HPP Budget Period 3 Exercise Checklist for the completion of this plan.
   b) Exercise Narrative: HPP awardees must provide an exercise narrative on the provided template for Budget Period 3. Please refer to the HPP Budget Period 3 Exercise Checklist for the completion of this plan.
2. Exercise Implementation: HPP awardees must ensure that their qualifying exercises meet HSEEP and HPP criteria. Awardees must show that they meet these criteria in their planning documents and the exercises' required AAR/IP. The HPP Budget Period 3 Exercise Checklist fully describes the implementation criteria, which includes:
   a) HSEEP Compliance: Awardees must conduct preparedness exercises in accordance with HSEEP fundamentals

b) Healthcare Coalition Participation: Each identified healthcare coalition must participate in at least one qualifying exercise. The exercise may be at the substate regional level or the statewide level (refer to the healthcare coalition participation definition for minimum requirements).

c) Hospital Participation: All HPP participating hospitals (and if possible other healthcare organizations) must participate in a qualifying exercise. This should be in conjunction with their respective healthcare coalitions' participation (refer to definition for hospital participation).

3. Exercise Evaluation: Qualifying HPP exercises must include evaluation of capability targets. Please refer to the HPP Budget Period 3 Exercise Checklist for the required objectives for these four capabilities:

   a) Emergency Operations Coordination
   b) Information Sharing
   c) Medical Surge
      - Special Consideration: Evacuation / Shelter-in-Place:
        If the primary risk for the healthcare coalition requires full-scale evacuation and shelter-in-place operations for the healthcare systems in the region, the healthcare coalition can exercise healthcare evacuation / shelter-in-place operations
   d) Recovery/Continuity of Operations

   Exercises for Remaining Capabilities: Awardees must demonstrate that all capabilities have been tested within their jurisdictions during the five-year project period. These capabilities may be demonstrated at the statewide level or at a singular (one substate region) level. Demonstrations for these capabilities may be achieved through any type of HSEEP exercise (i.e., drill, tabletop exercise, functional exercise, or full-scale exercise) to meet the objectives of the capability. These exercises do not need to be included on the exercise schedule. Completed AAR/IPs may be requested as part of monitoring. This includes:

   a) Capability 5: Fatality Management
   b) Capability 14: Responder Safety and Health
   c) Capability 15: Volunteer Management (must be tested to meet HPP-PHEP Performance Measure 15.1)

HPP Budget Period 3 Exercise and Training Reporting Requirements

1. Exercise and Training Reporting: Awardees must submit AAR/IPs for qualifying exercises and a training report of all funded trainings to meeting reporting requirements.

   a) Exercise Report: As part of the Budget Period 3 annual progress report due September 30, 2015, awardees must report on qualifying exercises conducted during Budget Period 3. The template for this report can be found in the PERFORMS Resource Library. All completed qualifying AAR/IP templates must be provided to ASPR within 90 days of exercise completion, or by September 30, 2015.

      Exercise Exemption: A real incident may be substituted for a qualifying exercise; however, the AAR must document how the healthcare coalition involvement met qualifying criteria.

   b) Training Report: As part of the Budget Period 3 annual progress report due September 30, 2015, awardees must report on funded trainings conducted during Budget Period 3. The template for this report can be found in the PERFORMS Resource Library. Awardees are required to use this form for application planning and throughout the budget period to track trainings. The completed template must be submitted by September 30, 2015.

Joint HPP-PHEP Exercise and 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, 2014, as an uploaded attachment in PERFORMS. A template for the MYTEP can be found in the in the PERFORMS Resource Library.

2. Joint HPP-PHEP Exercise Implementation: HPP and PHEP require one joint demonstration of both public health and healthcare preparedness capabilities within the five-year project period that includes participation from a healthcare

coalition and a public health jurisdiction. Awardees must submit the AAR/IP from the full-scale exercise to both ASPR and CDC for acceptability.

HPP Option: HPP encourages healthcare coalition participation with a PHEP Cities Readiness Initiative (CRI) planning jurisdiction exercise. This includes participation from a healthcare coalition within the associated CRI metropolitan statistical area (MSA). At a minimum, the healthcare coalition associated with the CRI MSA should participate in the full-scale exercise to meet minimal HPP requirements outlined in the Joint HPP-PHEP Evaluation Criteria. If there is no healthcare coalition within the CRI MSA, hospital participation is encouraged as a part of the full-scale exercise.

3. Joint HPP-PHEP Evaluation Criteria: Healthcare Coalition Minimal Evaluation Requirements: At a minimum, awardees should demonstrate and validate healthcare coalition or hospital participation in resource and information management as outlined in the HPP-PHEP aligned capabilities, Capability 3: Emergency Operations Coordination and Capability 6: Information Sharing. If the joint exercise also tests all four of the specific HPP objectives, it may be used to meet HPP-specific requirements in addition to the joint requirement.

HPP Allowable Costs

1. Costs associated with planning, developing, executing, and evaluating exercises.
2. 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 progressive planning approach for exercise development and execution, are integrated with a functional or full-scale exercise during the five-year project period.
3. Allowable drills as described above to meet specific program 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.
4. Costs associated with enhancement and upgrade of emergency operations plans based on exercise evaluation and improvement plans (including those from the previous budget period).
5. Costs associated with release time for healthcare workers to attend exercises.

HPP Unallowable Costs

1. Salaries for backfilling are not allowable costs under this funding announcement.
2. Individual facility exercises are not allowable. HPP funds cannot be used to support stand-alone, single-facility exercises of any type. If a single facility is scheduled to exercise using HPP funds, they must, at a minimum, include the community emergency management partner and/or incident management, the community public health partner and the EMS agency during the design, development, and implementation. All HPP- funded exercises should be cleared with the HPP awardee exercise program. These exercises should be part of the progressive planning approach of the healthcare coalition to meet the deliverable of a qualifying exercise.

Hospital Preparedness Program (HPP)
Budget Period 3
Awardee Training and Exercise Requirement Checklist

The Hospital Preparedness Program (HPP) and the Public Health Emergency Preparedness (PHEP) cooperative agreements have specific planning, implementation, and evaluation criteria for exercises. These may be HPP-specific, PHEP-specific, or joint HPP and PHEP criteria. Awardees must complete these HPP-specific components of exercises and training.

1. Planning Criteria: Awardees must submit exercise and training planning documents for certain HPP exercises and training
2. Implementation Criteria: Awardees must implement planned HPP exercises following acceptable guidelines for design, development, and participation.
3. Evaluation Criteria: Awardees must demonstrate healthcare preparedness capabilities[8]-based and objective-driven exercises, which includes submission of after-action report and improvement plan (AAR/IP) documentation to report successes and planned corrective actions.

Section 1: Planning Criteria Checklist

	HPP Planning Documentation Criteria	DUE
☐	1. **Training Schedule**: HPP awardees must provide a training schedule using the template in the PERFORMS Resource Library. All proposed training projects (funded) for Budget Period 3 must be listed on the schedule. **Definition**: This schedule provides the proposed gap-based training for Budget Period 3.	September 30, 2014
☐	2. **Exercise Schedule:** HPP awardees must provide a schedule of proposed Budget Period 3 exercises on the template in the PERFORMS Resource Library. **Definition:** Only exercises that meet the implementation and evaluation criteria must be reported on the schedule (see Sections 2 and 3). Exercises that meet these criteria are considered "qualifying exercises."	September 30, 2014
☐	3. **Exercise Narrative:** HPP awardees must provide an exercise narrative on the provided template. **Definition:** The narrative must provide a description of the awardee Homeland Security Exercise and Evaluation Program (HSEEP) compliance process and community participation, the remaining five-year project period exercise strategy, and the scheduled joint HPP-PHEP exercise(s). **Special Considerations:** • If no joint exercise is planned, this section should indicate "No Scheduled Joint Exercise." • A rotational strategy for healthcare coalition exercises is highly recommended for awardees and must be forecasted for the remainder of the five-year project period in the narrative. ASPR recognizes this forecast is subject to change.	September 30, 2014

[8] www.phe.gov/Preparedness/planning/hpp/reports/Documents/capabilities.pdf

☐	**Joint-HPP PHEP Planning Criteria** **Multiyear Training and Exercise Plan (MYTEP):** HPP and PHEP awardees must provide a MYTEP. **Definition:** Each year, awardees must conduct or participate in a training and exercise planning workshop (T&EPW) and submit a MYTEP. A standard MYTEP template is available at https://www.llis.dhs.gov/hseep. The MYTEP should be coordinated with other partners in the jurisdiction. **Special Consideration:** Awardees must work with relevant state and local officials to provide information for the National Exercise Schedule (NEXS) to facilitate coordination of exercises across all levels of government and healthcare entities. Additionally, awardees must engage at-risk populations and/or those who represent them in exercise planning and implementation.	September 30, 2014

Section 2: Implementation Criteria Checklist

	HPP Qualifying Exercise Implementation Criteria	DUE

☐	**HSEEP:** Awardees must conduct preparedness exercises in accordance with the HSEEP fundamentals including
	• The Fundamental Principles
	• Exercise Program Management
	• Exercise Methodology
	  • Exercise Design & Development
	  • Exercise Conduct
	  • Exercise Evaluation and
	  • Improvement Planning
	
	More information on the April 2013 HSEEP guidelines and exercise policy is available at https://www.llis.dhs.gov/content/homeland-security-exercise-and-evaluation-program-hseep.
	
	The HSEEP building-block approach (progressive planning) is an acceptable model leading 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.
		Each Exercise

☐	**Healthcare Coalition Participation:** Each identified healthcare coalition must participate in at least one qualifying exercise. This may be at the substate regional level or the statewide level (refer to the Healthcare Coalition Participation definition for minimum requirements). **Hospital Participation:** All HPP participating hospitals (and if possible other healthcare organizations) must participate in a qualifying exercise. This should be in conjunction with their respective healthcare coalitions' participation (refer to definition for hospital participation). **Exercise Exemption:** A real incident may be substituted for a qualifying exercise; however, the after-action report (AAR) must document how the healthcare coalition involvement met qualifying criteria.	Five-year Project Period
☐	**Joint HPP-PHEP Exercise Implementation Criteria** HPP and PHEP require a joint demonstration of both public health and healthcare preparedness capabilities within the five-year project period that includes participation from a healthcare coalition and a public health jurisdiction. Awardees must submit the AAR/IP from the full-scale exercise to both ASPR and CDC for acceptability. HPP Option: HPP encourages healthcare coalition participation with a PHEP Cities Readiness Initiative (CRI) planning jurisdiction exercise. This includes participation from a healthcare coalition within the associated CRI metropolitan statistical area (MSA). At a minimum, the healthcare coalition associated with the CRI MSA should participate in the full-scale exercise to meet minimal HPP requirements outlined in the Joint HPP-PHEP Evaluation Criteria. If there is no healthcare coalition within the CRI MSA, hospital participation is encouraged as a part of the FSE.	Five-year Project Period

Section 3: Evaluation Criteria Checklist

	HPP awardee exercises will be evaluated based on specific HPP objectives. Qualifying HPP exercises must include evaluation of objectives and capability targets for these four capabilities:	**DUE**
☐	**1. Emergency Operations Coordination** Required objectives for Healthcare Preparedness Capability 3: Emergency Operations Coordination (EOC) include Healthcare Coalition Developmental Assessment Factors #11, 12, and 14. These are listed under HPP Exercise Objectives at the end of this document.	Five-year Project Period
☐	**2. Information Sharing** Required objectives for Healthcare Preparedness Capability 6: Information Sharing include Continuity of Healthcare Operations Program Measure Indicator #4, and HPP-PHEP Performance Measure 6.1. These are listed under HPP Exercise Objectives at the end of this document.	Five-year Project Period
☐	**3. Medical Surge** Required objectives for Healthcare Preparedness Capability 10: Medical Surge (MS) include Medical Surge Program Measure Indicators #4 and #5 and Continuity of Healthcare Operations Program Measure #3. These are listed under HPP Exercise Objectives at the end of this document. **Special Consideration: Evacuation Shelter-in-Place** The associated program measure indicator must be tested (listed above). *However, if the primary risk for the healthcare coalition requires full-scale evacuation and shelter-in-place operations for the healthcare systems in the region*, the required objective for Capability 10: Medical Surge, Function 5, includes Healthcare Coalition Developmental Assessment Factor #15. Meeting this objective may be considered as the medical surge demonstration.	Five-year Project Period
☐	**4. Recovery/Continuity of Operations** Required objectives for Healthcare Preparedness Capability 2 include Continuity of Healthcare Operations Program Measure Indicator #6. This objective is listed under HPP Exercise Objectives at the end of this document.	Five-year Project Period
☐	**Special Consideration (Exercises for Remaining Capabilities)**: Awardees must demonstrate that all capabilities have been tested within their jurisdictions during the five-year project period. Capability 5: Fatality Management and Capability 14: Responder Safety and Health may be demonstrated at the statewide level or at a singular (one substate region) level. Demonstrations for these capabilities may be achieved through any HSEEP exercise to meet the objectives of the capability. These exercises do not need to be included on the exercise schedule. Completed AAR/IPs may be requested as part of monitoring. Capability 15: Volunteer Management must be tested per HPP-PHEP Performance Measure 15.1	Five-year Project Period
☐	**Joint HPP-PHEP Evaluation Criteria** **Healthcare Coalition Minimal Evaluation Requirements:** At a minimum, awardees should demonstrate and validate healthcare coalition or hospital participation in resource and information management as outlined in the HPP-PHEP aligned capabilities, Capability 3: Emergency Operations Coordination and Capability 6: Information Sharing. If the joint exercise also tests all four of the specific healthcare preparedness capabilities, it may be used to meet HPP-specific requirements in addition to the joint requirement.	Five-year Project Period

	Exercise Reporting	**DUE**
☐	**HPP Exercise Reporting**: HPP awardees are encouraged to provide an AAR/IP for each qualifying exercise within 90 days of exercise completion but no later than September 30, 2015. The required exercise report must be completed on the report template found in the PERFORMS Resource Library. The field project officer may request to review the AAR/IP following the 90-day completion timeframe.	September 30, 2015

	Training Report	DUE
☐	Awardees must report on the preparedness training conducted during Budget Period 3 and describe the impact the training had on the jurisdiction on the provided template found in the PERFORMS Resource Library. This report is an extension of the training plan submitted with application.	September 30 , 2015

Definitions

Healthcare Coalition (Minimum Participation Requirements): The definitions and standards of coalition participation are dependent on reporting of coalition members in an acceptable HPP reporting system (PERFORMS) and based on minimum requirements. According to Healthcare Coalition Developmental Assessment Factor #2, membership should consist of, at a minimum, participating hospitals, emergency medical services (EMS), emergency management (EM), and public health. Incorporating long-term care (LTC) and mental and behavioral health (M/BH) members should be a priority.
Other healthcare (e.g., pediatric professionals, substance abuse professionals) and nonhealthcare entities (e.g., public works, faith-based organizations), are highly encouraged to be added based on planning priorities. These may include partners such as dialysis partners, community health centers, Veterans Affairs and Department of Defense hospitals, and private agencies / associations.
The goal for member participation in healthcare coalitions are hospitals, public health, EMS, EM, LTC, M/BH, and any other specialty organizations that would be needed to assist with preparedness and response.

HPP Qualifying Exercise (Reportable): A healthcare coalition exercise that meets HPP-specific qualifying exercise implementation criteria and the specific HPP evaluation criteria (HPP objectives 1-4).

Participating Hospital
A participating hospital is:
1. A hospital that has received direct HPP funding or indirect HPP funding / benefit
    a. A direct benefit participant would include an organization that receives HPP funding or HPP-funded products (equipment, training, or exercises).
    b. An indirect benefit participant is a member who **regularly** takes part in and benefits from preparedness efforts such as planning, training, or exercising but does not receive direct HPP funds.
2. A hospital that has been identified as part of one of the coalitions in the state
    a. Participants are self-identified by the coalitions and reported on ASPR's HPP reporting documents

Progressive Planning Approach (Building-block Approach): Per HSEEP Fundamentals (April 2013 Revision), a progressive approach includes the use of various exercises aligned to a common set of exercise program priorities and objectives with an increasing level of complexity over time. Progressive exercise planning does not imply a linear progression of exercise types. The April 2013 HSEEP guidance can be found at https://www.llis.dhs.gov/HSEEP/Documents/homeland-security-exercise-and-evaluation-program-hseep

Allowable Costs

HPP Allowable Costs
1. Costs associated with planning, developing, executing, and evaluating exercises.
2. 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 progressive planning approach for exercise development and execution, dovetail with a functional or full-scale exercise during the five-year project period.
3. 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.
4. Costs associated with enhancement and upgrade of emergency operations plans based on exercise evaluation and improvement plans (including those from the previous budget period).
5. Costs associated with release time for healthcare workers to attend exercises.

HPP Unallowable Costs

1. Salaries for backfilling are not allowable costs under this funding announcement.
2. Individual facility exercises are not allowable. HPP funds cannot be used to support stand-alone, single-facility exercises of any type. If a single facility is scheduled to exercise using HPP funds, they must, at a minimum, include the community emergency management partner and/or incident management, the community public health partner and the EMS agency during the design, development, and implementation. All HPP- funded exercises should be cleared with the HPP awardee exercise program. These exercises should be part of the progressive planning approach of the healthcare coalition to meet the deliverable of a qualifying exercise.

HPP Exercise Objectives

1. Capability 3: Emergency Operations Coordination
    a. Objective 1: HCDDA #11: Healthcare coalition demonstrates coordination within the jurisdictional response framework during emergency operations
    b. Objective 2: HCDDA #12: Healthcare coalition demonstrates they can communicate the status of the healthcare system during response
    c. Objective 3: HCDDA #14: Healthcare coalition engages in the jurisdictional resource management process to support healthcare system operations
2. Capability 6: Information Sharing
    a. Objective 1: Continuity #4: Healthcare coalition demonstrates redundant means of communication for achieving and sustaining situational awareness.
    b. Objective 2: Joint Measure #6.1: Report Essential Elements of Information
3. Capability 10: Medical surge
    a. Objective 1: MS #4: Implement resource management processes to deliver appropriate levels of care to all patients as well as to provide no less than 20% immediate availability of staffed members' beds, within 4 hours of a disaster
    b. Objective 2: MS #5: Monitor acuity, staff, beds; off-load and on-load patients, track patient movement
    c. Objective 3: Continuity #3: Implement a process to enhance its members' situational awareness to support activation of immediate bed availability through continuous monitoring
4. Capability 2: Recovery/Continuity of Operations
    a. Objective 1: Continuity #6: Implement resource processes to assist healthcare coalition members to ensure the delivery of essential healthcare services

Appendix 8
Public Health Emergency Preparedness (PHEP) Budget Period 3
Awardee Training and Exercise Requirement Checklist

The Hospital Preparedness Program (HPP) and the Public Health Emergency Preparedness (PHEP) cooperative agreements have specific planning, implementation, and evaluation criteria for exercises. These may be HPP-specific, PHEP-specific, or joint HPP and PHEP criteria. PHEP awardees must complete these PHEP-specific components for exercises and training.

4. Planning Criteria: Awardees must submit exercise and training planning documents for certain PHEP exercises.
5. Implementation Criteria: Awardees must implement planned PHEP exercises following acceptable guidelines for design, development, and participation.
6. Evaluation Criteria: Awardees must demonstrate public health preparedness capabilities[9]-based and objective-driven exercises. This includes submission of after-action report and improvement plan (AAR/IP) documentation to report successes and planned corrective actions.

Section 1: Planning Criteria Checklist

	PHEP Planning Documentation Criteria	DUE
☐	**Multiyear Training and Exercise Plan (MYTEP):** PHEP awardees must have a current MYTEP. **Definition:** Each year, awardees must conduct or participate in training and exercise planning workshop (T&EPW) and prepare a MYTEP. A standard MYTEP template is available at https://www.llis.dhs.gov/hseep. The MYTEP should be coordinated with other partners in the jurisdiction. PHEP project officers will review this document during site visits. **Special Consideration:** Awardees must work with relevant state and local officials to provide information for the National Exercise Schedule (NEXS) to facilitate coordination of exercises across all levels of government and healthcare entities.	Annually

Section 2: Implementation Criteria Checklist

	PHEP Exercise Implementation Criteria	DUE

[9] www.cdc.gov/phpr/capabilities/index.htm

☐	**HSEEP:** Awardees must conduct preparedness exercises in accordance with the HSEEP fundamentals including
	• The Fundamental Principles
	• Exercise Program Management
	• Exercise Methodology
	  ○ Exercise Design & Development
	  ○ Exercise Conduct
	  ○ Exercise Evaluation and
	  ○ Improvement Planning
	More information on the April 2013 HSEEP guidelines and exercise policy is available at https://www.llis.dhs.gov/content/homeland-security-exercise-and-evaluation-program-hseep.
	The HSEEP building block approach (progressive planning) is an acceptable model leading 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.	

☐	**Annual Exercise Compliance**: PHEP awardees must conduct at least one annual exercise to test preparedness and response capabilities including submission of an after-action report (AAR) and improvement plan (IP). **Special Consideration:** Medical countermeasure (MCM)-related drills, by themselves, are very narrowly focused and are no longer sufficient to meet this annual exercise requirement. The jurisdiction's annual exercises should focus more broadly to address multiple operational gaps and developmental areas. Annual PHEP exercises must be jointly planned and executed with as many healthcare sector, emergency management agency, and community partners as are available. **Exercise Exemption:** 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.	Annually
☐	PHEP awardees must assure that they will conduct, at least annually, an exercise or drill that addresses the needs of at-risk individuals and will report on the strengths and weaknesses identified through such exercise or drill and corrective actions taken to address material weaknesses in the following year's funding application.	Annually
☐	**Medical Countermeasure/Cities Readiness Initiative (MCM/CRI) Exercise Compliance:** 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 metropolitan statistical areas (MSAs) and each local planning jurisdiction within the 72 CRI areas and four directly funded localities. Distribution and dispensing full-scale exercises are optional for the eight U.S. territories and freely associated states. **Special Consideration:** Several PHEP awardees performed the requirements for a joint full-scale exercise through a real response and recovery or planned 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 within the current five- year project period. If the awardee obtained the performance planning metrics (observed data) for the indicated performance measures[10] through exercises conducted in Budget Period 11, they may use the Budget Period 11 performance planning metrics as an option and focus full-scale exercise planning on items in the IP from the Budget Period 11 exercise.	Five-year Project Period

[10] Refer to the *Public Health Emergency Preparedness Cooperative Agreement Budget Period 2 Medical Countermeasure Reference Guide*.

☐	**Joint HPP-PHEP Exercise Implementation Criteria** HPP and PHEP require a joint demonstration of both public health and healthcare preparedness capabilities within the five-year project period that includes participation from a healthcare coalition and a public health jurisdiction. Awardees must submit the AAR/IP from the full-scale exercise to both ASPR and CDC for acceptability. HPP Option: HPP encourages healthcare coalition participation with a PHEP Cities Readiness Initiative (CRI) planning jurisdiction exercise. This includes participation from a healthcare coalition within the associated CRI metropolitan statistical area (MSA). At a minimum, the healthcare coalition associated with the CRI MSA should participate in the FSE to meet minimal HPP requirements outlined in the Joint HPP-PHEP Evaluation Criteria. If there is no healthcare coalition within the CRI MSA, hospital participation is encouraged as a part of the FSE.	Five-year Project Period

Section 3: Evaluation Criteria Checklist

PHEP	**PHEP annual exercises will be evaluated based on specific public health preparedness capabilities.** **Reference:** *Public Health Preparedness Capabilities: National Standards for State and Local Planning*	
☐	**Joint HPP-PHEP Evaluation Criteria** **Healthcare Coalition Minimal Evaluation Requirements:** At a minimum, awardees should demonstrate and validate healthcare coalition or hospital participation in resource and information management as outlined in the HPP-PHEP aligned capabilities, Capability 3: Emergency Operations Coordination and Capability 6: Information Sharing. If the joint healthcare coalition CRI full-scale exercise also tests all four of the specific HPP objectives, it may be used to meet HPP-specific requirements in addition to the joint requirement.	Five-year Project Period

	Exercise Reporting	**Deadline**
☐	**PHEP Exercise Reporting:** PHEP awardees are encouraged to provide an AAR/IP for each qualifying exercise within 90 days of exercise completion but no later than September 30, 2015, (due as part of the PHEP Budget Period 3 [BP3] annual progress report) and show evidence of the HSEEP building-block approach. The project officer may request to review the AAR/IP following the 90-day completion timeframe.	September 30, 2015

	Training Reporting	**DUE**
☐	Awardees must report on preparedness training conducted during Budget Period 3 and describe the training's impact on the jurisdiction using the template provided in the PERFORMS Resource Library.	September 30, 2015

Definitions

Joint Exercise: An exercise in which the minimal requirements of the joint CRI objectives are met (see Evaluation Criteria).

Progressive Planning Approach (Building-block Approach): Per HSEEP Fundamentals (April 2013 Revision), a progressive approach includes the use of various exercises aligned to a common set of exercise program priorities and objectives with an increasing level of complexity over time. Progressive exercise planning does not imply a linear progression of exercise types. The April 2013 HSEEP guidance is available at https://www.llis.dhs.gov/HSEEP/Documents/homeland-security-exercise-and-evaluation-program-hseep.

Appendix 9
Public Health Emergency Preparedness Budget Period 3 Requirements for Territories and Freely Associated States

CDC recognizes the unique infrastructure and geographic challenges faced by the U.S. territories and freely associated states that receive limited 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.

CDC has responded by modifying the PHEP requirements that these awardees can realistically achieve in Budget Period 3. 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. 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 preparedness capabilities, ensuring that federal preparedness funds are directed to priority areas within their jurisdictions as identified through their strategic planning efforts.

PHEP Requirements for Territories and Freely Associated States
Following are the Budget Period 3 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.

1. Complete and submit all required Budget Period 3 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 3. The project narrative may briefly address cross-cutting activities and plans for addressing any challenges or barriers that may impede progress

   Capabilities Work Plan and Budget: The Budget Period 3 capabilities work plan and budget should address the *Public Health Preparedness Capabilities: National Standards for State and Local Planning* and take into consideration the results from the jurisdictional risk assessment conducted. 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 3.

Budget Period 3 Report Submission Requirements:

- Interim progress reports/funding applications are due 60 calendar days following initial publication of the Budget Period 3 continuation guidance on www.grants.gov.
- 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.

2. 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.

3. Conduct multiyear training and exercise planning.

   Awardees must review and update their multiyear training and exercise plans to include planned training sessions for public health capabilities. Plans should include goals and objectives for each exercise and training activity. Updated plans should be submitted as part of the funding applications.

   During the five-year 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.

4. Engage with 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 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 PHEP project officers once every 12 to 18 months.

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

   CDC has determined that awardees can satisfy the 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

6. 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 3 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.

7. 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 2015 summit will be provided to awardees when finalized.

Budget Period 3 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 PHEP project officers will conduct an evidence-based analysis of these performance goals during site visits and provide technical assistance as needed.

Overall

8. **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

9. **Performance Goal:** Public health emergency operations plans address preparedness and response strategies that address the public health needs of at-risk individuals and the elderly in the event of a public health emergency. The term "at-risk individuals" means children, pregnant women, senior citizens and other individuals who have special needs in the event of a public health emergency, as determined by the Secretary. †
   Demonstration: Provide excerpt from the public health emergency operations plans that address at-risk and elderly individuals.
10. **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. † Jurisdictions may elect to combine 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 3.

Capability 3: Emergency Operations Coordination

11. **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.

12. **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. These two drills will meet the MCM drill requirement.

Capability 4: Emergency Public Information and Warning

13. **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 3.

Capability 6: Information Sharing

No performance goals for Budget Period 3.

Capability 7: Mass Care

No performance goals for Budget Period 3.

Capability 8: Medical Countermeasure Dispensing

14. **Performance Goal:** In Budget Period 3, CDC will implement a new method of evaluating measure a jurisdiction's operational readiness to successfully execute any large-scale response requiring distribution and dispensing of medical countermeasures and to provide a snapshot of the nation's medical countermeasure programs as a whole.
    Demonstration: CDC will release, later in May 2014, more detailed guidance on the new assessment process and the data collection tool that will be used as part of this new evaluation.

Capability 9: Medical Materiel Management and Distribution

15. **Performance Goal:** Conduct three (3) operational drills from the PHEP Cooperative Agreement Online Data Collection Submission suite.
    Demonstration: Utilize the online reporting template (web address will be provided during Budget Period 3) to report the observed data on any three *different* drills conducted during Budget Period 3.

Capability 10: Medical Surge

No performance goals for Budget Period 3.

Capability 11: Non-Pharmaceutical Interventions

No performance goals for Budget Period 3.

Capability 12: Public Health Laboratory Testing

16. **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.

17. **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

18. **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.

19. **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

20. **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

21. **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.

Budget Period 3
Summary of PHEP Requirements for Territories and Freely Associated States

Requirement	
1	Submit Budget Period 3 application and required reports *
2	Foster HPP and PHEP alignment
3	Develop multiyear training and exercise plan
4	Engage with project officers
5	Submit influenza pandemic plans *†
6	Comply with PGO assurances †
7	Attend annual Public Health Preparedness Summit
8	Reconcile financial records †
9	Include plans for at-risk and elderly populations †
10	Develop senior advisory committee/healthcare coalition †
11	Develop mutual aid agreements or EMAC *(Guam & USVI only)* †
12	Conduct call down drills
13	Disseminate public information

14	Operational readiness for medical countermeasure distribution
15	Conduct three operational drills
16	Maintain IATA certification for laboratory staff
17	Develop procedures for specimen shipping
18	Collect syndromic surveillance data
19	Analyze syndromic surveillance data
20	Meet NIMS compliance†
21	Address volunteer management†

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

Appendix 10
2014 Checklist of Requirements for Laboratory Response Network - B Standard Level Reference Laboratories

	Requirements	References
I. Minimum Laboratory Testing Capabilities	1. Demonstrates proficiency in applying the multi-agent screening protocol to designated high risk environmental samples.	LRN Laboratory Qualification Agreement (LQA) 2011, Requirements 6,7, and 11; CDC Public Health Preparedness Capability 12: Function 3. Skills 2
	2. Demonstrates proficiency in performing rapid detection and confirmatory methods for clinical and high-risk environmental samples to identify designated high-priority threat agents.	LQA Requirements 6,7,11; CDC Public Health Preparedness Capability 12" Function 3, Skills 2
	3. Maintains awareness of and compliance with all LRN policies including proficiency testing, notification, and data messaging.	Laboratory Qualification Agreement (all)
	4. Plans, optimizes processes, and exercises laboratory surge testing capacity as may be needed for large-scale events to include maintaining chain of custody and data messaging of large volume of results.	LQA Requirement 12, see also "Determining Surge Capacity in the Laboratory Response Network, Guidance for Conducting Assessments" APHL, RAND, CDC LRN Oct 2008; CDC Public Health Preparedness Capability 12: Functions 2 and 3, Priority 1
II. Logistical Support and Administrative Activities	1. Staffs program so as to maintain proper oversight of training and membership registry of state's Sentinel Laboratory network of clinical diagnostic laboratories.	CDC Public Health Preparedness Capability 12: Function 1,Priorities 1 and 2, Skills 2
	2. Staffs program so as to maintain sufficient number of trained and cross-trained personnel to support ongoing LRN testing and potential surge demands.	LQA Requirement 12; CDC Public Health Preparedness Capability 12: Function 3, Priority 1
	3. Maintains Select Agent and Toxins registration.	LQA Requirement 2
	4. Maintains USDA/APHIS permits to receive proficiency test samples and LRN reagents.	LQA Requirements 1 and 2
	5. Maintains ability to notify appropriate partners of laboratory testing results according to LRN policies and procedures	LQA Requirement 5; CDC Public Health Preparedness Capability 12: Function 5
	6. a) At least annually, laboratory directors of state and large city/county public health laboratories that receive PHEP funding should meet with the PHEP directors to discuss LRN-B support requirements, preparedness investment strategies, and effective resource allocation plans. b) At least annually, laboratory directors of state public health laboratories should meet with laboratory directors in the Urban Areas Security Initiative jurisdictions in their states to discuss LRN-B membership requirements and establish strategies and support for laboratory testing.	Public Health Emergency Preparedness Cooperative Agreement Budget Period 3 Continuation Guidance, page 25

	Requirements	References
	7. Ensures maintenance of service contracts for LRN-required equipment.	LQA Requirement 10, CDC Public Health Preparedness Capability 12: Functions 2 and 3
	8. Ensures redundancy in LRN-required laboratory equipment to support surge demands.	LQA Requirement 10 and 12; CDC Public Health Preparedness Capability 12: Functions 2 and 3
	9. Maintains updated laboratory capabilities and current contact information on the LRN website.	LQA Requirement 10
	10. Maintains an inventory management system of LRN reagents and supplies with back-up materials or just-in-time processes in place to respond to routine and surge testing needs.	LQA Requirements 7 and 12; CDC Public Health Preparedness Capability 12: Functions 2 and 3
	11. Maintains proficiency in messaging test results using LRN Results Messenger and/or compatible Laboratory Information Management System (LIMS) as well as providing training of staff when required for nonroutine use (e.g. EID events).	LQA Requirement 5; CDC Public Health Preparedness Capability 12: Functions 3 and 5
	12. Maintains good laboratory practices for sample processing that includes the following: accessioning, aliquots, storage, safety procedures including personal protective equipment required, controlled access, and unique identifiers for samples.	CDC Public Health Preparedness Capability 12: Functions 2 and 3
	13. Maintains a surge support plan that is reviewed annually by all laboratory staff.	LQA Requirement 12; CDC Public Health Preparedness Capability 12: Function 3, Priority 1
III. Emerging Infectious Diseases (EID) Preparedness	1. Plans and prepares for potential testing, mobilization, and sustainment as may be associated with CDC-designated EID emergency preparedness and response events.	LQA Requirement 12; CDC Public Health Preparedness Capability 12: Function 3
	2. Incorporates or obtains access to additional instrumentation as may be needed during an EID surge event.	LQA Requirement 12; CDC Public Health Preparedness Capability 12: Function 3
	3. Plans for appropriate organizational management and chain of command for laboratory testing in an EID surge event.	LQA Requirement 12, CDC Public Health Preparedness Capability 12: Function 3.
	4. Maintains timely review of LRN policies and procedures as necessary to respond to a designated EID event.	LQA Requirement 12, CDC Public Health Preparedness Capability 12: Function 3

IV. Minimum Instrumentation, Facilities, and Equipment	1. ABI 7500 Fast DX	LQA Requirement 10; CDC Public Health Preparedness Capability 12: Functions 2 and 3
	2. Victor X4, Victor 2 or Victor 3	LQA Requirement 10; CDC Public Health Preparedness Capability 12: Functions 2 and 3
	3. Maintain sufficient test reagents and supplies to support routine and surge testing, including validated and approved extraction kits and master mix as listed on the LRN website.	LQA Requirements 7 and 12; CDC Public Health Preparedness Capability 12: Functions 2 and 3, Priority 2
	4. Biosafety Level 3 (BSL3) Laboratory (as described in the Biosafety in Microbiology and Biomedical Laboratories) 5th edition, including all safety requirements such as personal protective equipment (PPE) and appropriate air handling systems	LQA Requirement 10; CDC Public Health Preparedness Capability 12: Functions 2 and 3, Priority 2
	5. Systems to provide controlled access to laboratory	CDC Public Health Preparedness Capability 12: Functions 2 and 3, Priority 2
	6. Computer dedicated to use for data messaging	CDC Public Health Preparedness Capability 12: Functions 2 and 3, Priority 2; Function 5
	7. Certified biological safety cabinets and autoclaves	CDC Public Health Preparedness Capability 12: Functions 2 and 3, Priority 2
	8. Emergency power source	CDC Public Health Preparedness Capability 12: Functions 2 and 3, Priority 2
	9. PCR workstation dedicated to polymerase chain reaction testing (PCR)	CDC Public Health Preparedness Capability 12: Functions 2 and 3, Priority 2

Appendix 11
HPP-PHEP Awardee Resources

At-risk Populations/Older Adults
- www.aoa.gov/AoARoot/Preparedness/Resources_Network/index.aspx
- www.aoa.gov/AoARoot/Preparedness/Resources_Network/pdf/disasterofficersdirectory.pdf
- www.acl.gov/Programs/AIDD/Programs/DDC/index.aspx
- www.acl.gov/Programs/AIDD/Programs/PA/index.aspx
- www.acl.gov/Programs/AIDD/Programs/DDC/index.aspx
- www.acl.gov/Programs/AIDD/Programs/PA/index.aspx
- www.fema.gov/pdf/government/**grant**/**bulletins**/info**361**.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://www.llis.dhs.gov/HSEEP

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/planning-preparedness/hospital/healthcarechecklist.pdf

Pandemic and All-Hazards Preparedness Reauthorization Act (PAHPRA)

- http://www.phe.gov/Preparedness/legal/pahpa/Pages/pahpra.aspx
- http://beta.congress.gov/113/bills/hr307/BILLS-113hr307enr.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 - https://www.agacgfm.org/AGA/ToolsResources/documents/riskassessmentmonitoringtool.pdf
- AGA's Financial and Administrative Monitoring Tool - http://www.gao.az.gov/docs/financialadministrativemonitoringtool.pdf
- AGA's Fraud Prevention Toolkit - http://www2.agacgfm.org/tools/FraudPrevention/.