NATIONAL BIOTERRORISM HOSPITAL PREPAREDNESS PROGRAM

FY 2005
Continuation Guidance
HRSA Announcement Number 5-U3R-05-001

Application Due Date: Postmarked by 5:00 P.M. ET - July, 1, 2005
CFDA # 93.889
Authority: Section 319C-1 of the Public Health Service (PHS) Act

U.S. Department of Health and Human Services
Health Resources and Services Administration
Healthcare Systems Bureau

INTRODUCTION

PURPOSE

The purpose of this program is to enhance the ability of hospitals and health care systems to prepare for and respond to bioterrorism and other public health emergencies. These emergency preparedness and response efforts are intended to support the National Response Plan www.dhs.gov/nationalresponseplan and the National Incident Management System www.fema.gov/nims

This guidance provides applicable updates to critical benchmarks, minimum levels of readiness and sentinel indicators. For supporting narrative of the attached critical benchmarks awardees are to reference the FY 2004 Application Guidance.

The funding cycle for this cooperative agreement is: Sept 1, 2005 – Aug 31, 2006.

LEGISLATIVE AUTHORITY AND ELIGIBLE ENTITIES

To follow up on the emergency bioterrorism legislation in fiscal year (FY) 2002 through the Public Health and Social Services Emergency Fund, Congress authorized a continuing response to bioterrorism and other public health emergencies in June 2002. The *Public Health Security and Bioterrorism Preparedness and Response Act of 2002* (Public Law 107-188) amended Section 319C-1 of the Public Health Service Act (42 U.S.C. 247d-3), which supports activities related to countering potential terrorist threats to civilian populations. Funding is provided under the *Consolidated Appropriations Act, 2005* (Public Law 108-447).

Only current awardees under this program are eligible to apply for continuation funding. Awardees will be notified as to their FY 2005 funding amount in a cover letter. The distribution of funds will be to the State or political subdivision of a State (cities and counties are considered political subdivisions of States. Territories are considered States for the purposes of the grant program). Hospitals, EMS systems, outpatient facilities, community health centers and poison control centers should work with the appropriate health department for funding through this program.

The administrative and funding instrument to be used for this program will be the cooperative agreement, in which substantial HRSA programmatic collaboration with awardees is anticipated during the performance of the project.

FEDERAL AND AWARDEE ROLES AND RESPONSIBILITIES

I. General Obligations of Awardee:

1. Appoint appropriate staff including a bioterrorism hospital preparedness coordinator, a medical director, and appropriate administrative staff.
2. Establish systems that, at a minimum, can provide triage treatment and initial stabilization, above the current daily staffed bed capacity, for the following classes of adult and pediatric patients requiring hospitalization within three hours in the wake of a terrorism incident or other public health emergency:
   - 500 cases per million population for patients with symptoms of acute infectious disease – especially smallpox, anthrax, plague, tularemia and influenza;
   - 50 cases per million population for patients with symptoms of acute botulinum intoxication or other acute chemical poisoning – especially that resulting from nerve agent exposure;
   - 50 cases per million population for patients suffering burn or trauma; and
   - 50 cases per million population for patients manifesting the symptoms of radiation-induced injury – especially bone marrow suppression.
3. Ensure that all participating hospitals have the capacity to maintain, in negative pressure isolation, at least one suspected case of a highly infectious disease (e.g., smallpox, pneumonic plague, SARS, influenza and hemorrhagic fevers) or febrile patient with a suspect rash or other symptoms of concern who might be developing a highly communicable disease. Awardees must identify at least one regional healthcare facility, in each awardee defined region, that is able to support the initial evaluation and treatment of at least 10 adult and pediatric patients at a time in negative pressure isolation within 3 hours post-event.
4. Develop a system that allows for the advance registration and credentialing of clinicians needed to augment a hospital or other medical facility to meet patient/victim care and increased surge capacity needs.
5. Establish a regional system that insures a sufficient supply of pharmaceuticals to provide prophylaxis for 3 days to hospital personnel (medical and ancillary staff), hospital based emergency first responders and their families -- in the wake of a terrorist-induced outbreak of anthrax or other disease for which such countermeasures are appropriate.
6. Each awardee must ensure adequate personal protective equipment (PPE) per awardee defined region, to protect current and additional health care personnel, during an incident. This benchmark is tied directly to the number of health care personnel the awardee must provide to support surge capacity for beds. The level of PPE will be established based on the HVA, and the level of decontamination that is being designed in CBM 2.7.

7. Insure that adequate portable or fixed decontamination systems exist for managing adult & pediatric patients as well as health care personnel, who have been exposed during a chemical, biological, radiological, or explosive incident in accordance with the numbers associated with CBM # 2-1.
8. Enhance the networking capacity and training of health care professionals to be able to recognize, treat and coordinate care related to the behavioral health consequences of bioterrorism or other public health emergencies.
9. Establish a secure and redundant communications system that insures connectivity during a terrorist incident or other public health emergency between health care facilities and state and local health departments, emergency medical services, emergency management agencies, public safety agencies, neighboring jurisdictions and federal public health officials.
10. Enhance the statewide mutual aid plan to deploy EMS units in jurisdictions/regions they do not normally cover, in response to a mass casualty incident due to terrorism. This plan must ensure the capability of providing EMS triage, transportation and patient tracking for at least 500 adult and pediatric patients per million population within 3 hours post-event. In addition, for each metropolitan area or other region of the state for which a predictable high-risk scenario has been identified during a HVA, the plan must describe a mechanism for transporting patients from an incident scene or from local hospitals to healthcare facilities in adjacent jurisdictions, to temporary healthcare facilities within or near the affected jurisdiction, and to nearby airports or rail stations for transport to more distant healthcare facilities. All scenarios documented by the applicant under Critical Benchmark 2.1 should be addressed in mutual aid plans for EMS.
11. Implement a hospital laboratory program that is coordinated with currently funded CDC laboratory capacity efforts, and which provides rapid and effective hospital laboratory services in response to terrorism and other public health emergencies.
12. Enhance the capability of rural and urban hospitals, clinics, emergency medical services systems and poison control centers to report syndromic and diagnostic data that is suggestive of terrorism or other highly infectious disease to their associated local and state health departments on a 24-hour-a-day, 7-day-a-week basis.
13. Awardees will utilize competency-based education and training programs for adult and pediatric pre-hospital, hospital, and outpatient health care personnel responding to a terrorist incident or other public health emergency.
14. As part of the state or jurisdiction's bioterrorism hospital preparedness plan, functional exercises will be conducted during FY 2005 and should be based on the Awardee HVA. These drills should involve several state agencies and implement the Incident Command Structure (ICS). To the extent possible, members of the public should be invited to participate. These exercises/drills should encompass, if possible, at least one biological agent. The inclusion of scenarios involving radiological and chemical agents as well as explosives may be

included as part of the exercises/drills.

15. Provide semi-annual progress reports on the measurable objectives identified in the approved grant

II. General Obligations of HRSA

HRSA responsibilities in the Cooperative Agreement, in addition to the required monitoring and technical assistance provided under grants include:

A. Assisting with the establishment of relationships with entities both at the Federal and State level whose participation may be relevant to the project's mission.
B. Reviewing the implementation plans submitted in cooperative agreement applications, and releasing funding for approved plans.
C. Participation in dissemination of information about project activities.
D. Conducting regular meetings to disseminate information on program developments.
E. Coordinating activities with CDC and other federal agencies as appropriate.

PROGRAM REALIGNMENT AND FUTURE DIRECTIONS

The activities described in this cooperative agreement guidance are designed to develop emergency-ready hospitals and health care systems in accord with the Interim National Preparedness Goal http://www.ojp.usdoj.gov/odp/assessments/hspd8.htm, the Interim Public Health and Healthcare Supplement to the NPG www.hhs.gov/ophep/, and the HRSA Critical Benchmarks (CB). Associated with the Interim NPG are two broad-gauged resources to help guide preparedness planning and implementation: a set of scenarios http://www.ojp.usdoj.gov/odp/assessments/hspd8.htm and the Target Capabilities List http://www.ojp.usdoj.gov/odp/assessments/hspd8.htm. The Department of Homeland Security developed the Interim NPG and the associated resources in concert with the Department of Health and Human Services and other agencies of the Federal Government as well as with representatives of state and local public health departments and other stakeholders. All of these documents will be refined and extended from time to time to capture lessons learned and to introduce new concepts as appropriate.

COORDINATION WITH CDC AND ODP AWARDEES

As mentioned in previous guidance documents, it is of great importance that HRSA Cooperative Agreement funds be looked at in conjunction with CDC Cooperative Agreement funds and the myriad of Department of Homeland Security (DHS) Office of Domestic Preparedness (ODP) funds that are available to states.

The Department of Health and Human Services (HHS) mandated the creation of Joint Advisory Committees (JACs) in FY 2003. It is expected that those committees still meet to decide upon the best use of cooperative agreement funding. In addition to blending the HRSA and CDC interests it is also important that ODP partners be at the table for funding decisions. This accomplishes a many-fold purpose to include greater education across agencies as to what specific grants and cooperative agreements can and cannot fund, what the mandate of the programs are, which is the best funding stream to pursue for certain activities in an attempt to minimize duplication and maximize resources for a common purpose of preparedness.

NATIONAL INCIDENT MANAGEMENT SYSTEM

In accordance with HSPD-5, the National Incident Management System (NIMS) provides a consistent approach for Federal, State, and local governments to work effectively and efficiently together to prepare for, prevent, respond to, and recover from domestic incidents, regardless of cause, size, or complexity. As a condition of receiving National Bioterrorism Hospital Preparedness Program support, awardees agree to adopt and implement the NIMS. In accordance with the eligibility and allowable uses of the cooperative agreement, awardees are encouraged to direct Fiscal Year 2005 (FY05) funding towards activities necessary to implement the NIMS.

On September 8, 2004, the former Secretary of Homeland Security, Tom Ridge, wrote a letter to the Governors outlining the important steps that State, territorial, tribal and local entities should take during FY05 to become compliant with the NIMS.[†]

In order to receive Fiscal Year 2006 (FY06) preparedness funding, the minimum FY05 compliance requirements described in the Secretary's letter must be met. Applicants will be required to certify as part of their FY06 grant applications that they have met the FY05 NIMS requirements.

NIMS compliance activities to be accomplished during FY05 are as follows:

States and Territories

- Incorporate NIMS into existing training programs and exercises;
- Ensure that federal preparedness funding (including the National Bioterrorism Hospital Preparedness Program) supports state, local and tribal NIMS implementation;
- Incorporate NIMS into Emergency Operations Plans (EOP);
- Promote intrastate mutual aid agreements;
- Coordinate and provide NIMS technical assistance to local entities; and
- Incorporate Incident Command Systems (ICS) into public health department, hospital and supporting health care systems.

State, Territorial, Local and Tribal Jurisdictions

- **Complete the NIMS Awareness Course: "National Incident Management System (NIMS), An Introduction" IS 700.**

This independent study course developed by the Emergency Management Institute (EMI) explains the purpose, principles, key components and benefits of NIMS. The course is available on the EMI web page at: http://training.fema.gov/EMIWeb/IS/is700.asp.

- **Formally recognize the NIMS and adopt NIMS principles and policies.**

States, territories, tribes and local entities should establish legislation, executive orders, resolutions, or ordinances to formally adopt the NIMS. Go to http://www.fema.gov/nims and see NIMS Resources for examples.

- **Determine which NIMS requirements have already been met.**

State, territorial, tribal, and local entities have already implemented many of the concepts and protocols identified in the NIMS. However, as gaps in compliance with the NIMS are identified, states, territories, tribes and local entities should use existing awards to develop strategies for addressing those gaps.

- **Develop a strategy and timeframe for full NIMS implementation.**

States, territories, tribes, and local entities are encouraged to achieve full NIMS implementation during FY05. To the extent that full implementation is not possible during FY05, federal preparedness assistance must be leveraged to complete NIMS implementation by FY06. By Fiscal Year 2007 (FY07), federal preparedness assistance will be conditioned by full compliance with the NIMS. States should work with tribal and local governments to develop a strategy for statewide compliance with the NIMS.

- **Incorporate Incident Command Systems (ICS) into public health department, hospital and supporting health care systems.**

All federal, state, territory, tribal and local jurisdictions are required to adopt ICS in order to be compliant with the NIMS. See NIMS and the Incident Command System at http://www.fema.gov/nims under NIMS Resources.

During the FY 2005 budget period the Department of Health and Human Services will continue to work closely with the NIMS Integration Center to clarify NIMS requirements for public health and medical communities. Both HRSA and CDC will continue to provide technical assistance throughout this process to assist awardees in meeting 2005 requirements.

† Available at http://www.fema.gov/doc/nims/letter_to_governors_09082004.doc

INTRASTATE AND INTERSTATE REGIONAL PLANNING

Since FY 2003 HRSA has mandated that awardees define regions to be used for planning and

response in relation to this cooperative agreement. As awardees continue to make progress in intrastate regions, it is also necessary that awardees explore and formalize interstate regional planning to develop multi-state regional inventories of health and medical assets and plans for how those assets would be shared across state lines.

Unless there is a robust, operational response capability within interstate regions critical delays in the delivery of emergency personnel, equipment, supplies and expertise to incident sites can result. Delays may be due to the time required to identify, mobilize, and then transport public health and medical assets that arrive from other states and the Federal government to the scene .

The Department of Health and Human Services (HHS) has hired Regional Emergency Coordinators (RECs) through the Office of Public Health Emergency Preparedness (OPHEP) to enhance the existing HHS interstate regional emergency response structures in order to more effectively plan for, and respond to, public health and medical emergencies. The RECs will be asked to assist states with maintaining preparedness and conducting response and recovery activities related to public health and medical emergencies due to natural and man made disasters, terrorism, infectious disease outbreaks and other threats.

The work of the REC is consistent with the philosophy of the National Incident Management System (NIMS) and National Response Plan (NRP), being all-hazard, promoting integration between levels of government and across state boundaries, and enhancing preparation for more everyday emergency events that don't rise to the level of Federal intervention. The REC will help augment current Federal, State, and Tribal programs and capabilities, in large part through coordination mechanisms, and through the use of existing platforms for mutual aid and other assistance (EMAC and others).

HAZARD VULNERABILITY ANALYSES (HVA)

Enhanced levels of preparedness must be established based on Hazard Vulnerability Analysis (HVA) and the level of threat or risk that is probable in relation to hospitals and regions that have been defined by awardees for this cooperative agreement. Hazard Vulnerability Analysis (HVA), identifies the disasters most likely to strike an organization (in this case hospitals and other health care entities) and the surrounding community and the probable impact if those disasters were to occur. Given recent events JCAHO recognizes that every health care organization should be reevaluating and redefining the realm of possible disasters that may affect operations.

Health care organizations have always prepared for various disasters; the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) environment of care emergency management standards** requires this.

In FY 2005 it is of paramount importance that the public health departments, in conjunction with hospitals and other healthcare entities, law enforcement and other first responders, engage in active planning and information sharing around HVAs that may have already been conducted to be sure that response plans are in accordance with identified and predictable scenarios. If HVAs have not been conducted by law enforcement, then health departments, hospitals and other healthcare entities will need to engage in regional analyses.

CDC is mandating the following requirements in the cooperative agreement guidance for state and local public health preparedness programs and all efforts must be made for health departments to coordinate the two programs in this area:

OUTCOME: Hazard and Vulnerability Analysis

Jurisdiction-specific hazards are identified and assessed to enable appropriate protection, prevention, and mitigation strategies so that the consequences of an incident are minimized.

Critical Tasks:

- Decrease the time to intervention by the identification and determination of potential hazards and threats, including quality of mapping, modeling, and forecasting
- Decrease human health threats associated with identified community risks and vulnerabilities (i.e., chemical plants, hazardous waste plants, hospitals, retail establishments with chemical and agricultural supplies)
- Through partners, increase the capability to monitor movement of releases and formulate public health response and interventions based on dispersion and characteristics over time

Measure:

Recommended courses of action to minimize human health threats associated with identified jurisdiction-specific risks and vulnerabilities. (Target: within 60 days of award).

The use of intra-regional HVAs will assist States in setting essential metrics in conjunction with their municipalities to base preparedness efforts for hospitals and healthcare systems. For those Awardees that identify high-risk scenarios that are predictable from HVAs that have been conducted in awardee defined intrastate regions, changes in the allocation of resources may be necessary to enhance those areas demonstrating the highest need via risk for the remainder of the project period.

While HVAs will be an integral activity for awardees to undertake to meet the terms and conditions of the cooperative agree, the Protective Security Division (PSD) of the Department of Homeland Security (DHS) offers a Soft Target Awareness Course (STAC) that is given to the

private sector to help increase their awareness and to assist them to better secure their facility. The course is designed to be given to front line personnel. The objective is to have them look at their facility through the terrorist eyes and identify their own vulnerabilities. The STAC gives a brief history of terrorism. Then the course reviews how to detect if your facility is under surveillance. Finally, STAC finishes with guided discussions and role playing among the group. The STAC is designed for people who have had little to no exposure to terrorism (non-military, non-law enforcement, etc.) For further information please contact:

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** Further definitive JCAHO guidance on HVAs can be found under Environment of Care Standard EC.1.4 - The organization has an emergency management plan.

METROPOLITAN CENTRICITY

Densely populated urban areas face unique challenges in terms of planning and response to events that may result in mass casualties and fatalities. There is strong sentiment on the part of the Department of Health and Humans Services (HHS), the Office of Management and Budget (OMB), the Health Resources and Services Administration (HRSA) and the National Bioterrorism Hospital Preparedness Program (NBHPP) as well as Congress that funds must be targeted to these areas in an effort to bolster planning and response capacities and capabilities.

There is already precedent for targeting funds. The NBHPP has given specific allocations to 4 cities since the start of the program, the Centers for Disease Control and Prevention (CDC) administers the Cities Readiness Initiative (CRI) and the Department of Homeland Security (DHS) administers the Urban Area Security Initiative (UASI) and Metropolitan Medical Response System (MMRS) programs.

Throughout the remainder of FY 2005 HRSA will be working in conjunction with HHS and CDC to identify the areas where funds will be targeted.

FUNDING FORMULA

Beginning in FY06, HRSA envisions that allocation of funds among eligible entities and among

preparedness priorities will be influenced increasingly by considerations of 1) the risks and likely medical consequences of various forms of terrorism and other public health emergencies when stratified across States and localities, 2) awardees' performance in enhancing public health and healthcare emergency preparedness, and 3) the relative merits of applicants' proposed initiatives toward selected preparedness priorities as determined by national competition.

CAPABILITIES BASED PLANNING AND RESPONSE

A logical progression to capabilities based planning and response has become evident over the past 3 years as awardees have made great strides in nearly full attainment of the current Capacity based critical benchmarks. This move is also consistent with the National Preparedness Goal that states:

> *"To achieve and sustain capabilities that enable the Nation to collaborate in successfully preventing terrorist attacks on the homeland, and rapidly and effectively responding to and recovering from any terrorist attack, major disaster, or other emergency that does occur to minimize the impact on lives, property and the economy. This state of national preparedness will be achieved by reaching risk-based target levels of capability, and sustained by measuring readiness and directing resources to areas of greatest risk and need."*

Capability-based planning is defined as planning, under uncertainty, to provide capabilities suitable for a wide range of threats and hazards while working within an economic framework that necessitates prioritization and choice. This method involves a functional analysis of operational requirements. Capabilities are identified based on the tasks required. Once the required capability inventory is defined the most cost effective and efficient options to satisfy the requirements are sought. [1]

Elements That Comprise a Capability

Personnel	Paid and volunteer staff who meet relevant qualification and certification standards necessary to perform assigned missions and tasks.
Planning	Collection and analysis of intelligence and information, and development of policies, plans, procedures, mutual aid agreements, strategies, and other publications that comply with relevant laws, regulations, and guidance necessary to perform assigned missions and tasks.

[1] Analytic Architecture for Capabilities-Based Planning, Mission-System Analysis, and Transformation, Paul K. Davis (monograph)

Organization and Leadership	Individual teams, an overall organizational structure, and leadership at each level in the structure that comply with relevant laws, regulations, and guidelines necessary to perform assigned missions and tasks.
Equipment and Systems	Major items of equipment, supplies, facilities, and communication systems that comply with relevant equipment standards necessary to perform assigned missions and tasks.
Training	Content and methods of delivery that comply with relevant training standards necessary to perform assigned missions and tasks.
Exercises, Evaluations, and Corrective Actions	Exercises, self-assessments, peer-assessments, outside review, compliance monitoring, and actual major events that provide opportunities to demonstrate, evaluate, and improve the combined capability and interoperability of the other elements to perform assigned missions and tasks to standards necessary to achieve successful outcomes.

GRANTS MANAGEMENT

SUBMISSION REQUIREMENTS

There are currently two ways to submit applications to HRSA, paper-based and electronically.

Instructions for filing paper-based applications:
Applications **must be postmarked by 5pm ET** on **July 1, 2005.** The original and 1 copy of the application must be submitted to HRSA via the HRSA Grants Application Center:

The HRSA Grants Application Center (GAC)
The Legin Group, Inc.
Attn: National Bioterrorism Hospital Preparedness Program
CFDA No. **93.889**
HRSA Announcement No. 5-U3R-05-001
901 Russell Avenue, Suite 450
Gaithersburg, MD 20879
Telephone: 877-477-2123

If an awardee submits a paper based application, an electronic copy must also be submitted to the HRSA project officer.

Pages must be numbered consecutively. Applications, whether submitted on paper or electronically, that exceed the specified limits (80 pages or approximately 10 MB, or that exceed 80 pages when printed by HRSA) will be deemed non-compliant. All non-compliant applications will be returned to the applicant, which may lead to a delay or lapse in funding.

Instructions for filing electronically:
HRSA strongly encourages grantees to submit noncompeting continuation applications electronically using the HRSA Electronic Handbooks (EHBs). To access the HRSA Electronic Hand Books (EHB), go to https://grants.hrsa.gov/webexternal/home.asp.

In order to take advantage of this electronic system, existing grantee/awardee organizations must register within the EHBs. The purpose of the registration process is to collect consistent information from all users, avoid collection of redundant information and uniquely identify each system user.

Registration within HRSA EHBs is a two-step process. In the first step, individual users from an organization who participate in the grants process, such as applying for non-competing continuations, must create individual system accounts. In the second step, the users must associate themselves with the appropriate grantee organization. (Note: All existing grantee organization records already exist within EHBs; there is no need to create a new one. Also note that registration within HRSA EHBs is required only once for each user for each organization they represent.)

Applications can be prepared by multiple individuals within your organization in a collaborative manner, but they can only be submitted by the Authorized Official (AO). Insure that your AO registers so that applications can be submitted.

To complete the registration quickly and efficiently we recommend that you have the following information handy:
1. Identify your role in the grants management process. HRSA EHBs offer three functional roles for external organization users namely Authorizing Official (AO), Business Official (BO) and Other Employee (for project directors, assistant staff, AO designees and others). For more information on functional responsibilities refer to the online help.
2. Have available your 10-digit grants number from an NGA belonging to your grant or cooperative agreement. Use the grant/cooperative agreement number to find your organization during registration.

To start your non-competing continuation application, click on “Non-competing Continuations” after logging in. Use your grant/cooperative agreement number to search for the funding opportunity and follow the instructions.

For assistance in using the online application system, call 877-GO4-HRSA (877-464-4772) between 8:30 am to 5:30 pm ET or email callcenter@hrsa.gov.

Application narratives and spreadsheets will need to be created separately and submitted as attachments to the application. You will be prompted to "upload" your attachments at strategic points within the application interface. The following document types will be accepted as attachments: WordPerfect (.wpd), Microsoft Word (.doc), Microsoft Excel (.xls), Rich Text Format (.rtf), Portable Document Format (.pdf). If there are tables that are not supported as data entry forms from within the application, they should be downloaded to your hard drive filled in and then uploaded as attachments with your applications.

Applications submitted electronically will be time/date stamped electronically, which will serve as receipt of submission.

The standard forms, such as PHS Form SF-5161, must be completed on line.

Online applications are required to submit **ONLY** one form in signed hard copy: the SF-424 Face Sheet, since that all other elements of the application have been captured and transmitted electronically.

Formal submission of the electronic application: Applications completed online are considered formally submitted when the Authorizing Official electronically submits the application to HRSA. However, to complete the submission requirements, a hard-copy of the SF-424 Face Sheet must be printed, signed, and submitted to the HRSA Grants Application Center. The SF-424 can be printed from the online application.

For an online application, the signed SF-424 must be sent to the HRSA GRANTS APPLICATION CENTER at the above address and received by HRSA by no later than five days after the due date.

Applications will be considered as having met the deadline if: (1) the application has been successfully transmitted electronically by your organization's Authorizing Official before the deadline date and time, and (2) the signed SF-424 Face Sheet is received by HRSA no later than five days after the deadline date.

REMINDER: Only applicants who apply online are permitted to forego hard-copy submission of all application forms EXCEPT the signed SF-424 Face Sheet.

If the application is submitted as a hard-copy, the rules of submission as described above must be followed.

Information on grant opportunities both within HRSA and in other Federal agencies is available

through http://www.grants.gov, the official E-Grants website where applicants can find and apply for federal funding opportunities.

Applications must be submitted electronically by **5:00 P.M. Eastern Time** on **July 1, 2005.**

DUNS Number

All applicants are now required to have a Data Universal Numbering System (DUNS) number to apply for a grant or cooperative agreement from the Federal Government. Go to the following website for detailed information on how to obtain a DUNS number: http://www.hrsa.gov/grants/preview/dunsccr.htm. Applications *will not* be reviewed without a DUNS Number.

In addition, to do business with the U.S. Government, including electronically applying for HRSA grants, your organization must register with the Central Contractor Registry (CCR). CCR Registration enables you to easily provide information about your organization, clarify where government payments to your organization should be made and make a change in one place and one time for all federal agencies to use. Go to the following website for detailed information on how to register: http://www.hrsa.gov/grants/preview/dunsccr.htm

REVIEW CRITERIA

Applications will be reviewed within HRSA. If the applications fulfill the review criteria, awards will be made by September 1, 2005. If recommendations from these reviews result in conditions of award the conditions will need to be addressed as instructed in the Notice of Grant Award (NGA).

Applications will be reviewed based on the following criteria:

- Extent to which the work plan meets benchmark requirements:
  - Extent to which the plan relates to identified needs
  - Extent to which terrorism preparedness issues are prioritized and addressed based on available funds
  - Extent to which requests for staffing, equipment and capital improvements relate to sustainable program goals
- Extent to which proposed goals, objectives and activities are an extension and progression of activities, including those listed in the Cross-cutting section of the 2004 NBHPP Guidance, started during FY 2003 and continued in FY 2004
  - Extent to which the proposed goals, objectives and activities show a sophistication and progression of the program from previous years
  - Extent to which the goals, objectives and activities can be accomplished within one year
- Extent to which goals, objectives and activities are measurable, achievable, and

sustainable
- Extent to which the needs of pediatrics and other vulnerable populations are addressed in the plan
- Extent to which terrorism disaster exercises feed back to revisions of the plan
- Clarity of budget and narrative justification, as well as the budget being presented on the approved HRSA template.

Grantees that fail to comply with the terms and conditions of this cooperative agreement, including responsiveness to program guidance, measured progress in meeting the performance measures outlined in the critical benchmarks, and adequate stewardship of these federal funds, may be subject to an administrative enforcement action. Administrative enforcement actions may include temporarily withholding cash payments or restricting a grantee's ability to draw down funds from the Payment Management System until the grantee has taken corrective action.

In circumstances where the grantee is unwilling or unable to take corrective action, and in other appropriate circumstances, HRSA may withhold (deny) a continuation award and require that the grantee repay any disallowed costs to the federal government from non-federal funds.

In all instances, grantees are reminded that continuation of funding under this cooperative agreement is additionally contingent upon continued availability of funds.

HHS CROSS-CUTTING BENCHMARKS AND ACTIVITIES

HHS cross-cutting benchmarks and activities will not be a separate section of the guidance nor will awardees be reporting on these issues separately. Throughout the funding application awardees will need to address the issues of:

Surveillance: *(This should be addressed in critical benchmark #4.2)*
Integration of disease surveillance systems at the state and local levels, including hospital-based surveillance systems so that relevant data on disease reporting is rapidly captured and analyzed. Systems should allow for electronic communication between hospitals and public health departments at all levels.

Coordination with Indian Tribe: *(This should be addressed in all critical benchmarks)*
Indian tribal government participation in state and local preparedness planning and implementation.

Populations with Special Need: *(This should be addressed in all critical benchmarks)*
Activities that will be implemented to meet the specific needs of special populations that include, but are not limited to, people with disabilities, people with serious mental illness, minority groups, the non-English speaking, children, and the elderly. These activities must take into

consideration all operational and infrastructure issues as well as public information/risk communication strategies. Such activities must be integrated between the public health and the hospital communities.

Planning for Psychosocial Consequences of Bioterrorism and Other Public Health Emergencies: *(This should be addressed in critical benchmark #2.8)*
Efforts the state health department is making to work with state and local mental health agencies, hospitals, mental health providers, and public and private emergency response and social services entities in planning to meet the psychosocial needs of victims, those at risk, their families, psychological casualties both with and without medical illness, and emergency responders (including healthcare personnel, public health professionals, EMTs etc.).

Education and Training: *(This should be addressed in critical benchmark #5)*
Activities that the health department will undertake to train or ensure training of its staff and those in local health departments, hospitals, major community health care institutions, emergency response agencies, public safety agencies, etc. to respond in a coordinated (non-overlapping) manner in the event of a bioterrorist attack or other public health emergency to minimize duplication and fill gaps.

Involvement of Academic Health Centers: *(This should be addressed in all critical benchmarks, where applicable)*
Activities that the state health department will be undertaking to involve academic health centers, if available in their regions, in their preparedness efforts.

Interoperability of IT Systems: *(This should be addressed in critical benchmark #4.1)*
Measures that the state will be taking to ensure the connectivity and interoperability, both vertically and horizontally, of its various IT systems with those of local health departments, hospitals, emergency management agencies, public safety agencies, neighboring states, federal public health officials and others.

Interstate Collaboration: *(This should be addressed in all critical benchmarks)*
Activities by states and local health departments in jurisdictions sharing a border with one or more states to foster interstate collaboration and coordination, especially in high population density areas along the state border(s). Special attention should be paid to any collaborative efforts undertaken by local health departments with hospitals in their communities to develop an integrated regional approach to a mass casualty event.

International Border States: *(This should be addressed in all critical benchmarks, where applicable)*
Efforts by state and local health departments in jurisdictions sharing an international border with Mexico or Canada to foster cross-border collaboration and coordination. States may use funds to conduct necessary activities in support of bi-national planning, coordination, communications, program development, and exercises with Mexico or Canada if such actions directly contribute to

health security in the United States.

Preparedness for Pandemic Influenza

An influenza pandemic will place a substantial burden on inpatient and outpatient health care services. Illness and absenteeism among health care workers in the context of increased demand for services will further strain the ability to provide quality care. In addition to a limited number of hospital beds and staff shortages, equipment such as respirators and supplies such as masks also may be in short supply overall or at individual facilities. The disruptions in the health care system that result from a pandemic may also have an impact on blood donation and supply. Planning by local health departments and the health care system is important to address these potential shortages.

Strategies to increase hospital bed availability include deferring elective procedures, more stringent triage for admission, and earlier discharge with follow-up by home health care personnel. Local coordination can help direct patients to hospitals with available beds and distribute resources to sites where they are needed. Health care facilities also can be established in non-traditional sites such as schools, community centers, etc. as needed and based on availability of staff. Specific challenges in these settings such as infection control must be addressed. Most ill persons will not require hospital care but may need other support services. These include home health care, delivery of prescription drugs, and meals. Local planning is needed to address the delivery of these and other essential community functions such as police, fire, and utility services.

As stated in the FY 2005 CDC cooperative agreement, awardees should provide a copy of the complete pandemic influenza plan for the jurisdiction to HHS Office of Public Health Emergency Preparedness (OPHEP) via CDC Division of State and Local Readiness' Management Information System (DSLR-MIS). This submission will count for both the CDC and HRSA cooperative agreements.

Awardees should collaborate with influenza programs to maximize the impact of funds and efforts and reduce duplication. Detailed information concerning the development of influenza pandemic preparedness plans is available in the document *Pandemic Influenza: A Planning Guide for State and Local Officials,* version 2.1 and Annex 2 (Planning Guidance for Health Care Systems) available at http://www.hhs.gov/nvpo/pubs/pandemicflu.htm.

Local Caches of Antiviral Drugs

Certain antiviral drugs are efficacious in countering influenza virus and could be the sole initial medical countermeasure against a pandemic strain until an effective vaccine is available. The H5N1 avian strain currently circulating widely in Asia has been shown to infect humans and cause significant mortality and morbidity; and the virus could trigger an influenza pandemic if it were to undergo genetic changes that enhance its transmissibility from person to person. One commonly available drug, Oseltamivir, has been shown to be effective against the current H5N1

strain. Because worldwide production capacity for antiviral drugs faces significant limitations, the Department of Health and Human Services is working to create a mechanism whereby it and it's State and local public health partners might acquire and pre-deploy predictable quantities of antiviral drugs during the next several years.

Healthcare professionals will be an indispensable resource in caring for pandemic victims. A strong, stable healthcare infrastructure could do much to blunt the medical and economic toll of an influenza pandemic. Therefore, as part of preparedness for an influenza pandemic, States and municipalities should consider amassing appropriate quantities of antiviral drugs as a first line of protection for the staff of hospitals, hospital based EMS providers, their family members and their most critically ill patients. This is consistent with the intent of Critical Benchmark #2.5.

To that end, please provide the following information as part of the HRSA cooperative agreement application:

- **Do any of the HRSA-funded hospital-based pharmaceutical caches within your jurisdiction maintain a supply of antiviral drugs?**
- **If so, please provide an estimate of the number of 10-day treatment courses on hand, facility-by-facility, as of June 15, 2005.**
- **Also, please indicate the quantity and estimated cost of antiviral drugs that the jurisdiction plans to acquire for these caches during the period September 1, 2005 to August 31, 2006 and how much of that cost is to be charged to the HRSA cooperative agreement.**

CRITICAL BENCHMARKS , MINIMAL LEVELS OF READINESS, SENTINEL INDICATORS

CRITICAL BENCHMARKS

Awardees are encouraged to carefully read through each critical benchmark contained in the guidance due to updates and modifications that have occurred since FY 2004.Two notable changes are as follows:

1. Critical benchmark #2.1 Surge Capacity – Beds - has been expanded and now incorporates critical benchmark #2.9 Trauma and Burn Care Capacity, as well as increased specificity.

2. Critical benchmark #2.3 Surge Capacity – Healthcare Personnel - has been incorporated into critical benchmark #2.4 Surge Capacity – Emergency System for the Advance Registration of Volunteer Health Professionals.

MINIMAL LEVELS OF READINESS

Awardees are encouraged to carefully read through each minimal level of readiness contained in the guidance due to updates and modifications that have occurred since FY 2004.

SENTINEL INDICATORS

When the sentinel indicators are presented for each critical benchmark, awardees will notice two sets of data reporting requirements.

One set of indicators is to be reported on with the application to demonstrate performance since the FY 2004 report.

The second set of indicators is to be reported with the mid-year progress report and the end-of-the-year progress report. This second set of indicators will require the awardee to report on three levels; the first level will be statewide, the second level will be for the 2 most populated awardee defined regions and the third level is other regions of the state for which predictable high-risk scenarios have been identified through the HVA

PRIORITY AREA #1: ADMINISTRATION

Critical Benchmark #1: Financial Accountability

Develop and maintain a financial accounting system capable of tracking expenditures by critical benchmark and by funds allocated to hospitals and other health care entities.

In FY 2005 awardees will be able to use up to 15% of the **direct costs** for Awardee Operating Costs (Administration) and up to 10% of **direct costs** for Awardee Wide Planning. Therefore a minimum of 75% of the award must be used for implementation.

To demonstrate compliance with this critical benchmark, awardees will report on the funds allocated to each Critical Benchmark and Type of Entity via:

1. HRSA Budget Template
2. Application format
3. Mid-year progress report format
4. End-of-the-year progress report format

To demonstrate compliance of the awardee in terms of expediting the flow of funds awardees will accomplish this through:

1. Interim Financial Status Reports (FSRs) submitted on a quarterly basis as well as a final FSR at the end of the budget period. These FSRs will document awardee ability to obligate as well as liquidate cooperative-agreement funds.

PRIORITY AREA #2: REGIONAL SURGE CAPACITY FOR THE CARE OF ADULT AND PEDIATRIC VICTIMS OF TERRORISM AND OTHER PUBLIC HEALTH EMERGENCIES

Critical Benchmark #2-1 SURGE Capacity: Beds

Establish systems that, at a minimum, can provide triage treatment and initial stabilization, <u>above the current daily staffed bed capacity</u>, for the following classes of adult and pediatric patients requiring hospitalization within three hours in the wake of a terrorism incident or other public health emergency:

a. 500 cases per million population for patients with symptoms of acute infectious

disease – especially smallpox, anthrax, plague, tularemia and influenza;

b. 50 cases per million population for patients with symptoms of acute botulinum intoxication or other acute chemical poisoning – especially that resulting from nerve agent exposure;
c. 50 cases per million population for patients suffering burn or trauma; and
d. 50 cases per million population for patients manifesting the symptoms of radiation-induced injury – especially bone marrow suppression.

Listed below are action steps that must be addressed and documented in the awardee executive summary.

1. For those Awardees that identify high-risk scenarios that are predictable from facility based HVAs that have been applied to HRSA awardee defined regions, higher levels of surge capacity and capability will be necessary, and adequate contingency planning must be implemented during FY 2005.

2. Preparedness planning must address not only enhancement of the surge capacity and capability of individual health care entities, but also the establishment of mutual aid agreements among them. Where appropriate, the applicant must develop and implement intra-state or multi-state regional workplans to maximize economies of scale in planning for an overwhelming terrorist incident or other public health emergency.

3. Awardees will work with hospitals to include off-site options for increasing bed capacity in their planning and drills to minimize the burden of surge on the hospital facilities. Off-site facilities may include mobile facilities, temporary facilities appropriate to an austere environment, large convention halls, armories, and State fair grounds. Additionally, any planning must account for the operational and physical needs of special populations; notably people with physical disabilities, geriatrics, and the mentally ill.

4. Awardees must identify the major urban and rural priorities to be implemented in the planning process, so that both rural communities and metropolitan areas are engaged and coordinated to the fullest extent possible. Funded municipalities planning for a large-scale event must include the surrounding areas likely to impact resources

5. Funded Territories and jurisdictions with geographically remote areas will identify any unusual circumstance that will require special procedures (such as evacuation or equipment availability) due to the geographic location. Where appropriate, the applicant should develop and implement intra-state and inter-state regional preparedness plans to maximize economies of scale in resource planning and isolation.

6. All awardees must insure that all participating healthcare entities have incorporated planning for a pediatric specific mass causality event (e.g., attack on elementary school).

Minimal Level of Readiness

Awardees will have systems that allow for the triage treatment and initial stabilization for the following classes of adult and pediatric patients requiring hospitalization within three hours in the wake of a terrorism incident or other public health emergency:

- 500 cases per million population for patients with symptoms of acute infectious disease – especially smallpox, anthrax, plague, tularemia and influenza;
- 50 cases per million population for patients with symptoms of acute botulinum intoxication or other acute chemical poisoning – especially that resulting from nerve agent exposure;
- 50 cases per million population for patients suffering burn or trauma; and
- 50 cases per million population for patients manifesting the symptoms of radiation-induced injury – especially bone marrow suppression.

In order to demonstrate compliance with the minimal level of readiness, awardees will submit the following documentation to HRSA, under separate cover, by the end of the FY 2005 budget period:

1. An executive summary of no more than fifteen pages summarizing the current systems/plans for addressing surge capacity by awardee defined region. The summary should separately address acute infectious disease, botulinum intoxication or other acute chemical poisoning, burn and trauma, and radiation-induced injury.
2. An inventory of total surge beds, by awardee defined region, which provides appropriate population demographic information for verification. The inventory should separately reflect beds for patients suffering from acute infectious disease, botulinum intoxication or other acute chemical poisoning, burn and trauma, and radiation-induced injury.
3. An electronic copy of the awardee's statewide bed surge capacity plan and regional plans that are currently in place and operational:
    a. The plans should describe the scenarios (e.g., accidental or terrorist-induced explosion at a petrochemical facility) that are pertinent to the community, assess the nature and extent of the patient surge that the incident would engender in each metropolitan area and other region of the state for which a predictable high-risk scenario has been identified, and detail how patient surge will be addressed.
    b. The plans should also identify and assess the likely events (including cyber threats and the high-risk scenarios identified in the HVA) that could affect adversely the quality, capacity, and continuity of healthcare operations for each participating hospital and other healthcare facility and describe plans to mitigate the consequences of such events.
    c. The plans should separately address acute infectious disease, botulinum intoxication or other acute chemical poisoning, burn and trauma, and radiation-

induced injury.

Sentinel Indicator #2-1

To be reported with the FY 2005 funding application

1). Number of beds which awardee is capable of surging beyond the current staffed bed capacity in a 24 hour period.

Sentinel Indicator #2-1
To be reported with the mid-year progress report and end-of-the-year report

1). Total population in each awardee defined region.

2). Number of participating hospitals **statewide.**

3). Number of participating hospitals **within the 2 most populated awardee defined regions**.

4). Number of participating hospitals in **other regions of the state for which predictable high-risk scenarios have been identified through the HVA.**

5). Number of beds **statewide**, above the current daily staffed bed capacity which awardee is capable of surging beyond **within 3 hours post-event** by type of illness or injury (i.e., acute infectious disease, botulinum intoxication or other acute chemical poisoning, burn and trauma, and radiation-induced injury).

6). Number of beds **statewide,** above the current daily staffed bed capacity which awardee is capable of surging beyond **within 24-hour post event** by type of illness or injury (i.e., acute infectious disease, botulinum intoxication or other acute chemical poisoning, burn and trauma, and radiation-induced injury).

7). Number of beds, above the current daily staffed bed capacity, **within the 2 most populated awardee defined regions**, that the awardee is capable of surging beyond **within 3 hours post-even**t by type of illness or injury (i.e., acute infectious disease, botulinum intoxication or other acute chemical poisoning, burn and trauma, and radiation-induced injury).

8). Number of beds, above the current daily staffed bed capacity, **within the 2 most populated awardee defined regions**, that the awardee is capable of surging beyond **within 24 hours post-event** by type of illness or injury (i.e., acute infectious disease, botulinum intoxication or other acute chemical poisoning, burn and trauma, and radiation-induced injury).

9). Number of beds, above the current daily staffed bed capacity, in **other regions of the state**

for which predictable high-risk scenarios have been identified through the HVA, that the awardee is capable of surging beyond **within 3 hours post-event** by type of illness or injury (i.e., acute infectious disease, botulinum intoxication or other acute chemical poisoning, burn and trauma, and radiation-induced injury).

10). Number of beds, above the current daily staffed bed capacity, **in other regions of the state for which predictable high-risk scenarios have been identified through the HVA**, that the awardee is capable of surging beyond **within 24 hours post-event** by type of illness or injury (i.e., acute infectious disease, botulinum intoxication or other acute chemical poisoning, burn and trauma, and radiation-induced injury).

Critical Benchmark #2-2 Surge Capacity: Isolation Capacity

Ensure that all participating hospitals have the capacity to maintain, in negative pressure isolation, at least one suspected case of a highly infectious disease (e.g., smallpox, pneumonic plague, SARS, influenza and hemorrhagic fevers) or febrile patient with a suspect rash or other symptoms of concern who might be developing a highly communicable disease.

Awardees must identify at least one regional healthcare facility, in each awardee defined region, that is able to support the initial evaluation and treatment of at least 10 adult and pediatric patients at a time in negative pressure isolation within 3 hours post-event.

Minimal Level of Readiness

1. 100% of participating hospitals have the capacity to maintain at least one suspected highly infectious disease case in negative pressure isolation.
2. 100% of awardee defined regions will have identified and upgraded (if needed) regional healthcare facilities to support the initial evaluation and treatment of at least 10 adult and pediatric patients at a time in negative pressure isolation within 3 hours post-event.

In order to demonstrate compliance with the minimal level of readiness, awardees will submit the following documentation to HRSA, under separate cover, 90 days after the end of the FY 2005 funding cycle:

1. An inventory, by awardee defined regions, of participating hospital based negative-pressure isolation capacity, to include number of patients that can be accommodated.
2. An inventory of all regional negative-pressure isolation capacity, to include number of

patients that can be accommodated within the awardee jurisdiction.

Sentinel Indicator #2-2
To be reported with the FY 2005 funding application

1). Number of patients awardee has capability to hold in negative-pressure isolation above current daily capacity for airborne diseases, during a declared state/local/regional public health emergency.

Sentinel Indicator #2-2
To be reported with the mid-year progress report and end-of-the-year report

1). Number of participating hospitals **statewide** the have the capacity to maintain at least one suspected highly infectious disease case in negative pressure isolation.

2). Number of participating hospitals, **within the 2 most populated awardee defined regions** that have the capacity to maintain at least one suspected highly infectious disease case in negative pressure isolation, **within 3-hours post-event.**

3). Number of participating hospitals, **within the 2 most populated awardee defined regions** that have the capacity to maintain at least one suspected highly infectious disease case in negative pressure isolation, **within 24-hours post-event.**

4). Number of participating hospitals, **in other regions of the state for which predictable high-risk scenarios have been identified through the HVA**, that have the capacity to maintain at least one suspected highly infectious disease case in negative pressure isolation, **within 3-hours post-event.**

5). Number of participating hospitals, **in other regions of the state for which predictable high-risk scenarios have been identified through the HVA**, that have the capacity to maintain at least one suspected highly infectious disease case in negative pressure isolation, **within 24-hours post-event.**

6). Number of awardee defined regions that have **regional facilities** to support the initial evaluation and treatment of at least 10 adult and pediatric patients at a time in negative pressure isolation **within 3 hours post-event.**

7). Number of awardee defined regions that have **regional facilities** to support the initial

evaluation and treatment of at least 10 adult and pediatric patients at a time in negative pressure isolation **within 24 hours post-event.**

Critical Benchmark #2.3: Surge Capacity: Health Care Personnel
This benchmark has been incorporated into Critical Benchmark 2.4.

Critical Benchmark #2-4 - Surge Capacity: Emergency System for Advance Registration of Volunteer Health Professionals

Develop a system that allows for the advance registration and credentialing of clinicians needed to augment a hospital or other medical facility to meet patient/victim care and increased surge capacity needs.

State-based Emergency Systems for Advance Registration of Volunteer Health Professionals (ESAR-VHP) provide for registering, verifying credentials and emergency utilization of volunteer health professionals in local, regional and national public health emergencies and disasters.

HRSA recently published the Interim *ESAR-VHP Technical and Policy Guidelines, Standards and Definitions* (Guidelines). The Guidelines are a product of collaboration of ten national working groups, comprised of states (awardees), and relevant Federal agency, association and organizational representatives. The Guidelines cover the entire spectrum of advance registration issues and components encompassing ESAR-VHP Planning, Authorities and Emergency Operations, System Design and Content, Recruitment and Retention of Volunteers, Credentialing, Privileging and Identification, Resource Typing, Training, Operations and Maintenance, Funding and Cost, Security and Privacy, Regionalizing and Nationalizing, and Common Definitions. The Guidelines are a "living document." It is anticipated that the Guidelines will be refined and updated as new information is processed. Comments are welcome from awardees and the health care community at large and may be sent to comments@esarvhp.com .

To further involve all of the NBHPP awardees in the Guidelines development, HRSA requested a thorough review of the draft Guidelines. Over 22 states responded with comments.

HRSA will provide assistance to each state in the development and operation of their ESAR-VHP in a phased approach over the period January 2005-December 2006. As part of the two-year ESAR-VHP implementation effort, states are encouraged to lay the groundwork for their state-based system in the first year. ESAR-VHP planning activities may include:

1. Establishing a formal advisory committee to strengthen partnerships, identify state issues and initiate planning of their ESAR-VHP System with relevant colleagues (e.g., State professional licensing boards, hospitals and hospital associations, and health care professional associations).

2. Identifying and collaborating with professional healthcare associations and societies that have membership databases to assist with recruiting health professionals for ESAR-VHP. The Medical Reserve Corps is one such example and it should be considered for inclusion in the overall State system.

3. Identifying relevant state and national databases from which critical information can be verified. These databases maintain up-to-date credentialing information, such as licensure status.

4. Reviewing the state's legal and regulatory environment for:
   a. Liability and worker's compensation protections for volunteers;
   b. Definitions of declared emergencies and declared public health emergencies; and
   c. Determining if new legislation or regulations are required for health volunteers to operate under ESAR-VHP.

Initial efforts should include, at a minimum, identification of volunteer Physicians, Registered Nurses and Behavioral Health Professionals (including social workers, psychologists, psychiatrists, and therapists) that can be called upon to augment staff at a hospital and/or other medical facility. When developing their system, awardees should consider the more stringent credentialing requirements of hospitals and other medical facilities.

Please note that credentialing requirements and Resource Typing and data definitions will be compiled for additional healthcare occupations over the next several months.

Minimal Level of Readiness

Awardees will have an established plan for their State–based system that allows qualified, competent volunteer health care professionals to work in hospitals or other medical facilities during an emergency situation throughout the grantee's jurisdiction.

In order to demonstrate compliance with the minimal level of readiness, awardees will submit the following documentation to HRSA, under separate cover, 90 days after the end of the FY 2005 funding cycle:

1. A summary of awardees activities to date documenting the planning efforts and establishment of a State ESAR-VHP system (e.g., workgroup and/or partnership development, identification of databases useful in further development of such a system).
2. A list of organizations and/or databases of potential volunteer health care personnel.

Sentinel Indicator #2-4
To be reported with the FY 2005 funding application

1). Number of volunteer health professionals registered in the advance registration system:

Doctors (including physician extenders)

Nurses

Behavioral health professionals (including social workers, psychologists, psychiatrists and therapists)

Sentinel Indicator #2-4
To be reported with the mid-year progress report and end-of-the-year report

1). Number of **volunteer health professionals** enrolled in the advance registration system:

i). Number of Physicians by Emergency Credentialing Level and Specialty

ii). Number of Registered Nurses by Emergency Credentialing Level

2). **Behavioral Health Professionals**:

i). Number of Medical and Public Health Social Workers by Emergency Credentialing Level

ii). Number of Mental Health and Substance Abuse Social Workers by Emergency Credentialing Level

iii). Number of Psychologists by Emergency Credentialing Level

iv). Number of Marriage and Family Therapists by Emergency Credentialing Level

v). Number of Mental Health Counselors by Emergency Credentialing Level

Critical Benchmark #2-5 Surge Capacity: Pharmaceutical Caches

Establish a regional system that insures a sufficient supply of pharmaceuticals to provide prophylaxis for 3 days to hospital personnel (medical and ancillary staff), hospital based emergency first responders and their families -- in the wake of a terrorist-induced outbreak of anthrax or other disease for which such countermeasures are appropriate.

Awardees may continue to use HRSA funds to purchase strategically placed pharmaceutical caches for hospitals. HRSA funds may continue to be used to allow participation in the joint CHEMPACK program with CDC. Through multiple mailings to awardees these funds must be approved in advance, may only be used for certain purposes and in FY 2005 will be limited to $2,500.00 per site.

Minimal Level of Readiness

1. 100% of participating hospitals will have access to pharmaceutical caches sufficient to cover hospital personnel (medical and ancillary), hospital based emergency first responders and family members associated with their facilities for a 72-hour time period.

In order to demonstrate compliance with the minimal level of readiness, awardees will submit the following documentation to HRSA, under separate cover, 90 days after the end of the FY 2005 funding cycle:

1. An inventory, by awardee defined regions, of all participating hospital facilities that have provided assurances that they have access to sufficient pharmaceutical caches for their hospital personnel (medical and ancillary), hospital based emergency first responders and family members.

Sentinel Indicator #2-5
To be reported with the FY 2005 funding application

1). Number of hospital personnel (medical and ancillary), emergency first responders and their family members for whom a 3-day supply of antibiotics is available through state, local and regional caches.

Sentinel Indicator #2-5
To be reported with the mid-year progress report and end-of-the-year report

1). Number of participating hospitals **statewide** that have access to pharmaceutical caches sufficient to cover hospital personnel (medical and ancillary), hospital based emergency first responders and family members associated with their facilities for a 72-hour time period.

2). Number of participating hospitals, **within the 2 most populated awardee defined regions**, that have access to pharmaceutical caches sufficient to cover hospital personnel (medical and ancillary), hospital based emergency first responders and family members associated with their facilities for a 72-hour time period.

3). Number of participating hospitals **in other regions of the state for which predictable high-risk scenarios have been identified through the HVA**, that have access to pharmaceutical caches sufficient to cover hospital personnel (medical and ancillary), hospital based emergency first responders and family members associated with their facilities for a 72-hour time period.

Critical Benchmark #2-6 Surge Capacity: Personal Protective Equipment

Each awardee must ensure adequate personal protective equipment (PPE) per awardee defined region, to protect current and additional health care personnel, during an incident. This benchmark is tied directly to the number of health care personnel the awardee must provide to support surge capacity for beds.

The level of PPE will be established based on the HVA, and the level of decontamination that is being designed in CBM 2.7.

For those hospitals that have identified probable high risk scenarios (i.e., the hospital functions near an organophosphate production plant with a history of employee contamination incidents) higher levels of PPE, and more stringent decontamination processes, are essential.

It is important that equipment purchased under this priority area is interoperable with equipment purchased with funds from the DHS State Homeland Security Grant Program (SHSGP) for first responders.

Minimal Level of Readiness

1. Awardees will possess sufficient numbers of PPE to protect both the current and additional health care personnel deployed in support of an event.
2. Awardees will develop contingency plans to establish sufficient numbers of PPE to protect both the current and additional health care personnel expected to be deployed in support of predictable high-risk scenarios.

In order to demonstrate compliance with the minimal level of readiness, awardees will submit the following documentation to HRSA, under separate cover, 90 days after the end of the FY 2005 funding cycle:

1. An executive summary of no more than five pages summarizing the current system/plan and capacity by awardee defined regions.
2. An inventory of PPE sets needed in support of events that have been identified the HVA, by awardee defined regions providing appropriate population demographic information for verification.

Sentinel Indicators #2-6
To be reported with the FY 2005 funding application

1). Number of health care personnel that can be adequately supplied with PPE for bio-related events.

Sentinel Indicator #2-6
To be reported with the mid-year progress report and end-of-the-year report

1). Number and level of PPE **statewide** to protect current and additional health care workers during an event.

2). Number and level of PPE sets, **within the 2 most populated awardee defined regions**, to protect current and additional health care workers during an event.

3). Number and level of PPE sets, **in other regions of the state for which predictable high-risk scenarios have been identified through the HVA**, to protect current and additional health care workers during an event.

Critical Benchmark #2-7 Surge Capacity: Decontamination

Insure that adequate portable or fixed decontamination systems exist for managing adult & pediatric patients as well as health care personnel, who have been exposed during a chemical, biological, radiological, or explosive incident in accordance with the numbers associated with CBM # 2-1.

In the Occupational Safety and Health Agency (OSHA) Best Practices for Hospital –Based First Receivers of Victims from Mass Casualty Incidents Involving the Release of Hazardous Substances:

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

All decontamination assets must be based on how many patients/providers can be decontaminated on an hourly basis. The awardee should plan to be able to decontaminate all patients and providers within 3 hours from the onset of the event.

Listed below are action steps that must be addressed and documented in the awardee executive summary in order to fulfill this critical benchmark.

1) Designated healthcare facilities will have the capability to decontaminate more than one patient at a time and be able to decontaminate both ambulatory and stretcher bound patients. The decontamination process must be integrated with local regional and statewide planning.

2) To fulfill the requirements for all participating hospitals to provide essential decontamination services, there must be the capability to have four (4) hospital employees available 24 hours a day to utilize Level C protection to decontaminate patients who are grossly contaminated.

    a) It is possible to utilize different types of staff in meeting this baseline level (environmental, plant engineering, nursing, and physicians). There is an advantage to have enough suits and respiratory protection to allow for three "shifts" (2 people in, 2 people out), keeping in mind that the teams will likely be limited to less than an hour in the decontamination environment.
    b) Awardees should use the common planning guidelines that a community be able to provide decontamination to 500 persons per million population in 3 hours. This should

allow hospitals to plan for one set of equipment that would serve ambulatory patients (a showering setup), and one set of equipment that would decontaminate non-ambulatory patients (two at a time, washed about 5 minutes a piece) but could be adapted if all persons are ambulatory.

3) The system designed by the participating hospitals will address these critical elements:

   a) Adequate outdoor or indoor systems, with consideration to typical ambient climate. There must be adequate lighting and systems to communicate with staff and patients, both indoors and outdoors.
   b) Separate entrance from typical ambulatory entrance, if the decontamination area is indoors. Some hospitals must combine the decontamination area with the EMS entrance. This is not desirable in the implementation of new systems, as hospitals do re-designs.
   c) Showerheads supplied with warm clean water.
   d) Address gender and privacy concerns.
   e) Capability to separate, isolate, and secure personal property for later decontamination.
   f) The hospital must have supplies (e.g., containers and nametags) and procedures for separately securing personal clothing and valuables, and a process that allows valuables to be matched back with the patient.
   g) The hospitals must have clothing for persons to don following the decontamination process.

Minimal Level of Readiness

Awardees will posses sufficient numbers of fixed and/or portable decontamination facilities for managing adult and pediatric victims as well as health care personnel, who have been exposed during a chemical, radiological, biological or explosive incident.

In order to demonstrate compliance with the minimal level of readiness, awardees will submit the following documentation to HRSA, under separate cover, 90 days after the end of the FY 2005 funding cycle:

1. An executive summary of no more than five pages summarizing the current system/plan and capacity by awardee defined region.

Sentinel Indicators #2-7
To be reported with the FY 2005 funding application

1). Number of ambulatory and non-ambulatory persons that can be decontaminated per hour, for a 6 hour period.

Sentinel Indicator #2-7
To be reported with the mid-year progress report and end-of-the-year report

1). Number of fixed and portable decontamination units **statewide.**

2). Number of fixed and portable decontamination units within the **2 most populated awardee defined regions.**

3). Number of fixed and portable decontamination units **in other regions of the state for which predictable high-risk scenarios have been identified through the HVA.**

4). Number of ambulatory and non-ambulatory persons that can be decontaminated **within a three-hour period, statewide.**

5). Number of ambulatory and non-ambulatory persons that can be decontaminated **within a three-hour period, within the 2 most populated awardee defined regions**.

6). Number of ambulatory and non-ambulatory persons that can be decontaminated **within a three-hour period, in other regions of the state for which predictable high-risk scenarios have been identified through the HVA.**

Critical Benchmark #2-8 Surge Capacity: Behavioral (Psychosocial) Health

Enhance the networking capacity and training of health care professionals to be able to recognize, treat and coordinate care related to the behavioral health consequences of bioterrorism or other public health emergencies.

Minimal Level of Readiness

Awardees will identify the minimum behavioral health training competencies for health care professionals responding to bioterrorism or other public health emergencies.

In order to demonstrate compliance with the minimal level of readiness, awardees will submit the following documentation to HRSA, under separate cover, 90 days after the end of the FY 2005 funding cycle:

1. An Executive Summary of no more than five pages that outlines by awardee defined regions, behavioral health resources, current gaps in behavioral health services, and anticipated needs.
2. A list detailing training activities completed on behavioral health issues that include the target audience, the date of the training and the objectives of the training.

Sentinel Indicator #2-8
To be reported with the FY 2005 funding application

1). Number of health professionals trained in the recognition, treatment and referral of patients exhibiting behavioral health consequences related to bioterrorism and other public health emergencies.

Sentinel Indicator #2-8
To be reported with the mid-year progress report and end-of-the-year report

1). Number of health professionals trained via competency based education, **statewide**, in the recognition, treatment and referral of patients exhibiting behavioral health consequences related to bioterrorism and other public health emergencies.

2). Number of competency based trainings conducted, **within the 2 most populated awardee defined regions**, that focus on the behavioral health consequences related to bioterrorism and other public health emergencies.

3). Number of competency based trainings conducted **in other regions of the state for which predictable high-risk scenarios have been identified through the HVA,** that focus on the behavioral health consequences related to bioterrorism and other public health emergencies.

Critical Benchmark #2-9 Surge Capacity: Trauma and Burn Care
This benchmark has been incorporated into Critical Benchmark 2.1

Critical Benchmark #2-10 Surge Capacity: Communications and Information Technology

Establish a secure and redundant communications system that insures connectivity during a terrorist incident or other public health emergency between health care facilities and state and local health departments, emergency medical services, emergency management agencies, public safety agencies, neighboring jurisdictions and federal public health officials.

Minimal Level of Readiness

All participating hospitals will have secure and redundant communications systems that allow connectivity to all other healthcare entities and emergency response agencies responding to a terrorist event or other public health emergency.

In order to demonstrate compliance with the minimal level of readiness, awardees will submit the following documentation to HRSA, under separate cover, 90 days after the end of the FY 2005 funding cycle:

1. An executive summary of no more than five pages that documents vertical and horizontal connectivity and interoperability of the current communications and IT systems among the entities listed in the benchmark.
2. A summary of all ongoing information technology activities in use across the state to include Internet connectivity, e-mail notifications of alerts and other critical communications.
3. Evidence of the establishment of back up systems for use in the event all the above mechanisms and systems fail.
4. A summary of all current communications capabilities in hospitals, clinics, EMS systems and poison control centers. This must include the ability of the statewide communication system to respond to overloading of standard telephone, cellular phone and radio communications during a terrorist incident.

Sentinel Indicator #2-10

To be reported with the FY 2005 funding application

1). Do hospitals have redundant communication systems with:

Public Health_____ Local EOC_____ EMS _____ Law Enforcement _____

Emergency Management_____

2). This communication system includes:

Phones ___ Dedicated phones ___ Fax ___ HAM radio ___ Email ___

800 MHz radios____ Fiber optics ___ Microwave radio ___ Satellite phones_____

Health Alert Networks_____

Sentinel Indicator #2-10
To be reported with the mid-year progress report and end-of-the-year report

1). Number of participating hospitals, **statewide,** that have redundant communication systems with:

Public Health
Local EOC
EMS
Law Enforcement
Emergency Management

2). Number of participating hospitals, **within the 2 most populated awardee defined regions,** which have redundant communication systems with:

Public Health
Local EOC
EMS
Law Enforcement
Emergency Management

3). Number of participating hospitals, **in other regions of the state for which predictable high-risk scenarios have been identified through the HVA**, which have redundant communication systems with:

Public Health
Local EOC
EMS
Law Enforcement
Emergency Management

4). Number of participating hospital communication systems, **statewide,** that include:

Phones
Dedicated phones
Fax
HAM radio
Email
800 MHz radios
Fiber optics
Microwave radio
Satellite phones

Health Alert Networks

5). Number of participating hospital communication systems, **within the 2 most populated awardee defined regions** that include:

Phones
Dedicated phones
Fax
HAM radio
Email
800 MHz radios
Fiber optics
Microwave radio
Satellite phones
Health Alert Networks

6). Number of participating hospital communication systems **in other regions of the state for which predictable high-risk scenarios have been identified through the HVA that** include:

Phones
Dedicated phones
Fax
HAM radio
Email
800 MHz radios
Fiber optics
Microwave radio
Satellite phones
Health Alert Networks

PRIORITY AREA 3: EMERGENCY MEDICAL SERVICES

Critical Benchmark #3: Emergency Medical Services

Enhance the statewide mutual aid plan to deploy EMS units in jurisdictions/regions they do not normally cover, in response to a mass casualty incident due to terrorism.

This plan must ensure the capability of providing EMS triage, transportation and patient tracking for at least 500 adult and pediatric patients per million population within 3 hours post-event. In addition, for each metropolitan area or other region of the state for which a

predictable high-risk scenario has been identified during a HVA, the plan must describe a mechanism for transporting patients from an incident scene or from local hospitals to healthcare facilities in adjacent jurisdictions, to temporary healthcare facilities within or near the affected jurisdiction, and to nearby airports or rail stations for transport to more distant healthcare facilities. All scenarios documented by the applicant under Critical Benchmark 2.1 should be addressed in mutual aid plans for EMS.

Minimal Level of Readiness

Awardees will have established mutual aid plans for upgrading and deploying EMS units in jurisdictions they do not normally cover to insure the capability of providing EMS triage, transportation and patient tracking for at least 500 adult and pediatric patients per million population. In metropolitan and other high-risk areas, awardees will have established plans to transport patients from an incident scene or from local hospitals to healthcare facilities in adjacent jurisdictions, to temporary healthcare facilities within or near the affected jurisdiction, and to nearby airports for transport to more distant healthcare facilities.

In order to demonstrate compliance with the minimal level of readiness, awardees will submit the following documentation to HRSA, under separate cover, 90 days after the end of the FY 2005 funding cycle:

1. A copy of the current mutual aid plan(s), by awardee defined region, that details transport from an incident scene or local hospitals to fixed or temporary healthcare facilities within or near the affected jurisdiction and to nearby airports.
2. Documentation that this plan is coordinated with local EMS Mass Casualty Plans and ensures the capability of providing EMS triage, transportation and patient tracking for at least 500 adult and pediatric patients per million population. Documentation should also detail how mutual aid plans will meet the patient surge needs estimated in the scenarios described under Critical Benchmark 2.1 including feasible destination areas/facilities.
3. Documentation of memorandums of agreements with local transportation authorities are in place. Particular attention should be given to metropolitan areas within the state and other high-risk areas identified during the HVA.

Sentinel Indicator #3
To be reported with the FY 2005 funding application

1). Number of transport units (buses/vans/trailers/ambulances, etc.) available to respond to a mass casualty incident at any one time.

2). Number of patients awardee has the ability to provide triage and transportation to.

Sentinel Indicator #3
To be reported with the mid-year progress report and end-of-the-year report

1). Number of EMS and auxiliary transport units available **statewide** under the established mutual aid plan to respond to a mass casualty **within 3-hours post-event.**

2). Number of EMS and auxiliary transport units available **statewide** under the established mutual aid plan to respond to a mass casualty **within 24-hours post-event.**

3). Number of EMS and auxiliary transport units available, **within the 2 most populated awardee defined regions**, under the established mutual aid plan to respond to a mass casualty **within 3-hours post-event.**

4). Number of EMS and auxiliary transport units available, **within the 2 most populated awardee defined regions**, under the established mutual aid plan to respond to a mass casualty **within 24-hours post-event.**

5). Number of EMS and auxiliary transport units available, **in other regions of the state for which predictable high-risk scenarios have been identified through the HVA**, under the established mutual aid plan to respond to a mass casualty **within 3-hours post-event.**

6). Number of EMS and auxiliary transport units available, **in other regions of the state for which predictable high-risk scenarios have been identified through the HVA**, under the established mutual aid plan to respond to a mass casualty **within 24-hours post-event.**

7). Number of patients, **statewide**, which the awardee has the ability to provide triage, transportation and patient tracking **within 3 hours post-event.**

8). Number of patients, **statewide**, which the awardee has the ability to provide triage, transportation and patient tracking **within 24- hours post-event.**

9). Number of patients, **within the 2 most populated awardee defined regions**, for which the awardee has the ability to provide triage, transportation and patient tracking **within 3-hours post-event**.

10). Number of patients, **within the 2 most populated awardee defined regions**, for which the awardee has the ability to provide triage, transportation and patient tracking **within 24- hours post-event**.

11). Number of patients, **in other regions of the state for which predictable high-risk scenarios have been identified through the HVA,** for which the awardee has the ability to provide triage, transportation and patient tracking within **3-hours post-event**.

12). Number of patients, **in other regions of the state for which predictable high-risk scenarios have been identified through the HVA,** for which the awardee has the ability to provide triage, transportation and patient tracking **within 24-hours post-event.**

PRIORITY AREA 4: LINKAGES TO PUBLIC HEALTH DEPARTMENTS

Critical Benchmark #4-1: Hospital Laboratories

Implement a hospital laboratory program that is coordinated with currently funded CDC laboratory capacity efforts, and which provides rapid and effective hospital laboratory services in response to terrorism and other public health emergencies.

Minimal Level of Readiness

1. Participating hospital labs will have protocols for rapid referral of clinical samples and associated information to labs in the Laboratory Response Network (LRN).
2. Participating hospital lab personnel will demonstrate competency in determining what situations warrant the initiation of these protocols as well as competency in following the protocols.

In order to demonstrate compliance with the minimal level of readiness, awardees will submit the following documentation to HRSA, under separate cover, 90 days after the end of the FY 2005 funding cycle:

1. An inventory, by awardee defined region, of hospital-based laboratory training that has been conducted. Please outline: title of training, target audience, the date of the training and the objectives of the training.
2. A flow chart showing how information is communicated between the state health lab, hospitals, the health department and other agencies.

Sentinel Indicator #4-1
To be reported with the FY 2005 funding application

1). Number of participating hospital labs that have personnel who are trained in the protocols for referral of clinical samples and associated information.

Sentinel Indicator #4-1
To be reported with the mid-year progress report and end-of-the-year report

1). Number of hospital lab personnel, **statewide,** who are trained in the protocols for referral of clinical samples and associated information.

2). Number of hospital lab personnel, **within the 2 most populated awardee defined regions,** who are trained in the protocols for referral of clinical samples and associated information.

3). Number of hospital lab personnel, **in other regions of the state for which predictable high-risk scenarios have been identified through the HVA**, who are trained in the protocols for referral of clinical samples and associated information.

Critical Benchmark #4-2: Surveillance

Enhance the capability of rural and urban hospitals, clinics, emergency medical services systems and poison control centers to report syndromic and diagnostic data that is suggestive of terrorism or other highly infectious disease to their associated local and state health departments on a 24-hour-a-day, 7-day-a-week basis.

Minimal Level of Readiness

Awardees will have an established surveillance system that allows rural and urban hospitals, emergency medical services systems and poison control centers to report data that is suggestive of terrorism to their local and state health departments on a 24-hour-a-day, 7-day-a-week basis.

In order to demonstrate compliance with the minimal level of readiness, awardees will submit the following documentation to HRSA, under separate cover, 90 days after the end of the FY 2005 funding cycle:

1. Documentation that all participating hospitals have the ability to report to the appropriate local or state health department diagnostic data that is suggestive of bioterrorism.
2. An inventory, by awardee defined regions, of the number of entities (e.g. hospitals, clinics, emergency medical services systems and poison control centers) that are connected to the state health department through an electronic surveillance system.

Sentinel Indicator #4-2

To be reported with the FY 2005 funding application

1). Number of each type of entity (e.g. hospitals, clinics, laboratories, emergency medical services systems and poison control centers) that is connected to the state and/or local health department.

2). Number of each of these entities that have the ability to report 24 hours/day, 365 days per year.

Sentinel Indicator #4-2
To be reported with the mid-year progress report and end-of-the-year report

1). Number of EMS providers (specify the number of hospital based and number of other) **statewide.**

2). Number of EMS providers (specify the number of hospital based and number of other) **within the 2 most populated awardee defined regions.**

3). Number of EMS providers (specify the number of hospital based and number of other) **in other regions of the state for which predictable high-risk scenarios have been identified through the HVA.**

4). Number of poison control centers **statewide.**

5). Number of poison control centers **within the 2 most populated awardee defined regions.**

6). Number of poison control **centers in other regions of the state for which predictable high-risk scenarios have been identified through the HVA.**

7). Number of community health centers **statewide.**

8). Number of community health centers **within the 2 most populated awardee defined regions.**

9). Number of community health centers **in other regions of the state for which predictable high-risk scenarios have been identified through the HVA.**

PRIORITY AREA 5: EDUCATION AND PREPAREDNESS TRAINING

Critical Benchmark #5: Education and Preparedness Training

Awardees will utilize competency-based education and training programs for adult and pediatric pre-hospital, hospital, and outpatient health care personnel responding to a terrorist incident or other public health emergency.

FY 2005 funds may be used to offset the cost of having hospital personnel participate in competency based training. HRSA fully expects that awardees will work closely with their sub-recipients in determining cost-sharing arrangements that will facilitate the maximum number of personnel being able to participate in drills and exercises. HRSA will not approve the use of these cooperative agreement funds to pay for pool staff to backfill the positions of staff who will be participating in these events.

Awardees must provide a description of the cost-sharing principles that have been established to ensure the maximum numbers of personnel are afforded the opportunity to participate in training as well as to insure that cooperative-agreement funds are not the sole source of funding for participation.

The use of cooperative agreement funds for curriculum development is restricted (regardless of the subject matter) without prior review and approval from the HRSA Project Officer after consultation with OPHEP.

Minimal Level of Readiness

Education and training programs for adult and pediatric pre-hospital, hospital, and outpatient health care personnel are competency based.

In order to demonstrate compliance with the minimal level of readiness, awardees will submit the following documentation to HRSA, under separate cover, 90 days after the end of the FY 2005 funding cycle:

1. A list of competency based training provided correlated directly to mass casualty incidents, detailing the subject matter, the targeted audience, and the date of the training and the objectives of the training.
2. A description of how the education and training activities discussed in this benchmark will be linked with the exercises/drills and with the overall state/jurisdiction preparedness plan. Particular attention should be given to the 2 most populated awardee defined regions and other regions of the state for which a predictable high-risk scenario has been identified through the HVA.

Sentinel Indicator #5
To be reported with the FY 2005 funding application

1). Number of health care personnel trained through competency-based programs annually.

Sentinel Indicator #5
To be reported with the mid-year progress report and end-of-the-year report

1). Number of healthcare personnel, **within the 2 most populated awardee defined regions**, that have been trained through competency-based programs.

2). Number of healthcare personnel**, in other regions of the state for which predictable high-risk scenarios have been identified through the HVA,** that have been trained through competency-based programs.

PRIORITY AREA 6: TERRORISM PREPAREDNESS EXERCISES

Critical Benchmark #6: Terrorism Preparedness Exercises

As part of the state or jurisdiction's bioterrorism hospital preparedness plan, functional exercises will be conducted during FY 2005 and should be based on the Awardee HVA. These drills should involve several state agencies and implement the Incident Command Structure (ICS). To the extent possible, members of the public should be invited to participate. These exercises/drills should encompass, if possible, at least one biological agent. The inclusion of scenarios involving radiological and chemical agents as well as explosives may be included as part of the exercises/drills.

FY 2005 funds may be used to offset the cost of having hospital personnel participate in drills and exercises. HRSA fully expects that awardees will work closely with their sub-recipients in determining cost-sharing arrangements that will facilitate the maximum number of personnel being able to participate in drills and exercises. HRSA will not approve the use of these cooperative agreement funds to pay for pool staff to backfill the positions of staff who will be participating in these events.

Awardees must provide a description of the cost-sharing principles that have been established to insure that maximum numbers of personnel are afforded the opportunity to participate in drills as well as to insure that cooperative-agreement funds are not the sole source of funding to enable that participation.

Minimal Level of Readiness

Awardees will conduct terrorism preparedness exercises/drills that:

1. Contain elements addressing the needs of special populations;
2. Emphasize a regional approach; and
3. Are coordinated with other state, local and Federal drills and exercises to maximize resources.

In order to demonstrate compliance with the minimal level of readiness, awardees will submit the following documentation to HRSA, under separate cover, 90 days after the end of the FY 2005 funding cycle:

1. A list, by awardee defined regions, of exercises/drills conducted throughout the year with a brief one- or two-sentence description.
2. After-action reports that detail:
    a. The date, location, personnel, participating agencies and funding source for the exercise (state, local, federal or a combination of all three)
    b. How the needs of special populations were incorporated into the drills and will be incorporated into future drills and exercises
    c. That all healthcare personnel practiced and understood their roles and lessons learned and how those will be applied to future exercises and drills and incorporated into response plan updates.

Sentinel Indicator #6
To be reported with the FY 2005 funding application

1). Number of statewide or regional drills carried out during the FY 2004 grant year

2). Agents involved in drill:
Chemical ___ Biological ___ Radiological ___ Nuclear ___ Explosive ___

3). Drills included the following:
EMS ___ Hospitals ___ Police ___ Labs ___ Public health entities ___
Indian Nations ___ Department of Homeland Security ___
Federal Bureau of Investigation ___ Federal Emergency Management Agency ___
Centers for Disease Control and Prevention ___

Sentinel Indicator #6
To be reported with the mid-year progress report and end-of-the-year report

1). Number of drills **conducted across the state** during the FY 2005 budget period that included hospital personnel, equipment or facilities.

2). Number of drills or exercises conducted, **within the 2 most populated awardee defined regions**, during the FY 2005 budget period that included hospital personnel, equipment or facilities. Specify the areas and/or region of the state where each drill was conducted.

3). Number of drills or exercises conducted, **in other regions of the state for which predictable high-risk scenarios have been identified through the HVA,** during the FY 2005 budget period that included hospital personnel, equipment or facilities. Specify the areas and/or region of the state where each drill was conducted.

4). Number of drills or exercises conducted **statewide** that focused on:

Chemical scenarios
Biologic Scenarios
Improvised Explosive Devices (IED) Scenarios
Nuclear Scenarios
Other (please specify):

5). Number of drills or exercises conducted, **within the 2 most populated awardee defined regions that** focused on:

Chemical scenarios
Biologic Scenarios
Improvised Explosive Devices (IED) Scenarios
Nuclear Scenarios
Other (please specify):

6). Number of drills or exercises conducted, **in other regions of the state for which predictable high-risk scenarios have been identified through the HVA** that focused on:

Chemical scenarios
Biologic Scenarios
Improvised Explosive Devices (IED) Scenarios
Nuclear Scenarios
Other (please specify):