Putting it Together

2012-13 Application Guidance for Local Health Departments and Local Hospital Preparedness Program Entities

Centers for Disease Control and Prevention
Public Health Emergency Preparedness Program
CDC CFDA # 93-069

State General Fund Pandemic Influenza Planning Program

U.S. Department of Health and Human Services
Assistant Secretary for Preparedness and Response
Hospital Preparedness Program
HPP CFDA # 93.889

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BE PREPARED CALIFORNIA

California Department of Public Health

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SECTION ONE

OVERVIEW: 2012-13 LOCAL GRANT REQUIREMENTS

This guidance describes the 2012-13 application process for Local Health Departments (LHD) and Local Hospital Preparedness Program (HPP) Entities to apply for funds available through the 2012-13 Public Health Emergency Preparedness (PHEP) Cooperative Agreement, HPP Cooperative Agreement, and State Pandemic Influenza (Pan Flu) allocation. In order to align the funding streams, ensure greater coordination of preparedness activities and maximize integration of funds, the California Department of Public Health (CDPH) is issuing a single combined guidance and a Comprehensive Agreement for all funding sources. However, PHEP, HPP and Pan Flu each require a separate work plan and budget.

HPP-PHEP Grant Alignment

In 2012, the federal government has undertaken alignment of the HPP and PHEP grants. This encompasses the following goals:

- Increase program impact and advance preparedness
- Reduce administrative burdens and enhance customer service provided to localities
- Promote innovation
- Demonstrate a clear return on investment and communicate preparedness accomplishments to help ensure sustainability of the PHEP and HPP cooperative agreements

This alignment has resulted in the following changes for the 2012-13 HPP-PHEP grant cycle:

- An aligned grant cycle for all funding streams beginning July 1 and ending June 30
- Aligned reporting requirements
- A new five year HPP-PHEP project period

Funding Authority

HPP: 319C-2 of the Public Health Service (PHS) Act, as amended by the Pandemic and All-Hazards Preparedness Act (PAHPA) (P.L. 109-417) (2006).

PHEP: 319C-1 of the Public Health Service (PHS) Act, as amended by the Pandemic and All-Hazards Preparedness Act (PAHPA) (P.L. 109-417) (2006).

Pan Flu

The State General Fund Pandemic Influenza (Pan Flu) Allocation was established in Chapter 33 of the State of California 2012 Budget Act.

Funding Source Purpose

HPP
HPP funds are awarded to California by the Assistant Secretary for Prevention and Response (ASPR) for healthcare facilities and emergency medical services (EMS) to develop and maintain all-hazards disaster preparedness.

PHEP
PHEP all-hazards funds are awarded to California by the Centers for Disease Control and Prevention (CDC) for CDPH and LHDs to develop and maintain public health disaster preparedness.

Pan Flu
Local Pan Flu funds are appropriated from the State General Fund for LHDs to develop and maintain preparedness for pandemic influenza events.

Capabilities-based Planning Approach

This approach focuses on the LHD's and Local HPP Entity's capacity to take a course of action. Capabilities-based planning answers the question, "Do I have the right mix of training, organizations, plans, people, leadership and management, equipment, and facilities to perform a required emergency function?" Each of the Public Health and Healthcare Preparedness Capabilities includes a definition of the capability and a list of the associated functions, tasks, and resource element considerations. LHDs and Local HPP Entities should *have* or *have access to* the priority resource elements included in the capabilities to fully achieve those capabilities.

PHEP Capabilities
In March 2011, CDC released Public Health Preparedness Capabilities: National Standards for State and Local Planning.
http://www.cdc.gov/phpr/capabilities/DSLR_capabilities_July.pdf).
This document outlined 15 PHEP Capabilities intended to serve as national standards for state and local planning efforts. The 2012-13 PHEP work plan is based on these Capabilities. The document contains a complete text of the Capabilities, Functions, and Resource Elements. These terms are discussed in the table below. The federal goal is to implement these 15 Public Health Preparedness Capabilities by the end of the 2017-18 grant year. The PHEP section of this document will explain which Capabilities are required of California LHDs in 2012-13.

HPP Capabilities
In January 2012, ASPR released Healthcare Preparedness Capabilities: National Guidance for Healthcare System Preparedness.
(http://www.phe.gov/Preparedness/planning/hpp/reports/Documents/capabilities.pdf) This document outlined eight Capabilities as the basis for healthcare system, Healthcare Partnerships, and healthcare organization preparedness. The 2012-13 HPP work plan is based on these Capabilities. The document contains a complete text of the Capabilities, Functions, and Resource Elements. These terms are discussed in the table below. The federal goal is to implement these eight Healthcare Preparedness Capabilities by the end

of the 2017-18 grant year. The HPP section of this document will explain which Capabilities are required of California Local HPP Entities this year.

Capability-based Planning Terminology

Capability	Broadly describes the goals and capabilities that LHDs and HPP Entities should be able to perform or accomplish in the listed categories.
Function	Describes the critical elements that need to occur to achieve the Capability.
Performance Measure	Identifies performance measures associated with a Function.
Task	Steps that need to occur to complete the Function
Resource Element	Resources a jurisdiction needs to have or have access to (via an arrangement with a partner organization, memoranda of understanding, etc.) to successfully perform a Function and the associated tasks. Resources are organized into three categories: 1. Planning, 2. Skills and Training, and 3. Equipment and Technology. Some Resources Elements are designated as "Priority."

Prioritization of HPP and PHEP Capabilities

CDPH has undertaken two parallel planning efforts to determine priorities for implementation of the Public Health Preparedness Capabilities in 2012-13. In spring 2012, CDPH convened the Local Capabilities Workgroup to establish a strategy and priorities for addressing the Public Health and Healthcare Preparedness Capabilities over the next five years. The Workgroup, comprised of representatives from CDPH, EMSA, Local HPP Entities, LHDs, LEMSAs, healthcare facilities and key associations representing health care facilities, identified the strategies to enable California to implement the Healthcare and Public Health Preparedness Capabilities over a five year timeframe in order to prepare for and respond to public health and medical emergencies.

In addition to the local workgroup, CDPH established intradepartmental workgroups to address Public Health and Healthcare Preparedness Capabilities. Program experts from across CDPH assessed California's current preparedness status under each Capability, Function, and Resource Element and made recommendations on the overall year one priorities and the grant years that follow. CDPH and EMSA further discussed these recommendations which were then reviewed with the Joint Advisory Committee for Public Health Preparedness for their comments and recommendations.

Based on departmental and stakeholder input, CDPH adopted Priority Levels for the Public Health and Healthcare Preparedness Capabilities to provide direction on the order in which California will complete its preparedness efforts. More information specific to each program's priority levels can be found in the program sections.

Key Dates

Application Submission Due Date	August 6, 2012
Funds Withdrawn if Complete Application is not Submitted*	August 20, 2012
All Work Plans and Budgets Approved*	October 30, 2012
Fully Executed Signed Agreement Submitted*	October 30, 2012
25% advance payments to Local HPP Entities	November 1, 2012
Reimbursement payments based on approved invoices and supporting documentation	Ongoing

*Failure to meet these critical deadlines will result in re-allocation of funds to other LHDs/Local HPP Entities.

Local Allocations

Allocations for each LHD or Local HPP Entity by funding source are displayed in the Local Allocations (Appendix A). Allocation distribution is determined for each funding source as follows.

PHEP: State statute requires allocation of 70% of the CDC PHEP Base grant award to LHDs. The CDC PHEP Base award for Grant Year 2012-13 is $42.8 million of which $23.5 million is allocated to LHDs. Of this, $20.3 million is the LHD Base allocation; $2.8 million is earmarked for public health laboratories; and $0.4 million is earmarked for lab training and lab assistance awards. Further guidance on lab stipends will be provided in subsequent guidance. The PHEP Base allocation of $20.2 million is distributed to LHDs according to a funding formula which allocates a $100,000 base plus a population based share of the remaining funds to each LHD. In additional to the CDC Base award, approximately $5.0 million is allocated to LHDs identified as CRI jurisdictions based on population within each MSA.

HPP: In 2012-13, $16.2 million is allocated directly to Local HPP Entities. The HPP funding formula allocates a base award of $135,000 (which includes a base of $85,000 plus $50,000 to support a Local HPP Coordinator) and a population based share of the remaining funds.

Pan Flu: The 2012-13 State Budget includes $4.96 million for distribution to LHDs for pandemic influenza preparedness. The funds are distributed according to a funding formula that allocates a base award of $60,000 plus a population based share of the remaining funds (These funds are subject to the enactment of the 2012-13 State Budget).

Application Submission

Each LHD and Local HPP Entity shall submit a complete application package, including the 5 Letters of Support from each healthcare partners and for each participating laboratory in the Consortium by August 6, 2012. Required attachments and supporting documents which define a complete application are indicated in the "Application Checklist" in Appendix B. The application package must be submitted electronically to CDPH at LHBTPROG@cdph.ca.gov. Please "cc" the CDPH Regional Project Officer in the e-mail submission. Incomplete applications will be returned to the LHD/Local HPP Entity for correction and resubmission. If a complete application package is not submitted by August 20, 2012, funds will be withdrawn and reallocated to other Local Entities.

Local applicants must submit the signed Agreement, a Non-Lobbying Statement, and a Non-Supplantation Statement no later than October 30, 2012. A customized agreement will be provided by email within two weeks of issuance of this guidance to each LHD/Local HPP Entity. The e-mail will be addressed to each Local Health Executive, Local Health Officer, Local PHEP Coordinator, Local Pandemic Influenza Coordinator, and Local HPP Coordinator. Applicants who do not receive their official Agreement within two weeks of issuance of this guidance should contact their CDPH Regional Project Officer immediately.

Any requests for an extension of submittal date of October 30, 2012, for submittal of the Agreement, Non-Lobbying Statement and Non-Supplantation Statement must be received by EPO prior to October 30, 2012. The LHD Health Officer or Health Executive must sign the extension request, must include the date to which the extension is requested,, and must include a copy of the Board of Supervisor's agenda showing the Comprehensive Agreement as an action item.

Signed Applications

The Signed Agreement, Non-Lobbying Certificate, and Non-Supplantation Form with original signatures must be submitted in hard copy to the mailing address below if sent by US Postal Service (please use overnight mail if mailed within 5 days of the final deadline) or the physical address below if sent by courier. CDPH requires only one signed original. LHDs/Local HPP Entities requesting signed originals to be returned to them must submit extra copies equal to the number requested.

Mailing Address (US Postal Service):
California Department of Public Health
Emergency Preparedness Office
Local Management Unit
Attn: CDC/HPP Application 2012/13
P.O. Box 997377, Suite 73.373, MS 7002
Sacramento, CA 95899-7377

Overnight Mail Address (Courier):
California Department of Public Health
Emergency Preparedness Office
Local Management Unit
Attn: CDC/HPP Application 2012/13
1615 Capitol Ave. Suite 73.373 MS 7002
Sacramento, CA 95814

ADDITIONAL REQUIREMENTS

Performance Measures

Where defined performance measures are identified for a given function, LHD and Local HPP Entities must provide a description of planned activities (e.g., drills, exercises, real incidents, and routine activities) that will demonstrate the performance measure. LHD and Local HPP Entities should include a description of any tools and data collection systems or processes that will be used. Further guidance on performance measures will be issued following the release of additional information from the Federal Government.

Public Health and Healthcare Capabilities Planning Guide (CPG) reports

Each LHD and HPP Entity should use its individual CPG assessment reports as a starting point for discussion with partners in identifying critical preparedness gaps and developing work plan activities for the 2012-13 PHEP and HPP application. CDPH will also utilize jurisdiction CPGs in evaluating local applications, ensuring Functions identified as critical or highly important with identified gaps in capability are addressed through work plan activities to mitigate these gaps.

Trust Fund Accounts

As stated in Exhibit B of the Comprehensive Agreement, the LHD/Local HPP Entity shall deposit all federal funds received from CDPH into Trust Funds established solely for the purposes of implementing the activities described in the LHD and/or Local HPP Entity approved Work Plan, Budget and Agreement before transferring or expending the funds for any of the uses allowed. Due to the new HPP and PHEP alignment, in 2012-13, the federal government requires a single Federal Trust Fund divided into subaccounts for PHEP and HPP funds. However, if separate organizations administer the two programs, separate trust funds should be established.

A trust fund account is not required for the Pan Flu funds.

Audits

Annual A-133 Audit for 2011-12 or Audit Promissory Letter
Each LHD and Local HPP Entity must submit the Annual A-133 Audit for 2011-12 as part of the application package. If the audit has not yet been completed, please submit an electronic Audit Promissory Letter on department letterhead indicating that the audit will be submitted to EPO when it is completed along with an estimated date of submission (month/year). If there are findings for the PHEP and/or HPP grant in the A-133 audit, please submit a Corrective Action Plan (CAP) using Attachment 11.

Fiscal Audit Corrective Action Plan (CAP)
Those LHDs/ Local HPP Entities that received final 2005-06 audits that resulted in findings after the 2011-12-grant application must submit a CAP. A template to complete the CAP is provided as Attachment 11. Questions on whether to submit a CAP as part of the

application package should be directed to the Regional Project Officer. This includes questions as to whether a CAP is required as part of your application package.

Subcontract Approval Process

- Subcontracts equal to or greater than $5,000 must be approved by CDPH prior to the contractor starting work.
- If available, provide a copy of the entire contract with the application package for pre-approval by EPO.
- If the contract has not been completed at the time of application submission, provide a summary of the intended scope of work within the budget template-contracts tab and acknowledge that a copy of the contract will be submitted to EPO for approval prior to executing the contract. Contract documents may be imbedded on a tab in the budget Excel workbook.
- Although CDPH can approve work plans and budgets without subcontract approval, CDPH must approve the contract before the contractor may start work.
- CDPH will approve contracts without signatures from both parties provided that the contract that is ultimately signed is the same as that approved by CDPH. Fully executed contracts must also be sent to EPO as soon as they are available.
- LHD/Local HPP Entities submitting subcontracts after submission of the application should email them to LHBTPROG@cdph.ca.gov with a copy to the Regional Project Officer.
- Any subcontract not preapproved by EPO is in violation of the signed agreement and the invoice for those services may be rejected and not reimbursed.

Progress Reports

Mid-year and year-end progress reports for the 2012-13 grant year are required on the due dates shown below. Budget instructions for progress reporting are included in the budget template. Work plan templates contain rows for mid-year and year-end progress report narrative. Please submit progress reports to LHBTPROG@cdph.ca.gov with a copy to the Regional Project Officer.

PHEP (Base, Labs, CRI), HPP and State General Fund Pan Flu			
	Reporting Period Begin Date	Reporting Period End Date	Report Due Date
2012-2013 Mid-Year Report Period	July 1, 2012	December 31, 2012	January 31, 2013
2012-2013 Year-End Report Period	July 1, 2012	June 30, 2013	September 1, 2013

LHD/Local HPP Entity Exercises/ Real Events After Action Reports

After Action Reports including Improvement Plans for exercises and real events must be submitted within 90 days of the exercise or actual event response. For specific reporting information, please refer to the relevant program section.

Maintaining Documentation

The Comprehensive Agreement requires that LHDs/Local HPP Entities maintain supporting documents for the expenditure of funds for a minimum of 10 years.

Questions

Please address questions about local applications to your Regional Project Officer as listed below:

Region	Name	Phone	E-Mail
I & VI	Stacy Sher	(916) 346-0765	Stacy.Sher@cdph.ca.gov
II	Tom Hoffman	(916) 346-0771	Tom.Hoffman@cdph.ca.gov
III	William Porter	(916) 650-0423	William.Porter@cdph.ca.gov
IV	Armando Arroyo	(916) 440-7154	Armando.Arroyo@cdph.ca.gov
V	Dan Nichols	(530) 589-4209	Dan.Nichols@cdph.ca.gov

Application Review

Reviewing and approving each application work plan and budget is an interactive process between LHDs/Local HPP Entities and CDPH. When CDPH receives the LHD/Local HPP Entity application, it is reviewed for completeness by Regional Project Officers, fiscal analysts, and appropriate subject matter experts, including laboratory, epidemiology, and pharmacy experts. LHDs/Local HPP Entities must work expeditiously with CDPH in responding to requests for additional information. CDPH will notify LHDs/Local HPP Entities of the results of the review and approval by e-mail.

CDPH will review all completed application packages in the order in which they are received. The review process will follow the timeframes set forth in the table below.

Activity	Number of Calendar Days
Upon initial submission of a complete application, CDPH will review Work Plans and Budgets and provide written comments to LHDs/Local HPP Entities within 21 calendar days.	21

Activity	Number of Calendar Days
If additional information is needed, LHDs/Local HPP Entities will be requested to respond within 5 calendar days of receipt of electronic comments from CDPH. If no comments are received within 5 calendar days, CDPH will send a follow-up letter to the Local Health Officer and Local Health Executive. The letter will emphasize the importance of submitting the comments and restate the consequences of not having an approved Work Plan and Budget by October 30, 2012.	5
CDPH will review additional information provided by the LHD/ Local HPP Entity and provide formal written comments to the LHD/Local HPP Entity within 5 calendar days of receipt.	5

Instructions for Counties in which Local HPP Entities are not LHDs:

In counties where the Local HPP Entity is not the LHD, the completed HPP application package may be submitted separately from the required PHEP and State Pan Flu materials. The LHD must provide the Local HPP Entity with a letter of waiver from the Health Officer if the LHD declines to serve as the Local HPP Entity.

Instructions for Los Angeles, Long Beach, and Pasadena:

Since the federal government directly funds Los Angeles County, CDPH will send Los Angeles, Pasadena and Long Beach Health Departments an application package that only includes Pan Flu planning funds.

SECTION TWO

GUIDANCE FOR PUBLIC HEALTH EMERGENCY PREPAREDNESS GRANT

This section provides guidance to assist Local Health Department (LHDs) in completing the 2012-13 application for the Public Health Preparedness Program (PHEP) grant.

Public Health Preparedness Strategic Planning for 2012 – 2016

As described in Section One, in Spring 2012, CDPH undertook two parallel planning efforts to determine priorities for implementation of the Public Health Preparedness Capabilities. Through these planning activities, the following strategies to enable California to implement the Public Health Preparedness Capabilities over a five year timeframe were identified:

- Maintain essential activities to respond to public health emergencies.
- Ensure sufficient capacity within California to respond to all hazards.
- Focus on activities that lay the foundation for others, creating a natural progression of activities.
- Allow local flexibility while providing statewide standardization in key areas.
- Focus first on core public health and overarching capabilities while LHDs and CDPH obtain a baseline assessment of their current status across all capabilities to develop priorities for future grant years.
- Acknowledge that real events may dictate a shift in focus on specific public health capabilities.

PHEP Capability Prioritization

In 2011, based on departmental and stakeholder input, CDPH adopted three Priority Levels for the Public Health Preparedness Capabilities to provide direction on the order in which California will complete its preparedness efforts. These priority levels are consistent with CDC's Tier I and Tier II recommendations. These Priority Levels are unchanged in 2012. The following chart outlines the Priority Levels for California:

PHEP Priority Levels

Priority Level I	Priority Level II	Priority Level III
Public Health Surveillance & Epidemiologic Investigations	Non-Pharmaceutical Interventions (CDC Tier II)	Community Recovery (CDC Tier II)
Public Health Laboratory Testing	Responder Safety and Health (CDC Tier I)	Fatality Management (CDC Tier II)
Emergency Operations Coordination	Volunteer Management (CDC Tier II)	Mass Care (CDC Tier II)
Emergency Public Information and Warning		Medical Surge (CDC Tier II)
Information Sharing		
Community Preparedness		
Medical Countermeasures Dispensing		
Medical Materiel Management & Distribution		

In 2012-13, the Priority Level 1 Capabilities initiated in 2011-12 are continued in the PHEP Scope of Work with additional Functions and Resource Elements included. In addition, Responder Safety and Health from Priority Level 2 and Mass Care from Priority Level 3 will be initiated in 2012-13.

In planning the 2012-13 activities, LHDs should take into consideration the findings of their hazard vulnerability assessments, public health risk assessments, current Capability Status, and real events occurring within the jurisdiction.

Laboratory Response Network (LRN) - Biological (B) Laboratories

The following 33 LHDs have LRN-B labs: Alameda, Butte, Contra Costa, El Dorado, Fresno, Humboldt, Imperial, Kern, Kings, Madera, Marin, Merced, Monterey, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Shasta, Sonoma, Stanislaus, Sutter, Tulare, Ventura, Yolo.

Requirements for Public Health Laboratories

LHDs with LRN laboratories must comply with the following requirements:

LRN Sentinel Laboratories

1. Subscribe to the Laboratory Preparedness Exercise (LPX) offered by the College of American Pathologists (CAP) and participate in the associated notification exercises.

LRN Reference Laboratories

1. Subscribe to the Laboratory Preparedness Exercise (LPX) offered by the College of American Pathologists (CAP) and participate in the associated notification exercises.
2. At the time of application, provide 24/7 contact information for Sentinel Laboratories within the LRN Reference Laboratory catchment area. An Excel spreadsheet for recording this information is available from Will Probert at Will.Probert@cdph.ca.gov.
3. At the time of application, provide a spreadsheet of "Bio Facility Capabilities" (agent, sample type, and test name) as listed under their "Facility Profile" on the secure site at http://lrnb.cdc.gov.
4. Record sentinel laboratory training sessions provided to clinical/hospital laboratories and submit a copy of the document with the year-end progress report. An Excel spreadsheet for recording this information is available from Will Probert at Will.Probert@cdph.ca.gov.

City Readiness Initiative (CRI)

To align with the PHEP Capabilities-based approach, CRI requirements support the Medical Countermeasure Dispensing and the Medical Materiel Management and Distribution Capabilities. As described in those Capabilities, CRI supports medical countermeasure (MCM) distribution and dispensing for all-hazards events, which includes the ability of jurisdictions to respond to a large-scale biologic attack, with anthrax as the primary threat consideration.

Seventeen California LHDs outside Los Angeles County are designated as CRI jurisdictions:

California CRI LHDs	
Alameda	Sacramento
City of Berkeley	San Benito
Contra Costa	San Bernardino
El Dorado	San Diego
Fresno	San Francisco
Marin	San Mateo
Orange	Santa Clara

California CRI LHDs	
Placer	Yolo
Riverside	

All LHDs receiving CRI funds must address all functions and priority resource elements for Medical Countermeasure Dispensing and Medical Material Management and Distribution Capabilities. In addition to the work plan, CRI jurisdictions are required to complete Rand Drills as detailed below.

RAND Drills

- All LHDs receiving CRI funds must complete a minimum of three different RAND drills (not the same drill performed three times) during 2012-13. The three required drills may be chosen from any of the eight available drills on the DSNS Extranet website at: https://www.orau.gov/snsnet/default.htm.

- Drill data and/or HSEEP AAR/IP for applicable drills must be submitted to lhbtprog@cdph.ca.gov no later than June 30, 2013.

- Real events can substitute for drills and exercises provided that target capabilities are sufficiently tested and documented.

Please reference Appendix D and the following link for more information on RAND drills.

https://www.orau.gov/snsnet/resources/guidance/DSNS_POD_Data_Template.xlsm

SECTION THREE

GUIDANCE FOR GENERAL FUND PANDEMIC INFLUENZA FUNDS

This section provides guidance to assist Local Health Departments (LHDs) in completing their 2012-13 Pandemic Influenza (Pan Flu) application. These funds enhance LHD preparedness for an influenza pandemic.

Required Activities:

- Pandemic Influenza Planning
  - Provide the name and contact information for the Pandemic Influenza Coordinator.
  - Define the roles and functions of the Pandemic Influenza Coordinator.
  - Identify Pan Flu planning gaps and explain how the LHD will address those gaps.
- Improve Pandemic Influenza Operational Response Plans.
- Maintain and strengthen Government-Authorized Alternate Care Sites.
- Maintain the local Disaster Healthcare Volunteers (DHV) Program. LHDs are expected to support and promote the DHV program for registration and credential verification of volunteer medical and health professionals, including Medical Reserve Corps members. All Medical Reserve Corps receiving Pan Flu funds are required to register in DHV.
- Preparedness for At-Risk Populations. LHDs are expected to assist and collaborate with the Local HPP Entity on their preparedness activities to provide access to medical care for at-risk populations.

Optional Activities:

- Purchase pneumococcal vaccine for a vaccination exercise. The budget for this activity cannot exceed 10% of the Pan Flu allocation.
- Activate a mass vaccination clinic for seasonal influenza focusing on at-risk populations and priority target groups. The budget for this activity cannot exceed 10% of Pan Flu allocation.
- Support warehouse costs for maintaining and storing medical material received from CDPH. LHDs may utilize up to 30% of their Pan Flu allocation for warehouse costs of maintaining and storing medical materiel received from CDPH.

SECTION FOUR

GUIDANCE FOR HOSPITAL PREPAREDNESS PROGRAM GRANT

Healthcare Preparedness Capability Prioritization

The section provides guidance to assist Local Hospital Preparedness Program (HPP) Entities in completing their 2012-13 application for the HPP grant.

Hospital Preparedness Program Strategic Planning for 2012 – 2016

As described in Section One, through two parallel planning efforts, California identified the following strategies to implement the Healthcare Preparedness Capabilities over a five year timeframe in order to prepare for and respond to public health and medical emergencies.

- Maintain essential activities to respond to public health and medical emergencies.
- Ensure sufficient capacity within California to respond to all hazards.
- Focus on activities that lay the foundation for others, creating a natural progression of activities.
- Allow local flexibility while providing statewide standardization in key areas.
- Focus first on core medical capabilities while healthcare organizations, CDPH and EMSA obtain baseline assessments of their current status across all capabilities to develop priorities for future grant years.
- Acknowledge that real events may dictate a shift in focus on specific Healthcare Preparedness Capability.

CDPH has developed a two level prioritization approach for implementation of the Healthcare Preparedness Capabilities to guide Local HPP Entities and Healthcare Partnerships in their preparedness efforts.

CDPH Priority Levels for Healthcare Preparedness Capabilities

Healthcare Preparedness Capabilities	
Priority Level I	**Priority Level II**
1. Healthcare System Preparedness	5. Fatality Management
2. Healthcare System Recovery	14. Responder Safety and Health
3. Emergency Operations Coordination	
6. Information Sharing	
10. Medical Surge	
15. Volunteer Management	

The five year strategy for addressing the eight Healthcare Preparedness Capabilities begins with the Level I Capabilities that focus on Healthcare Partnership development and planning and overarching response capabilities. Within the Level I Capabilities, Local HPP Entities will first address those Functions and Resource Elements that address individual

healthcare organization preparedness and then move to those Functions and Resource Elements that require system assessments and activities. Specifically, 2012-13 activities focus on Functions and Resource Elements within the six Priority Level I Healthcare Preparedness Capabilities as depicted in the table above as these serve as building blocks for subsequent activities.

In planning the 2012-13 activities, Local HPP Entities should take into consideration the findings of their jurisdiction's hazard vulnerability assessments, public health risk assessments, current Capability status, and real events occurring within the jurisdiction.

Local HPP Entity Healthcare Partnerships

A cornerstone of California's HPP has been the requirement that Local HPP Entities establish functional Healthcare Partnerships that include hospitals, clinics, skilled nursing facilities, LHDs, local EMS agencies, mental health facilities, community services agencies, local emergency management agencies and other community participants. These Partnerships are required to plan, train, drill and exercise throughout the grant year. California's Healthcare Partnerships have focused on preparedness activities, recognizing that California has a well-established system for emergency response which connects the healthcare delivery system to emergency management through the MHOAC in each operational area. The MHOAC coordinates public health and medical response by gathering situational awareness and coordinating resource requests stemming from the healthcare organizations within the jurisdiction into the broader public health and medical emergency management structure.

ASPR has established the following stages of Healthcare Partnership development that will be used during the five year project period.

Stage 1:
- Determine geographic boundaries
- Identify essential partners documented through written documents such as MOUs, letters of agreement, etc.
- Determine governance structure (e.g. charter or by-laws)

Stage 2:
- Maintain Stage 1 requirements through sustainment and preparedness activities
- Perform preparedness activities

Stage 3:
- Determine how Healthcare Partnerships will connect with the Operational Area response system and perform ongoing regional exercises to test this capability.

In April 2012, each Local HPP Entity indicated the stage of their Partnership development. For 2012-13, within the Healthcare Preparedness Capability, each Partnership should identify gaps in Partnership development, describe activities to mitigate these gaps, and indicate the projected stage of development by the end of 2012-13.

Essential Healthcare Partnership Membership

Healthcare Partnership membership should include:

- Hospitals servicing the Operational Area, at least one of which shall be a designated trauma center, if applicable
- One or more clinics (including American Indian clinics), ambulatory care centers, or primary care facilities
- Skilled nursing facilities
- EMS providers
- LEMSAs
- Emergency Management/Public Safety
- Medical Health Operational Area Coordinator Program
- Long-term care providers
- Mental/behavioral health providers
- Private entities associated with healthcare (e.g., Hospital associations)
- Specialty service providers (e.g., dialysis, pediatrics, woman's health, stand-alone surgery, urgent care)
- Support service providers (e.g., laboratories, pharmacies, blood banks, poison control)
- Primary care providers
- Community Health Centers
- Public Health
- Federal entities (e.g., NDMS, VA hospitals, IHS facilities, Department of Defense facilities)

Additional Healthcare Partnership Members

Healthcare Partnerships network with subject matter experts (SMEs) for improved coordination of preparedness, response, and recovery activities. These memberships may be dependent on the area, participant availability, and the Healthcare Partnership's unique needs. Examples of organizations that may be considered include but are not limited to:

- Home health agencies
- Hospices
- Freestanding Surgery Centers
- Pre-hospital care providers including dispatchers
- Local OES
- Local Welfare and Social Services Departments
- Developmental Centers
- Regional Centers
- Mental Health Facilities
- Maternal and Child Health Programs
- Public Works
- Local and state law enforcement and fire services

- Private organizations
- Non-governmental organizations
- Non-profit organizations
- Faith-based Organizations (FBOs)
- Community-based Organizations (CBOs)
- Volunteer medical organizations (e.g., American Red Cross)
- Others partnerships as relevant
- Coroners and/or Medical Examiners
- Amateur Radio Operators
- Additional partners as determined by the partnership/coalition

It is expected that all healthcare facilities and organizations receiving HPP funding from the Local HPP Entity will participate in the local Partnership.

CDPH recognizes that additional resources may be needed to coordinate all partners in completing the deliverables. Local HPP Entities in Operational Areas with more than 180 licensed healthcare facilities may direct an additional $50,000 to Partnership staffing; Local HPP Entities in Operational Areas with 30 or more licensed healthcare facilities may direct an additional $25,000 to Partnership staffing; and those Local HPP Entities in Operational Areas with fewer than 30 licensed healthcare facilities may provide justification as to how they would use up to an additional $25,000 to achieve Partnership deliverables. (See Appendix E for listing of the number of licensed healthcare facilities in each county.)

Local Emergency Medical Service Agency (LEMSA) Deliverables and Allocations

Each LEMSA shall designate a LEMSA Coordinator who shall participate in the activities described below.

In recognition that LEMSAs are an integral part of the local Healthcare Partnership, each Local HPP Entity is allocated funds for a LEMSA Coordinator. LEMSAs representing single Operational Areas will be allocated, via the Local HPP Entity, $50,000 for a half-time position or contract to participate in the Healthcare Partnership, including planning and exercising.

LEMSAs representing multiple Operational Areas will receive a total of $65,000 for a part-time staff person or contract to participate in local planning and exercising. Each Local HPP Entity within a multi- Operational Area LEMSA is allocated an equal share of the $65,000. Local HPP Entities within a regional LEMSA may agree to a different funding formula for reaching the $65,000 LEMSA funding requirement.

To streamline the contracting process, CDPH will contract directly with Regional LEMSAs for the $65,000 allocation. Allocations to Local HPP Entities served by a Regional LEMSA will be reduced by the amount of funding they allocated to their LEMSA in 2011-12.

LEMSA Coordinator Requirements

Healthcare System Preparedness

- Participate in Healthcare Partnership development as part of medical health disaster regional partnerships and participate in developing or maintaining local operational areas medical health disaster coalition and provide documentation of participation and activities of the local coalitions.
- Clearly articulate, within emergency response plans, LEMSA roles and responsibilities for providing emergency medical services elements of the MHOAC Program.

Information Sharing

- Participate in State sponsored training on the California Public Health and Medical Emergency Operations Manual.
- Continue to modify LEMSA plans, policies and procedures that address information management and resource requesting to be consistent with the California Public Health and Medical Emergency Operations Manual and integrated with Operational Area response plans.

Healthcare System Recovery

- Assist in the development of tools necessary to review and identify gaps of Emergency Medical Services Agency COOP plans.

Medical Surge

- Assist EMS provider organizations with the coordination of responding during incidents that require medical surge
    - Develop (if not completed) Mass or Multi Casualty Incident (MCI) plans and policies and conduct and/or participate in training and exercising plans; and consider incorporating Field Treatment Site plans in collaboration with healthcare partners.
- Continue to participate in HAvBED data collection activities including training and exercises according to roles established in local policies and procedures. After each exercise, identify any gaps in local policies and procedures and modify plans to address the gaps.
- Participate in the Statewide Medical and Health Exercise in coordination with Operational Area exercise play.