National Bioterrorism Hospital Preparedness Program

Cooperative Agreement Guidance

Health Resources and Services Administration
U.S. Department of Health and Human Services

DRAFT: March 14, 2003

I. Introduction

In the wake of the terrorist attacks of September 11, 2001, and the subsequent anthrax epidemic, attention was focused on the ability of the health care system, including hospitals, emergency medical services (EMS) systems and outpatient facilities to respond to terrorist events and other public health emergencies. All components of the health care system face the challenge of becoming trained and prepared to respond to biological, chemical and radiological casualties, whether they present in large numbers acutely or in small cohorts over a long period of time. While generally well prepared to respond to routine emergencies and minor epidemics, the system lacks the plans and infrastructure to respond to the new challenges posed by terrorist acts. An acute influx of large numbers of sick or contaminated patients from such an attack could completely overwhelm the medical system.

To follow up on the emergency bioterrorism legislation in 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) authorizes Section 319-C of the Public Health Service Act (42 U.S.C. 201 et seq.), which supports activities related to countering potential terrorist threats to civilian populations. Funding was provided under the *Consolidated Appropriations Resolution of 2003* (Public Law 108-7).

As part of this initiative, the Health Resources and Services Administration (HRSA) announces that $498 million is available in fiscal year 2003 for cooperative agreements with 62 public health departments of States, territories, municipalities and Pacific nations (all jurisdictions hereinafter referred to as “States” for simplicity). These awards are for the development and implementation of regional (either intra-state or multi-state) plans to improve the capacity of the health care system, including hospitals, emergency departments, outpatient facilities, emergency medical services (EMS) systems and poison control centers, to respond to incidents requiring mass immunization, isolation, decontamination, diagnosis and treatment, in the aftermath of terrorism or other public health emergencies.

II. Purpose

The mission of the National Bioterrorism Hospital Preparedness Program is to ready hospitals and supporting health care systems to deliver coordinated and effective care to victims of terrorism and other public health emergencies.

The purpose of this cooperative agreement program is to build upon the planning, infrastructure development and implementation that began under FY 2002 funding, to continue to upgrade the preparedness of the Nation's health care system to respond to terrorism. This will also allow the health care system to become more prepared to deal with non-terrorist epidemics of rare diseases, exposures to chemical toxins and radiological materials, and mass trauma incidents. The prime focus will be on further development, implementation and intensification of terrorism preparedness plans and protocols for hospitals, outpatient facilities, EMS systems (both freestanding and fire-based) and poison control centers in collaborative statewide or regional models. Collaboration with other States, Indian tribes, bordering countries and expert national organizations is encouraged. Integration of the health care system plans with the public health department response is critical.

The cooperative agreements will consist of continuations of successful FY 2002 bioterrorism preparedness activities. The cooperative agreement activities will also include needs assessments, planning and implementation of new activities designed to prepare the regional health care systems for incidents of terrorism and other public health emergencies. States will continue, and Pacific nations will begin, to involve their partners in this effort. These partners include, but are not limited to, pediatric and adult hospital associations, emergency medical services systems, emergency management agencies, rural health offices, primary care associations, health care professional organizations and federal health care facilities (including the Indian Health Service, Veteran's Administration and Department of Defense).

Each regional plan is expected to integrate its proposal for this cooperative agreement with FY 2003 funds available through: (1) the CDC cooperative agreements for upgrading State and local public health preparedness for terrorism; and (2) funds directed to selected municipalities by the Department of Homeland Security for Metropolitan Medical Response Systems.

Grantees will be given the flexibility to prioritize funding for specific activities based upon their needs assessment, within the overall context of national terrorism preparedness objectives. This should result in grantees being able to upgrade the ability of health care entities to respond to terrorist incidents, to develop a multitiered system in which these entities are prepared to triage, isolate, diagnose, treat and refer multiple victims of a terrorist incident or subsequent infectious disease epidemic to identified centers of excellence, and to develop regional consortia to pool limited funding to accomplish these goals.

Grantee health departments will be required to allocate most of these funds to hospitals, emergency medical systems, community health centers, rural health centers, federally qualified health centers, Tribal health care facilities serving American Indians and

Alaska Natives, and other outpatient facilities that serve as vital points of entry into the health care system. Poison control centers may also be funded by the State in order to support the health care system's ability to respond. While associations of hospitals and other health care entities may serve as contractors to grantees to implement this program, the intent of the program is primarily to fund health care entities directly for their preparedness activities.

II. Who Can Apply

The distribution of funds will be to all 50 States, the District of Columbia, the Commonwealths of Puerto Rico and the Northern Mariana Islands, the territories of American Samoa, Guam and the U.S. Virgin Islands, the nation's three largest municipalities (New York City, Chicago and Los Angeles County), and the freely associated nations of the Pacific (Federated States of Micronesia, Marshall Islands and Palau). Funding will be provided to the health departments of those jurisdictions. Hospitals, EMS systems, outpatient facilities and poison control centers should apply to the appropriate health department for funding through this program.

IV. Funding

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. Under the cooperative agreement, HRSA will support activities of awardees through a memorandum of agreement.

$498 million will be allocated to cooperative agreements. Minimum allotments will be available of $2,000,000 to the District of Columbia, $1,000,000 to the States, Puerto Rico and the three municipalities, and $500,000 to the other four territories and the three Pacific nations. Remaining funds will be distributed to these jurisdictions using a formula based on population.

Given the responsibilities of Federal, State, and local governments to protect the public in the event of bioterrorism, funds from this grant must be used to supplement and not supplant the non-Federal funds that would otherwise be made available for this activity.

Awards are intended to support needs assessments and the development and implementation of an action plan, provided this plan is approved by DHHS. These funds are expected to result in subsequent contractual awards to health care entities by the health departments, to upgrade their ability to respond to terrorist incidents.

Funds will be awarded for a twelve-month period initially, with an option to apply for continuation funds for subsequent twelve-month periods through FY 2006. The full formula-determined amount of funding will be provided to each eligible entity in any given year contingent upon accomplishment of the previous fiscal year's objectives, the requirements of the cooperative agreement program, and the availability of funds.

V. Timeline

Grantees must file an application with HRSA as soon as feasible after receipt of this announcement, but no later than **June 1, 2003.** In order to facilitate rapid review by HRSA, copies of the application may be electronically mailed to HRSA.

Applications will be reviewed by review committees within both HRSA and DHHS. If the plans fulfill the review criteria (Section VIII below), funding will be awarded by **August 31, 2003.** Recommendations arising from these reviews which result in funding restrictions on the award must be addressed according to time deadlines to be determined.

VI. Application Requirements

Applicants should use the Public Health Service Grant Application Form (PHS 5161-1), which can also be viewed on line at www.mchb.hrsa.gov. From there, look under *Funding Opportunities*, then *Forms*.

Item 10 on the cover sheet should reference Catalog of Federal Domestic Assistance (CFDA) Number 93.003. Under contact person, include name, telephone and FAX numbers and an e-mail address.

The application must address the following items.

A. Summary of FY 2002 Needs Assessment: In no more than 5 pages, please summarize the results of the needs assessment done as part of the FY 2002 HRSA Bioterrorism Hospital Preparedness Program. This should be brief, as specific details will be asked for below as part of the justification for individual priority area activities.

New grantees should assess their unmet needs in being able to implement a hospital, outpatient and EMS terrorism response. Where substantial needs assessment activities have been completed or are in progress, summarize the results to date and provide a time line for addressing further issues, including measurable milestones to facilitate accountability.

Ongoing identification of needs may be based on objective data collected from surveys or other evaluation tools, and after-action reports from the grantee's response to past terrorism or natural disasters.

B: Overview of Implementation Plan: In no more than 5 pages, please provide a brief narrative on the approach to developing or updating a plan for a comprehensive terrorism response program that addresses the priorities identified in the needs assessment. Please provide an integrated summary of the plan, that ties together the priority areas discussed in detail below.

C: Priority Planning Areas: Recognizing the comprehensive nature of an effective response plan for bioterrorism and other public health emergencies, HRSA has identified 14 priority areas for the implementation plan. The application for the FY 2003 Cooperative Agreement must address each Priority Area:

1. Program Governance
2. Regional Plan for Optimizing Hospital Surge Capacity
3. Pediatrics
4. Medications and Vaccines
5. Hospital Laboratories
6. Health Care System Surveillance and Epidemiology
7. Chemical and Radiological Preparedness
8. Personal Protection and Decontamination
9. Emergency Medical Services
10. Trauma and Burn Center Capacity
11. Mental Health
12. Communications and Information Technology
13. Education and Training
14. Biological, Chemical and Radiological Disaster Drills

Several of the Priority Areas include Critical Benchmarks, which are the required elements that must be implemented as soon as possible. For each Critical Benchmark the grantee must provide a brief proposal for accomplishing the objective during this budget period. Please include a time line to guide implementation, measurable milestones to facilitate accountability, and a proposed budget.

There are other activities in this guidance that may be proposed for funding, which have benchmarks not defined as critical. These activities should be addressed only after Critical Benchmarks have been achieved or are well along in development. Recipients are encouraged to choose among these suggested activities.

PRIORITY AREA #1: **Program Governance and Administration**

In no more than 10 pages, these elements must be addressed in order to ensure an adequate infrastructure to support the planning and implementation process.

Program Direction: There must be leadership at the health department level to ensure coordination of all three funding streams. In addition, specific direction for the hospital preparedness plan will be needed. The application must discuss the staffing plan, including the required positions of Bioterrorism Hospital Preparedness Coordinator and Medical Director, and appropriate administrative staff to support them.

The Coordinator is responsible for providing overall leadership to this program in the grantee's jurisdiction, as well as for implementing the needs assessment and operational plans for terrorism health care system preparedness in the State. He or she should have training and experience in disaster response planning, including knowledge

of clinical issues, administrative procedures, linkages to appropriate agencies and organizations, and training issues appropriate to bioterrorism preparedness.

- Describe the duties of the Bioterrorism Hospital Preparedness Coordinator (BHPC).

- Identify the person holding the position of BHPC. As an appendix to this application, include a curriculum vitae that describes the education, training and experience that qualify this person for the position.

Medical Direction: If the BHPC is not a physician, the plan must address how the State will obtain medical expertise in developing its terrorism preparedness plan. This could include support of the State EMS medical director or contracting with other qualified physicians for these services. Physicians with board certification in emergency medicine, and training and experience in disaster medicine, infectious disease, toxicology, radiation and trauma would be desirable for this position.

- Describe the duties of the Medical Director, including that person's role in providing expert guidance to the terrorism preparedness program.

- Identify the person holding the position of Medical Director. As an appendix to this application, include a curriculum vitae that describes the education, training and experience that qualify this person for the position.

- If the Medical Director is not the State EMS medical director, discuss the role of the EMS medical director in the terrorism health care system preparedness program. *See Priority Area #14 below.*

Administrative Staffing: The plan may include positions for persons qualified in grant proposal writing, financial management, administrative support and other essential functions that facilitate the operation of a successful terrorism preparedness program.

- Describe the overall staffing plan for the terrorism health care system preparedness program.
- Justify the staffing plan in terms of necessary functions and cost-effectiveness.

- Briefly discuss the training and experience possessed by the people who will staff this program.

Terrorism Preparedness Planning Committee: To ensure representation of appropriate entities best equipped to deal with terrorist threats, a Terrorism Preparedness Planning Committee must be continued or established to advise the health department in its health care system preparedness efforts. It should meet at least quarterly to provide guidance, direction and oversight to the State health department in planning for terrorism response.

In addition to a representative from the grantee health department, this group must include these entities:

- State emergency medical services office
- State emergency management agency
- State hospital association
- State or regional primary care associations
- State office of rural health
- Veterans Administration health care facilities
- Military treatment facilities
- State or regional poison control center
- CDC-funded State Terrorism Preparedness and Response Program
- Metropolitan medical response system
- American Indian or Alaska Native Tribal or Federal health care facilities
- Tertiary care centers serving as referral facilities or centers of excellence for terrorism preparedness

Within these required entities, the committee representatives must include at least one and preferably more of each of the following professional disciplines.

- Medicine (preferred specialties include emergency medicine, family medicine, internal medicine, pediatrics, critical care, infectious disease, toxicology, radiation medicine)
- Nursing (preferred expertise as for medicine, plus occupational and school health)
- Pharmacy
- Mental health (critical incident stress management background preferred)
- Emergency medical technician
- Hospital administration
- Hospital engineering
- Laboratory science

Optional entities may include, but are not limited to:

- Academic medical centers expected to take a leadership role
- Clinical professional societies
- Local emergency medical systems
- Disaster medical assistance teams (DMAT)
- Police and fire departments
- Red Cross and other voluntary organizations
- Consumer representatives
- Experts in medical, nursing, pharmacy and public health specialties such as emergency medicine, primary care, pediatrics, infectious disease, toxicology, radiation medicine, occupational health and school health

In this application, please discuss the following issues.

- Provide a description or charter defining the mission and duties of this planning committee.

- Provide a current roster of the planning committee, and the rationale for inclusion of each member.

- If the planning committee formed under the HRSA guidance is blended or identical with similar committees for the CDC cooperative agreement or other grantee emergency preparedness efforts, please discuss how health care system preparedness issues will receive top priority consideration in light of those multiple missions.

- Provide a schedule of anticipated meetings of this committee for the next cooperative agreement year.

- Describe how the planning committee will formally signify its consensus and support of the work plan submitted as part of this application, and any updates thereafter, in accordance with state laws and established policies.

- Describe how issues of security and confidentiality will be addressed in committee discussions on sensitive issues (open versus closed meetings).

Coordination with Other Terrorism Preparedness Activities: The HRSA work plan will be expected to integrate proposed uses of FY 2003 funds with other sources of terrorism emergency preparedness funds.

Grantees may choose to submit joint cooperative agreement applications, pooling funds to develop a multi-state regional plan where economies of scale might make this more practical. Examples of this include neighboring states with large rural and frontier areas, shared metropolitan areas, and international borders with frequent population movement across them.

- For each priority planning area in this guidance, demonstrate how the health care system preparedness funds (HRSA) coordinate with the relevant focus areas in the public health preparedness funds (CDC) to ensure that gaps are bridged and duplication is avoided.

- Describe the regional approach being proposed for efficient, cost-effective use of limited funding. Defined regions may be within the grantee jurisdiction, or may cross interstate lines, city limits or international borders.

- Please discuss the roles of local, Tribal, Federal and military health care entities in this plan, including how they collaborate through such mechanisms as mutual aid agreements and regional consortia.

- Describe how other terrorism preparedness resources on the local, regional, State and national level are utilized in grantee planning efforts. Examples of resources include State and local emergency medical services, professional

organizations, poison control centers, metropolitan medical response teams, disaster medical assistance teams, State and Federal emergency management agencies and Federal programs.

Letters of Support: These must be submitted by entities required as members on the hospital preparedness planning committee, and desirable from other organizations considered key by the grantee. The letters should document objectively the collaboration that is occurring between the grantee and the supporting organization. Letters are required from the following entities.

- State emergency medical services office
- State emergency management agency
- State hospital association
- State or regional primary care association
- State office of rural health
- Veterans Administration health care facility
- Military treatment facility
- State or regional poison control center
- CDC-funded State Terrorism Preparedness and Response Program
- Metropolitan medical response system
- American Indian or Alaska Native Tribal and/or Federal health care facility
- Tertiary care centers serving as referral facilities or centers of excellence for terrorism incidents. Letters must be obtained from all such centers that are integrated into the grantee's terrorism preparedness plan.

PRIORITY AREA #2: Regional Hospital Plan for Optimizing Surge Capacity

It is critical that grantee health departments plan for an epidemic involving at least 500 acutely ill patients per million population in each region, plus the much larger demand expected from people who require preventive, diagnostic, minor medical or supportive care. Recognizing that many patients come from rural areas served by referral centers in metropolitan areas, planning must include the surrounding areas likely to impact the resources of these cities.

Needs Assessment: Please provide an objective justification for the proposed regional hospital plan, based on the needs assessment completed using FY 2002 funds and any updates to that assessment. For new grantees, please provide needs information from other assessments that may have been done previously, or from a new assessment developed in response to this guidance. The needs assessment should include: (a) a brief description of the existing hospital and regional capacity, and (b) an assessment of whether this capacity is adequate when compared to the critical benchmark discussed below.

[Need to provide them with a template so they know what we expect of them – Wil's database with benchmarks under each priority area.]

- Existing plans that address triage, isolation, decontamination, stabilization, treatment and referral of multiple casualties (whether presenting all at once or more gradually)
- Identification of EMS systems, emergency departments and outpatient centers capable of initial assessment and treatment of terrorist victims
- Linkages to expert consultation and definitive referral centers
- Need for reconfiguration of hospital space for isolation of communicable diseases and treatment of infectious disease epidemics
- Collaborative systems between hospitals and EMS systems that support effective diversion and referral plans
- Need for personnel augmentation (physicians, nurses, pharmacists, mental health professionals and others) to handle large influxes of patients
- Need for credentialing and supervision of clinicians not normally working in facilities responding to a terrorist incident
- Need for mechanisms to manage unsolicited clinical help and donated items
- Need for delivery to facilities of essential goods and services such as food, water, shelter and electricity
- Need for security services to enforce isolation requirements

Year 1 Progress Report: For grantees receiving funds in FY 2002, please provide a detailed progress report showing how the previously approved plan for FY 2002 Critical Benchmark #3 (Regional Hospital Plans) and FY 2002 Second Priority Areas #1 (Personnel) and #3 (Patient Transfer) has been implemented. This will serve as a logical basis for requesting FY 2003 funding to expand efforts in this priority area.

- The State health department must plan for a potential epidemic involving at least 500 patients in the State or region.
- The work plan must include the surrounding counties (i.e. rural) likely to be impacted by the resources of the cities.
- The work plan must include a timeline that describes the approach to development and implementation of the regional hospital plan for large-scale epidemics.

- The work plan must describe increasing hospital bed capacity to accommodate increases in admissions from an infectious disease epidemic over an extended period of time.
- The work plan must describe providing isolation and quarantine for casualties, using such references as CDC's for Type C (contagious) facilities.
- The work plan must address overcrowding and the need for hospital diversion, with large numbers of acute casualties arriving on their own or by ambulance.
- The work plan must include a rapid communication plan with EMS units that allow them to determine a destination immediately at any time.
- The work plan must describe how hospitals will receive patients on a daily basis when several hospitals are on diversion simultaneously.
- The work plan must ensure movement of equipment maintained by hospitals or EMS systems to the scene of a bioterrorist event.
- The work plan must describe how the special needs of children, pregnant women, the elderly and those with disabilities will be addressed in ensuring access to medically appropriate care.
- The planning for children must include school settings and the clinicians caring for them there.
- The work plan must describe how essential goods and services such as food, water, electricity and shelter will be delivered to patients and hospitals.
- The work plan must describe how hospital security will be provided (crowd control, patient traffic to support triage decisions, prevention of further terrorist attacks at the hospital).
- The work plan must describe procedures for safe and appropriate disposal of medical waste by hospitals.
- The work plan must describe how additional hospital and EMS personnel will be recruited and deployed at the local level to implement an effective medical bioterrorism response plan.
- The work plan must describe ensuring support for hospitals and EMS systems through mutual aid agreements with metropolitan medical response systems or disaster medical assistance teams.
- The work plan must describe license reciprocity, credentialing and supervision of clinicians not normally working in facilities responding to bioterrorism.

- The work plan must describe how unsolicited offers of help from undocumented clinicians arriving in a biological disaster area will be managed.
- The work plan must describe how hospitals will be evacuated in the event of a bioterrorist attack, and how the hospital patients will be housed to ensure safety and good medical care.
- The work plan must describe how patients could be triaged to make additional hospital bed space available during a terrorism event.
- The work plan must describe how hospitals and EMS will deal with patient transports and destinations associated with communicable diseases.
- The work plan must describe a plan for using nonhospital facilities to shelter and treat mass casualties or epidemic victims if hospitals are overwhelmed.
- The work plan must describe how the needs of children, pregnant women, the elderly and those with disabilities will be addressed during patient transfers.
- The work plan must describe the role of schools in a bioterrorism incident; as potential targets, as facilities for emergency shelter or quarantine, and as resources for clinicians such as school nurses who may be assigned there.

[Suggest feasible timelines (e.g., by first quarter) for accomplishing.]

FY 2003 Implementation Plan: Please describe the plan for continuation or expansion of activities in this priority area, based on the needs assessment and year 1 accomplishments. Where the needs assessment showed capacity to be inadequate, a proposal for effecting improvements, consistent with the available funding during this budget period, should be presented.

Since grantees will also be applying for CDC funds to support health department preparedness for terrorism, the HRSA application must include a narrative showing how this Priority Planning Area will be coordinated with CDC Focus Area A to prevent overlap or gaps between the two cooperative agreements.

The application must include a timeline to guide implementation, and measurable milestones to facilitate accountability, that describes the approach to development and implementation of a regional hospital plan for large-scale epidemics, chemical or radiological contamination incidents, and mass trauma casualties.

Under the authorizing legislation, priority must be given to biological events before using these funds for chemical, radiological or explosive incident planning.

Planning should include provisions for emergency increases in staffing with physicians, nurses, pharmacists, mental health professionals, emergency medical technicians and others, and for linkages with other hospitals and EMS systems.

Planning should also include coordination with health care reimbursement plans that may impact the ability of hospitals, outpatient centers and clinicians to respond efficiently in the event of a major terrorist disaster.

Critical Benchmark #2-1: *Submit or update the plan for triage, treatment and disposition of 500 patients per 1,000,000 of population with acute illness or trauma from a biological, chemical, radiological or explosive terrorist incident. This plan must address the entire health care system (inpatient, outpatient and prehospital), not just any one component.* **(up to 5 pages)**

- Set up triage locations both at the site of a mass casualty, and at emergency departments experiencing large numbers of patients.
- Increase hospital bed capacity, including off-site options, to accommodate increases in admissions from an infectious disease epidemic or radiologic exposure over an extended period of time. This plan may be modeled on similar plans for large-scale epidemics such as influenza.
- Increase hospital bed capacity, including off-site options, to accommodate acute admissions from mass casualties secondary to a chemical or explosive incident.
- Address emergency department overcrowding, including off-site options, to accommodate acute or ongoing increases in patient demand from either epidemics or mass casualty incidents.
- Address the need for hospital diversion in a catastrophic challenge to surge capacity, including a rapid communication plan with EMS units that allows them to determine a destination immediately at any time.
- Describe how the participating hospitals in a regional plan will receive patients when all hospitals are on diversion simultaneously.
- Resolve EMTALA legislation with the statewide plans for hospital diversion and triage into off-site facilities during a large-scale disaster.
- Describe how hospitals will be evacuated in the event of a terrorist attack on that facility, and how the evacuated patients will be housed to ensure safety and good medical care.
- Describe how patients will be tracked during triage, referral and evacuation during a mass casualty incident or large-scale infectious disease epidemic.

- Describe how patients already admitted or ready to be seen for minor emergencies could be triaged to make additional hospital and emergency department space available during a terrorism event.

- Ensure transport of mobile equipment maintained by hospitals or EMS systems to off-site facilities responding to large numbers of epidemic or mass casualty patients.

- Comply with HIPAA as regards sharing patient information and location with family and friends during a large scale disaster.

- Address the special needs of the elderly and those with disabilities in ensuring access to medically appropriate care during a terrorist incident.

- Deliver essential goods and services such as food, water, electricity and shelter to patients and hospitals.

- Provide security (crowd control, patient traffic to support triage decisions, prevention of further terrorist attacks at the hospital) during a terrorist incident.

- Describe procedures for safe and appropriate disposal of medical waste.

***Critical Benchmark #2-2**: Submit or update the plan for triage, treatment and disposition of 10,000 patients per 1,000,000 population with exposure to an infectious disease or radiologic source requiring medication prophylaxis or immunization within the first four days of a terrorist incident.* **(up to 5 pages)**

- Set up prophylaxis and immunization clinics for large numbers of patients.

- Describe the patient education and informed consent procedures to be utilized during a mass preventive medicine campaign.

- Provide language translation services appropriate for the grantee jurisdiction (including American Sign Language for the hearing impaired) to ensure appropriate informed consent for preventive medical treatment.

- Describe how prophylaxis or immunization interventions will be recorded and tracked, both at the time treatment is rendered, and afterwards to detect and treat complications in a timely manner.

- Address the special needs of the elderly and those with disabilities in ensuring access to medically appropriate care during a terrorist incident.

- Provide security (crowd control, patient traffic through the intervention process, prevention of secondary terrorist attacks at the facility) during a mass preventive medicine effort.

- Describe procedures for safe and appropriate disposal of medical waste.

<u>Critical Benchmark #2-3</u>: *Inventory all available hospital-based isolation facilities, both fixed and mobile, in the grantee jurisdiction. Present a plan to upgrade this capacity to have at least one negative pressure, HEPA-filtered isolation facility per million population (but not less than one per grantee). This facility must be able to support the triage of 10 patients at a time having a clinical syndrome suggestive of smallpox, plague or hemorrhagic fever, prior to movement to a designated quarantine area or type "C" isolation facility.* **(up to 5 pages)**

- Route patients with suspected communicable disease from a bioterrorist source to other facilities, after initial triage, for further diagnosis and treatment. This plan may consider non-hospital-based, off-site locations that become part of the hospital's approved system for admitting its patients.

- Provide isolation, either on site or by referral, for large numbers of communicable disease patients presenting at any hospital in the grantee jurisdiction, using such references as CDC's for Type C (contagious) facilities.[2]

- Describe which hospitals will be targeted for capital improvements to assure safe and effective isolation of large numbers of infectious patients.

- Upgrade existing patient isolation systems to allow for large numbers of patients exposed to infectious material from an airborne or environmental release to be safely isolated from the general patient populations within the designated facilities.

<u>Critical Benchmark #2-4</u>: *Present a plan to immediately deploy 100 or more extra personnel per million population in urban areas, and 50 or more personnel per million population in rural areas.* **(up to 5 pages)**

- Describe how additional hospital, outpatient and EMS personnel will be deployed at the local level to implement an effective medical terrorism response plan. Resources may include, but are not limited to, metropolitan medical response systems or disaster medical assistance teams (DMAT).

- Describe the State's arrangements with the federal Office of Emergency Response for deploying DMATs as state assets, where a conflict may exist with these resources being deployed elsewhere as part of the Federal Response Plan.

- Share clinical personnel between hospitals when needed for a terrorism response.

- Describe the plan to manage clinical personnel who fail to report to work during a disaster, including issues of adequate preparation and training, fear mitigation, provision of adequate protective gear, finite rotation schedules, and family care.

- Protect responding hospital and pre-hospital clinicians and their families from exposures to biochemical casualties and environments (such as provision of personal protective equipment, antibiotics or vaccines).

- Describe how hospitals and EMS will deal with patient transports and destinations associated with communicable diseases or surface contaminants.

- Avoid double counting of resources being tapped simultaneously by different hospitals (such as temporary nursing agencies).

- Plan for recruiting and supervising clinicians not normally working in facilities responding to bioterrorism, including personnel from out of state. Ensure that barriers to license reciprocity and credentialing are addressed prior to a terrorist event.

- Manage unsolicited offers of help from undocumented clinicians arriving in a disaster area.

PRIORITY AREA #3: **Pediatrics**

The needs of children during a terrorist incident are unique, and special attention is necessary to ensure that those needs are met proactively. Although pediatric issues touch on all priority areas, medication doses, decontamination procedures, equipment specifications and management strategies for biological and chemical agents differ for children.

Needs Assessment: Please provide an objective justification for the proposed plan for including pediatric hospitals, outpatient facilities, pediatric emergency medical services and poison control centers in a statewide response plan for biological, chemical, radiological and explosive terrorism, based on the needs assessment completed using FY 2002 funds and any updates to that assessment. For new grantees, please provide needs information from other assessments that may have been done previously, or from a new assessment developed in response to this guidance.

FY 2003 Implementation Plan: Please describe the plan for expansion of activities in this priority area, based on the needs assessment. The application must include a time line for implementation of a plan for addressing pediatric issues in the grantee jurisdiction, that covers scenarios dealing with large-scale epidemics, chemical or radiological contamination incidents, and mass trauma casualties.

- Address the special needs of children and pregnant women in ensuring access to medically appropriate care during a terrorist incident.

- Address the needs of children during disasters requiring sheltering in place or mass evacuations with or without family members.

- Develop procedures for rendering needed medical treatment without parental permission during a mass disaster.

- Develop a plan for managing parents who are separated from their children.

- Describe the role of schools in a terrorism incident; as potential targets, as facilities for emergency shelter or isolation, and as resources for clinicians such as school nurses who may be assigned there.

PRIORITY AREA #4: **Medications and Vaccines**

There must be contingency plans for antibiotic and vaccine treatment of biological exposures, and antidote and prophylactic treatment for chemical and radiological exposures. These must include a practical action plan for tapping into Federal resources such as the CDC National Pharmaceutical Stockpile.

Recognizing that a Federal response is secondary to a local jurisdiction's ability to respond to a disaster, plans should be articulated for stockpiling of medications at the State or local level for an immediate response. Consistent with concerns that have been expressed about potential overuse of medical treatments for biological or chemical exposures, stockpiling and treatment protocols must be consistent with generally accepted clinical recommendations, such as those promulgated by CDC and relevant professional organizations.

Needs Assessment: Please provide an objective justification for the proposed medication and vaccine stockpiling and distribution plan, based on the needs assessment completed using FY 2002 funds and any updates to that assessment. For new grantees, please provide needs information from other assessments that may have been done previously, or from a new assessment developed in response to this guidance.

Year 1 Progress Report: For grantees receiving funds in FY 2002, please provide a detailed progress report showing how the previously approved plan for FY 2002 First Priority Planning Area #1 (Medications and Vaccines) has been implemented. This will serve as a logical basis for requesting FY 2003 funding to continue or expand efforts in this priority area.

- The work plan must describe the State health department readiness plan for immediate receipt and distribution of antibiotics and smallpox vaccines made available from Federal sources.

- The work plan must describe arrangements for tapping into other resources for antibiotic and vaccine treatment of biological exposures, such as pharmaceutical caches of metropolitan medical response systems funded by the Office of Emergency Preparedness, or other public and private sources.

- The work plan must justify the composition of planned State and local antibiotic and vaccine stockpiles on the basis of generally accepted clinical recommendations, if planned State and local antibiotic and vaccine stockpiles exist.

FY 2003 Implementation Plan: Please describe the plan for expansion of activities in this priority area, based on the needs assessment and year 1 accomplishments. The application must include a timeline that describes the approach to development and implementation of a medication and vaccine stockpile and distribution plan for large-scale epidemics and chemical or radiological contamination incidents.

Critical Benchmark #4-1: *Before any plan for the local stockpiling of medications and vaccines using HRSA funds may be considered, the grantee must demonstrate that there is a CDC-funded National Pharmaceutical Stockpile (NPS) plan in place, with a CDC NPS evaluation score of at least Amber-plus.* **(up to 5 pages)**

- Describe the health department readiness plan for immediate receipt and distribution of medications and vaccines made available from the National Pharmaceutical Stockpile. This plan must operate 24 hours a day, 7 days a week.

- As an appendix to this application, please provide a copy of the CDC NPS evaluation.

- Ensure that all emergency responders and their families will be treated from the local medication and vaccine cache within 12 hours or until the NPS is received.

- Arrange to tap into other resources for medications and vaccines, such as the caches of Metropolitan Medical Response Systems or other public or private sources.

- Justify the composition of planned local medication and vaccine stockpiles, on the basis of generally accepted clinical recommendations. The medications in the local cache should match those of the NPS and MMRS stockpiles.

- Consider establishing a pharmacy and therapeutics committee to plan local pharmaceutical stockpiles. This committee should report to both the HRSA and CDC Advisory Committees. Membership may include the grantee's NPS coordinator, local pharmacists, and representatives from MMRS programs with pharmaceutical stockpiles, the state Board of Pharmacy, a pharmacy school, and chain pharmacy operations.

- Consider using a vendor managed inventory and the FDA shelf life extension program to replenish outdated or short-dated medications.

- Provide patient information materials at the time of vaccine administration or medication dispensing.

- Consider using pre-printed labels for dispensing medications from the caches.

- Track the use of medications dispensed from the local caches. This system should allow redundancy in case the primary tracking system is compromised.

***Critical Benchmark #4-2**:* *To justify the use of HRSA funds in implementing a local cache of medications, develop a plan for distribution of antibiotics and chemical agent antidotes to local and regional areas. Distribution must be to the entire population within 4 days, and to all pre-identified emergency response personnel in hospitals, clinics and emergency medical services systems, and their families, within 12 hours.* **(up to 5 pages)**

- Describe the storage sites for antibiotics, antidotes, and potassium iodide that meet specifications for environmental acceptability (moisture-free with a temperature range controlled to remain between 58☜F and 86☜F).

- Identify all emergency personnel and their family members who may be eligible for prophylaxis within 12 hours of a terrorist event.

- Maintain an active contact list of these persons, updating it not less frequently than once each calendar quarter.

- Access alternative sources to ensure that sufficient supplies of medications are on hand in a terrorist emergency. Please consider the following issues and options in developing this plan.
  1) Outright purchase of medications and vaccines by the grantee using HRSA funds is not recommended, because of expiration issues. However, the grantee may develop Memoranda of Understanding (MOU) or Agreement (MOA) with local pharmacies to reimburse them for medications supplied in an emergency.
  2) Access the pharmaceutical caches of metropolitan medical response systems (MMRS) funded by the Office of Emergency Response (OER).
  3) Consider increasing the par level of necessary medications in hospitals and health centers receiving federal or state funds, to mitigate the problem of outdated medications by rotating them through the system to insure product freshness.
  4) Consider entering into partnerships with local independent and chain pharmacies that are able to stock more than the usual par level of required medications for daily needs.

5) Describe any agreements with pharmaceutical wholesalers that can deal effectively with filling orders from their client pharmacies in a terrorist emergency, by arranging to have sufficient stocks on hand to meet emergency needs.
6) Consult with CDC regarding participation in the ChemPack program, which allows grantees to establish stocks of medications to be used in strategic locations in the event of a chemical attack.
7) Describe agreements with drug wholesalers that offer a Vendor Managed Inventory (VMI) arrangement to ensure that medications are in date.

PRIORITY AREA #5: **Hospital Laboratories**

This section is to ensure and enhance regional hospital laboratory capacity throughout the U.S. to diagnose and report on biological and chemical agents used by terrorists. The intent is look at hospital laboratories as they coordinate with those of public health departments, in order to ensure optimal capacity to respond to terrorism, infectious disease outbreaks, and other public health emergencies.

Needs Assessment: Please provide an objective justification for the proposed hospital laboratory upgrades, based on the needs information from assessments that may have been done previously, or from a new assessment developed in response to this guidance.

- Please describe briefly the existing capacity of the hospital laboratories in the grantee jurisdiction.

- Provide an assessment of whether this hospital laboratory capacity is adequate to respond to terrorism incidents or related public health emergencies.

FY 2003 Implementation Plan: Please describe the plan for activities in this priority area, based on the needs assessment. The application must include a timeline for the development and implementation of hospital laboratory upgrades for large-scale epidemics and chemical or radiological contamination incidents.

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

- Based on the needs assessment, improve deficiencies during this budget period, including a timeline to guide implementation, measurable milestones to facilitate accountability, and a proposed budget.

- Describe the plan for upgrading hospital laboratories or their equipment, in order to be able to screen or test biological, chemical or radiological terrorist agents.

- Describe the plan for recruiting and training hospital laboratory personnel capable of testing biological, chemical and radiological terrorist agents.

- Ensure that communication and educational efforts are functioning smoothly and efficaciously between regional hospital laboratories, Level A (clinical) laboratories, Level B and C Laboratory Response Network facilities, and state laboratory associations in the following areas:
  (b) performing rule-out testing on critical biological, chemical and radiological agents;
  (c) educating personnel in hospital laboratories to safely package and handle specimens; and
  (d) referring when necessary to higher level laboratories for further testing.

- Develop an integrated regional response plan that directs how the hospital laboratories will respond to a terrorism incident to include:
  (a) roles and responsibilities;
  (a) inter- and intra-jurisdictional laboratory surge capacity;
  (b) integration of the laboratory plan with other statewide emergency response efforts;
  (c) protocols for safe transport of specimens by air and ground; and
  (d) reporting of lab results and sharing with local public health and law enforcement agencies.

- Describe the information technology plan for coordinating communications between hospital and public health laboratories to ensure a seamless screening, testing and reporting hierarchy, including BSL-4 federal laboratory facilities at CDC and USAMRIID.

- Support electronic reporting of laboratory results to hospitals and clinicians that ensures rapid access to critical diagnostic information. Discuss coordination with the state health department laboratories.

- Describe the plan to educate laboratorians about forensic handling of biological and chemical specimens that might constitute criminal evidence.

- Establish operational relationships with local members of hazardous materials teams, first responders, and the FBI to provide hospital laboratory support for their response to terrorism, including environmental testing and chain-of-custody procedures. Establish designated points of contact, cross-training in each discipline, and joint sponsorship of conferences.

- Enhance relationships between hospital laboratories and community laboratory practitioners, university laboratories, and infectious disease physicians through participation in grand rounds and conferences.

- Where deemed appropriate by grantees who share common borders, please describe joint efforts to fund and implement a multi-state plan for regional hospital laboratories capable of assisting in a biological, chemical or radiological terrorism response.

- Conduct at least one simulation exercise per year in conjunction with the state laboratory that specifically tests hospital laboratory readiness and capability to detect and identify at least one bioterrorist threat agent.

PRIORITY AREA #6: **Health Care System Surveillance and Epidemiology**

It is critical for hospitals, laboratories, clinics and EMS systems to be able to participate in a highly functional rapid detection system for disease syndromes or toxidromes that suggest a terrorist origin, that ties in to the local and State health department.

The purpose of this priority area is to continue at the hospital, outpatient and prehospital domains what is being accomplished through the CDC terrorism cooperative agreement at the health department level. Thus, all efforts in this area must be done in coordination with efforts in CDC focus area B (See CDC Appendix 6, IT Functions #1-6.)

The needs assessment should describe existing local and State epidemiologic surveillance capabilities in place in hospitals, clinics and emergency medical services systems, and the ability of the statewide surveillance system to respond rapidly to identification of a syndrome that is suggestive of terrorist involvement.

Proposals under the HRSA cooperative agreement to enhance health system surveillance abilities must be clearly distinguished from similar proposals that respond to the CDC guidance addressing health department surveillance.

Needs Assessment: Please provide an objective justification for the proposed statewide surveillance plan, based on the needs assessments that may have been done previously, or from a new assessment developed in response to this guidance.

- In support of the effort to improve health care system epidemiological capacity for terrorist-related conditions, evaluate and improve the timely and complete reporting of key categories of reportable diseases, such as influenza, vaccine preventable diseases, vector-, food- and water-borne diseases, and dermatological conditions that mimic smallpox.

FY 2003 Implementation Plan: Please describe the plan for activities in this priority area, based on the needs assessment. The application must include a time line for implementation of an interoperable statewide surveillance plan for large-scale epidemics and chemical or radiological contamination incidents.

<u>Critical Benchmark #6-1</u>: *Develop a health care system syndromic surveillance program that can input and receive feedback from urgent disease reports from health care facilities on a 24-hour-per-day, 7-day-per-week basis.*

- Monitor all emergency department and outpatient visits, complaints, and diagnosis from a surveillance and detection perspective, and describe how this will be integrated with the State health department surveillance system.

- Describe the legal authority in the grantee jurisdiction to require, receive and transmit hospital, outpatient and EMS-based patient reports on suspect cases or unusual illness clusters.

- Assess quarterly the timeliness and completeness of the reportable disease surveillance system, especially for naturally occurring illnesses that mimic those resulting from a terrorist action.

- Provide ongoing disease surveillance and epidemiology training in terrorist-related subjects for public health, clinical, and other health care professionals. (Link with CDC Focus Area G.)

- In coordination with local public health agencies, use the NEDSS system to develop or enhance electronic surveillance applications. (Link with CDC Focus Area E.)

- Acquire and disseminate information and fact sheets about terrorism and other public health emergencies, including information for public use in response to a terrorist incident.

- Identify clinicians with key terrorism-related skills, such as those who have seen and treated smallpox or other infectious or tropical diseases, toxic exposures and radiation illnesses and their sequelae.

- Describe collaborative efforts for enhancing surveillance capacity, such as multi-disciplinary conference participation, developing and evaluating surveillance activities, or engaging in NEDSS-related activities for development of electronic systems for emergency department reporting. (See CDC Appendix 6, IT Functions #1-2.)

PRIORITY AREA #7: Chemical and Radiological Preparedness

There should be contingency plans for chemical and radiological terrorism preparedness, after biological terrorism preparedness is fully addressed as required under the authorizing legislation.

Needs Assessment: Please provide an objective justification for the proposed chemical and radiological preparedness plan, based on needs information from

assessments that may have been done previously, or from a new assessment developed in response to this guidance. For this Priority Planning Area, the needs assessment must provide a brief description of the existing capacity in the grantee jurisdiction, and an assessment of whether this capacity is adequate.

FY 2003 Implementation Plan: Please describe the plan for activities based on the needs assessment. The application must include a timeline for the development and implementation of a chemical and radiological preparedness plan, measurable milestones to facilitate accountability, a narrative to how this priority area will be coordinated with the appropriate CDC focus area to prevent overlap.

- Describe the existing chemical and radiological response equipment in the grantee jurisdiction.

- Describe the degree of interoperability of personal protective equipment (levels A-D), decontamination assets, and radiological and chemical detection equipment.

- Propose a training plan for all hospital and emergency medical service based personnel who may respond to or treat patients that have been chemically or radiological contaminated. This must be done in conjunction with any ongoing training efforts in the jurisdiction from CDC Focus Area G.

PRIORITY AREA #8: **Personal Protection and Decontamination**

It is important to plan for personal protective equipment to protect health care workers and patients during a biological, chemical or radiological threat, as well as to provide for portable or fixed decontamination systems. Capital improvements for decontamination and treatment of chemical and radiological casualties may also be needed.

Needs Assessment: Please provide an objective justification for the proposed personal protection and decontamination plan, based on the needs assessment completed using FY 2002 funds and any updates to that assessment. For new grantees, please provide needs information from other assessments that may have been done previously, or from a new assessment developed in response to this guidance.

- Assess the availability of existing personal protective and decontamination equipment in the grantee jurisdiction; and determine what unmet needs exist in order to adequately protect emergency medical responders in a terrorist incident.

Year 1 Progress Report: For grantees receiving funds in FY 2002, please provide a detailed progress report showing how the previously approved plan for FY 2002 First Priority Planning Area #2 (Personal Protection, Quarantine and Decontamination) has been implemented. This will serve as a logical basis for requesting FY 2003 funding to continue or expand efforts in this priority area.

- The work plan must describe how responding clinicians and their families will be protected from exposures to biochemical casualties and environments (such as provision of personal protective equipment, antibiotics and vaccines).

- The work plan must describe how existing decontamination systems will be upgraded to allow for large numbers of patients exposed to particulate infectious material from an airborne or environmental release (such as fixed hospital units, portable units, or DMATs capable of mobile decontamination).

- The work plan must describe which hospitals in the State (such as the dedicated referral hospital for CDC's Division of Global Migration and Quarantine) will be targeted for capital improvements (such as air-filtered quarantine units or biological decontamination facilities) to assure safe and effective isolation and decontamination of large numbers of patients with communicable bioterrorist diseases.

- The work plan must provide an accurate number of hospitals in the State, Territory or Municipality that currently have an isolation room (s) capable of protecting responding clinicians against communicable bioterrorist diseases.

- The work plan must provide an accurate number of isolation rooms currently in the State, Territory or Municipality?

- The work plan must describe how additional needed decontamination equipment will be deployed to maximize statewide benefit and cost-effectiveness. This may include plans for mobile caches of supplies that could be deployed to areas with an acute need.

FY 2003 Implementation Plan: Please describe the plan for expansion of activities in this priority area, based on the needs assessment and year 1 accomplishments. The application must include a time line for implementation of a statewide plan to ensure adequate protection of health care workers and decontamination of exposed casualties.

- Link hospital and prehospital emergency medical responders to local hazardous materials (HAZMAT) teams, local offices of emergency management, and fire and police departments to ensure a coordinated response to a terrorist incident.

- Ensure interoperability for personal protective equipment on a statewide basis.

- Educate health care providers on the proper use of personal protective equipment. Update and drill on this training periodically.

- Upgrade existing decontamination systems to allow for large numbers of patients exposed to particulate infectious material from an airborne or environmental release (such as fixed hospital units, portable units, or DMATs capable of mobile decontamination).

- Describe which hospitals in the State will be targeted for capital improvements for decontamination facilities, to assure safe and effective decontamination of large numbers of patients with particulate biological, chemical or radiological exposures.

- Deploy additional needed mobile decontamination facilities and mobile supply caches to maximize statewide benefit and cost-effectiveness.

Priority Area #9: **Emergency Medical Services**

Emergency medical services (EMS) systems are critical partners in a comprehensive terrorism preparedness plan, especially in a chemical agent release or mass trauma scenario where they will be the first medical personnel to respond. In the FY 2002 Bioterrorism Hospital Preparedness Program, EMS systems were eligible recipients of funding, but were overshadowed by hospital needs given the limited funding and comprehensive requirements of a bioterrorism response plan. During the FY 2003 appropriations process, Congress specifically encouraged HRSA to consider a statewide assessment of emergency medical preparedness needs in the event of a public health emergency, as well as a plan to address those needs as part of the State application for hospital preparedness funds.

Needs Assessment: Please provide an objective justification for the proposed emergency medical services terrorism preparedness plan, based on needs information from assessments that may have been done previously, or from a new assessment developed in response to this guidance. For this Priority Area, the needs assessment must provide a brief description of the existing capacity in the grantee jurisdiction, and an assessment of whether this capacity is adequate. Please address the following areas:

1) personnel
2) training
3) communications
4) equipment
5) protocols
6) medical direction
7) mutual aid

FY 2003 Implementation Plan: Please describe the plan for activities based on the needs assessment. The application must include a timeline for the development and

implementation of an emergency medical services preparedness plan and measurable milestones to facilitate accountability. Especially for children, this plan should build upon programs funded through the HRSA EMS for Children Program, but must not supplant initiatives available under that program.

Critical Benchmark #9-1: *If the medical director for this program is not the state emergency medical services medical director, provide up to one full time equivalent (FTE) position for the State EMS medical director. Physicians with board certification in emergency medicine, and training and experience in disaster medicine would be desirable for this position.*

Describe the duties of the State EMS Medical Director in terms of providing expert leadership to the EMS terrorism preparedness effort.

- Justify the percentage of support for this position against assigned responsibilities for Statewide EMS terrorism response leadership.
- Identify the person holding the position of State EMS Medical Director. As an appendix to this application, include a curriculum vitae that describes the education, training and experience that qualify this person for the position.

Critical Benchmark #9-2: *Develop a mutual aid plan for deploying EMS units in jurisdictions they don't normally cover, in response to a mass casualty incident due to terrorism. Resources may include, but are not limited to, metropolitan medical response systems or disaster medical assistance teams.*

- Describe how paramedics and other emergency medical technicians will be deployed at the local level to implement an effective prehospital terrorism response plan.
- Describe how additional EMS support staff, including drivers, dispatchers and others, will be deployed at the local level to implement an effective prehospital terrorism response plan.
- Present a regional plan for upgrading EMS equipment to accommodate mass casualty prehospital response capability in the State.

Priority Area #10: Trauma and Burn Center Capacity

Injury due to explosive devices has been, to date, the most common outcome of terrorist attacks both globally and domestically, and is likely to continue to be so in the future. Our nation must be prepared optimally for this eventuality. One of the best ways to prepare for this is to support organized systems of trauma care.

The authorizing legislation provides for development and implementation of the trauma and burn center care components of the State plans for the provision of emergency medical services in the event of a terrorist incident. There should be contingency plans

for terrorism preparedness involving mass trauma or burn casualties, after biological terrorism preparedness is fully addressed as required under the same law.

Needs Assessment: Please provide an objective justification for the proposed trauma and burn preparedness plan, based on needs information from assessments that may have been done previously, or from a new assessment developed in response to this guidance. For this Priority Area, the needs assessment must provide a brief description of the existing capacity in the grantee jurisdiction, and an assessment of whether this capacity is adequate.

- Briefly summarize the findings in your State of the 2003 HRSA Trauma-EMS program's trauma system assessment, as they apply to mass explosive emergencies due to terrorism.

FY 2003 Implementation Plan: Please describe the plan for activities based on the needs assessment. The application must include a timeline for the development and implementation of a trauma and burn preparedness plan and measurable milestones to facilitate accountability. This plan should build upon programs funded through the HRSA Trauma-EMS Program, but must not supplant initiatives available under that program.

- Describe how general surgeons, trauma surgeons, neurosurgeons, orthopedic surgeons, other surgical specialists and anesthesiologists will be deployed at the local level to implement an effective surgical and burn unit terrorism response plan.

- Describe how additional surgical staff, including nurses and ancillary health care personnel, will be deployed at the local level to implement an effective surgical and burn unit terrorism response plan. Resources may include, but are not limited to, metropolitan medical response systems or disaster medical assistance teams.

- Present a plan for using mobile surgical response teams in a terrorist incident.

- Present a regional plan for upgrading equipment or facilities to accommodate mass surgical and burn casualties in the State.

PRIORITY AREA #11: **Mental Health**

Most survivors of terrorism experience a variety of stress reactions. However, as many as one in three survivors develop critical symptoms, which if not addressed can lead to chronic post-traumatic stress syndrome, anxiety and depression. The most important factor in resiliency is appropriate interpersonal support.

Needs Assessment: Please provide a plan for addressing mental health needs as part of a statewide response plan for biological, chemical, radiological and explosive terrorism, based on the needs assessment completed using FY 2002 funds and any updates to that assessment. For new grantees, please provide needs information from other assessments that may have been done previously, or from a new assessment developed in response to this guidance.

- Assess the adequacy of current hospital and outpatient mental health resources for survivors of terrorism. Identified opportunities for improvement should serve as the basis for timelined plans that will address the issues listed below.

- Assess the hospital and outpatient facility post-event mental health capacity for capacity to respond to large numbers of people experiencing mental health complications of a terrorist event, such as grief, depression, anxiety, adjustment disorders, post-traumatic stress disorder (PTSD), organic mental disorders secondary to head trauma or toxic exposures, family violence and substance abuse.

FY 2003 Implementation Plan: Please describe the plan for expansion of activities in this priority area, based on the needs assessment. The application must include a time line for addressing mental health issues that follow from large-scale epidemics, chemical or radiological contamination incidents, and mass trauma casualties.

- Provide education to the general public and the staff of hospitals and outpatient facilities, to minimize ongoing psychological damage in the event of a future terrorist incident.

- Present a plan for how large numbers of victims of a terrorist attack will receive adequate mental health services, long-term treatment planning and follow-up care. These victims include those directly affected by an attack, those at risk, those described as “worried well” and their families.

- Describe how medical first responders and hospital and outpatient staff will receive adequate mental health services.

- Implement training programs to ensure that all personnel have the appropriate training to treat adults and children with mental health complications of an emotional, cognitive, physical or interpersonal nature.

- Ensure that victims will receive adequate follow-up mental health services, who are experiencing serious short and long term reactions such as dissociation, blackouts, intrusive re-experiencing (terrifying memories, nightmares, or flashbacks), extreme attempts to avoid disturbing memories (e.g., through substance abuse and/or self-mutilation), and intense emotional numbing.

- Define which hospitals or outpatient centers will provide mental health services to assure that the psychological needs of the community are addressed after a terrorist incident.

- Describe how existing mental health professionals (e.g., CISD-trained personnel, clinical social workers, psychologists, psychiatrists, psychiatric nurses and other mental health professionals) will be utilized after a terrorist attack.

- Consider creating a data bank that lists eligible or certified mental health professionals who can provide on-site and long term followup mental health services.

PRIORITY AREA #12: **Communications and Information Technology**

The needs assessment should address local and State communications capabilities available to hospitals, clinics and EMS systems, and the ability of the statewide communication system to respond to overloading of standard telephone, cellular phone and radio communications during a terrorist incident.

Funding proposals for information technology must be consistent with the approach and technical specifications contained in the CDC guidance on the Public Health Preparedness Program (Information Technology Functions and Specifications Appendix, CDC focus area E).

Proposals under the HRSA cooperative agreement to enhance hospital preparedness communication abilities must be clearly distinguished from similar proposals that respond to the CDC guidance addressing health department preparedness.

Needs Assessment: Please provide an objective justification for the proposed statewide communication plan, based on the needs assessment completed using FY 2002 funds and any updates to that assessment. For new grantees, please provide needs information from other assessments that may have been done previously, or from a new assessment developed in response to this guidance.

- Assess the capacity in the grantee jurisdiction for redundant communication devices (such as two-way radios, cell phones, voice mail boxes, satellite phones, or wireless messaging).

- Assess the capacity of existing systems at the state and local level to broadcast or auto-dial automatically distributed alerts and messages to these devices.

- Assess the capacity to link the emergency communication systems of local emergency response partners.

- Assess policies and procedures for protecting and granting access to systems for the management of secure information and to system backups.

- Assess the capacity in the grantee jurisdiction to exchange electronic data in compliance with hospital information and data exchange standards referenced in the NEDSS initiative. (See CDC Appendix 6, IT Functions #1-9.)

- Assess the existing capacity to fully provide information technology support according to industry standard practices for user support and ongoing monitoring and maintenance.

Year 1 Progress Report: For grantees receiving funds in FY 2002, please provide a detailed progress report showing how the previously approved plan for FY 2002 First Priority Planning Area #3 (Communications) has been implemented. This will serve as a logical basis for requesting FY 2003 funding to continue or expand efforts in this priority area.

- The work plan must describe how the State bioterrorism hospital preparedness program will be activated during an acute incident, or one involving an epidemic developing over a longer time period.

- The work plan must address gaps in the communications systems among hospital emergency departments, outpatient facilities, EMS systems and State and local emergency management, public health and law enforcement agencies, as they relate to bioterrorism response.

- The work plan must describe how communication systems will be made redundant to ensure communication backup in the event of failure or excess load on land line and cellular telephone systems and Internet communications.

- The work plan must describe how bed status across the State will be tracked, and how this information will be updated continuously.

- The work plan must describe how all emergency department and outpatient visits, complaints, and diagnosis from a surveillance and detection perspective will be monitored, and how this information will be integrated on the State and national level.

- The work plan must describe how the general public will be educated as to where and when to present to the hospital or to activate EMS.

- The work plan must describe the public relations plan for dealing with large numbers of patients, worried well, family and friends, and media.

FY 2003 Implementation Plan: Please describe the plan for expansion of activities based on the needs assessment and year 1 accomplishments. The application must include a time line for implementation of an interoperable statewide communications plan for large-scale epidemics, chemical or radiological contamination incidents, and mass trauma casualties.

Critical Bench Mark #12-1: *Prepare a plan to ensure communications connectivity between health care organizations and health departments on the state and local level. This plan must include: a) Internet connectivity; b) routine use of electronic mail for notification of alerts and other critical communications; and c) radio backup for land-lineand cellular phone systems that may be compromised during a terrorist incident.*

- Prepare a timeline for the development of a regional hospital based communications system that works in conjunction with the Health Alert Network (CDC focus area E), to provide a flow of critical health information among emergency departments and state and local health officials.

- Describe the communications infrastructure that will allow the grantee terrorism preparedness program to be activated during an acute incident, or one involving an epidemic developing over a longer time period.

- Address gaps in the communications systems among emergency departments, hospitals, trauma and burn centers, outpatient facilities, EMS systems, State and local emergency management, public health and law enforcement agencies, and poison control centers as they relate to terrorism response.

- Describe how communication systems will be made interoperable, to facilitate the most direct communication possible among different state or local agencies responding to a terrorist attack.

- Implement electronic tracking of bed status across the jurisdiction with a central device or system, and describe how this information will be updated continuously to maintain currency.

- Present a plan for how the general public will be educated as to where and when to present to the hospital or to activate EMS during a terrorist incident.

- Describe the public relations plan for dealing with large numbers of patients, worried well, family and friends, and media.

- Consider establishing or enhancing a Web site for health care organizations that contains current relevant hospital and public health information, including health alerts, advisories, and updates. (See CDC Appendix 6, IT Functions #8-9.)

Critical Benchmark #12-2: *Present a plan that ensures redundancy in emergency communication among health care system and public health department emergency responders.*

- Develop redundant communication systems to ensure backup in the event of failure or excess load on land lines, cellular telephone systems or Internet communications. Other options could include two-way radios, pagers, voice mail boxes, satellite phones, wireless messaging, broadcasting or auto-dialing automatically distributed alerts and messages.

- Assess quarterly the timeliness and completeness of the redundant alert methods in support of the ability to reach responders during a public health emergency. (See CDC Appendix 6, IT function #9.)

Critical Benchmark #12-3: *Ensure the ongoing protection of critical data, information systems and capabilities for continuity of operations. (CDC Appendix 6, IT Function #8.)*

- Perform regular independent validation and verification of Internet security, vulnerability assessment, continuity of operations practices, and describe how recommended remedial actions will be implemented rapidly.

- Ensure security of electronically exchanged clinical, laboratory, environmental and other public health information between the computer systems of public health and health care system partners. Such data would include case reports, possible contacts, specimen information, environmental sample information, lab results and threat information. (See CDC Appendix 6, IT Functions #1-9).

- Confirm quarterly the successful transmission and receipt of information to and from health system and public health partners.

- Consider establishing a firewall for the protection of critical information resources from the Internet.

- Consider implementing Public Key Encryption (PKE) or equivalent methods of strong authentication for remote access from the Internet.

- Consider instituting server- and client-based virus checking software to protect critical systems.

- Consider participation in data modeling activities and joint grant application development sessions to specify the data types that will be exchanged among public health partners.

PRIORITY AREA #13: **Education and Training**

Education and training of hospital, outpatient and pre-hospital clinicians at all levels will be encouraged. This training may focus on recognition of bioterrorism-related diseases, toxidromes of major chemical terrorist agents, decontamination and isolation procedures, triage, stabilization and transport of mass casualties, treatment under standing orders for advanced or paramedic-level EMS systems, diagnosis, treatment and stabilization at hospitals and outpatient facilities, and definitive care at centers of excellence in infectious disease, toxicology, radiation medicine, trauma and burns.

Needs Assessment: Please provide an objective justification for the proposed statewide education and training plan for biological, chemical, radiological and explosive terrorism, based on the needs assessment completed using FY 2002 funds and any updates to that assessment. For new grantees, please provide needs information from other assessments that may have been done previously, or from a new assessment developed in response to this guidance.

Assess the need for training in recognition of rare diseases with bioterrorism potential, toxidromes of chemical warfare agents, immediate and delayed manifestations of radiation illness, and assessment and management of mass trauma casualties.

- Assess the need for diagnostic and treatment protocols addressing bioterrorist infectious diseases or chemical toxidromes with early nonspecific syndromes, and for mechanisms to bring clinicians up to speed on these protocols before and during a terrorism incident

Year 1 Progress Report: For grantees receiving funds in FY 2002, please provide a detailed progress report showing how the previously approved plan for FY 2002 Second Priority Planning Area #1 (Training) has been implemented. This will serve as a logical basis for requesting FY 2003 funding to continue or expand efforts in this priority area.

- The work plan must describe how hospital and EMS clinicians will be trained and educated to respond to a bioterrorism event, including components for managing fears about personal exposure to biological agents

- The work plan must describe existing State or national training resources that will be utilized in developing the State's bioterrorism training program.

- The work plan must describe how diagnostic and treatment protocols for bioterrorist infectious diseases and toxins with early nonspecific

syndromes, to be used in emergency departments, outpatient and inpatient facilities and intensive care units, and the prehospital environment will be developed or updated.

- The work plan must describe how special issues affecting children, pregnant women, the elderly and those with disabilities will be addressed in these protocols.

- The work plan must describe how immediate information needs experienced by clinicians caring for patients or serving as EMS medical control officers will be addressed during a bioterrorist incident (such as web-based diagnostic and treatment protocols or telephone consultation).

- The work plan must describe the plan for enhancing the ability of poison control centers serving the State to respond immediately to requests for information from clinicians and the general public following a bioterrorist incident.

- The work plan must describe ensuring continuing professional education credentialing of in-services or conferences on bioterrorism?

- The work plan must describe statewide bioterrorism education and certification programs for clinicians, or a plan for linking the State's efforts into similar available national programs, including those of the military.

FY 2003 Implementation Plan: Please describe the plan for expansion of activities in this priority area, based on the needs assessment and year 1 accomplishments. The application must include a time-line for development of a schedule of education and training in the grantee jurisdiction, that covers scenarios dealing with large-scale epidemics, chemical or radiological contamination incidents, and mass trauma casualties.

- Implement a plan for training and educating hospital, outpatient and EMS clinicians to respond to a terrorism event, including components for managing fears about personal exposure to biological, chemical or radiological agents.

- Develop a coordinated approach to using State or national training resources for developing the grantee's terrorism preparedness training program, especially CDC education and training funds for public health preparedness, HRSA Curriculum Development and Training funds, and opportunities made available by the Department of Health and Human Services from time to time.

- Into local or State protocols, incorporate national standards for diagnosis and treatment of bioterrorist infectious diseases and biological, chemical and radiological toxins with early nonspecific syndromes or delayed manifestations, to be used in the prehospital environment, emergency departments, outpatient and inpatient facilities, and intensive care units. Priority should be given to the following:[1]
  1. Viruses: smallpox, hemorrhagic fevers and equine encephalitides
  2. *Bacteria:* anthrax, plague, brucellosis, Q fever and tularemia
  3. *Toxins:* ricin, botulinum, staphylococcal enterotoxin-B and T-2 mycotoxin
  4. *Nerve agents*: organophosphates, sarin, tabun, soman, VX
  5. *Respiratory agents:* cyanide
  6. *Radiation illness*: acute manifestations, delayed complications

- Include in standard protocols the special issues affecting children, pregnant women, the elderly and those with disabilities.

- Describe how immediate information needs of clinicians caring for patients, serving as EMS medical control officers, or staffing poison control centers will be addressed during a terrorist incident (such as web-based diagnostic and treatment protocols or telephone consultation).

- Develop training opportunities for all categories of clinicians, in concert with academic institutions, to become familiar with the treatment of biological, chemical, radiological and explosive casualties. This may be profession-specific, or designed for cross-training between disciplines. Training development should provide for awarding continuing education credit.

- Enhance the ability of poison control centers serving the State to respond immediately to requests for information from clinicians and the general public following a terrorist incident.

- Ensure continuing professional education credentialing of training efforts on terrorism preparedness.

- Develop a plan for a Statewide bioterrorism education and certification program for clinicians, or a plan for linking the State's efforts into similar available national programs.

- Use the resources of the Noble Training Center or USAMRIID in training grantee staff and practicing clinicians.

PRIORITY AREA #14: Biological, Chemical and Radiological Disaster Drills

Many grantees have staged a variety of community disaster drills focusing on biological and other terrorist threats over the last year. It is critical that practical exercises

continue that both reinforce knowledge and uncover opportunities for improvement in the written terrorism disaster plan.

Needs Assessment: Please provide an objective justification for the proposed statewide disaster drill plan for biological, chemical, radiological and explosive terrorism scenarios, based on the needs assessment completed using FY 2002 funds and any updates to that assessment. For new grantees, please provide needs information from other assessments that may have been done previously, or from a new assessment developed in response to this guidance.

Year 1 Progress Report: For grantees receiving funds in FY 2002, please provide a detailed progress report showing how the previously approved plan for FY 2002 First Priority Planning Area #4 (Biological Disaster Drills) has been implemented. This will serve as a logical basis for requesting FY 2003 funding to continue or expand efforts in this priority area.

- For grantees who have had to mobilize their response systems to respond to an actual terrorist threat during the first year of funding, please include a discussion of lessons learned from this event that will impact on the plan for FY 2003.

- The work plan must describe testing State and local bioterrorism response plans and training efforts will be reinforced as a result of the testing.

- The work plan must provide an accurate number of bioterrorism response drills the State has had to date.

- The work plan must provide the dates of those drills.

- The work plan must provide an accurate number of the bioterrorism response drills the State has planned, or is planning for the upcoming fiscal year.

- The work plan must provide the dates of these upcoming drills.

- The work plan must describe how biological disaster drills will be of sufficient intensity to impact the community's normal operations during the exercise, in a way similar to what would be expected during an actual biological terrorist incident.

- The work plan must describe the process for incorporating lessons learned from the drills into periodic revisions of the bioterrorism response plan.

FY 2003 Implementation Plan: Please describe the plan for expansion of activities in this priority area, based on the needs assessment and year 1 accomplishments. The application must include a time line for developing a schedule of terrorism disaster drills

in the grantee jurisdiction, that covers scenarios of large-scale epidemics, chemical or radiological contamination incidents, and mass trauma and burn casualties.

- Describe how biological disaster drills will be of sufficient intensity to impact the community's normal operations during the exercise, in a way similar to what would be expected during an actual terrorist incident. Drills should include multiple regions and other grantee jurisdictions where conditions make this advisable and feasible.

- Exercise the deployment of the local pharmaceutical cache on a quarterly basis.

- Integrate JCAHO accreditation requirements into the grantee jurisdiction's disaster drill plan.

- Describe the process for incorporating lessons learned from the drills into periodic revisions of the bioterrorism response plan.

D. Budget:

Provide a line-item budget using the attached template. Include a narrative justification for each line item.

Indirect Costs: These are incurred for common objectives within an organization's budget, and therefore cannot be identified readily and specifically with a particular program. For example, the costs of operating and maintaining facilities, depreciation, and administrative salaries are generally treated as indirect costs.

For this cooperative agreement, indirect costs are budgeted at the state's prenegotiated rate, but at no more than 10% of the total award.

Grantee Operating Costs: Operating costs that can be specifically allocated to this program must be justified. Since this program exists primarily to support health care entities directly in preparing for terrorism, contract line items that provide support to the grantee through hospital associations and the like are treated as extensions of health department operating costs, not as direct health care entity support. Cost items may include:

- Terrorism Preparedness Coordinator: up to 1 full-time equivalent (FTE)
- Medical Director: up to 1 FTE
- Professional and administrative staff
- Travel expenses necessary to meet with collaborating entities
- Meeting expenses for either training or networking
- Administrative equipment and supplies
- Communications (phone, electronic mail, etc.)

For this cooperative agreement, operating costs may be budgeted at no more than 10% of direct costs.

Planning Costs: Costs attributable to planning and coordination for the State health department and its contractors must be justified. Examples of these costs include performance of needs assessments and development of plans, operational protocols, policies and procedures. Like operating costs, planning costs contracted to hospital associations or other contractors will be treated as health department costs, not as direct support to health care entities.

Up to 15% of direct costs may be allocated to planning efforts done by the health department and its contractors.

Implementation Costs: These are expenses provided directly to hospitals, outpatient facilities, emergency medical services and poison control centers for implementing the plans developed under the priority areas. Expenses borne by health departments and their contractors for direct support of regional systems of care may also be treated as implementation costs.

Examples of implementation expenses include purchase of medications, personal protective equipment, mobile decontamination facilities or communications equipment either directly by a health care entity or on behalf of it by the grantee or its contractors. Expenses of putting on a disaster drill may also be treated as implementation costs. Examples of non-implementation funds subject to the percentage limitations above include development of individual hospital or regional plans, or staffing and operating costs to support such planning or coordination efforts.

Provide an itemized budget and justification for the proposed distribution of funds to hospitals, outpatient facilities, EMS systems and poison control centers, or to implementation costs borne by health departments and their contractors in direct support of priority areas as described above.

At least 75% of the funds awarded for direct costs must be clearly allocated to hospitals, outpatient facilities, EMS systems or poison control centers through written contractual agreements or purchase orders.

Obligation of FY 2002 Funds: Because of the rapidity of the distribution of funds to grantees during FY 2002, many jurisdictions are still in the process of obligating funds for concrete implementation efforts. In order to justify distribution of FY 2003 funds, a line-item narrative describing how FY 2002 funds have been obligated to various priority areas must be presented. If FY 2002 funds are still unobligated, FY 2003 funds for similar priority areas will likely be awarded with a funding restriction attached. This restriction will be lifted when FY 2002 implementation efforts on specific priority areas are complete.

VII: Semiannual Reports

The objective measures called for in the needs assessments under each priority area will serve as the basis for semi-annual program reports. By using this method, data can be gathered that is consistent across grantees for national planning purposes.

On the grantee level, this data can serve as the basis for a continuous quality improvement plan, in which the initial needs assessment is continually updated and forms the basis for changes in the implementation plan. The quality of the semi-annual reports will have an impact on how rapidly funds are released for this and future iterations of this program.

VIII. Review Criteria

Applications will be reviewed based on the following criteria:

1. Extent to which plan relates to identified needs
2. Extent to which terrorism preparedness issues are addressed comprehensively
3. 3. Extent to which BT coordinator and medical director are objectively qualified
4. Extent to which requests for staffing, equipment and capital improvements relate to sustainable program goals
5. Extent to which objective are measurable and achievable
6. Extent to which all priority areas are addressed and prioritized
7. Extent to which program objectives can be accomplished within one year
8. Extent to which HRSA- and CDC-funded activities are coordinated in a way that leaves neither gaps nor overlaps in the work plan
9. Extent to which metropolitan medical response teams and disaster medical assistance teams are integrated into the plan
10. Extent to which the needs of both pediatric and adult age groups are addressed
11. Extent to which terrorism disaster drills feed back to revisions of the plan
12. Clarity of budget and associated narrative justification

IX. Application Submission

Applications must be submitted to both HRSA and DHHS in separate mailings or electronic transmissions by close of business on May 16, 2003. After a simultaneous dual review process at both the agency and departmental levels, funds will be awarded by August 31, 2003. Based on demonstrated ability to obligate FY 2002 funds by the FY 2003 application date, post-award funding restrictions may apply until the grantee is ready to spend the funds.

Applications must be addressed to both of the following addresses separately, either by mail or electronic transmission, to ensure efficient review at both levels and timely

award of funding. It is critical that this dual mailing be accomplished by the applicant, as HRSA will be unable to duplicate and forward grant applications to OASPHEP.

Health Resources and Services Administration, US DHHS
ATTN: Jackie Whitaker, Grants Management Specialist
Parklawn Building, Room 11-11
5600 Fishers Lane
Rockville, MD 20857
jwhitaker@hrsa.gov
(301) 443-1440

Office of the Assistant Secretary for Public Health Emergency Preparedness, US DHHS
ATTN: Lily Engstrom, Director, Office of State and Local Programs
Hubert H. Humphrey Building, Room 638-G
200 Independence Avenue, SW
Washington, DC 20201
lily.engstrom@hhs.gov
(202) 401-4862

X. National Bioterrorism Hospital Preparedness Program Contacts

Grantees are assigned project officers to work with in developing their terrorism response programs in accord with federal cooperative agreement requirements, and in obtaining appropriate technical assistance. The mailing address and fax number for all program staff is as follows. Individual e-mail and phone contacts follow.

Parklawn Building, Room 18A-38
5600 Fishers Lane, Rockville, MD 20857
(301) 443-1296 (Fax)

Richard Niska, MD, MPH, FACEP
Captain, US Public Health Service
Program Director
301-443-4996
Rniska@hrsa.gov

Andrea Argabrite, RN, MPH, MS-FNP
Commander, US Public Health Service
Deputy Program Director
301-443-5372
Aargabrite@hrsa.gov

Brad Austin, MPH

Commander, US Public Health Service
Senior Program Analyst
301-443-1860
baustin@hrsa.gov

Alexandr Kosyak, RPh
Commander, US Public Health Service
Senior Program Analyst
301-443-4566
akosyak@hrsa.gov

Wilmer Alvarez, BS
Program Analyst
(301) 443-1950
walvarez@hrsa.gov

Sumner Bossler, RN, CEN
Lieutenant, US Public Health Service
Program Analyst
301-443-1095
sbossler@hrsa.gov

X. References

1. United States Army Medical Research Institute of Infectious Diseases (USAMRIID). *Medical Management of Biowarfare Casualties.* February 2000.

1. *CDC Interim Smallpox Response Plan and Guidelines,* Draft 2.0, 21 November 2001. http://www.bt.cdc.gov/agent/smallpox/smallpox.asp

Table of Contents – Glossary of Terms – Separate chapters for different areas – Org chart of BHPP and DHHS