BIOTERRORISM HOSPITAL PREPAREDNESS PROGRAM

Summary: In order to improve the capacity of the Nation's hospitals, emergency departments, State and local health departments and other components of the health care system to respond to bioterrorist attacks as well as to large scale epidemics, the Department of Health and Human Services (HHS) announces the availability of a new cooperative agreement program. HHS will issue awards to State and Territorial Health Departments (and selected municipal governments) to be used to facilitate State and regional planning with local hospitals, emergency medical services (EMS) systems, and other health care facilities that will lead to implementation of programs to improve their preparedness to work together to combat biological terrorist attacks, as well as other outbreaks of infectious disease.

The Hospital Preparedness Program will be administered by the Health Resources and Services Administration (HRSA). Funds for the program are intended to supplement, not supplant other Federal, State, and local public health funds available for emergency activities to combat threats to public health.

In order to make rapid awards and to provide the Phase 1 allocation (20 percent of the total award), the program will use a simple application process, speedy review and abbreviated administrative procedures. Cooperative agreement awards will go to recipients rapidly.
A cooperative agreement is an award instrument of financial assistance where "substantial involvement" is anticipated between the HHS awarding agency and the recipient during performance of the contemplated project or activity. "Substantial involvement" means that the recipient can expect Federal programmatic collaboration or participation in managing the award.

Name of Grant Program: Bioterrorism Hospital Preparedness Program

Program Authorization: Section 319 of the Public Health Service Act, 42 U.S.C.247d. Funding was provided under the Department of Defense Appropriations Act, 2002, and Supplemental Appropriations, 2002, Public Law 107-117.

Purpose: The purpose of this cooperative agreement program is to upgrade the preparedness of the Nation's hospitals and health care system to respond to bioterrorist events. Such an upgrade will allow the health care system to become more prepared to deal with nonterrorist epidemics as well, such as outbreaks of rare diseases. A prime focus area will be identification and implementation of bioterrorism preparedness plans and protocols for hospitals and other participating health care entities. Development of statewide models for such protocols is encouraged, as is collaboration with other states and national organizations with expertise in this subject.
The cooperative agreements will cover two phases:

Phase 1 (Needs Assessment/Plan and Initial Implementation): This will consist of a state/territorial/regional level effort to involve appropriate entities (such as hospital associations, individual hospitals, emergency management agencies, emergency medical systems, primary care associations, rural health offices and VA and military hospitals) in a needs assessment of preparedness to respond to a bioterrorist incident, and to develop a plan of action in response to the identified needs. Twenty percent of a grantee's total award will be made available in Phase 1, with up to half of this amount allowed for planning and development of your implementation plan. Funds from this initial award should also be used for addressing critical benchmarks. To the extent states have already completed portions of their plan, a higher proportion may be used for implementation.

Phase 2 (Implementation): The remaining 80 percent of your allocation will be released as soon as your implementation plans for addressing the program guidance and critical benchmarks are approved by the Department. States will be given the flexibility to prioritize funding for specific activities based upon their needs assessment. This implementation phase should result in states being able to upgrade the ability of hospitals and other health care entities to respond to biological events, to develop a multitiered system in which local health care entities are prepared to triage, treat, stabilize and refer multiple casualties of a bioterrorist event to identified centers of excellence, or to develop multistate or regional consortia to pool limited funding to accomplish these goals. Grantees will be required to allocate at least 80% of the Phase 2 funds to hospitals through written contractual agreements. To the extent justified, a portion of these funds could be made available to collaborating entities that improve hospital preparedness.

Eligible Applicants: The distribution of funds will be to all fifty states, the District of Columbia, the Commonwealth of Puerto Rico, the territories of American Samoa, Guam and the U.S. Virgin Islands, the Commonwealth of the Northern Mariana Islands and the nation's three largest cities (New York, Chicago and Los

Angeles). Funding will be provided to State or Territorial Health Departments and in the case of the three municipalities, a local government or health department entity. Individual hospitals, EMS systems, health centers and poison control centers should work with their state health department for funding through this program.

Amount of Funding Available: $125 million. All awards under the Hospital Preparedness Program cooperative agreements will be distributed using a formula based primarily on population with certain minimum allotments.

Funding allocations will be made in two phases: (1) Phase 1, funded at approximately $25 million, is intended to help the State/Territorial Health Departments initiate a State-level effort to involve appropriate entities (noted above) in a needs assessment of preparedness to respond to a bioterrorism incident, and to develop a plan of action to respond to the identified needs; and (2) Phase 2, funded at approximately $100 million, will be released to grantees for implementation efforts, provided the needs assessment/plan is approved. These implementation funds are expected to result in subsequent contractual awards by States to upgrade the ability of hospitals and collaborating health care entities to respond to bioterrorist and other events.

Hospital Bioterrorism Preparedness Planning Committee: To ensure representation of appropriate entities best equipped to deal with bioterrorist threats, a Hospital Bioterrorism Preparedness Planning Committee must be established to assist the health department and the Statewide Bioterrorism Advisory Committee in its hospital preparedness efforts. The application must describe the anticipated composition of the advisory group, and a brief rationale for inclusion of each member.

The composition of this group should include representation from the following entities:

- State, territorial or municipal health department
- State emergency medical services office
- State emergency management agency
- State hospital association
- State office of rural health
- Veterans Affairs and military hospitals (where applicable)
- Primary care associations

Other entities may include key nonfederal, tribal, and Indian Health Service hospitals expected to take a leadership role in a state bio-preparedness program, medical, nursing and other professional societies, local emergency medical systems, state or regional poison control centers, metropolitan medical response systems, disaster medical assistance teams (DMAT), consumer representatives, and experts in medical, nursing and pharmacy specialties such as emergency medicine, primary care, infectious disease and toxicology.

Coordination and Collaboration: The Implementation Plan required for Phase 2 will be expected to provide an integrated plan for proposed uses of FY 2002 funds from HRSA, the Centers for Disease Control and Prevention (CDC) and the Office of Emergency Preparedness (OEP), although the budget should identify what is funded from the three sources.

For the Phase 1 application, provide a brief narrative on how the needs assessment and implementation plan funded under this program will be coordinated with plans being developed using funds from CDC and OEP. If the state anticipates developing regional plans within the state, or collaborating with other states either to meet the needs of a shared metropolitan area or to pool limited funds to develop a multistate plan, provide a brief narrative outlining this proposal.

Needs Assessment: Provide a brief narrative on the approach to developing and implementing a needs assessment for a comprehensive bioterrorism preparedness program.

Implementation Plan: Provide a brief narrative on the approach to developing a plan that addresses the priorities identified in the needs assessment, or to assessing and updating an existing plan for a comprehensive bioterrorism preparedness program.

3. The applicant will need to provide a budget which covers Phase 1 funding in some detail, and a broad outline of Phase 2 funding. Phase 1 should include an itemized budget for the administrative and infrastructure components, as well as any implementation components that will be initiated during this phase. Indirect costs will be limited to 10 percent under this cooperative agreement.

- Coordinator for Hospital Preparedness Planning (up to 1 FTE)
- Medical direction (up to 1 FTE)
- Support staff
- Travel expenses
- Meeting expenses
- Administrative equipment and supplies
- Communications (phone, long distance, electronic mail, etc.)
- Implementation funding to hospitals and other health care entities via contractual arrangements.

Application Requirements (Phase 2):

More detailed guidance for developing your needs assessment/implementation plan, including instructions for preparation of the associated budget proposal, will be sent to State Health Offices in two weeks.

Timeline:

I. States/Territories/3 Municipalities file an application as soon as feasible after receipt of this announcement, with a target date of no later than February 25.

II. Grant awards will be made shortly after receipt of the applications. The amount of the award will reflect the total amount available to the State/territory/municipality under the program. Only the amount identified for Phase 1: Needs Assessment and Planning, however, will be released at this point.

III. States/Territories/3 Municipalities must file an implementation plan (Phase 2) as soon as March 15 and no later than April 15, 2002.

IV. Phase 2 applications will be reviewed by a DHHS committee

V. Review of implementation plans will be completed by May 15, or within 30 days of receipt, whichever is sooner, with release of funds shortly thereafter.

Application Submission: HRSA will begin accepting applications for phase 1 as soon after receipt of this guidance as possible, but with a target date of no later than February 25, 2002. Awards will be made as applications are received.

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Hospital Preparedness for Bioterrorism
Health Resources and Services Administration

	HRSA Hospital First Allocation (20%)	HRSA Hospital Second Bioterrorism Allocation (80%)	HRSA Hospital Total
Alabama	$394,567	$1,578,266	$1,972,833
Alaska	$98,575	$394,302	$492,877
Arizona	$447,527	$1,790,110	$2,237,637
Arkansas	$257,138	$1,028,553	$1,285,691
California	$1,992,580	$7,970,325	$9,962,905
Los Angeles (county)	$731,834	$2,927,338	$3,659,172
Colorado	$383,267	$1,533,067	$1,916,334
Connecticut	$313,867	$1,255,469	$1,569,336
Delaware	$110,714	$442,857	$553,571
DC	$144,324	$577,295	$721,619
Florida	$1,288,334	$5,153,335	$6,441,669
Georgia	$684,296	$2,737,185	$3,421,481
Hawaii	$143,871	$575,485	$719,356
Idaho	$150,257	$601,028	$751,285
Illinois	$787,875	$3,151,499	$3,939,374
Chicago	$274,387	$1,097,547	$1,371,934
Indiana	$521,123	$2,084,493	$2,605,616
Iowa	$276,735	$1,106,940	$1,383,675
Kansas	$258,302	$1,033,207	$1,291,509
Kentucky	$363,161	$1,452,644	$1,815,805
Louisiana	$396,262	$1,585,046	$1,981,308
Maine	$148,783	$595,130	$743,913
Maryland	$460,378	$1,841,512	$2,301,890
Massachusetts	$541,936	$2,167,742	$2,709,678
Michigan	$820,042	$3,280,170	$4,100,212
Minnesota	$431,167	$1,724,668	$2,155,835
Mississippi	$270,407	$1,081,630	$1,352,037
Missouri	$483,524	$1,934,094	$2,417,618
Montana	$119,903	$479,613	$599,516
Nebraska	$182,591	$730,363	$912,954
Nevada	$204,827	$819,309	$1,024,136
New Hampshire	$145,750	$583,001	$728,751
New Jersey	$701,954	$2,807,815	$3,509,769
New Mexico	$190,942	$763,767	$954,709
New York	$899,828	$3,599,310	$4,499,138
New York City	$670,491	$2,681,964	$3,352,455
North Carolina	$673,670	$2,694,681	$3,368,351
North Dakota	$99,758	$399,034	$498,792
Ohio	$929,655	$3,718,619	$4,648,274
Oklahoma	$317,361	$1,269,443	$1,586,804
Oregon	$315,094	$1,260,376	$1,575,470
Pennsylvania	$1,001,551	$4,006,203	$5,007,754
Rhode Island	$131,225	$524,900	$656,125

	HRSA Hospital First Allocation (20%)	HRSA Hospital Second Bioterrorism Allocation (80%)	HRSA Hospital Total
South Carolina	$360,855	$1,443,422	$1,804,277
South Dakota	$108,486	$433,945	$542,431
Tennessee	$490,812	$1,963,250	$2,454,062
Texas	$1,665,624	$6,662,495	$8,328,119
Utah	$223,029	$892,114	$1,115,143
Vermont	$97,173	$388,691	$485,864
Virginia	$598,452	$2,393,807	$2,992,259
Washington	$506,684	$2,026,734	$2,533,418
West Virginia	$190,113	$760,451	$950,564
Wisconsin	$465,584	$1,862,336	$2,327,920
Wyoming	$88,259	$353,037	$441,296
Puerto Rico	$345,096	$1,380,383	$1,725,479
Totals	$24,900,000	$99,600,000	$124,500,000

Territory	HRSA Hospital First Allocation	HRSA Hospital Second Bioterrorism Allocation	HRSA Hospital Total
Guam	$ 30,000	$ 120,000	$ 150,000
N. Mariana Islands	$ 30,000	$ 120,000	$ 150,000
American Samoa	$ 30,000	$ 120,000	$ 150,000
USVI	$ 30,000	$ 120,000	$ 150,000
Totals	$ 120,000	$ 480,000	$ 600,000
Grand Total	**$ 25,020,000**	**$ 100,080,000**	**$ 125,100,000**

2/5/2002

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