Centers for Disease Control and Prevention (CDC) Office of Financial Resources (OFR)
Instructions for Preparing an Annual Performance Report and Continuation Funding Application
Catalog of Federal Domestic Assistance (CFDA): 93.074
Funding Opportunity Announcement (FOA) Number: **CDC-RFA-TP12-120105CONT16**

Hospital Preparedness Program (HPP) and
Public Health Emergency Preparedness (PHEP) Cooperative Agreements Assistant Secretary for Preparedness and Response/National Healthcare Preparedness Programs Centers for Disease Control and Prevention/Office of Public Health Preparedness and Response

Eligibility

This award will be a continuation of funds intended only for awardees previously awarded under **CDC-RFA- TP12-1201: Hospital Preparedness Program (HPP) and Public Health Emergency Preparedness (PHEP) Cooperative Agreements**. A total of $840,250,000 in fiscal year 2016 funds is currently available for Budget Period 5, which begins **July 1, 2016**, and ends **June 30, 2017**. The HPP and PHEP funding amounts shown in Appendices 1 and 2 are for planning purposes only and will be revised based on the final fiscal year 2016 budget.

Statutory Authority

Hospital Preparedness Program Funding (HPP): 319C-2 of the Public Health Service (PHS) Act, as amended.

Contingent Emergency Response Funding (HPP Only)
Section 311 of the PHS Act (42 USC § 243), subject to available funding and other requirements and limitations.

This guidance describes a separate mechanism for awarding future contingent emergency response funding that may be issued in the event of a pandemic or an all-hazards public health emergency in one or more jurisdictions. Such funding is subject to restrictions imposed by ASPR at the time of the emergency and would provide funding under circumstances when a delay in award would result in serious injury or other adverse impact to the public.

Since the funding is contingent upon Congressional appropriations, whether contingent emergency response funding awards can be made will depend upon the facts and circumstances that exist at the time of the emergency; the particular appropriation from which the awards would be made, including whether it contains limitations on its use; authorities for implementation; or other relevant factors. Funding will be subject to the funding authority, e.g., Section 311 of the PHS Act (42 USC § 243) or other applicable authority, the relevant notice of award, including restrictions imposed at the time of the emergency, and applicable grants regulations and policies.

Public Health Emergency Preparedness Program Funding (PHEP): 319C-1 of the PHS Act, as amended.

Contingent Emergency Response Funding (PHEP Only)
317(a) and 317(d) of the PHS Act, subject to available funding and other requirements and limitations.

This guidance describes a separate mechanism for awarding future contingent emergency response funding that may be issued in the event of a pandemic or an all-hazards public health emergency in one or more

jurisdictions. Such funding is subject to restrictions imposed by CDC at the time of the emergency and would provide funding under circumstances when a delay in award would result in serious injury or other adverse impact to the public.

Since the funding is contingent upon Congressional appropriations, whether contingent emergency response funding awards can be made will depend upon the facts and circumstances that exist at the time of the emergency; the particular appropriation from which the awards would be made, including whether it contains limitations on its use; authorities for implementation; or other relevant factors. Funding will be subject to the funding authority, e.g., sections 317(a) and (e) of the PHS Act or other applicable authority, the relevant notice of award, including restrictions imposed at the time of the emergency, and applicable grants regulations and policies.

Application Submission

The U.S. Department of Health and Human Services' (HHS) Office of the Assistant Secretary for Preparedness and Response (ASPR) and the Centers for Disease Control and Prevention (CDC) require awardees to submit their annual performance reports, which also serve as their continuation funding applications, through www.Grants.gov ***no later than 11:59 p.m. EST on Tuesday, April 5, 2016.***

If you encounter difficulties submitting your annual performance report through www.Grants.gov, please contact CDC's Technical Information Management Section at 770-488-2700 prior to the submission deadline. If you need further information regarding the annual performance report process, please contact CDC Grants Management Officer Shicann Phillips at 770-488-2809. For HPP-specific programmatic information, please contact R. Scott Dugas at (202) 245-0732. For PHEP-specific programmatic information, please contact Sharon Sharpe at (404) 639-0817.

Reports must be submitted by April 1, 2016, for the reporting period July 1, 2016 – June 30, 2017. Late or incomplete reports could result in an enforcement action such as a delay in the award or a reduction in funds. On rare occasions, ASPR and CDC will accept requests for a deadline extension only after adequate justification has been provided.

General Application Packet Tips

- Properly label each item of the application packet.
- Each section should use 12-point font and 1.5 spacing with one-inch margins.
- Number all narrative pages only.
- This report must not exceed 45 pages excluding administrative reporting; web links are allowed
- Where the instruction on the application forms conflict with these instructions, follow these instructions.
- ALL attachments must be in PDF format. Use of other file formats may result in the file being unreadable. Direction for creating PDF files can be found on www.Grants.gov.

Checklist of Required Contents of Application Packet

1. Application for Federal Domestic Assistance-Short Organizational Form
2. SF-424A Budget Information-Non-Construction Programs
3. Budget Justification
4. Indirect Cost Rate Agreement
5. Project Narrative
    - Budget Period 4 Progress Update (one each for HPP and PHEP)

- Program Requirements Update (one each for HPP and PHEP)
- Work Plan (Capabilities Plan - one each for HPP and PHEP)

6. Other Attachments Forms (1 each unless otherwise noted)
   - Attachment A: Additional SF-424A
   - Attachment B: Budget Justification Report
   - Attachment C: Additional Indirect Cost Rate Agreement
   - Attachment D: Preparedness Program Organizational Chart (one each of HPP and PHEP)
   - Attachment E: Local Concurrence Letter (applicable PHEP awardees) or documentation of negotiation process
   - Attachment F: Preparedness, Epidemiology, Laboratory Coordination Letter
   - Attachment G: Updated Multiyear Training and Exercise Plan (combined PHEP and HPP)
   - Attachment H: Subawardee Contracts Plan (optional; one each of HPP and PHEP)
   - Attachment I: Interim Federal Financial Report (optional)

Instructions for Accessing and Completing Required Contents of the Application Package

a. Go to: www.Grants.gov
b. Select: "Apply for Grants"
c. Select: "Step 1: Download a Grant Application"
d. Insert: **CDC-RFA-TP12-120105CONT16**
e. Download application package and complete all sections

Completing the Budget

1. SF-424 Application for Federal Domestic Assistance - Short Organizational Form

- Complete all sections.
- In Block #5a, insert the legal name of your organization and the CDC award number provided in the CDC Notice of Award. Failure to provide your award number could cause delay in processing your application.
- In Block #8, insert your organization's business official information.

Special Note: The following items 2, 3, and 4 should be attached to the application through the "Mandatory Documents" section of the Grant Application page. Select "Other Attachments Form" and attach as a PDF file.

2. SF-424A Budget Information and Justification

Download SF-424A from www.grants.gov and complete all applicable sections.

Estimated Unobligated
Funds that remain unobligated at the end of the current fiscal year remain available to awardees for the next fiscal year for the purposes for which such funds were provided.

Expanded Authority for Unobligated Funds
In accordance with 45 CFR § 75.308(d), awardees are given expanded authority to carry forward unobligated balances to the successive budget period without receiving prior approval from CDC's Office of Grants Services. The following restrictions apply with this authority.

1. The expanded authority can only be used to carry over unobligated balances from one budget period to the next successive budget period. Any unobligated funds not expended in the

successive budget period must be deobligated and returned to the Treasury as required.

2. Extensions will not be allowed for the last 12 months of the budget/project period.
3. The recipient must report the amount carried over on the Federal Financial Report for the period in which the funds remained unobligated.
4. This authority does not diminish or relinquish CDC and ASPR administrative oversight of the HPP and PHEP programs. The CDC and ASPR program offices will continue to provide oversight and guidance to the award recipients to ensure they are in compliance with statutes, regulations, and internal guidelines.
5. The roles and responsibilities of the CDC and ASPR project officers will remain the same as indicated in the terms and conditions of the award.
6. The roles and responsibilities of the grants management specialists in CDC's Office of Grants Services will remain the same as indicated in the terms and conditions of the award.
7. All other terms and conditions remain in effect throughout the budget period unless otherwise changed in writing by the CDC grants management officer.

Note: Awardees are responsible for ensuring that all costs allocated and obligated are allowable, reasonable, and allocable and in line with the goals and objectives outlined in the base FOA TP12-1201 and approved work plans.

Proposed Budget

The proposed budget should be based on the planning numbers provided in Appendices 1 and 2.

Budget Justification

In a separate narrative, provide a detailed, line-item budget justification of the funding amount requested to support the activities to be conducted with those funds. The budget justification must be prepared in the general form format, and to the level of detail as described in CDC's guidance for developing a sample budget available at: http://www.cdc.gov/od/pgo/funding/grants/foamain.shtm. Create a PDF of the narrative and attach it in the "Mandatory Documents" box under "Budget Narrative Attachment Form."

Awardees should consider the following in development of their budgets (SF-424A) and budget justification narratives:

- The itemized budget for conducting the project and the corresponding justification is allowable under HPP and PHEP programs, is reasonable and consistent with public health and healthcare preparedness program capabilities, and is consistent with stated objectives and planned program activities.
- While the HPP and PHEP programs are aligned and complementary, activities and their respective costs are not interchangeable. All costs must meet the criteria specified in the appropriate cost principles as necessary and reasonable for proper and efficient performance and administration of the respective HPP and PHEP components.
- For any new proposed subcontracts, provide the information specified in the CDC budget guidance.
- Nonfederal matching is required. Awardees must provide a line-item list of nonfederal contributions including source, amount, and/or value of third-party contributions proposed to meet a matching requirement.

Funding Formula, Use of Funds during Response, Match, Maintenance of Funding

Refer to CDC-RFA-TP12-1201 for guidance related to the funding formula, cost sharing or matching, maintenance of funding (MOF), and use of HPP and PHEP funds for emergency response.

Funding Restrictions

Funding restrictions, which apply to both awardees and their subawardees, must be taken into account while writing the budget. Restrictions are as follows:

- None of the funds awarded to these programs may be used to pay the salary of an individual at a rate in excess of Executive Level II or $185,100 per year. (See http://grants.nih.gov/grants/policy/salcap_summary.htm.)
- Recipients cannot use funds for fund raising activities or lobbying.
- Recipients cannot use funds for research.
- Recipients cannot use funds for construction or major renovations.
- Recipients cannot use funds for clinical care.
- Recipients cannot use funds to acquire real property such as land, land improvements, structures, and appurtenances thereto. In addition, activities under individual grants that constitute major renovation of real property or purchase of a trailer or modular unit that will be used as real property may be charged to HHS grants only with specific statutory authority and GMO approval.
- Recipients cannot use funds for reimbursement of pre-award costs.
- Recipients may supplement but not supplant existing state or federal funds for activities described in the budget.
- The direct and primary recipient in a cooperative agreement program must perform a substantial role in carrying out project objectives and not merely serve as a conduit for an award to another party or provider who is ineligible.
- Payment or reimbursement of backfilling cost for staff, including healthcare personnel for exercises, is not allowed.
- HPP awardees cannot use funds to support stand-alone, single-facility exercises.
- PHEP awardees cannot use funds to purchase vehicles to be used as means of transportation for carrying people or goods, such as passenger cars or trucks and electrical or gas-driven motorized carts.

Other funding notes:

- PHEP awardees can use funds to support appropriate accreditation activities that meet the Public Health Accreditation Board's preparedness-related standards.
- PHEP awardees can (with prior approval) use funds to purchase material-handling equipment (MHE) such as industrial or warehouse-use trucks to be used to move materials, such as forklifts, lift trucks, turret trucks, etc. Vehicles must be of a type not licensed to travel on public roads.
- PHEP awardees can (with prior approval) use funds to lease vehicles to be used as means of transportation for carrying people or goods, e.g., passenger cars or trucks and electrical or gas-driven motorized carts.
- HPP awardees can continue use of funds only for existing vehicle lease agreements during Budget Period 5.
- PHEP awardees can use funds to purchase caches of antibiotics for use by first responders and their families to assure the health and safety of the public health workforce.

Direct Assistance

PHEP awardees may request direct assistance (DA) for personnel (e.g. public health advisors, Career Epidemiology Field Officers, or other technical consultants) in lieu of financial assistance, provided the work is within scope of the cooperative agreement and is financially justified. PHEP awardees planning to request DA for personnel should submit a written request to their project officer stating they would like to continue funding their current CEFO/PHA no later than **February 19, 2016**. DA may also be requested for Statistical Analysis Software (SAS) licenses. DA requests for SAS licenses should be submitted no later than **November 14, 2016**.

HPP Funding Considerations
In the original HPP-PHEP funding opportunity announcement, CDC-RFA-TP12-1201, ASPR strongly encouraged HPP awardees to allocate 75% of HPP funds in support of local healthcare preparedness activities."
In Budget Period 5, ASPR strongly recommends HPP awardees continue these efforts, with a concentrated effort to maximize efficiency. To achieve this, ASPR recommends the following:

- Awardees and subrecipients should consider limiting the use of contracts to only those projects where expertise does not exist among agency personnel or partner agencies or agency personnel are not appropriate for completing the specified project. When contracts are utilized, awardees must ensure the contract achieves set deliverables and that the contractor's work is durable and sustainable.
- Awardees should consider the feasibility of hiring term employees or examine other jurisdictions' best practices regarding hiring efficiency.

3. Indirect Cost Rate Agreement

If indirect costs are requested, include a copy of the current negotiated federal indirect cost rate agreement or a cost allocation plan approval letter for those awardees under such a plan. Clearly describe the method used to calculate indirect costs and make sure the method is consistent with the indirect cost rate agreement.

To use indirect cost rates, a rate agreement must be in effect at the start of the budget period. If an indirect cost rate agreement is not in effect, indirect costs may be charged as direct if:

1. This practice is consistent with the awardee's approved accounting practices, and costs are adequately supported and justified.

Please see the CDC budget guidelines (http://www.cdc.gov/od/pgo/funding/grants/foamain.shtm) for additional information. If applicable, awardees must attach the indirect cost agreement form in the "Mandatory Documents" box under "Other Attachments Form" and name the document "Indirect Cost Rate."

4. Project Narrative

Section I. Current Budget Period Progress

Provide a brief report on Budget Period 4 goals and objectives, including:

1. **Status of Objectives:** For those capabilities on which an awardee worked during Budget Period 4, a brief status update (e.g. completed, ongoing and on schedule, ongoing but not on schedule, or discontinued) is required for each objective proposed in Budget Period 4.
    a. **Progress to Date:** Awardees must report progress on completing activities outlined within capability work plans, including descriptions of outcomes or outputs. Awardees should describe any additional successes, identified through evaluation results or lessons learned, achieved to date, including public health and medical preparedness and response accomplishments resulting from HPP- and PHEP-funded activities.
2. **Risks/Challenges:** In this section, awardees must describe:
    a. Any challenges that might affect their ability to achieve Budget Period 4 goals/objectives, meet performance/program measures, or complete work plan activities.
    b. Additional challenges encountered to date as identified through evaluation results or lessons learned.

Section II. New Budget Period Proposed Objectives and Activities

Budget Period 5 Program Requirements

For Budget Period 5, awardees must address and comply with joint program requirements, HPP-specific requirements, and PHEP-specific requirements. The joint requirements apply to HPP and PHEP awardees, including territories and freely associated states.

CDC will provide technical assistance documents that describe modified requirements for American Samoa, Commonwealth of the Northern Mariana Islands, Guam, U.S. Virgin Islands, and the freely associated states including Federated States of Micronesia, Republic of the Marshall Islands, and Republic of Palau. HPP has no modified requirements for territories and freely associated states; HPP field project officers will work with those awardees to ensure that they can meet program requirements.

In the Program Requirements Update, awardees must provide updates on joint, HPP-specific, and PHEP-specific program requirements, which are briefly outlined below. Refer to CDC-RFA-TP12-120103CONT14 for prior guidance. Completed program requirements updates must be attached as a PDF to the application through the "Other Attachments Form" when submitting via Grants. gov.

Interagency Grant Coordination

Federal agencies participating in the Emergency Preparedness Grant Coordination process are working to identify current preparedness activities and areas for collaboration across federal grants with public health and healthcare preparedness components. The participating federal agencies include:

- Department of Health and Human Services (HHS) Assistant Secretary for Preparedness and Response (ASPR)
- Department of Homeland Security (DHS) Federal Emergency Management Agency (FEMA)
- HHS Centers for Disease Control and Prevention (CDC)
- HHS Health Resources and Services Administration (HRSA)
- Department of Transportation (DOT) National Highway Traffic Safety Administration (NHTSA)

Federal agencies are actively coordinating guidance and technical assistance and encourage all recipients to actively coordinate preparedness activities for their jurisdictions. More information on the Emergency Preparedness Grant Coordination process effort can be found at www.phe.gov/preparedness/planning/hpp/pages/default.aspx. Awardees are encouraged to use their Budget Period 5 funding for initiatives that improve the coordination of federal investments from more than one agency so that emergency preparedness efforts are strategic and sustainable.

Joint Requirements

1. **Achieve progress on capability development as outlined in the strategic forecast.**
    - Awardees must:
        - Describe their top jurisdictional strategic priorities for the remainder of the project period.
        - Identify the data sources used to inform their Budget Period 5 strategic priorities. Sources include but are not limited to jurisdictional risk assessments, capability self-assessments, and after-action reviews and improvement plans.
        - List challenges or barriers that are anticipated for Budget Period 5, including any budgetary issues that might hinder the success or completion of the project as originally proposed and approved.

2. **Conduct jurisdictional risk assessments.**

Awardees are required to complete jurisdictional risk assessments (JRA) to identify potential hazards, vulnerabilities, and risks within the community, including interjurisdictional (e.g., cross-border) risks as appropriate, that specifically relate to the public health, medical, and behavioral health systems and the functional needs of at-risk individuals. Awardees must provide the date the jurisdictional risk assessment was completed or is projected to be completed.

In addition, HPP and PHEP awardees must coordinate risk assessment activities with relevant emergency management and homeland security programs in their jurisdictions to account for specific factors that affect the community. Active coordination supports whole community planning, builds community resiliency, and should support the comprehensive jurisdictional Threat and Hazard Identification and Risk Assessment (THIRA) administered by the U.S. Department of Homeland Security's (DHS) Federal Emergency Management Agency (FEMA).

3. **Coordinate exercise planning and implementation.**
   - Awardees must update their multiyear training and exercise plans (TEPs) to reflect planned activities. Updated TEPs must be submitted at the time of application.
     - In Budget Period 5, ASPR will no longer require submission of separate HPP exercise plans, exercise narratives, and training plans.
   - Awardees must conduct one joint statewide or regional full-scale exercise within the five-year project period to test public health and healthcare preparedness capabilities.
     - Joint exercises must include participation from healthcare coalitions (including, at a minimum, hospitals, public health departments, emergency management agencies, and emergency medical services) and public health jurisdictions.
     - In addition, joint exercises should meet multiple program requirements, including HPP, PHEP, medical countermeasures planning and Cities Readiness Initiative (CRI) requirements, to help minimize the burden on exercise planners and participants.
     - Exercises conducted with funding from other preparedness grant programs with similar exercise requirements may be used to fulfill the joint HPP-PHEP exercise requirements if the public health and healthcare preparedness capabilities are tested and evaluated. Awardees are encouraged to invite participation from representatives/planners involved with other federally mandated or private exercise activities. At a minimum, ASPR and CDC encourage HPP and PHEP awardees to share their TEP schedules with the entities included in their exercise plans.
   - Awardees must conduct an annual public health and medical preparedness exercise or drill that specifically includes at-risk individuals or populations (see www.phe.gov/Preparedness/planning/abc/Pages/atrisk.aspx) and report in the following year's funding application on the strengths and weaknesses identified and corrective actions taken to address weaknesses. HPP awardees should consider the access and functional needs of at-risk individuals and engage these populations as they plan Budget Period 5 healthcare coalition-based exercises.
   - Awardees must complete and submit after-action reports and improvement plans (AAR/IPs) for all responses to real incidents and for exercises conducted during Budget Period 5 to demonstrate compliance with HPP and PHEP program requirements. HPP and PHEP awardees should provide an AAR/IPs for each qualifying exercise within 90 days.
   - ASPR and CDC will provide awardees with technical assistance documents that provide more information on exercise planning and implementation.
   - Awardees are strongly encouraged to nominate exercises into the National Exercise Program. (NEP). The NEP is critical to our nation's ability to test and validate core capabilities. For additional information on the NEP, please refer to www.fema.gov/national-exercise-program.

4. **Continue to develop and implement administrative preparedness strategies.**
    - Awardees must work with their local public health jurisdictions to test and strengthen administrative preparedness planning including coordination with healthcare systems, law enforcement, and other relevant stakeholders. For Budget Period 5, awardees must also identify whether their jurisdictions have:
        - Tested expedited procedures as identified in their administrative preparedness plans for:
            - receiving emergency funds during a real incident or exercise
            - reducing the cycle time for contracting and/or procurement during a real emergency or exercise
        - Implemented internal controls related to subrecipient monitoring and any negative audit findings resulting from suboptimal internal controls.
        - Tested emergency authorities and mechanisms as identified in their administrative preparedness plans to reduce time for hiring and/or reassignment of staff (workforce surge). If they were tested, identify which procedures were tested and describe the average times for recruitment and/or hiring of staff in routine and emergency circumstances.

5. **Conduct all-hazards preparedness and response planning.**
Awardees must maintain current all-hazards public health emergency preparedness and response plans and be prepared to submit plans to ASPR or CDC if requested and make plans available for review during site visits. In the Program Requirements Update, awardees must describe activities and the role of public health, healthcare, and behavioral health systems related to all-hazards preparedness and response planning, the process for obtaining public comment, and any cross-border activities (for border states only).

    While the overarching focus of this continuation guidance is on healthcare preparedness (HPP) and public health preparedness (PHEP), it must be recognized that preparedness is but one element of the emergency management cycle that emphasizes preparedness "for response." Response capabilities, whenever possible, should be included in preparedness efforts. How any given hospital, healthcare coalition, public health agency, emergency medical services entity, or region "responds" to an event is the ultimate measure of success, not simply the efficacy or cumulative acquisitions supported by the preparedness effort alone. Preparedness should be tested, mitigation strategies should be developed or adjusted based on those tests (or response to real incidents), and the results of such efforts should be incorporated into the preparedness portfolio whenever possible. Thus, continuity from preparedness to response should always be the ultimate goal.

6. **Submit pandemic influenza preparedness plans.**
Awardees are required to have updated plans describing activities they will conduct with respect to pandemic influenza as required by Sections 319C-1 and 319C-2 of the PHS Act. HPP awardees can satisfy the annual requirement through the submission of required program data such as the capability self-assessment and program measures that provide information on the status of state and local pandemic response readiness, barriers and challenges to preparedness and operational readiness, and efforts to address the needs of at-risk individuals. PHEP awardees must submit status reports describing corrective actions plans and improvements taken to address operational readiness gaps identified in the CDC pandemic influenza readiness assessment (PIRA) completed in 2015. Awardees must submit the status reports within 90 days of receiving their PIRA summary reports outlining operational gaps. In addition, awardees must submit any follow-up data needed to better inform the

PIRA baseline data.

7. **Integrate the access and functional needs of at-risk individuals.**
   Awardees must describe the structure or processes in place to integrate the access and functional needs of at-risk individuals, including but not limited to children, pregnant women, older adults, people with disabilities, and people with limited English proficiency and non-English speaking populations. Strategies to integrate the access and functional needs of at-risk individuals involve inclusion in public health, healthcare, and behavioral health response strategies; furthermore, these strategies are identified and addressed in operational work plans. Awardees, subawardees, and healthcare coalitions are encouraged to identify community partners with established relationships with diverse at-risk populations, such as social services organizations, and to use demographic tools such as the Social Vulnerability Index and the U.S. Census/American Community Survey to better anticipate the potential access and functional needs of at-risk community members before, during, and after an emergency.

8. **Address the needs of individuals with chronic medical conditions.**
   Awardees must describe the structure or processes in place to integrate individuals with chronic medical conditions, including individuals who rely on electricity to power life-sustaining medical and assistive equipment and health care services. Examples of such equipment includes, but is not limited to, ventilators, oxygen concentrators, enteral feeding machines, intravenous pumps, suction pumps, at-home dialysis machines, electric wheelchairs and scooters, and electric beds, as well as beneficiaries who rely on specific healthcare services including dialysis, oxygen tank services, and home health visits. Strategies to integrate the needs of individuals with chronic medical conditions involve inclusion in public health, healthcare, and behavioral health response strategies; furthermore, these strategies are identified and addressed in operational work plans. Awardees, subawardees, and healthcare organization are encouraged to use the HHS emPOWER Map at www.phe.gov/empowermap/Pages/default.aspx to better anticipate the potential access and functional needs of individuals with chronic medical conditions before, during, and after an emergency.

9. **Ensure cross-discipline coordination.**
   Awardees can use HPP and PHEP funding to support coordination activities, such as local health departments planning with health care coalitions, and must track accomplishments. Awardees should coordinate activities with state emergency management agencies, emergency medical services providers (including the State Office of Emergency Medical Services), mental health agencies (including the State Mental Health Authority and the Disaster Behavioral Health Coordinator), healthcare coalitions, and educational agencies and state child care lead agencies. When possible, efforts to coordinate with other stakeholders in the healthcare delivery system (skilled nursing facilities, dialysis centers, ambulatory clinics, community health centers, and other outpatient care delivery partners) should also be supported. HHS strongly encourages awardees to work collaboratively with other federal health and preparedness programs in their jurisdictions, including the Emergency Medical Services for Children Program, to maximize resources and prevent duplicative efforts.

10. **Support integration with the daily healthcare delivery system.**
    The daily delivery of public health and health care, including accountable care organizations, health information exchanges, and integrated behavioral healthcare, impacts both public health and health care preparedness and response. Awardees should consider linkages with programs and activities that would improve their ability to execute the public health or health care preparedness capabilities. As awardees develop and refine health care coalitions, they should plan coalition activities that are built

around day-to-day health care systems and referral patterns. In addition, awardees must work to establish new partnerships with infection control or prevention programs in their jurisdictions that can advance the development of stronger healthcare system infection control and prevention programs.

11. **Establish and maintain senior advisory committees.**
    Awardees must establish and maintain advisory committees or similar mechanisms of senior officials from governmental and nongovernmental organizations involved in homeland security, health care, public health, and behavioral health to help integrate preparedness efforts across jurisdictions and to maximize funding streams. This will enable HPP and PHEP programs to better coordinate with relevant public health, health care, and preparedness programs.

12. **Obtain public comment and input on public health emergency preparedness and response plans and their implementation.**
    Awardees must obtain public comment and input on public health emergency preparedness and response plans and their implementation using existing advisory committees or a similar mechanism to ensure continuous input from other state, local, and tribal stakeholders and the general public, including those with an understanding of at-risk populations and their needs.

13. **Comply with SAFECOM requirements.**
    Awardees and subawardees that use federal preparedness grant funds to support emergency communications activities must comply with current SAFECOM guidance for emergency communications grants. SAFECOM guidance is available at www.safecomprogram.gov.

14. **Meet Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) compliance requirements.**
    The ESAR-VHP compliance requirements identify capabilities and procedures that state ESAR-VHP programs must have in place to ensure effective management and interjurisdictional movement of volunteer health personnel in emergencies. Awardees must coordinate with volunteer health professional entities and are encouraged to collaborate with the Medical Reserve Corps (MRC) to facilitate the integration of MRC units with the local, state, and regional infrastructure to help ensure an efficient response to a public health emergency. More information about the MRC program can be found at www.medicalreservecorps.gov.

15. **Engage State Unit on Aging or Equivalent Office.**
    HPP and PHEP awardees must engage the State Unit on Aging, Area Agency on Aging, or an equivalent office in addressing the public health emergency preparedness, response, and recovery needs of older adults. Awardees must provide evidence that this state office is engaged in the jurisdictional planning process.

16. **Utilize Emergency Management Assistance Compact (EMAC).**
    Awardees must describe in their all-hazards public health emergency preparedness and response plans how they will use EMAC or other mutual aid agreements for medical and public health mutual aid to support coordinated activities and to share resources, facilities, services, and other potential support required when responding to public health emergencies.

17. **Conduct activities to enhance border health.**
    Awardees in jurisdictions located on the United States-Mexico border or the United States-Canada border must conduct activities that enhance border health, particularly regarding disease detection, identification, investigation, and preparedness and response activities related to emerging diseases and

infectious disease outbreaks whether naturally occurring or due to bioterrorism. This focus on cross-border preparedness reinforces the U.S. public health and health system preparedness whole-of-community approach which is essential for local-to-global threat risk management and response to actual events regardless of source or origin.

18. **Develop response plans for chemical, biological, radiological, or nuclear threats.**
Awardees must conduct activities to meet preparedness goals with respect to chemical, biological, radiological, or nuclear threats, whether naturally occurring, unintentional, or deliberate. Awardees should also consider active shooter and bombing threats. Emphasis on the response should include the ability to create medical surge capacity and capability. Plans should highlight the importance of using a "systems" approach to manage scarce resources, including limited medical countermeasures, staff, and medical resources.

19. **Enhance partnerships to ensure cross-discipline information sharing among state, local, and territorial public health preparedness programs and healthcare coalition (HCC) members, surveillance programs, communicable disease programs, and healthcare-associated infection control (HAI) programs.**
Public health preparedness programs should prioritize and emphasize strengthening and sustaining cross-discipline coordination and communication between preparedness programs and HCC members, communicable disease programs, and state HAI programs/advisory groups (or other infection control groups) to advance infectious disease preparedness planning across the public health and healthcare systems. ASPR and CDC have developed guidelines to assist with further developing and refining healthcare and public health preparedness capability-based work plans to include, but not limited to, healthcare system and community preparedness, emergency public information and warning, information sharing, medical surge, non- pharmaceutical interventions, and responder safety and health**.** These guidelines are available in the PERFORMS Resource Library.

20. **Coordinate emergency public health and healthcare preparedness and response plans with educational agencies and state child care lead agencies.**
Awardees must ensure emergency preparedness and response coordination with designated educational agencies and lead child care agencies in their jurisdictions.

21. **Assure compliance with the following requirements.**
    - Maintain a current all-hazards public health emergency preparedness and response plan and submit to ASPR or CDC when requested and make available for review during site visits.
    - Submit required progress reports and program and financial data, including progress in achieving evidence-based benchmarks and objective standards; performance measures data including data from local health departments; outcomes of annual preparedness exercises including strengths, weaknesses and associated corrective actions; and accomplishments highlighting the impact and value of the HPP and PHEP programs in their jurisdictions.
    - Inform and educate hospitals and healthcare coalitions within the jurisdiction on their role in public health emergency preparedness and response.
    - Submit an independent audit report every two years to the Federal Audit Clearinghouse within 30 days of receipt of the report.
    - Provide situational awareness data during emergency response operations and other times as requested.
    - Document maintenance of funding and matching funds.
    - Have in place fiscal and programmatic systems to document accountability and improvement. The following are accountability processes designed to generate programmatic improvements:

- Plan and participate in joint site visits at least once every 12-24 months. In addition to site visits, awardees are encouraged to invite HPP and PHEP project officers and senior ASPR and CDC staff to attend or observe events such as scheduled exercises, regional meetings, jurisdictional conferences, senior advisory committee meetings, and coalition meetings supported by HPP and PHEP funding to gain insight on strengths and challenges in preparedness planning.
- Participate in mandatory meetings and training. The following meetings are considered mandatory, and awardees should budget travel funds accordingly:
    - Annual preparedness summit sponsored by the National Association of County and City Health Officials (NACCHO)
    - Directors of public health preparedness annual meeting sponsored by the Association of State and Territorial Health Officials
    - Healthcare coalition preparedness conference as specified by ASPR
    - Other mandatory training sessions that may be conducted via webinar or other remote meeting venues.
- Engage in technical assistance planning. Awardees must actively work with their HPP and PHEP project officers to properly identify, manage, and update technical assistance plans at least quarterly during Budget Period 5.
- Maintain all program documentation for purposes of data verification and validation. ASPR and CDC strongly encourage awardees to develop internal electronic systems that allow jurisdictions to share documentation with HPP and PHEP project officers, including evidence of progress completing corrective actions for weaknesses identified during exercises and drills. In Budget Period 5, ASPR and CDC will strengthen the emphasis on verification and validation of requirements to identify strengths and potential gaps, better review and evaluate progress, and engage in technical assistance.

HPP-specific Requirements

The purpose of the HPP component of this cooperative agreement is to build and maintain prepared healthcare systems, advance the development and maturation of healthcare coalitions, strengthen regional coordination, and ensure the healthcare system can maintain operations and surge to provide acute medical care during all- hazards emergencies. A prepared healthcare system is capable of "responding" to events, based on risks, threats and vulnerabilities that are identified using a process that allows for input from multiple stakeholders and takes into account a variety of data sources.

- HPP awardees must ensure the healthcare coalitions in their jurisdictions actively engage public health, emergency medical services (EMS), hospitals, and emergency management in preparedness activities. In particular, EMS providers should be integrated into planning for tracking emergency patients and to prevent critical deficits in transport capabilities during hospital evacuations, casualty redistribution between healthcare facilities, and initial transport capabilities and patient care from incident scenes to healthcare facilities. EMS is an integral partner in patient tracking. HPP awardees should familiarize themselves with the following data standards: the National Emergency Medical Services Information System (NEMSIS) data standard, the Tracking of Emergency Patients data standard, and the Hospital Availability Exchange (HAVE) data standard.
- HPP awardees, through their healthcare coalitions, must develop partnerships with other entities, such as behavioral health, home health care, ambulatory care, long-term care facilities, and dialysis/end-stage renal disease providers, community health centers, and pharmacies, to ensure they are fully integrated in planning and response efforts as their continuous operations and contributions to surge capacity are critical to healthcare system success in large-scale incidents. The coalitions' partnerships with these entities may be accomplished through committees or work groups structured to prevent

coalition size from becoming unmanageable.
    - ASPR encourages coalitions to conduct social network analyses. While ASPR does not promote any specific tool, some options include the PARTNER tool and the Public Health PBRN Network Analysis Survey Instrument.
- HPP awardees must work with healthcare coalitions to define their operational responsibilities during an incident and detail how information is shared and exchanged. As coalitions mature, many work with state and local authorities on assuming more policy and resource management responsibilities.
- HPP awardees should ensure the development of coalitions reflects the usual patterns of medical care and transportation and should recognize the tiered approach articulated in ASPR's Medical Surge Capacity and Capability (MSCC) framework.
- HPP awardees should recognize the growing reliance on computer-based operating systems, especially the use of the electronic health record (EHR) and application service provider (ASP) Web-based information sharing tools. Given this reliance, there is a growing threat to cybersecurity that must be mitigated. Such efforts may be conducted in conjunction with projects spearheaded by the HHS Critical Infrastructure Protection (CIP) Program. Coordination of plans and integration of healthcare platforms' cybersecurity into existing planning efforts should be prioritized whenever possible.
- HPP awardees must ensure their jurisdictions conduct regional planning to respond to special emergency situations resulting in burns, radiation exposure, pediatric illnesses or injuries, active shooters, bombings, and illnesses resulting from special pathogens.
- HPP awardees must leverage available HPP funds to benefit the system as a whole. This includes joint training and exercising, patient tracking, creation of common response plans, purchase of resources to support a regional communication or specialty response plan, and other uses of funds that promote consistency and operational capacity within healthcare coalitions.
- HPP awardees may provide funding to individual hospitals or other healthcare facilities, as long as the funding is used for activities to advance regional and healthcare system-wide priorities, and are in line with ASPR's eight healthcare preparedness capabilities.

Following are additional HPP requirements:

1. **Ensure healthcare coalition hospitals address National Incident Management System (NIMS) implementation activities.**
   HPP awardees must ensure that the hospitals in their healthcare coalitions are conducting the 11 hospital-related NIMS implementation activities and must allocate funds to ensure the 11 NIMS implementation activities continue for hospitals engaged in healthcare coalition development. Awardees must report on status of these activities in their Budget Period 5 annual progress reports. More information is also available at http://www.phe.gov/Preparedness/planning/hpp/reports/Documents/nims-implementation-guide-jan2015.pdf.

   In addition, HPP awardees must ensure hospitals have all-hazards and hazard-specific preparedness and response plans, as well as the space, staff, and supplies needed to provide immediate bed availability to assure appropriate early medical care for individuals affected by disasters and public health incidents.

2. **Develop multiyear training and exercise plans (TEPs).**
   HPP awardees should submit a complete TEP for Budget Period 5 as outlined under the joint requirements section to include all training plans and exercises scheduled for the next three years, or, at a minimum, Budget Period 5.

3. **Submit HPP After-Action Reports/Improvement Plans (AAR/IP)**
   HPP awardees must submit required AAR/IPs resulting from qualifying exercises and real incidents to ASPR_Ex@ynhh.org with an email copy to their field project officers. AAR/IPs that contain hospital-specific information, must be redacted. Although the HPP version is preferred, it is acceptable for awardees to use AAR/IP templates of their choice as long as they include the key HPP components as identified in the HPP requirements found in the supplemental joint HPP-PHEP training and exercise document found in the PERFORMS Resource Library.

4. **Comply with National Hospital Available Beds for Emergencies and Disasters (HAvBED) standards.**
   HPP awardees are required to maintain and refine an operational bed-tracking, accountability/availability system compatible with the HAvBED data standards and definitions. Systems must be maintained, refined, and adhere to all requirements and definitions in the CDC-RFA-TP12-1201 funding opportunity announcement, including the following modifications:
   - Awardees should continue working on implementation strategies for HAvBED version 4 during the last year of this project period.
     - In the interim, HAvBED version 4 will be available for production and will be fully compatible with state systems using HAvBED version 3. Please see Appendix 14 for additional details.
   - Complete yearly data sharing agreements provided by ASPR.

   States must also demonstrate the ongoing ability to submit required data to the ASPR Office of Emergency Management (OEM) using either the HAvBED Web portal or the HAvBED EDXL Communication Schema (found at https://havbedws.hhs.gov). Information and technical assistance will be provided to awardees on both options. The HAvBED Web portal is available at https://havbed.hhs.gov. For more information, contact Jewel Wright at Jewel.Wright@hhs.gov.

5. **Review Capability 14: Responder Safety and Health for gaps.**
   HPP awardees should evaluate state, healthcare coalition, and hospital needs for personal protective equipment (PPE) and training resulting from lessons learned during the 2014 Ebola response. Awardees should review the responder safety and health capability describing the ability of healthcare organizations to protect the safety and health of healthcare workers from a variety of hazards during emergencies and disasters. This healthcare preparedness capability includes processes to equip, train, and provide other resources needed to ensure healthcare workers at the highest risk for adverse exposure, illness, injury, and behavioral health consequences are adequately protected from all hazards during response and recovery operations.

6. **Operationalize healthcare coalitions.**
   HPP awardees should work to increase membership diversity and move healthcare coalition membership from meetings and plan development to operational constructs that ensure coalitions can share information, effectively communicate with each other, have visibility of needs during an emergency, and integrate with Emergency Support Function 8. HPP awardees are encouraged to use the following tools and resources while crafting work plans to move from healthcare coalition planning to operational constructs:

   - HHS Compendium of Response Resources
     - www.phe.gov/emergency/hhscapabilities/Pages/default.aspx
   - emPower Map
     - www.phe.gov/empowermap

- Hospital Surge Evaluation Tool
  - www.phe.gov/Preparedness/planning/hpp/surge/Pages/default.aspx
- TRACIE – Technical Resources, Assistance Center and Information Exchange
  - https://asprtracie.hhs.gov/
- Disaster Behavioral Health Capacity Assessment Tool
  - www.phe.gov/Preparedness/planning/abc/Documents/dbh-capacity-tool.pdf
- Psychological First Aid – A Course for Supervisors and Leaders
  - https://live.blueskybroadcast.com/bsb/client/CL_DEFAULT.asp?Client=354947&PCAT=7365&CAT=9403

7. **Identify existing healthcare coalitions.**
   All identified coalitions, in partnership with each HPP awardee, may be asked to complete a questionnaire that describes the coalition and its functions. ASPR will provide details on such questionnaires in advance of the request and similar inquiries along with adequate completion timeframes. ASPR will use this data to update information on existing coalitions. ASPR will share results with awardees.

PHEP-specific Requirements

1. **Obtain local concurrence.**
   PHEP awardees must seek and obtain local health department concurrence (applicable to decentralized state health departments). Awardees must consult with local public health departments or other subdivisions within their jurisdictions to reach consensus, approval, or concurrence on the overall strategies, approaches, and priorities described in their work plans and on the relative distribution of funding as outlined in the budgets associated with the work plans. Awardees do not need to obtain concurrence on the specific funding amounts but rather the process and formula used to determine local health department amounts. Awardees must describe the process used to obtain concurrence, including any nonconcurrence issues encountered, and plans to resolve issues identified.

   State awardees must provide signed letters of concurrence on official agency letterhead from local health departments or representative entities upon request. Awardees who are unable to gain 100% concurrence must submit a PDF document with their applications describing the reasons for lack of concurrence and the steps taken to address them. CDC will work with awardees unable to gain concurrence to help develop strategies to resolve concurrence issues.

2. **Obtain tribal input.**
   PHEP awardees must describe the mechanism by which they seek to obtain comments from tribal stakeholders on public health emergency preparedness and response plans and their implementation, which must be an advisory committee or a similar mechanism to ensure input.

3. **Assure coordination among preparedness epidemiology and laboratory programs.**
   PHEP awardee investments in Capability 12: Public Health Laboratory Testing and Capability 13: Public Health Surveillance and Epidemiological Investigation continue to represent a significant proportion of PHEP program investments. Continued coordination among jurisdictional preparedness, epidemiology, and laboratory programs will be particularly critical for updating chemical laboratory instrumentation and implementing targeted informatics and surveillance initiatives while balancing other jurisdictional priorities and PHEP cooperative agreement program requirements. Coordination among epidemiology, laboratory, and preparedness programs should occur when developing annual funding applications and continue throughout the budget period.

Each PHEP awardee must provide a letter signed by the jurisdiction's senior health official on official agency letterhead confirming the PHEP director, the epidemiology lead, the public health laboratory director, or their designated representatives, have provided input into plans, strategies, and investment priorities within epidemiology, surveillance, and laboratory work plans. Awardees who are unable to obtain effective input from these stakeholders must submit a separate attachment with their applications describing the reasons why and the steps taken to address them. CDC will work with awardees to help resolve issues as necessary. An optional letter template is available in the PERFORMS Resource Library.

4. **Comply with medical countermeasure planning/Cities Readiness Initiative (CRI) requirements.** CDC will continue in Budget Period 5 its medical countermeasure (MCM) operational readiness review (ORR) process to advance state and local medical countermeasure operational readiness. The MCM ORR is intended to identify medical countermeasure response planning and operational capabilities as well as gaps that may require more targeted technical assistance.

   Following the full implementation of the MCM ORR process in Budget Period 4 to collect baseline data, CDC will focus on targeted technical assistance planning in Budget Period 5 based on MCM ORR results. To help jurisdictions move toward "established" planning and operational status levels by 2022, CDC will work with awardees and local planning jurisdictions to complete the following activities designed to address identified planning and operational gaps.
   - All 62 awardees and each local CRI planning jurisdiction must submit a summary of completed activities in response to technical assistance plans developed as a result of their Budget Period 4 MCM ORR outcomes.
   - State awardees are required to develop MCM ORR technical assistance plans for all remaining CRI local planning jurisdictions not reviewed by CDC and must submit completed plans to CDC.

   Awardees must also meet the following requirements:
   - Conduct three different MCM planning drills during Budget Period 5 and provide reports to CDC. This requirement applies to each CRI local planning jurisdiction within the 72 metropolitan statistical areas (MSAs), including the four directly funded localities.
   - Conduct the following exercises and provide results to CDC:
     - One MCM distribution full-scale exercise (FSE) during the current project period.
     - One MCM dispensing FSE conducted in each CRI MSA during the current project period.
   - Have current receipt, stage, and store (RSS) site survey information on file with CDC for all potential RSS sites in their jurisdictions. RSS site information should be updated to reflect any changes affecting operational capabilities. Awardees must survey their RSS sites at least once every three years and provide updated RSS site information to CDC.
   - Respond to CDC's Inventory Management and Tracking System (IMATS) data request. Awardees may use CDC's electronic data exchange for reporting. Awardees that do not have this ability must implement the CDC inventory management system that can automatically generate inventory reports for a public health emergency.
   - Have current operational information on file with CDC to identify points of contact to facilitate time-sensitive, accurate information sharing prior to a public health emergency. Awardees must review and update the operational critical contact information that is on the CDC MCM SharePoint site, at least every six months or as changes occur.
   - Work with hospitals and healthcare coalitions to develop or leverage existing activities to meet PHEP exercise requirements and achieve common preparedness goals as referenced in

the Budget Period 5 Medical Countermeasure (MCM) Reference Guide.

- State awardees are required to provide MCM guidance to local planning jurisdictions, as well as monitor, and evaluate dispensing and distribution activities and program requirements.

5. **Continue to build and sustain Level 1 and Level 2 chemical laboratory capability.**
CDC's Laboratory Response Network chemical laboratory (LRN-C) program is updating its testing profile to include an additional testing matrix for the organophosphorus nerve agent (OPNA) method. Expanding testing matrices for OPNA metabolites improves response capability to exposures from high threat chemical agents. The OPNA method in serum will replace the metabolic toxin panel method (MTP) as one of the nine core methods in the LRN-C proficiency testing (PT) program. Once retired, the LRN-C technical program will no longer support the materials and PT programs for the MTP method. CDC does not anticipate additional program costs for this replacement.

   LRN-C Equipment Refresh
   LRN-C uses highly specialized instruments, referred to as ICP-MS (inductively coupled plasma mass spectrometry), to detect and measure toxic metals in people. These instruments enable high-speed, accurate, precise, and sensitive analytical methods for the detection of toxic metals in people at extremely low concentrations.

   Originally purchased LRN-C ICP-MS instruments will require replacement as, beginning in 2017, the manufacturer will no longer provide consumables, parts, maintenance, and service for this equipment. As a result, replacement of Perkin Elmer ELAN DRC II® equipment used for the toxic element, arsenic, and blood metals methods must be included within Budget Period 5 Capability 12 work plans. Awardees must consult with their chemical threat program coordinators and their laboratory directors to develop fiscal allocation strategies for the selection of appropriate replacement equipment. The inability to replace equipment by the end of Budget Period 5 will compromise Level 1 and Level 2 chemical laboratory capability to test for toxic threats from exposures to arsenic, lead, mercury, thallium, uranium, cadmium, barium, and beryllium. Equipment specifications and guidelines are located in the PERFORMS Resource Library and on the LRN-C website at https://lrnb.cdc.gov/. Additional technical assistance is available through the LRN-C Technical Program Office at LRN-C_QA_Program@cdc.gov.

   LRN-C Laboratory Partnership Agreement and Laboratory Checklist
   In 2017, CDC will transfer newly developed high-threat methods to LRN-C labs. In preparation for these activities, laboratories must ensure that minimal technical requirements are met. The LRN-C Laboratory Partnership Agreement (LPA) and Laboratory Checklist, available in the PERFORMS Resource Library, provide guidance on LRN-C program policies, procedures, and rules of conduct required for LRN-C membership. Noncompliance with the LPA or the Laboratory Checklist could result in loss of LRN-C proficiency testing program subscriptions. Additional information is available by contacting the LRN-C Technical Program Office at LRN-C_QA_Program@cdc.gov.

6. **Continue to meet LRN requirements for biological laboratories.**
CDC has finalized its LRN policy to refine membership and nomenclature for biological reference laboratories (LRN-B). Introduced last year, the new policy now includes advanced reference laboratories and continues to use the term high priority areas (HPAs) rather than Urban Areas Security Initiative (UASI) jurisdictions to describe areas that must have access to standard level testing capabilities. HPAs are not expected to change over time.

   Standard reference laboratories must be able to perform multiple-agent screening on high-risk

environmental samples, as well as other capabilities in the checklist posted on the LRN website and in the PERFORMS Resource Library. Advanced reference laboratories are required to meet the standard reference level requirements, as well as maintain Select Agent certification, and, if requested, support the LRN-B program with assay development, evaluation of new technologies, proficiency testing remediation, and high throughput surge capacity. Additional information is available by contacting the LRN-B Technical Program Office at LRN@cdc.gov

In collaboration with the Association of Public Health Laboratories (APHL), CDC's LRN-B program office has identified the following 14 public health laboratories as advanced reference laboratories.

1. Arizona
2. California
3. Colorado
4. Florida
5. Los Angeles County
6. Maryland
7. Massachusetts
8. Michigan
9. Minnesota
10. New York
11. North Carolina
12. Texas
13. Virginia
14. Washington

7. **Coordinate with cross-cutting public health preparedness partners.**
PHEP awardees must coordinate their PHEP program components with other public health, healthcare, and emergency management programs as applicable. For example, awardees should ensure public health emergency preparedness activities complement the core public health activities within CDC's Epidemiology and Laboratory Capacity (ELC) for Infectious Diseases cooperative agreement. Awardees must also collaborate with immunization programs, syndromic surveillance efforts, public health informatics initiatives and other activities to prepare and respond to vaccine-preventable diseases, novel influenza, emerging infectious disease and other public health threats and emergencies.

8. **Sustain and enhance public health information systems.**
Public health information technology improvements offer tremendous potential to improve the timeliness, validity, and efficiency of public health data collection, analysis, and information sharing. This can help decision makers take action earlier and more appropriately while also linking public health agencies and systems more effectively with clinical systems and healthcare professionals. To advance these efforts, preparedness programs must harmonize PHEP information technology strategies, objectives, goals, and investments where applicable with CDC's National Notifiable Diseases Surveillance System (NNDSS) Modernization Initiative, the Epidemiology and Laboratory Capacity (ELC) program, the Immunization and Vaccines for Children Program, the National Syndromic Surveillance Program (NSSP), and other initiatives that advance public health informatics preparedness. Information technology work plans supported with PHEP funding should include input from state laboratory directors, state epidemiologists, IT/informatics directors, or specifically designated individuals empowered by these authorities. Guidelines for developing public health informatics within associated capability-based work plans including, but not limited to Capability 6:

Information Sharing; Capability 12: Public Health Laboratory Testing; and Capability 13: Public Health Surveillance and Epidemiological Investigation are located in the PERFORMS Resource Library.

9. **Analyze real-time clinical specimens.**
   PHEP awardees must develop plans to analyze real-time clinical specimens for pathogens of public health or bioterrorism significance, including any utilization of poison control centers.

10. **Conduct an annual PHEP exercise.**
    Awardees must conduct an annual public health exercise or drill that includes the access and functional needs of at-risk individuals.

Work Plan

The Budget Period 5 work plan includes a capabilities plan and an optional subawardee contracts plan.

Capabilities Plan

Awardees must describe the short-term goals, supporting objectives, and planned activities that lead to proposed outputs for the capabilities they plan to address in their Budget Period 5 work plans. For HPP and PHEP awardees, their short-term goals, objectives, planned activities, and proposed outputs should support the long-term goals of building and sustaining each program's preparedness capabilities.

HPP awardees are expected to describe specific activities to build or sustain any previously funded capability from the eight healthcare preparedness capabilities in their applications. For those capabilities funded in Budget Period 5, awardees should identify work plan objectives and planned activities that result in outcomes and outputs aligned with HPP program measures and healthcare coalition developmental assessment (HCCDA) factors. Awardees should indicate in their work plans the program measure indicators and HCCDA factors targeted for advancement in Budget Period 5.

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

A complete Budget Period 5 capabilities plan includes the following nine elements.

1. A chosen planned activity type for each capability, using one of the following options:
   a. Build
   b. Sustain
   c. Scale back
   d. No planned activities for Budget Period 5

   If "sustain" is selected, the awardee must identify in the short-term goal what level of sustainment or target is desired during Budget Period 5.

   If there are no planned activities, the awardee must:
   a. Identify any challenges or barriers that may have led to having no planned activities for Budget

Period 5.

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

2. Short-term goals.
   Short-term goal descriptions should answer the question: For a specific capability, what operational gaps and programs or systems need to be created or improved with program funding during Budget Period 5? The description must identify the specific, measurable changes awardees need to achieve for each capability or to what degree the capability needs to be sustained. The goal can span multiple functions, tasks, or resource elements within each capability. Awardees can include multiple goals per capability.

3. Funding information.
   Awardees must select one of the following sources of funding for each capability with planned activities:
   a. HPP
   b. PHEP
   c. Other funding source (state, local, DHS, other)

   Any capability functions with objectives supported by HPP or PHEP funding must have at least one line item associated with that function in the budget.

4. Objectives.
   Awardees must provide at least one objective for each short-term goal. These objectives must support the intent of the original funding opportunity announcement (FOA) for this project period. The objective descriptions must also be specific, measurable, and directly support or contribute to the achievement of the short-term goal.

   The objectives should also describe a desired outcome which could be reported as part of the Budget Period 5 annual progress report.

5. Planned activities.
   Awardees must provide at least one planned activity for each objective that describes the necessary tasks, deliverables, or products required to meet the objective. The planned activities should describe specific actions that support the completion of an objective. Planned activities should lead to measurable outputs linked to program activities and outcomes.

6. Proposed outputs.
   Awardees must provide at least one proposed output for each objective. The proposed outputs should directly relate to the expected results of completing the planned activities or objectives.

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

8. Timeline for accomplishment(s).
   Awardees must provide a timeline for accomplishing a proposed objective.

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

applicable. This includes a description of how ASPR or CDC can help them overcome challenges to achieving annual and project period outcomes, performance/program measures, and/or completing activities outlined in the work plan.

Subawardee Contracts Plan (Optional)

See Budget Period 3 continuation guidance for information on the optional subawardee contracts plan.

Performance Measure Reporting

ASPR and CDC will release Budget Period 5 guidance documents for the HPP program measures and the PHEP performance measures, including detailed reporting requirements. ASPR and CDC recommend that awardees reflect performance/program measure requirements, in contracts, memoranda of understanding, and other binding documents with subawardees.

HPP-specific Provisions

ASPR's evaluation model includes two program measures: medical surge and continuity of healthcare operations. Each of the program measures includes seven indicators, which incorporate critical components of ASPR's *National Healthcare Preparedness Capabilities: National Guidance for Healthcare System Preparedness* and align with the National Health Security Strategy. The indicators represent more concise and informed measures that integrate key tenets and reduce awardee burden. ASPR expects that these HPP program measures and indicators will stay consistent throughout the remainder of the project period.

HPP awardees are required to collect data on program measure indicators and report their data to ASPR as part of the Budget Period 5 annual progress report. The unit of measurement for the majority of HPP-specific indicators is at the healthcare coalition level. Awardees must collect and aggregate the healthcare coalition indicators and report these along with awardee-level data. To meet HPP requirements, awardees must submit a response to ASPR for each program measure indicator.

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

During Budget Period 5 ASPR will evaluate HPP awardees based on these sources of information:

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

More information is available in the current HPP Program Measure Manual: Implementation Guidance for the HPP Program Measures at www.phe.gov/Preparedness/planning/sharper/Documents/bp3-hpp-implementation-guide.pdf.

PHEP-specific Provisions

CDC's PHEP Budget Period 5 performance measure guidance will be very similar to the current Budget Period 4 guidance. Awardees must comply with the reporting requirements for all performance measures and evaluation tools in Budget Period 5. Except where noted in the performance measure implementation guidance, a small subset of measures will require data drawn from real incidents, exercises, or drills. For these measures, awardees cannot indicate they have no data to report; instead, they must conduct an exercise or, if permissible, a drill, to collect appropriate data if they do not experience a real incident or cannot use the data from such an event. Finally, awardees that experience significant public health emergencies or disasters are strongly encouraged to collect relevant performance measure data from such incidents.

Performance measure data, as well as data collected through the medical countermeasure operational readiness review, may be subject to public dissemination.

For Budget Period 5, the performance measure reporting requirements remain the same for most territorial awardees. American Samoa, the Commonwealth of the Northern Mariana Islands, Guam, the Federated States of Micronesia, the Republic of the Marshall Islands, the Republic of Palau, and the U.S. Virgin Islands must report data on recently developed performance goals, Community Preparedness Evaluation Tool, HPP-PHEP 6.1 and HPP-PHEP 15.1. CDC will provide awardees with technical assistance documents that provide more information.

Evidence-based Benchmarks

HPP and PHEP have specified a subset of measures and select program requirements as benchmarks as mandated by Sections 319C-1 and 319C-2 of the Public Health Service Act as amended. Awardees must document, or demonstrate, that they have substantially met a benchmark by providing complete and accurate information describing how the benchmark was achieved. ASPR and CDC expect awardees to achieve, maintain, and report on benchmarks throughout the five-year project period. Note that a key benchmark for both programs, "demonstrated adherence to application and reporting deadlines," requires timely submission of applicable information throughout Budget Period 5. HPP and PHEP benchmarks can be found in Appendices 4 and 5.

Awardees should review funding opportunity announcement CDC-RFA-TP12-1201 for information on accountability provisions, enforcement actions and disputes, as well as withholding and repayment guidance.

Budget Period 5 Reporting Requirements

HPP and PHEP awardees must complete and submit all required HPP and PHEP program components by the published deadlines. Compliance with this key programmatic requirement is a Budget Period 5 benchmark subject to potential withholding of funds if awardees fail to meet this benchmark. Awardees may submit requests for extensions of reporting deadlines to ASPR and CDC. Such requests must be made in writing at least five business days prior to the deadline and submitted to CDC's Office of Grants Services, formerly the Procurement and Grants Office, with copies provided to preparedness@cdc.gov.

Programmatic Reporting Requirements

- Descriptions of pandemic influenza plans: Sections 319C-1 and 319C-2 of the PHS Act, as amended, currently require that HPP and PHEP awardees annually submit descriptions of their pandemic influenza preparedness and response activities.

    - HPP awardees can satisfy the annual requirement through the submission of required program data such as the capability self-assessment and program measures that provide information on the status of state and local pandemic response readiness, barriers and challenges to preparedness and operational readiness, and efforts to address the needs of at-risk individuals.

    - PHEP awardees must submit status reports describing corrective actions plans and improvements taken to address operational readiness gaps identified in the CDC pandemic influenza readiness assessment (PIRA) completed in 2015. Awardees must submit the status reports within 90 days of receiving their PIRA summary reports outlining operational gaps. In addition, awardees must submit any follow-up data needed to better inform the PIRA baseline data.

- Awardees must document and submit annually data on their current preparedness status and self-identified gaps based on the public health and healthcare preparedness capabilities as they relate to overall jurisdictional needs. Further guidance and templates will be provided separately.

- A Budget Period 5 annual progress is due 90 days after the end of the budget period. This report should include updates on work plan activities including local contracts and progress on implementation of technical assistance plans; applicable PAHPRA benchmark data; program/performance measure data and supporting information; training updates; preparedness accomplishments, success stories, and program impact statements; PHEP outputs; healthcare coalition assessments (HPP only); updated healthcare coalition information (HPP only); NIMS compliance activities for hospitals within healthcare coalitions; and ESAR-VHP requirements (HPP only).

- Awardees must submit AAR/IP and training outcome information as detailed in the supporting Budget Period 5 joint training and exercise checklist found in the PERFORMS Resource Library.

- Each funded awardee must provide an annual performance report submitted via www.grants.gov.

Financial Reporting Requirements

- Combined HPP and PHEP Budget Period 5 Federal Financial Report (FFR) (SF-425) submitted in eRA Commons no later than 90 days after the end of the calendar quarter.

- Separate HPP and PHEP Budget Period 5 Final Federal Financial Reports (SF-425) submitted no later than 90 days after the end of the calendar quarter.

- Federal Funding Accountability And Transparency Act of 2006 (FFATA) Public Law 109-282, the Federal Funding Accountability and Transparency Act of 2006 as amended (FFATA) requires disclosures of the following:
    - information on executive compensation when not already reported through the Central

Contractor Registry; and

- similar information on all subawards/subcontracts/consortiums more than $25,000. For the full text of the requirements under FFATA, review: http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=109_cong_bills&docid=f:s2590enr.txt.pdf.

Project Period Closeout Requirements

1. **Final Performance Report**
   The Final Performance Report should include information to fulfill any specific reporting requirements in the assistance award, a summary statement of progress toward the achievement of the originally stated aims, a list of the results (positive or negative) considered significant, and a list of publications resulting from the project, with plans, if any, for further publications. An original and two copies of the report are required.

2. **Financial Status Report (FSR)**
   The enclosed SF 269 is to be used in preparing the final *Financial Status Report* (FSR). A cumulative FSR for the total project period is required. An original and two copies are required. Unobligated funds reported on the FSR will revert to the U.S. government, subject to the carry-over provisions discussed on pages 3-4. Should that amount not agree with the final expenditures reported to the Health and Human Services Payment Management System (PMS), awardees will be required to update their records to PMS accordingly.

3. **Equipment inventory/property accountability requirement.**
   An original and two copies of a complete inventory must be submitted for all major equipment or property acquired or furnished under this project with a unit acquisition cost of $5,000 or more. The inventory list must include the description of the item, manufacturer serial and/or identification number, acquisition date and cost, and percentage of federal funds used in the acquisition of the item. Awardees should also identify each item of equipment that you wish to retain for continued use in accordance with 45 CFR § 74.323 or 45 CFR § 75.381 for state and local governments. These requirements do not apply to equipment purchased with nonfederal funds for this program.

   The awarding agency may exercise its right to require the transfer of equipment purchased under the assistance award referenced in the cover letter (45 CFR § 75.320) for state and local governments. We will notify you if transfer to title will be required and provide disposition instruction on all major equipment.

   Equipment, with a unit acquisition cost of less than $5,000 that is no longer to be used in projects or programs currently or previously sponsored by the U.S. government, may be retained, sold or disposed of, with no further obligation to the U.S. government. If no equipment was acquired under this grant/cooperative agreement, a negative report is required.

4. **Final invention statement**
   An original and two copies of a final *Invention Statement* are required. If no inventions were conceived under this assistance award, a negative report is required. This statement may be included in a cover letter.

5. **Audits**
   - State and local governments: Reference 45 CFR § 75.501.
   - Institutions of higher learning and other non-profit institutions: Reference 45 CFR § 75.501.

- Small Business Innovative Research (SBIR): Reference 45 CFR § 75.501(d).

6. **General information**
   All records pertaining to the activities performed under this assistance award must be retained in accordance with 45 CFR 75.361.

Audit Requirements

An awardee may use its single audit to comply with 42 USC 247d-3a(i)(2) if at least once every two years, the awardee obtains an audit in accordance with the Single Audit Act (31 USC 7501-7507) and 2 CFR 200 Subpart F; submits that audit to and has the audit accepted by the Federal Audit Clearinghouse; and ensures that applicable HPP and PHEP CFDA numbers 93.069, 93.074, and 93.889 are listed on the Schedule of Expenditures of Federal Awards (SEFA) contained in that audit.

The audit requirement at 42 USC 247d-3a(i)(2) does not:

1. Conflict with the single audit requirement.
2. Require an audit of the applicable CFDAs in addition to the single audit.
3. Require submission of the single audit to CDC's Office of Grants Services in addition to the Federal Audit Clearinghouse.
4. Mandate treatment of the applicable CFDAs as major programs in the single audit.

Appendix 1: HPP Budget Period 5 (Fiscal Year 2016) Funding[1]

Awardee	FY 2016 Total Funding Available
Alabama	$3,213,182
Alaska	$946,524
American Samoa	$278,816
Arizona	$3,802,604
Arkansas	$2,021,657
California	$23,405,491
Chicago	$2,763,365
Colorado	$3,019,385
Connecticut	$2,351,714
Delaware	$1,057,820
Florida	$11,834,415
Georgia	$6,009,692
Guam	$358,284
Hawaii	$1,253,321
Idaho	$1,252,520
Illinois	$8,882,060
Indiana	$3,973,603
Iowa	$2,126,090
Kansas	$2,052,547
Kentucky	$2,798,229
Los Angeles County	$9,261,848
Louisiana	$2,899,154
Maine	$1,080,551
Marshall Islands	$268,005
Maryland	$4,911,525
Massachusetts	$4,372,887
Michigan	$6,172,668
Micronesia	$276,806
Minnesota	$3,546,523
Mississippi	$2,166,456
Missouri	$3,621,262
Montana	$927,401
Nebraska	$1,362,493
Nevada	$1,929,769
New Hampshire	$1,101,804
New Jersey	$5,459,638
New Mexico	$1,537,475
New York	$9,757,860
New York City	$8,033,288
North Carolina	$5,908,241

[1] HPP funding amounts are for planning purposes only and are subject to change based on the final fiscal year 2016 budget.

Awardee	FY 2016 Total Funding Available
North Dakota	$886,426
Northern Mariana Islands	$270,553
Ohio	$7,210,035
Oklahoma	$2,612,637
Oregon	$2,580,105
Palau	$255,373
Pennsylvania	$8,193,982
Puerto Rico	$2,589,207
Rhode Island	$945,077
South Carolina	$3,120,729
South Dakota	$854,218
Tennessee	$4,062,164
Texas	$16,294,177
Utah	$2,288,020
Vermont	$782,301
Virgin Islands (U.S.)	$306,399
Virginia	$6,117,444
Washington	$4,292,040
Washington, D.C.	$948,679
West Virginia	$1,411,417
Wisconsin	$3,638,592
Wyoming	$843,452
Total FY 2016 HPP Funding	**$228,500,000**

Appendix 2: PHEP Budget Period 5 (Fiscal Year 2016) Funding[2]

Awardee	FY 2016 Total Base Plus Population Funding	FY 2016 Cities Readiness Initiative Funding	FY2016 Level 1 Chemical Laboratory Funding	FY 2016 Total Funding Available
Alabama	$8,589,780	$306,430	$0	$8,896,210
Alaska	$4,034,197	$169,600	$0	$4,203,797
American Samoa	$363,274	$0	$0	$363,274
Arizona	$10,672,362	$1,155,230	$0	$11,827,592
Arkansas	$6,421,361	$205,669	$0	$6,627,030
California	$35,999,744	$5,375,338	$1,175,583	$42,550,665
Chicago	$8,143,473	$1,649,890	$0	$9,793,363
Colorado	$9,096,364	$704,097	$0	$9,800,461
Connecticut	$7,162,089	$562,012	$0	$7,724,101
Delaware	$4,069,899	$316,507	$0	$4,386,406
Florida	$25,664,771	$2,889,447	$932,317	$29,486,535
Georgia	$14,557,415	$1,455,897	$0	$16,013,312
Guam	$485,453	$0	$0	$485,453
Hawaii	$4,629,279	$261,094	$0	$4,890,373
Idaho	$4,865,007	$170,232	$0	$5,035,239
Illinois	$14,762,101	$1,955,185	$0	$16,717,286
Indiana	$10,598,028	$801,105	$0	$11,399,133
Iowa	$6,575,821	$202,802	$0	$6,778,623
Kansas	$6,348,552	$396,124	$0	$6,744,676
Kentucky	$8,087,447	$377,907	$0	$8,465,354
Los Angeles County	$16,438,904	$3,299,780	$0	$19,738,684
Louisiana	$8,353,061	$546,195	$0	$8,899,256
Maine	$4,536,441	$169,600	$0	$4,706,041
Marshall Islands	$380,652	$0	$0	$380,652
Maryland	$9,867,244	$1,400,200	$0	$11,267,444
Massachusetts	$10,757,790	$1,281,167	$1,080,144	$13,119,101
Michigan	$14,445,751	$1,162,649	$1,063,587	$16,671,987
Micronesia	$422,693	$0	$0	$422,693
Minnesota	$9,269,786	$899,938	$1,092,880	$11,262,604
Mississippi	$6,460,030	$236,929	$0	$6,696,959
Missouri	$9,990,025	$895,907	$0	$10,885,932
Montana	$4,173,535	$169,600	$0	$4,343,135

[2] PHEP funding amounts are for planning purposes only and are subject to change based on the final fiscal year 2016 budget.

Awardee	FY 2016 Total Base Plus Population Funding	FY 2016 Cities Readiness Initiative Funding	FY2016 Level 1 Chemical Laboratory Funding	FY 2016 Total Funding Available
Nebraska	$5,161,178	$203,987	$0	$5,365,165
Nevada	$6,227,937	$535,063	$0	$6,763,000
New Hampshire	$4,529,404	$283,425	$0	$4,812,829
New Jersey	$13,304,793	$2,288,058	$0	$15,592,851
New Mexico	$5,413,176	$241,759	$1,096,376	$6,751,311
New York	$16,213,214	$1,864,769	$1,726,734	$19,804,717
New York City	$14,560,668	$3,917,158	$0	$18,477,826
North Carolina	$14,388,771	$529,244	$0	$14,918,015
North Dakota	$4,034,197	$169,600	$0	$4,203,797
N. Mariana Islands	$359,170	$0	$0	$359,170
Ohio	$16,381,259	$1,523,143	$0	$17,904,402
Oklahoma	$7,455,543	$345,850	$0	$7,801,393
Oregon	$7,542,212	$491,756	$0	$8,033,968
Palau	$324,408	$0	$0	$324,408
Pennsylvania	$17,779,620	$1,744,657	$0	$19,524,277
Puerto Rico	$7,158,040	$0	$0	$7,158,040
Rhode Island	$4,218,043	$284,646	$0	$4,502,689
South Carolina	$8,518,008	$302,741	$1,010,999	$9,831,748
South Dakota	$3,977,703	$169,600	$0	$4,147,303
Tennessee	$10,513,101	$740,326	$0	$11,253,427
Texas	$33,649,728	$4,014,369	$0	$37,664,097
Utah	$6,356,631	$299,732	$0	$6,656,363
Vermont	$4,034,197	$169,600	$0	$4,203,797
Virgin Islands (US)	$421,112	$0	$0	$421,112
Virginia	$12,563,393	$1,523,497	$962,945	$15,049,835
Washington	$11,064,069	$1,068,625	$0	$12,132,694
Washington, D.C.	$5,750,598	$638,667	$0	$6,389,265
West Virginia	$5,143,400	$184,251	$0	$5,327,651
Wisconsin	$9,640,850	$501,597	$1,445,235	$11,587,682
Wyoming	$4,034,197	$169,600	$0	$4,203,797
Total FY 2016 PHEP Funding	**$546,940,949**	**$53,222,251**	**$11,586,800**	**$611,750,000**

Appendix 3: Cities Readiness Initiative (CRI) Budget Period 5 (Fiscal Year 2016) Funding[3]

Awardee	CRI City	2013 Census Population	FY 2016 Awardee Total
Alabama	Birmingham	1,132,182	$306,430
Alaska	Anchorage	386,756	$169,600
Arizona	Phoenix	4,268,289	$1,155,230
Arkansas	Little Rock	709,447	$205,669
Arkansas	Memphis	50,447	
California	Los Angeles	3,051,771	$5,375,338
California	Riverside	4,285,443	
California	Sacramento	2,174,401	
California	San Diego	3,138,265	
California	San Francisco	4,402,729	
California	San Jose	1,868,323	
California	Fresno	930,450	
Chicago	Chicago	2,718,782	$1,649,890
Colorado	Denver	2,601,465	$704,097
Connecticut	Hartford	1,213,883	$562,012
Connecticut	New Haven	862,611	
Delaware	Philadelphia	542,784	$316,507
Delaware	Dover	165,030	
Florida	Miami	5,673,185	$2,889,447
Florida	Orlando	2,183,363	
Florida	Tampa	2,819,241	
Georgia	Atlanta	5,379,176	$1,455,897
Hawaii	Honolulu	964,678	$261,094
Idaho	Boise	628,966	$170,232
Illinois	Chicago	5,895,870	
Illinois	St Louis	701,423	

[3] PHEP CRI funding amounts are for planning purposes only and are subject to change based on the final fiscal year 2016 budget.

Awardee	CRI City	2013 Census Population	FY 2016 Awardee Total
Illinois	Peoria	380,163	$1,955,185
Indiana	Chicago	706,967	
Indiana	Indianapolis	1,911,795	
Indiana	Cincinnati	63,470	
Indiana	Louisville	277,653	$801,105
Iowa	Des Moines	580,913	
Iowa	Omaha	122,674	$202,802
Kansas	Wichita	633,020	
Kansas	Kansas City	830,559	$396,124
Kentucky	Louisville	967,227	
Kentucky	Cincinnati	429,044	$377,907
Los Angeles	Los Angeles	9,893,481	$3,299,780
Louisiana	Baton Rouge	808,816	
Louisiana	New Orleans	1,209,239	$546,195
Maine	Portland	516,460	$169,600
Maryland	Baltimore	2,734,044	
Maryland	Washington D.C	2,337,912	$1,400,200
Maryland	Philadelphia	101,435	
Massachusetts	Boston	4,183,724	
Massachusetts	Providence	549,870	$1,281,167
Michigan	Detroit	4,295,700	$1,162,649
Minnesota	Fargo	59,638	
Minnesota	Minneapolis	3,265,409	$899,938
Mississippi	Jackson	571,881	
Mississippi	Memphis	248,765	$236,929
Missouri	St. Louis	2,115,415	
Missouri	Kansas City	1,194,738	$895,907
Montana	Billings	160,991	$169,600

Awardee	CRI City	2013 Census Population	FY 2016 Awardee Total
Nebraska	Omaha	753,681	$203,987
Nevada	Las Vegas	1,976,925	$535,063
New Hampshire	Boston	420,554	$283,425
New Hampshire	Manchester	402,017	
New Jersey	New York City	6,508,777	$2,288,058
New Jersey	Philadelphia	1,318,399	
New Jersey	Trenton	368,094	
New Mexico	Albuquerque	893,241	$241,759
New York	Albany	873,238	$1,864,769
New York	Buffalo	1,134,695	
New York	New York City	4,881,925	
New York City	New York City	8,268,999	$3,917,158
North Carolina	Charlotte	1,919,562	$529,244
North Carolina	Virginia Beach	35,862	
North Dakota	Fargo	154,080	$169,600
Ohio	Cincinnati	1,630,426	$1,523,143
Ohio	Cleveland	2,070,965	
Ohio	Columbus	1,926,242	
Oklahoma	Oklahoma City	1,277,830	$345,850
Oregon	Portland	1,816,916	$491,756
Pennsylvania	Philadelphia	4,030,148	$1,744,657
Pennsylvania	Pittsburgh	2,358,746	
Pennsylvania	New York City	57,179	
Rhode Island	Providence	1,051,695	$284,646
South Carolina	Columbia	776,794	$302,741
South Carolina	Charlotte	341,759	
South Dakota	Sioux Falls	233,750	$169,600
Tennessee	Nashville	1,702,603	

Awardee	CRI City	2013 Census Population	FY 2016 Awardee Total
Tennessee	Memphis	1,032,719	$740,326
Texas	Dallas	6,575,833	
Texas	Houston	6,063,540	$4,014,369
Texas	San Antonio	2,192,724	
Utah	Salt Lake City	1,107,434	$299,732
Vermont	Burlington	212,640	$169,600
Virginia	Richmond	1,221,729	$1,523,497
Virginia	Virginia Beach	1,659,298	
Virginia	Washington D.C	2,747,916	
Washington	Seattle	3,504,628	$1,068,625
Washington	Portland	443,675	
Washington D.C	Washington D.C	619,371	$638,667
West Virginia	Charleston	226,180	$184,251
West Virginia	Washington D.C	54,131	
Wisconsin	Chicago	166,874	$501,597
Wisconsin	Milwaukee	1,560,621	
Wisconsin	Minneapolis	125,782	
Wyoming	Cheyenne	93,073	$169,600
Total FY 2016 Cities Readiness Initiative Funding		**175,240,879**	**$53,222,251**

Appendix 4: HPP Budget Period 5 PAHPRA Benchmarks Subject to Withholding

ASPR has identified the following fiscal year 2016 benchmarks for Budget Period 5 to be used as a basis for withholding of fiscal year 2017 funding for HPP awardees. Awardees that fail to "substantially meet" the benchmarks are subject to withholding penalties to be applied the following fiscal year. Awardees that demonstrate achievement of these requirements are not subject to withholding of funds.

HPP PAHPRA1	Awardees must submit timely and complete data for the annual progress report.
HPP PAHPRA2	Awardees must submit healthcare coalition development assessment (HCCDA) factor data with their annual progress reports.
HPP PAHPRA3	Awardees must develop training and exercise plans and submit according to Budget Period 5 continuation guidance requirements. Plans must include a proposed exercise schedule and a discussion of the plans for healthcare coalition exercise development, conduct, evaluation, and improvement planning. Exercise plans must demonstrate: ▪ participation by healthcare coalitions and their participating hospitals ▪ include participating organizations ▪ anticipate capabilities to be tested
HPP PAHPRA4	Awardees must submit work plan activities according to Budget Period 5 continuation guidance requirements. Activities must ensure that coalitions' hospitals are addressing the 11 NIMS implementation activities for hospitals and report on the status of those activities for each hospital in their Budget Period 5 annual progress reports.
HPP PAHPRA5	Awardees must update annual pandemic influenza preparedness plans in accordance with sections 319C-1 and 319C-2 of the PHS Act as amended. Data points reviewed: ▪ The healthcare coalition has tested its ability to address its members' healthcare workforce safety needs through training and resources. ▪ The healthcare coalition has demonstrated the ability to do the following during an incident, exercise or event: 1) Monitor patient acuity and staffed bed availability in real-time and 2) Off-load patients.

Table 1
Criteria to Determine Potential Withholding of HPP Fiscal Year 2017 Funds

	Benchmark Measure	Yes	No	Possible % Withholding
1	Did the awardee (all awardees) meet all application and reporting deadlines?			10%
2	Did the awardee (all awardees) submit healthcare coalition development assessment (HCCDA) factor data as required?			
3	Did the awardee (all awardees) develop training and exercise plans and submit a TEP according to Budget Period 5 continuation guidance requirements?			
4	Did the awardees (all awardees) submit work plan activities according to Budget Period 5 continuation guidance requirements, including NIMS implementation activities for hospitals?			
5	Did the awardee (all awardees) meet the 2016 pandemic influenza plan requirement?			10%
Total Potential Withholding Percentage				20%

Scoring Criteria

The first four benchmarks are weighted the same, so failure to substantially meet any one of the four benchmarks will count as one failure and result in withholding of 10% of the fiscal year 2017 HPP award. Failure to submit the 2016 pandemic influenza preparedness plan as required may result in withholding of 10% of the fiscal year 2017 HPP award.

More information on withholding and repayment is available in the CDC-RFA-TP12-1201 funding opportunity announcement posted at http://www.cdc.gov/phpr/documents/cdc-rfa-tp12-1201_4_17_12_FINAL.pdf.

Appendix 5: PHEP Budget Period 5 PAHPRA Benchmarks Subject to Withholding

CDC has identified the following fiscal year 2016 benchmarks for Budget Period 5 to be used as a basis for withholding of fiscal year 2017 funding for PHEP awardees. Awardees that fail to "substantially meet" the benchmarks are subject to withholding penalties to be applied the following fiscal year. Awardees that demonstrate achievement of these requirements are not subject to withholding of funds.

PHEP PAHPRA1	**Awardees must adhere to all PHEP reporting deadlines.** This benchmark applies to all 62 awardees. Required reports include: ▪ HHS capabilities self-assessments (Capabilities Planning Guide) due in early 2017 ▪ Fiscal year 2017 funding applications due approximately 60 calendar days following initial publication of the continuation guidance. The application includes a Budget Period 5 progress update, program requirements update, work plan, and budget justification ▪ Budget Period 4 annual progress reports (APR), due 90 days after the end of Budget Period 4 (September 30, 2016). Annual progress reports must include updates on work plan activities including local contracts and progress on implementation of technical assistance plans; PAHPRA benchmark data; performance measure data and supporting information; responses to program data questions; training updates; preparedness accomplishments, and program impact statements.
PHEP PAHPRA2	**Awardees must demonstrate capability to receive, stage, store, distribute, and dispense material during a public health emergency.** This benchmark applies to all 62 awardees. ▪ As part of their response to public health emergencies, public health departments must be able to provide countermeasures to 100% of their identified population within 48 hours of the federal decision to do so. PHEP awardees must ensure that each local planning jurisdiction within their CRI metropolitan statistical areas, including the four directly funded localities, conduct three different drills. Drills should be part of the progressive approach outlined in the Homeland Security Exercise and Evaluation Program (HSEEP); results of the drills will be reviewed during site visits. ▪ Maintain and provide to CDC current receipt, stage, and store (RSS) information for all potential RSS facilities in their jurisdictions using the RSS site survey form. Site surveys must be conducted at least once every three years to ensure they reflect current operational capabilities.
PHEP PAHPRA3	**Awardees must demonstrate that Laboratory Response Network laboratories biological (LRN-B) can pass proficiency testing which includes the ability to receive, test, and report on one or more suspected biological agents.** This benchmark applies to each of the 50 state public health laboratories plus the LRN-B laboratories in Los Angeles County, New York City, and Washington, D.C. Successful demonstration of this capability is defined by the LRN-B proficiency testing policy. ▪ CDC will use the following elements to determine if the awardee met this benchmark: o Number of LRN-B proficiency tests successfully passed by the PHEP-funded laboratory (during any attempt, including remediation if applicable) o Number of LRN-B proficiency tests participated in by the PHEP-funded laboratory (includes remediation, if applicable) ▪ PHEP-funded laboratory cannot fail more than one proficiency testing challenge.

	CDC's LRN-B program office requires state public health laboratories to participate in all available proficiency testing challenges specific to each laboratory's testing capability; if a laboratory has testing capability for a specific agent and a proficiency testing challenge for that agent is being offered, the PHEP-funded laboratory must participate in that proficiency testing challenge. PHEP-funded laboratories that are offline long-term, undergoing renovation, or have other special circumstances are not expected to have their proficiency testing challenges completed by partner or back-up labs (such as municipal labs or labs in neighboring states). Instead, those laboratories are expected to report to the LRN-B program office what they would do in real situations had the proficiency testing challenge been associated with a true emergency event. In such a circumstance, this will not adversely affect an awardee in terms of determining whether this benchmark has been met. Although laboratories are required to participate in all available proficiency testing challenges (based on the individual lab's testing capability), the determination for meeting this benchmark will be based exclusively on participation in, and successfully passing, proficiency tests as described in the Checklist of Laboratory Requirements for LRN-B Member Standard Level Reference Laboratories: Section I. Minimum Laboratory Testing Capabilities elements 1 and 2 (an updated version of this document is located in the PERFORMS Resource Library). Additional information is available by contacting the LRN-B Technical Program Office at LRN@cdc.gov
PHEP PAHPRA4	**Awardees must ensure that at least one LRN chemical (LRN-C) laboratory in their jurisdictions passes the LRN-C specimen packaging, and shipping (SPaS) exercise.** This benchmark applies to the 50 states; the directly funded localities of Los Angeles County, New York City, and Washington, D.C. This annual exercise evaluates the ability of a laboratory to collect relevant samples for clinical chemical analysis and ship those samples in compliance with International Air Transport Association regulations. Awardees must ensure at least one LRN-C laboratory passes CDC's SPaS exercise. If a laboratory fails the exercise on its first attempt but passes on the second attempt, then the awardee will meet the benchmark. If a PHEP awardee has multiple laboratories, at least one laboratory must participate and pass. To pass, a laboratory must score at least 90% on the exercise.
PHEP PAHPRA5	**Awardees must ensure that LRN-C laboratories pass proficiency testing in core and additional analysis methods.** This benchmark applies to the 10 awardees with Level 1 laboratories (California, Florida, Massachusetts, Michigan, Minnesota, New Mexico, New York, South Carolina, Virginia, and Wisconsin). Although this benchmark does not apply to awardees with Level 2 laboratories during Budget Period 5, awardees with Level 2 laboratories must report on LRN-C proficiency testing performance measures as specified in PHEP performance measure and specifications guidance. The LRN-C conducts proficiency testing for all Level 1 and Level 2 chemical laboratories to support meeting the regulatory requirements for the reporting of patient results as part of an emergency response program. Each high complexity test is proficiency tested three times per budget period and each laboratory is evaluated on the ability to report accurate and timely results through secure electronic reporting mechanisms. CDC has identified nine core methods and four additional methods for detecting and measuring these agents and conducts testing to determine a laboratory's proficiency in these

	methods. The core methods are 1) arsenic in urine by DRC ICP-MS; 2) cadmium/lead/mercury in blood by ICP-MS; 3) cyanide in blood by headspace GC-MS; 4) volatile organic chemicals (VOCs) in blood by SPME GC-MS; 5) nerve agent metabolites (OPNAs) in urine by LC-MS/MS; 6) nerve agent metabolites (OPNAs) in serum by LC-MS/MS; 7) tetramine in urine by GC-MS; 8) toxic elements (barium, beryllium, cadmium, lead, uranium, and thallium) in urine by ICP-MS; and 9) plant toxins in urine by LC-MS/MS. Additional methods are 1) sulfur mustard metabolite in urine by LC-MS/MS; 2) Lewisite metabolite in urine by LC-ICP-MS; 3) nitrogen mustard metabolites in urine by LC-MS/MS; and 4) tetranitromethane biomarker in urine by LC-MS/MS
PHEP PAHPRA6	Update and maintain Epi-X membership for jurisdictional PHEP directors, epidemiology leads, and laboratory directors and provide the CDC PHEP program office with current contact information for individuals in each role.
PHEP PAHPRA7	Awardees must update annual pandemic influenza preparedness plans in accordance with Section 319C-1 of the PHS Act as amended. Updates should reflect corrective actions plans and improvements taken to address operational readiness gaps identified in the CDC pandemic influenza readiness assessment (PIRA) completed in 2015. Awardees must submit the status updates within 90 days of receiving their PIRA summary reports outlining operational gaps. In addition, awardees must submit any follow-up data needed to better inform the PIRA baseline data.

Table 2
Criteria to Determine Potential Withholding of PHEP Fiscal Year 2017 Funds

	Benchmark Measure	Yes	No	Possible % Withholding
1	Did the awardee (all awardees) meet all application and reporting deadlines?			
2	Did the awardee (all awardees) demonstrate capability to receive, stage, store, distribute, and dispense material during a public health emergency?			
3	Did the applicable awardee demonstrate proficiency in public health laboratory testing and/or exercises for biological agents?			10%
4	Did the applicable awardee meet packaging and shipping requirements for chemical specimens?			
5	Did the applicable awardee demonstrate proficiency in public health laboratory testing and/or exercises for chemical agents?			
6	Did the awardee (all awardees) update and maintain Epi-X membership for appropriate jurisdictional partners?			
7	Did the awardee (all awardees) meet the 2016 pandemic influenza plan requirement?			10%
Total Potential Withholding Percentage				20%

Scoring Criteria

The first six benchmarks are weighted the same, so failure to substantially meet any one of the six benchmarks will count as one failure and result in withholding of 10% of the fiscal year 2017 PHEP award. Failure to submit the 2016 pandemic influenza preparedness plan as required may result in withholding of 10% of the fiscal year 2017 PHEP award.

More information on withholding and repayment is available in the CDC-RFA-TP12-1201 funding opportunity announcement posted at http://www.cdc.gov/phpr/documents/cdc-rfa-tp12-1201_4_17_12_FINAL.pdf.